Novant Health Cabarrus Medical Center
Novant Health, Inc.

New Acute Care Hospital
Cabarrus County

Certificate of Need Application

Submitted February 13, 2025 for
March 1, 2025 Review

Department of Health and Human Services
Division of Health Service Regulation
Healthcare Planning and Certificate of Need Section

Certificate of Need Application Fee Sheet

Project ID # **Internal Use Only**	
Date Received **Internal Use Only**	

There are rows for up to three applicants. If there are more than three applicants, add another row.

Applicant 1 *	Novant Health Cabarrus Medical Center, LLC
Applicant 2 *	Novant Health, Inc.
Applicant 3 *	

*This should match the name provided in Section A, Question 1.

Total Projected Capital Expenditure *	**$336,434,895**

*This should match Form F.1a Capital Cost or Form F.1b Capital Cost for Cost Overrun or Change of Scope.

1. If the Total Projected Capital Expenditure is **less than or equal to $1,000,000**, the application fee is **$5,000**.

2. If the Projected Capital Expenditure is **more than $1,000,000**, the application fee is calculated as follows:

a	Total Projected Capital Expenditure *	$336,434,895
b	Subtract $1,000,000	$1,000,000
c	Subtotal	$335,434,895
d	Multiply the Subtotal by $0.003 and **round to the nearest whole dollar**	$1,006,305
e	Add $5,000	$5,000
f	Total Fee Due **	**$50,000**

*This should match Form F.1a Capital Cost or Form F.1b Capital Cost for Cost Overrun or Change of Scope.

** Pursuant to G.S. 131E-182(c), the maximum certificate of need application fee is **$50,000**.

Make checks payable to:

Healthcare Planning and Certificate of Need Section, DHSR, DHHS

CERTIFICATE OF NEED APPLICATION

(Do **Not** Use for Dialysis Services)

Internal Use Only
Stamp Date Agency Received Application Here

Project ID #: _____
(Internal Use Only)

FID #: _____
(Internal Use Only)

TABLE OF CONTENTS

CERTIFICATION PAGE

(Include this Certification Page as part of your application)

There are tables for up to three applicants. If there are more than three applicants, copy the first table, insert it below the third table, and change the 1s to 4s. Repeat this process if there are more than four applicants.

The undersigned hereby certifies that the information included in this application form is correct to the best of my knowledge and belief and that the applicant intends to develop and offer the proposed new institutional health service(s) within the timeframe proposed in Section P and as described in the application.	
Legal Name of **Applicant 1** *	Novant Health Cabarrus Medical Center, LLC
Name of the Person Certifying for Applicant 1 (print/type name)	Saad Ehtisham
Title	SVP & President – Novant Health Presbyterian & Greater Charlotte Market
Signature **	DocuSigned by: Saad Ehtisham D932BDE53121431...
Date Signed	02/06/2025 | 2:52:58 PM

* This should match the name provided in Section A, Question 1.

** Inserting a picture of your signature is acceptable.

The undersigned hereby certifies that the information included in this application form is correct to the best of my knowledge and belief and that the applicant intends to develop and offer the proposed new institutional health service(s) within the timeframe proposed in Section P and as described in the application.	
Legal Name of **Applicant 2** *	Novant Health, Inc.
Name of the Person Certifying for Applicant 2 (print/type name)	Andrea Gymer
Title	Vice President, Strategic and Business Planning
Signature **	DocuSigned by: Andrea Gymer 15FFC84DBF354FC...
Date Signed	02/06/2025 | 1:57:48 PM

* This should match the name provided in Section A, Question 1.

** Inserting a picture of your signature is acceptable.

The undersigned hereby certifies that the information included in this application form is correct to the best of my knowledge and belief and that the applicant intends to develop and offer the proposed new institutional health service(s) within the timeframe proposed in Section P and as described in the application.	
Legal Name of **Applicant 3** *	
Name of the Person Certifying for Applicant 3 (print/type name)	
Title	
Signature **	
Date Signed	

* This should match the name provided in Section A, Question 1.

** Inserting a picture of your signature is acceptable.

PETITION FOR EXPEDITED REVIEW

(Include this Petition for Expedited Review as part of your application even if left blank)

Pursuant to G.S. 131E-185 and G.S. 131E-176(7b), the applicant(s) hereby petition that the review of the project identified below be expedited.

Date	
Legal Name of **Applicant 1** *	
Legal Name of **Applicant 2** *	
Legal Name of **Applicant 3** *	
Name of Health Service Facility **	
Project Description ^	
County	
Total Projected Capital Expenditure ^^	
Name of Person Signing (print/type name)	
Title	
Company	
Signature	

* This should match the response provided in Section A, Question 1.
** This should match the response provided in Section A, Question 4.a.
^ This should match the response in Section A, Question 5.a.
^^ This should match the responses in Section A, Question 3, and Form F.1a or Form F.1b.

In accordance with G.S. 131 E-176(7b), a request for an expedited review cannot be granted unless the Agency finds that all the following conditions are met:

a. The review is not competitive;
b. The proposed capital expenditure is less than five million dollars ($5,000,000);
c. The CON Section has not determined that a public hearing is in the public interest; and
d. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.

Internal Use Only (Assistant Chief or Team Leader)

Date: _____ Project ID #: _____ FID #: _____

a. The review is **not** competitive? Yes No

b. The total projected capital cost is **less than** $5,000,000? Yes No

c. The CON Section has **not** determined that a public hearing is in the public interest? Yes No

If **ALL** the answers above are **YES**, the petition is approved assuming no request for a public hearing is received during the written comment period.

Initials _____

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THE APPLICATION

(Include these Instruction pages as part of your application)

Contact the CON Section at (919) 855-3873 if you have questions about this application form and ask for the project analyst assigned to the county where the proposal would be located. Project analyst county assignments are available online at: https://info.ncdhhs.gov/dhsr/coneed/pdf/CountyAssignments.pdf.

APPLICATION

1. Pursuant to 10A NCAC 14C .0203(e)(4), each applicant identified in Section A, Question 1, must sign the Certification Page.
2. The burden is on the applicant to demonstrate that its proposal is consistent with or not in conflict with all applicable statutory review criteria and CON rules. Each statutory review criterion is addressed in a separate section of the application form and the language of the statutory review criterion is provided at the beginning of the section. The questions that follow are designed to assist the applicant in providing the information that the CON Section needs in order to determine if the applicant has met its burden.
3. Answer every question. If you believe that a question is not applicable to your project, explain why you believe the question is not applicable. Failure to answer a question is not a basis for finding the application nonconforming if the necessary information is provided elsewhere in your application or exhibits but it is preferred that the information appear where it is requested.
4. Answer as many questions on a single page as space permits, but the first question of each section should begin on a new page.
5. Insert a tabbed divider between each section.
6. Do **not** change headers, footers, margins, font, font size, or page orientation in the Word document (Sections A - P) or the Excel spreadsheets in Section Q.
7. Do **not** bold entire questions. Do **not** bold entire responses. Applicants may use underlining or bold for emphasis in narrative responses.
8. There are page breaks in the blank Word document and Excel spreadsheets. The applicant may change the page breaks as necessary and is strongly encouraged to reset the page breaks and insert new ones so material that should be on the same page remains on the same page whenever possible (particularly tables).
9. Complete the tables in the Word document (Sections A - P) where they appear in the application form. Do **not** place them in an exhibit. Do not modify the tables except for: adding rows; deleting rows; adding dates or a facility name to a header; or making other edits specifically addressed in the instructions for the table.

EXHIBITS

1. Exhibits
   a. Paper versions– the exhibits should be bound together **separately** from the application form.
   b. Electronic versions – the exhibits should be saved as a **separate** pdf from the pdf of the application.
2. Provide a table of contents for the exhibits. If more than one volume of exhibits is submitted, place a complete table of contents at the beginning of each volume.
3. Insert a tabbed divider in front of each exhibit.
4. Do not submit originals of folded, stapled, or bound annual reports, brochures, or pamphlets as exhibits. Instead, such materials should be photocopied on 8.5” x 11” paper. Oversized line drawings, surveys and maps may be inserted in plastic sleeves bound in the application. All other oversized or undersized exhibits should be photocopied on 8.5” x 11” paper.

5. If you include more than one document in an exhibit, number the pages in the exhibit (the numbers may be handwritten) and reference both the letter and the page number of the exhibit when citing to the document in the application.

SUBMITTING THE APPLICATION

1. Pursuant to 10A NCAC 14C .0203(e), each volume of the application **must be bound together by punching holes in the left-hand margin and fastening the pages together with a metal paper fastener** (e.g., ACCO ® Paper Fasteners). Place a sturdy cover on the front and back to protect the first and last pages from damage. **Do not submit the application in a 3-ring binder or notebook.**

2. Pursuant to 10A NCAC 14C .0203(e), the applicant is required to submit a signed original and a copy of the application. The original application, including exhibits, must be printed, placed between a front and back cover, bound with metal fasteners, and submitted as a "hard copy." The applicant may submit the **copy** of the application on a flash drive in lieu of a second paper copy. If the applicant chooses to submit the copy on a flash drive, the application and exhibits must be converted to PDF, saved on one flash drive, and shall not be encrypted or password protected. No more than one application, including exhibits, should be saved onto the same flash drive.

3. Submit the signed original and one copy of the completed application with the application fee to:

Via US Postal Service:	**Healthcare Planning and Certificate of Need Section, DHSR, DHHS** **2704 Mail Service Center** **Raleigh NC 27699-2704**
	OR
Via Hand Delivery or Overnight [1]	**Healthcare Planning and Certificate of Need Section, DHSR, DHHS** **809 Ruggles Drive** **Raleigh, NC 27603**

4. Pursuant to 10A NCAC 14C .0203(e), both the signed original, the copy of the completed application, **and the entire application fee must be received** by the CON Section by the application deadline which is **5:00 PM** on the **15th of the month prior to the beginning of the review period**, unless the 15th is on a weekend or holiday, then the application deadline is no later than **5:00 PM** on the next business day.

5. If you are requesting an **expedited review** pursuant to G.S. 131E-185(a2) and G.S. 131E-176(7b), complete the **Petition for Expedited Review** on page 3 of this application form.

6. Pursuant to 10A NCAC 14C .0203(j), an application will **not** be included in a scheduled review **unless it is received by the CON Section no later than 5:00 PM on the application deadline** shown in the SMFP for the review period.

7. **Once the application is received** by the CON Section, pursuant to 10A NCAC 14C .0204 **it may not be amended**. Any additional information submitted to the CON Section related to the application after the application deadline that was **not** requested by the CON Section, may have the effect of amending the application. Therefore, do not state in the application that documents will be submitted later (e.g., letters of support, transfer or referral agreements, letters from health care providers agreeing to provide services, service contracts, letters from financial institutions or others regarding funding for the project, and options on property).

8. **All information submitted in an application** received by the CON Section is **public** information and is **subject to disclosure** upon written request and availability.

[1] The US Postal Service will not deliver overnight packages to 809 Ruggles Drive. Instead, the US Postal Service delivers all mail, including overnight packages, to the Mail Service Center, which may or may not deliver the package to 809 Ruggles Drive the day after the applicant put it in the mail.

DEFINITIONS FOR TERMS USED IN THE APPLICATION FORM

(Include these Definitions pages as part of your application)

If any definition in this section is not consistent with the definition of the same term found in the CON Law or Rules, the definition in the CON Law or Rules controls.

Adult care home (ACH): The term "ACH," which is defined in G.S. 131E-176(1), means "*A facility with seven or more beds licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes or under this Chapter that provides residential care for aged individuals or individuals with disabilities whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.*"

Adults: The term "adults" means individuals age 18 or older.

Ambulatory surgical facility (ASF): The term "ASF," which is defined in G.S. 131E-176(1b), means *"A facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional, or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room or gastrointestinal endoscopy room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under Part 4 of Article 6 of this Chapter, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility."*

Applicant: For the purposes of completing this application form, the term "applicant" means each person, as that term is defined in G.S. 131E-176(19), who will:

- Incur an obligation for a capital expenditure to develop or offer the proposed new institutional health service(s); or
- Offer or develop the proposed new institutional health service(s).

Application deadline: The term "application deadline," which is defined in 10A NCAC 14C .0202(2), means *"no later than 5:00 p.m. on the 15th day of the month preceding the month that the review period begins. If the 15th day of the month falls on a weekend or a State holiday as set forth in 25 NCAC 01E .0901, which is hereby incorporated by reference including subsequent amendments and editions, the application deadline is the next business day."*

Application: The term "application" means the application form as submitted, including any exhibits.

Application form: The term "application form" means the Microsoft Word document (Table of Contents, Certification Page, Petition for Expedited Review, Instructions, Definitions, and Sections A - P), and the Microsoft Excel file (Section Q).

Bed capacity: The term "bed capacity," which is defined in G.S. 131E-176(2), means *"Space used exclusively for inpatient care, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage."*

Campus: The term "campus," which is defined in G.S. 131E-176(2c), means *"The adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health service facility and related health care entities."*

Capital cost: The term "capital cost" has the same meaning as the term "capital expenditure" which is defined in G.S. 131E-176(2d) as *"An expenditure for a project, including but not limited to the cost of construction, engineering, and equipment which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase."*

Change in bed capacity: The term "change in bed capacity," which is defined in G.S. 131E-176(5), means *"Any of the following:*

a. *Any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another.*
b. *Any redistribution of health service facility bed capacity among the categories of health service facility bed.*
c. *Any increase in the number of health service facility beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units."*

Change of scope: For the purpose of completing this application form, the term "change of scope" means adding a new service component or changing a service component in a way that is not materially consistent with the representations made in the previously approved application (original project) if the change is proposed during development of the original project or within 12 months after the original project was determined to be complete by the CON Section. It also means a change of location which is not materially consistent with the representations made in the original project if proposed during development of the original project. **Please contact the CON Section if you have any question about whether the proposal is a change of scope of a previously approved application.**

Children/Adolescents: The term "children/adolescents" means individuals from birth through age 17.

Combination nursing facility: The term "combination nursing facility," defined in G.S. 131E-101(1a) as a "combination home," means *"a nursing home offering one or more levels of care, including any combination of skilled nursing, intermediate care, and adult care home."*

CMS: The term "CMS" means the Centers for Medicare and Medicaid Services, part of the U.S. Department of Health and Human Services.

CON rules: The term "CON rules" refers to the rules promulgated in 10A NCAC 14C (Subchapter 14C).

CON Section: The term "CON Section," which is defined in 10A NCAC 14C .0202(4)," means *"the Healthcare Planning and Certificate of Need Section of the Division of Health Service Regulation."*

Continuing care retirement community (CCRC): The term "CCRC" means a retirement community or communities in which a provider undertakes to provide continuing care to an individual. The term "continuing care" is defined in G.S. 58-64-1(1) to mean "*The furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under a contract approved by the Department* [of Insurance] *in accordance with … Article* [64 of Chapter 58 of the NC General Statutes] *effective for the life of the individual or for a period longer than one year."*

Cost overrun: For the purpose of completing this application form, the term "cost overrun" means an increase of more than 115% of the approved capital expenditure for a project for which a certificate of need was issued (original project) if the increase is proposed during development of the original project or within 12 months after the original project was determined to be complete by the CON Section.

Diagnostic center: The term "diagnostic center," which is defined in G.S. 131E-176(7a), means *"A freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds three million dollars ($3,000,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than three million dollars ($3,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1."*

Entire facility: For the purpose of completing this application form, the term "entire facility" means all service components offered by a health service facility or all service components offered on all campuses on the same hospital license.

Some questions ask for information regarding either the **entire facility** or **campus**. Most applicants should provide a response for the entire facility. Depending on the nature of the project, **facilities with more than one campus on the same license** may provide a response for the campus identified in Section A, Question 4, not the entire facility unless a policy in the SMFP or a CON rule requires a response for the entire facility.

Facility: For the purpose of completing this application form, the term "facility" means a health service facility.

Facility identification number (FID#): The term "FID#" means the unique 6-digit number assigned to each health service facility in the Division of Health Service Regulation's databases.

Full fiscal year (FY): The term "full FY," which is defined in 10A NCAC 14C .0202(5), means *"the 12-month period used by the applicant to track and report revenues and operating expenses for the services proposed in the application."* For the purpose of completing this application form, the term also means the 12-month period used by the applicant to track and report numbers of patients, cases, procedures, or treatments. Examples of typical full FYs are:

- January 1st to December 31st;
- July 1st to June 30th; or
- October 1st to September 30th.

Gastrointestinal endoscopy room (GI endo room): The term "GI endo room," which is defined in G.S. 131E-176(7d), means *"A room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes."*

Health service: The term "health service," which is defined in G.S. 131E-176(9a), means *"An organized, interrelated activity that is medical, diagnostic, therapeutic, rehabilitative, or a combination thereof and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. 'Health service' does not include administrative and other activities that are not integral to clinical management."*

For the purposes of completing this application form, the term health service includes but is not limited to the following services: hospital;[2] adult care home; bone marrow transplantation; burn intensive care; cardiac catheterization; GI endoscopy; home health; hospice home care; hospice inpatient; hospice residential; inpatient rehabilitation; intermediate care for persons with intellectual disabilities; long-term care hospital; medical equipment; neonatal intensive care; nursing home facility; open heart; solid organ transplantation; and surgical (ORs).

[2] See the definition of the term "hospital services."

Health service facility: For the purpose of completing this application form, the term "health service facility," which is defined in G.S. 131E-176(9b), means *"A hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; … intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility."*

Health service facility bed: The term "health service facility bed," which is defined in G.S. 131E-176(9c), means *"A bed licensed for use in a health service facility in the categories of (i) acute care beds; (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for individuals with intellectual disabilities; (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; (ix) adult care home beds; and (x) long-term care hospital beds."*

Health system: For the purpose of completing this application form, the term "health system" has the same meaning as that term is defined in Chapter 6 in the State Medical Facilities Plan (SMFP) in effect at the time the review begins. The SMFP can be obtained at no cost on the Division's website at: https://info.ncdhhs.gov/dhsr/ncsmfp/index.html.

Home health agency: The term "home health agency," which is defined in G.S. 131E-176(12), means *"A private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services."*

Home Health Definitions

Duplicated clients: For home health agency proposals, the term "duplicated clients" means the total number of home health clients served or projected to be served during a given fiscal year by each staff discipline. If the client is seen by more than one discipline, the related client visits should be counted under each staff discipline.

Unduplicated clients: For home health agency proposals, the term "unduplicated clients" means the total number of home health clients served or projected to be served during a given fiscal year. Each home health client should be counted only once regardless of the number of times the clients are admitted during the given fiscal year.

Staff discipline: For home health agency proposals, the term "staff discipline" means nursing (RN or LPN), physical therapy, occupational therapy, speech therapy, medical social worker, or home health aide.

Visits: For home health agency proposals, the term "visits" means direct care visits provided to the client by home health staff members or by others under contract with the home health agency for which the home health agency bills the client.

Hospice: The term "hospice," which is defined in G.S. 131E-176(13a), means *"Any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement."*

Hospice Home Care Definitions

Days of care: For hospice home care proposals, the term "days of care" means the number of days hospice services were provided by a hospice office during a given fiscal year. Count or include all days for each episode for patients with multiple episodes of care during the same fiscal year.

New (unduplicated) admissions: For hospice home care proposals, the term "new (unduplicated) admissions" means patients admitted or projected to be admitted to the facility for the first-time during a given fiscal year. Patients admitted or projected to be admitted multiple times within the same fiscal year should only be included or counted once. Patients carried over from the previous fiscal year should not be included or counted.

Patients served: For hospice home care proposals, the term "patients served" includes patients carried over from the previous fiscal year and new (unduplicated) admissions during a given fiscal year. However, patients admitted more than once during the same fiscal year should be counted or included only once.

Hospice inpatient facility: The term "hospice inpatient facility," which is defined in G.S. 131E-176(13b), means *"A freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in an inpatient setting."*

Hospice residential care facility: The term "hospice residential care facility," which is defined in G.S. 131E-176(13c), means *"A freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting."*

Hospital: The term "hospital," which is defined in G.S. 131E-176(13), means *"A public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term includes all facilities licensed pursuant to G.S. 131E-77, except long-term care hospitals."*

For the purpose of completing this application form, the term refers to acute care hospitals.

Hospital services: For the purpose of completing this application form, the term "hospital services" refers to services provided by acute care hospitals, long-term care hospitals, and inpatient rehabilitation hospitals. It includes but is not limited to the following services: nursing (general med/surg, intensive care, neonatal, pediatric, obstetric, etc.); emergency; laboratory; radiology (imaging and interventional); pharmacy; physical, occupational and speech therapies; cardiopulmonary therapy; GI endoscopy; and surgical (ORs).

Immediate jeopardy: The term "immediate jeopardy," which is defined in 42 CFR Part 489.3, means *"a situation in which the provider's … non-compliance with one or more requirements, conditions of participation, conditions for coverage, or conditions for certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient."*

Initial operating costs: For the purpose of completing this application form, the term "initial operating costs" means the difference between:

1. total cash outflow (operating costs) during the initial operating period for the entire facility; and
2. total cash inflow (revenues) during the initial operating period for the entire facility.

Initial operating period: For the purpose of completing this application form, the term "initial operating period" means the number of months, if any, during which cash outflow (operating costs) for the entire facility exceeds cash inflow (revenues) for the entire facility.

Intermediate care facility for individuals with intellectual disabilities (ICF/IID): The term "ICF/IID," which is defined in G.S. 131E-176(14a), means *"Facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions."*

Inpatient rehabilitation bed: The term "inpatient rehabilitation bed" means a bed licensed as an inpatient rehabilitation bed and included in the inventory of inpatient rehabilitation beds in the SMFP.

Local management entity/Managed care organization (LME/MCO): The term "LME/MCO," which is defined in G.S. 122C-3(20c), means *"a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act or to operate a capitated PHP contract under Article 4 of Chapter 108D of the General Statutes."*

Long-term care hospital (LTCH): The term "LTCH," which is defined in G.S. 131E-176(14k), means *"A hospital that has been classified and designated as a long-term care hospital by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 412."*

Main campus: For the purpose of completing this application form, the term "main campus" means the campus of a facility with more than one campus on the same license where the facility provides clinical patient services and exercises financial and administrative control over the entire facility. **The term as used in this application form is similar to but not identical to the same term as defined in G.S. 131E-176(14n)**.

Major medical equipment: The term "major medical equipment," which is defined in G.S. 131E-176(14o), means *"A single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than two million dollars ($2,000,000)… Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1."* The term as used in this application form does NOT include: cardiac catheterization equipment; gamma knives; heart-lung bypass machines; linear accelerators; lithotriptors; MRI scanners; PET scanners; or simulators.

Medical equipment: For the purpose of completing this application form, the term "medical equipment" means equipment used to diagnose and treat patients, including the following:

- Cardiac catheterization equipment, gamma knives, heart-lung bypass machines, linear accelerators, lithotriptors, MRI scanners, PET scanners, or simulators;
- Major medical equipment as that term is defined in G.S. 131E-176(14o); and
- For diagnostic center proposals, any unit of diagnostic medical equipment costing $10,000 or more.

Medically indigent: For the purpose of completing this application form, the term "medically indigent" means patients with no health insurance; inadequate health insurance; or low-income patients with health insurance plans with high deductibles, co-pays or coinsurance provisions.

Medically underserved: For the purpose of completing this application form, the term "medically underserved" means the types of patients described in G.S. 131E-183(a)(13), including medically indigent or low-income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and persons with disabilities.

Multispecialty ambulatory surgical program: The term "multispecialty ambulatory surgical program," which is defined in G.S. 131E-176(15a), means *"A formal program for providing on a same-day basis surgical procedures for at least three of the following specialty areas: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, orthopedic, or oral surgery."*

New institutional health service: The term "new institutional health service," which is defined in G.S. 131E-176(16), means *"Any of the following:*

a. The construction, development, or other establishment of a new health service facility.

*b. (**Effective until November 21, 2025**) Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding four million dollars ($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds four million dollars ($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.b. (**Effective November 21, 2025**) Except with respect to qualified ambulatory surgical facilities and*

except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding four million dollars ($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds four million dollars ($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

c. *Any change in bed capacity.*
d. *The offering of … home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.*
e. *A change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed. For purposes of this subdivision, a change in a project is a change of more than fifteen percent (15%) of the approved capital expenditure amount or the addition of a health service that is to be located in the facility, or portion thereof, that was constructed or developed in the project.*
f. *The development or offering of a health service as listed in this subdivision by or on behalf of any person:*
    1. *Bone marrow transplantation services.*
    2. *Burn intensive care services.*
    2a. *Cardiac catheterization services, except cardiac catheterization services provided on equipment furnished by a person authorized to operate the equipment in North Carolina pursuant to either a certificate of need issued for mobile cardiac catheterization equipment or a settlement agreement executed by the Department for provision of cardiac catheterization services.*
    3. *Neonatal intensive care services.*
    4. *Open-heart surgery services.*
    5. *Solid organ transplantation services.*
f1. *The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any person:*
    1. *Air ambulance.*[3]
    2. *Repealed.*
    3. *Cardiac catheterization equipment.*
    4. *Gamma knife.*
    5. *Heart-lung bypass machine.*
    5a. *Linear accelerator.*
    6. *Lithotriptor.*
    7. ***(Effective until November 21, 2026)** Magnetic resonance imaging scanner.*
    7. ***(Effective November 21, 2026)** Magnetic resonance imaging scanner. This sub-sub-subdivision applies only to counties with a population of 125,000 or less according to the federal 2020 decennial census or any subsequent federal decennial census.*
    8. *Positron emission tomography scanner.*
    9. *Simulator.*

g.to k. *Repealed.*

[3]Pursuant to an Order of Permanent Injunction issued by the United States District Court for the Eastern District of North Carolina Western Division on October 15, 2008, the North Carolina Department of Health and Human Services is prohibited from requiring that any person obtain a certificate of need before acquiring an air ambulance.

l. *The purchase, lease, or acquisition of any health service facility, or portion thereof, or a controlling interest in the health service facility or portion thereof, if the health service facility was developed under a certificate of need issued pursuant to G.S. 131E-180* [Health Maintenance Organizations].
m. *Any conversion of nonhealth service facility beds to health service facility beds.*
n. *The construction, development or other establishment of a hospice, hospice inpatient facility, or hospice residential care facility.*
o. *The opening of an additional office by an existing home health agency **or** hospice within its service area as defined by rules adopted by the Department; or the opening of any office by an existing home health agency or hospice outside its service area as defined by rules adopted by the Department.*
p. *The acquisition by purchase, donation, lease, transfer, or comparable arrangement by any person of major medical equipment.*
q. *The relocation of a health service facility from one service area to another.*
r. *The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.*
s. *The furnishing of mobile medical equipment to any person to provide health services in North Carolina, which was not in use in North Carolina prior to the adoption of this provision, if the equipment would otherwise be subject to review in accordance with sub-subdivision f1. of this subdivision or sub-subdivision p. of this subdivision if it had been acquired in North Carolina.*
t. *Repealed.*
u. *The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.*
v. *The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005."*

Nursing Home Facility (NF): The term "NF," which is defined in G.S. 131E-176(17b), means "*A health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds."*

Operating room (OR): The term "OR," which is defined in G.S. 131E-176(18c), means "*A room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room."*

OR Need Methodology: For the purpose of completing this application form, the term "OR Need Methodology" means the methodology for projecting OR need as described in Chapter 6 in the SMFP in effect on the date the review begins. The SMFP can be obtained at no cost on the Division's website at: https://info.ncdhhs.gov/dhsr/ncsmfp/index.html.

Person: The term "person," which is defined in G.S. 131E-176(19), means *"An individual; a trust or estate; a partnership; a corporation, including associations, joint stock companies, and insurance companies; the State; or a political subdivision or agency or instrumentality of the State."*

Proposal: For the purposes of completing this application form, the term "proposal," which is defined in 10A NCAC 14C .0202(9), means the new institutional health service(s) proposed in this application form.

Rehabilitation facility: The term "rehabilitation facility," which is defined in G.S. 131E-176(22), means *"A public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of individuals with disabilities through an integrated program of medical and other services which are provided under competent, professional supervision."* In this application form, this type of facility is referred to as an inpatient rehabilitation hospital.

Related entity: The term "related entity," which is defined in 10A NCAC 14C .0202(10), means *"a person that:*

(a) shares the same parent corporation or holding company with the applicant;
(b) is a subsidiary of the same parent corporation or holding company as the applicant; or
(c) participates with the applicant in a joint venture that provides the same type of health services proposed in the application."

Satellite campus: For the purpose of completing this application form, the term "satellite campus" means any campus on the license of a health service facility with more than one campus on the same license other than the main campus.

Service area: The term "service area," which is defined in G.S.131E-176(24a), means *"The area of the State, as defined in the State Medical Facilities Plan* [SMFP] *or in rules adopted by the Department, which receives services from a health service facility."* If neither the SMFP nor the CON Rules define the service area, the service area is the same as the projected patient origin reported in Section C, Question 3.

Service component: For the purpose of completing this application form, the term "service component" means each type of the following included in the proposal:

- Health service facility bed;
- Health service;
- Hospital service; or
- Medical equipment.

Special care unit (SCU): The term "SCU" means either:

a. ACH *"a wing or hallway within an adult care home, or a program provided by an adult care home, that is designated especially for residents with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease or condition as determined by the Medical Care Commission."* [G.S.131D-4.6(a)] or

b. NF *"a wing or hallway within a nursing home, or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities."* [G.S. 131E-114(e)]

Specialty ambulatory surgical program: The term "specialty ambulatory surgical program," which is defined in G.S. 131E-176(24f), means *"A formal program for providing on a same-day basis surgical procedures for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center and* [or] *authorized by its certificate of need."*

Start-up costs: For the purpose of completing this application form, the term "start-up costs" means costs that are:

- not capital costs based on generally accepted accounting principles;
- necessary in order to offer the proposed new institutional health service; and
- incurred prior to offering the proposed new institutional health service.

State Medical Facilities Plan (SMFP): For the purpose of completing this application form, the term "SMFP," which is defined in G.S. 131E-176(25), means the annual SMFP signed by the Governor that is in effect as of the application deadline. The SMFP can be obtained at no cost on the Division's website at: https://info.ncdhhs.gov/dhsr/ncsmfp/index.html.

Substandard quality of care: For the purpose of completing this application form, the term "substandard quality of care" refers to Level 4 (immediate jeopardy) CMS survey deficiencies in a **nursing home facility** if the requirement that is not met falls under:

- 42 CFR 483.13 Resident Behavior and Facility Practices;
- 42 CFR 483.15 Quality of Life; or
- 42 CFR 483.25 Quality of Care.

Severity		Scope		
		Isolated	**Pattern**	**Widespread**
Level 4	Immediate jeopardy to resident health or safety	J	K	L
Level 3	Actual harm that is not immediate jeopardy	G	H	I
Level 2	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F
Level 1	No actual harm with potential for minimal harm	A	B	C

Section A - Identification

1. **Applicant(s):** There are tables for up to three applicants. See the definitions for who should be identified as an applicant. If there are more than three applicants, copy the first table, insert it below the third table, and change the 1 to a 4. Repeat this process if there are more than four applicants.

Applicant 1		
Business ID # (Internal Use Only)		
Legal Name (do NOT include a d/b/a)		Novant Health Cabarrus Medical Center, LLC
Street or Post Office Box		2401 Trinity Church Road
City		Concord
State		NC
ZIP Code		28027
Name of parent or holding company		Novant Health, Inc.
Is this an existing legal entity?	Yes	If not an existing legal entity, briefly explain in the cell below

Applicant 2		
Business ID # (Internal Use Only)		
Legal Name (do NOT include a d/b/a)		Novant Health, Inc.
Street or Post Office Box		2085 Frontis Plaza Blvd
City		Winston-Salem
State		NC
ZIP Code		27103
Name of parent or holding company		
Is this an existing legal entity?	Yes	

Applicant 3		
Business ID # (Internal Use Only)		
Legal Name (do NOT include a d/b/a)		
Street or Post Office Box		
City		
State		
ZIP Code		
Name of parent or holding company		
Is this an existing legal entity?		If not an existing legal entity, briefly explain in the cell below

2. **Contact Individual**: The **one** individual to whom all correspondence regarding this application should be directed by the CON Section. The individual should be able to provide clarifying or supplemental information regarding this application if requested by the CON Section during the review. If a certificate of need is issued for the project, the certificate holder(s) may designate a different individual to be the contact individual to whom all correspondence related to progress reports will be directed by the CON Section. The Agency Decision and Required State Agency Findings for your application will be mailed and emailed to the Contact Individual.

Contact Individual	
Individual ID # (Internal Use Only)	
Name (First, Middle, Last) *	Andrea Gymer
Title	Vice President, Strategic & Business Planning, Novant Health Inc.
Street or Post Office Box * ^	2085 Frontis Plaza Blvd
City *	Winston Salem
State *	NC
ZIP Code *	27103
Direct Telephone Number *	336.341.0408
Email Address *	amgymer@novanthealth.org

* Required

^ Provide the address where mail is received.

3. **Total Projected Capital Cost** *

$336,434,895

* The total projected capital cost must equal the total capital cost reported in Form F.1a Capital Cost or Form F.1b Capital Cost for Cost Overrun or Change of Scope, both of which are found in Section Q.

4. **Health Service Facility:** Respond for the facility or campus where the proposal will be developed or offered. For mobile health services, enter the service name and service/business address below.

a. **Name and Site Address**

Name *	Novant Health Cabarrus Medical Center (NH Cabarrus)
Street Address ^	2401 Trinity Church Road
City ^	Concord
State	North Carolina
ZIP Code ^	28027
County	Cabarrus
FID # **	N/A
License Number	N/A
Provider Number	N/A

* If the proposal will be developed or offered at an existing facility, this should be the name as it appears on the facility's current license or signage. For new facilities, this should be the name as it will appear on the facility's license or signage. The name should not include any of the following: Inc., Incorporated, Corp., LLC, PA, etc. unless those terms are actually part of the d/b/a name.

^ For new facilities, relocations of an entire existing facility, or new campuses of a facility with multiple campuses on the same license, this must be the same as the site address provided in Section K, Question 4.a. Please be as specific as possible.

** The FID # can be found on the license along with the license number. To obtain the FID # for an existing diagnostic center, contact the Project Analyst for the county where the diagnostic center is located.

b. **Type of Health Service Facility** (Do **NOT** check more than one type)

Type of Health Service or Health Service Facility		Internal Use Only	
		MFF	**Access**
	Adult Care Home (ACH)	HA	ACH
	Ambulatory Surgical Facility (ASF)	AS	ASC
	Diagnostic Center	DIA	DXCTR
	Home Health Agency	HC	HC
	Hospice Home Care	HOS	HOSPICE
	Hospice Inpatient / Residential Care	HOS	HOSPICE
X	Hospital	HL	HOSPITAL
	ICF/IID	MHL	MHL
	Inpatient Rehabilitation Hospital	HL	HOSPITAL
	Long-term Care Hospital (LTCH)	HL	HOSPITAL
	Nursing Facility (NF)	NH	NF

c. If the type of health service facility selected in Question 4.b is an **ASF**, complete the following table by checking **each** surgical specialty that will be offered at the facility upon completion of this project. **Do not change or add any other specialties**. The specialties listed below are the only ones listed in the definition of multispecialty ambulatory surgical program found in G.S. 131E-176(15a) and the Definitions section of the application form.

	Gynecology
	Otolaryngology
	Plastic Surgery
	General Surgery
	Ophthalmology
	Orthopaedic
	Oral Surgery

Not applicable. The project does not involve an ASF.

d. If the type of health service facility selected in Question 4.b is a **hospital, LTCH, or rehabilitation hospital**, indicate in the following table whether the facility does or will consist of multiple campuses on the same license. If the facility does or will consist of multiple campuses on the same license, identify all existing, approved, and proposed campuses by name and indicate which campus is the main campus. Add more rows if necessary.

Does or will the facility consist of multiple campuses on one license?	No
If you answered yes, identify all existing, approved, and proposed campuses that are or would be on the same license and identify which one is or will be the main campus.	

Name of Campus	Existing, Approved or Proposed?	Main Campus?

e. **Ownership and Operation**

Building	
Does or will an applicant own the building?	Yes
If not, identify the owner of the building	
Land	
Does or will an applicant own the land?	Yes
If not, identify the owner of the land	
Operator	
Does or will an applicant operate the health service or facility?	Yes
If not, identify the operator of the health service or facility	

5. **Proposal**

a. **Description**: Provide a brief, one or two sentence description of the proposal in the table below.

Establish a new acute care hospital in Cabarrus County with 50 acute care beds.

b. Check **all** the following that describe this proposal.

X	Acquiring equipment (Complete 5.f below)		
	Change of scope for previously approved project(s)	Project ID #(s)	
	Cost overrun for previously approved project(s)	Project ID #(s)	
	Developing a new campus of <insert name of hospital here>, an existing acute care hospital *		
X	Developing a new health service facility *		
	Developing a satellite emergency department (ED) of <insert name of hospital here>		
X	Developing or offering a service component in response to a need determination in the SMFP		
	Physically expanding the existing health service facility on the same campus		
	Relocating a service component to a new, existing or previously approved facility or campus		
	Relocating the entire existing health service facility to a new campus *		
	Renovating the existing health service facility on the existing campus		

* Developing a new campus of an existing facility with multiple campuses on the same license or relocating the entire health service facility to a new campus is **not** the development of a **new** health service facility.

c. **Health Services**: Check **each** health service included in this proposal.

	Adult care home
	Bone marrow transplantation
	Burn intensive care
	Cardiac catheterization
	GI endoscopy
	Home health
	Hospice home care
	Hospice inpatient
	Hospice residential
X	Hospital (Complete 5.d below)
	Inpatient psychiatric
	Inpatient rehabilitation (Complete 5.d below)
	Intermediate care for persons with intellectual disabilities
	Long-term care hospital (Complete 5.d below)
	Medical equipment (Complete 5.f below)
	Neonatal intensive care
	Nursing home facility
	Open heart
	Solid organ transplantation
	Substance use disorder treatment
	Surgical
	Other (**describe**)

d. **Hospital Services**: If the facility is an acute care hospital, LTCH, or inpatient rehabilitation hospital and the proposal includes hospital services, complete the following table by checking **each** hospital service included in this proposal.

X	Nursing
X	Emergency
X	Laboratory
X	Radiology
X	Pharmacy
X	Physical therapy
X	Occupational therapy
X	Speech therapy
X	Cardiopulmonary therapy
	GI endoscopy
X	Surgical
	Other (**describe**)

e. **Health Service Facility Beds**: Complete the table **only** for the **types of health service facility beds included in this proposal**. Facilities with more than one campus on the same license, should provide the information for the entire facility (i.e., all campuses on that license).

Type of Health Service Facility Bed	**Currently Licensed**	**Previously Approved to be Added or (Deleted)**	**Proposed as Part of this Project**	**Total Upon Completion of all Projects**
Acute Care Hospital			50	50
Burn Intensive Care Unit (BICU)				
Neonatal Intensive Care Unit (NICU)				
Long-term Care Hospital				
Inpatient Rehabilitation				
Nursing Facility				
Adult Care Home				
Hospice Inpatient				
Hospice Residential				
ICF/IID				

f. **Medical Equipment**: Complete the table **only** for the **types of medical equipment included in this proposal**. Facilities with more than one campus on the same license should provide the information for the entire facility (i.e., all campuses on that license).

Type of Medical Equipment	Number of Units			
	Existing	Previously Approved to be Added or (Deleted)	Proposed as Part of this Project	Total upon Completion of All Projects
Cardiac catheterization equipment				
CT scanner			2	2
Gamma knife				
Heart-lung bypass machine				
Linear accelerator				
Lithotriptor				
Major medical equipment *				
MRI scanner				
PET scanner				
Simulator				
Other **				
Ultrasound			3	3
Nuclear Medicine/SPECT			1	1
Fixed X-ray			2	2
Portable X-ray			2	2
Echocardiogram			1	1

* Excluding the medical equipment listed separately in the table.

** This is relevant to a diagnostic center proposal where the medical equipment costs more than $10,000 but less than $3,000,000 adjusted based on the monetary threshold set forth in G.S. 131E-176(7a). It is also relevant to a proposal to develop a new hospital or a new hospital campus which includes acquisition of X-ray, ultrasound, mammography, C-arms, etc. that cost more than $10,000 but less than the monetary threshold set forth in G.S. 131E-176(16).

6. **Experience**

a. How many existing and approved facilities of the type reported in Question 4.b does the applicant or a related entity own, operate, or manage in North Carolina?

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See Form O in Section Q.

Novant Health operates and manages 13 hospital licenses (17 facilities) in the state of North Carolina. Novant Health also has two CON-approved but not yet operational hospitals: Novant Health Steele Creek Medical Center (NH Steele Creek) and Novant Health Scotts Hill Medical Center (NH Scotts Hill). These facilities bring Novant Health's related entities to 14 hospital licenses and 18 facilities.[4]

[4] Novant Health New Hanover Medical Center's license currently operates two facilities: 17th Street and Cape Fear Orthopedic Hospital. NH Scotts Hill will be under the Novant Health New Hanover Medical Center license when it opens. The Cape Fear facility will close when NH Scotts Hill opens.

Section B - Criterion (1)

G.S. 131E-183(a)(1)

"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on 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."

1. a. **Applications submitted in response to a need determination in the SMFP** – Identify the need determination in the table below (For example: 2016 SMFP, Orange County, 84 acute care beds).

2025 SMFP, Cabarrus County, 126 acute care beds

b. **Applications submitted in response to a need determination for acute care beds in Chapter 5 of the SMFP** – Document that the applicant meets all of the following requirements:

1) Does the hospital or will the hospital provide a 24-hour emergency department?

Yes

NH Cabarrus will provide a 24-hour emergency department.

2) Does the hospital or will the hospital provide inpatient medical services to both surgical and non-surgical patients?

Yes

NH Cabarrus will provide inpatient medical services to both surgical and non-surgical patients.

3) If proposing a new hospital, will the hospital provide medical and surgical services daily within at least five of the major diagnostic categories as recognized by the Centers for Medicare and Medicaid Services (CMS) which are listed in Chapter 5 of the SMFP?

Yes

4) Provide supporting documentation in an Exhibit.

NH Cabarrus will provide medical and surgical services on a daily basis within at least five of the Major Diagnostic Categories (MDCs) as recognized by CMS.

As documented in Form C.3.b and Section Q, NH Cabarrus projects the following acute care utilization.

NH Cabarrus Med/Surg Discharges

	2030	2031	2032
Medical Inpatients (74.7%)	951	1,542	2,529
Average Medical Discharges Per Day	*2.6*	*4.2*	*6.9*
Surgical Inpatients (25.3%)	321	521	855
Average Medical Discharges Per Day	*0.9*	*1.4*	*2.3*
Total Med/Surg Discharges	**1,272**	**2,063**	**3,384**

As shown in the previous table, NH Cabarrus projects an average of 6.9 medical discharges per day and 2.3 surgical discharges per day during the third project year.

As documented in Form C.3.b and Section Q, NH Cabarrus projects the following surgical utilization.

NH Cabarrus
Projected Surgical Cases

	2030	2031	2032
Inpatient Surgery Cases	321	521	855
Outpatient Surgery Cases	524	849	1,393
C-Section Surgery Cases Performed in Dedicated C-Section OR	97	158	259
Grand Total Surgical Cases	**942**	**1,528**	**2,506**
Average Surgical Cases per Day	**2.6**	**4.2**	**6.9**

Source: Form C.3.b & Section Q Assumptions and Methodology

As shown in the previous table, NH Cabarrus projects an average of 6.9 surgical cases per day during the third project year.

Please see the following table, which identifies the MDCs that will be provided at NH Cabarrus in the initial years of operations.

Novant Health Cabarrus Medical Center
Major Diagnostic Categories Served During Initial Three Operating Years

MDC	Description
1	Diseases and Disorders of the Nervous System
3	Diseases and Disorders of the Ear, Nose, Mouth And Throat
4	Diseases and Disorders of the Respiratory System
5	Diseases and Disorders of the Circulatory System
6	Diseases and Disorders of the Digestive System
7	Diseases and Disorders of the Hepatobiliary System And Pancreas
8	Diseases and Disorders of the Musculoskeletal System And Connective Tissue
9	Diseases and Disorders of the Skin, Subcutaneous Tissue And Breast
10	Diseases and Disorders of the Endocrine, Nutritional And Metabolic System
11	Diseases and Disorders of the Kidney And Urinary Tract
12	Diseases and Disorders of the Male Reproductive System
14	Pregnancy, childbirth and the puerperium
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders
18	Infectious and Parasitic DDs (Systemic or unspecified sites)
21	Injuries, Poison And Toxic Effect of Drugs
23	Factors Influencing Health Status and Other Contacts with Health Services
25	Human Immunodeficiency Virus Infection

2. Check **each** policy below, from Chapter 4 of the SMFP, which is applicable to this proposal:

	Policy AC-3	Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects
	Policy AC-4	Reconversion to Acute Care
	Policy AC-6	Heart-Lung Bypass Machines for Emergency Coverage
	Policy NH-2	Plan Exemption for Continuing Care Retirement Communities
	Policy NH-5	Transfer of Nursing Home Beds from State Psychiatric Hospital Nursing Facilities to Community Facilities
	Policy NH-6	Relocation of Nursing Facility Beds
	Policy NH-8	Innovations in Nursing Facility Design
	Policy LTC-1	Plan Exemption for Continuing Care Retirement Communities – Adult Care Home Beds
	Policy LTC-2	Relocation of Adult Care Home Beds
	Policy LTC-3	Certification of Beds for Special Assistance
	Policy MH-1	Linkages between Treatment Settings (this policy will always be applicable to proposals involving ICF/IID beds or facilities)
	Policy ICF/IID-5	Transfer of ICF/IID Beds from State Operated Developmental Centers to Community-Based Facilities
	Policy TE-1	Conversion of Fixed PET Scanners to Mobile PET Scanners
	Policy TE-2	Intraoperative Magnetic Resonance Scanners
	Policy TE-3	Plan Exemption for Fixed Magnetic Resonance Imaging Scanners
	Policy TE-4	Plan Exemption for Dual Functioning Fixed PET Scanners in Mid-Sized Cancer Centers
X	Policy GEN-4	Energy Efficiency and Sustainability for Health Service Facilities
X	Policy GEN-5	Access to Culturally Competent Healthcare

The language of each policy follows in the same order as listed above. Following each policy are questions that should be answered if the policy is applicable to this proposal. If a policy is not applicable, delete the language of the policy and the questions related to that policy. However, do not renumber any following questions.

If the language of the policy in the application form differs from the language in the SMFP, the language in the SMFP controls.

If there is a policy in the SMFP that is not listed in the table above and that policy is applicable to the proposal, the policy in the SMFP controls. Please add that policy to your application at the end of this section and provide a response.

Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects

Not applicable. The proposed project does not involve an exemption from plan provisions for an Academic Medical Center Teaching Hospital project.

Policy AC-4: Reconversion to Acute Care

Not applicable. The proposed project does not involve the reconversion of bed capacity to acute care.

Policy AC-6: Heart-Lung Bypass Machines for Emergency Coverage

Not applicable. The proposed project does not involve heart-lung bypass machines.

Policy NH-2: Plan Exemption for Continuing Care Retirement Communities

Not applicable. The proposed project does not involve Continuing Care Retirement Communities.

Policy NH-5: Transfer of Nursing Home Facility Beds from State Psychiatric Hospital Nursing Facilities to Community Facilities

Not applicable. The proposed project does not involve nursing home facility beds from State Psychiatric Hospital Nursing Facilities.

Policy NH-6: Relocation of Nursing Home Facility Beds

Not applicable. The proposed project does not involve nursing home facility beds.

Policy NH-8: Innovations in Nursing Home Facility Design

Not applicable. The proposed project does not involve nursing home facility beds.

Policy LTC-1: Plan Exemption for Continuing Care Retirement Communities – Adult Care Home Beds

Not applicable. The proposed project does not involve adult care home beds in a Continuing Care Retirement Community.

Policy LTC-2: Relocation of Adult Care Home Beds

Not applicable. The proposed project does not involve adult care home beds.

Policy LTC-3: Certification of Beds for Special Assistance

Not applicable. The proposed project does not involve beds for special assistance.

Policy MH-1: Linkages between Treatment Settings

Not applicable. The proposed project does not involve inpatient psychiatric beds.

Policy PSY-1: Transfer of Beds from State Psychiatric Hospitals to Community Facilities

Not applicable. The proposed project does not involve inpatient psychiatric beds.

Policy ICF/IID-5: Transfer of ICF/IID Beds from State Operated Developmental Centers to Community-Based Facilities

Not applicable. The proposed project does not involve ICF/IID beds.

Policy TE-1: Conversion of Fixed Pet Scanners to Mobile Pet Scanners

Not applicable. The proposed project does not involve PET scanners.

Policy TE-2: Intraoperative Magnetic Resonance Scanners

Not applicable. The proposed project does not involve MRI scanners.

Policy TE-3: Plan Exemption for Fixed Magnetic Resonance Imaging Scanners

Not applicable. The proposed project does not involve MRI scanners.

Policy TE-4: Plan Exemption for Dual Functioning Fixed PET Scanners in Mid-Sized Cancer Centers

Not applicable. The proposed project does not involve fixed PET scanners.

Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities

"Any person proposing a capital expenditure greater than $4 million to develop, replace, renovate, or add to a health service facility pursuant to G.S. 131E-178 shall include in its certificate of need application a written statement describing the project's plan to assure improved energy efficiency and water conservation.

In approving a certificate of need proposing an expenditure greater than $5 million to develop, replace, renovate, or add to a health service facility pursuant to G.S. 131E-178, Certificate of Need shall impose a condition requiring the applicant to develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4.

Any person awarded a certificate of need for a project or an exemption from review pursuant to G.S. 131E-184 is required to submit a plan for energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of the Division of Health Service Regulation. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy-GEN 4. The plan shall not adversely affect patient or resident health, safety, or infection control."

21. If the proposed capital cost is $4 million or greater, provide a written statement describing the project's plan to assure improved:

    a. Energy efficiency; and
    b. Water conservation.

    Note: Once a certificate of need is approved, if the proposed capital cost of the project is $5 million or greater, a condition will be imposed requiring the applicant to submit an Energy Efficiency and Sustainability Plan to the Agency's Construction Section that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes and is consistent with the applicant's written statement in Section B, Question 11. The plan shall not adversely affect patient or resident health, safety, or infection control.

The capital expenditure for this project is more than $4 million. NH Cabarrus is committed to environmental responsibility to its team members, patients, visitors, and the communities it serves. As a newly constructed facility, NH Cabarrus will be designed in compliance with all applicable federal, state, and local requirements for energy efficiency and consumption, including the 2025 SMFP Policy. NH Cabarrus will be managed by computerized energy and building management systems designed for the most effective and efficient operations.

This project site design will meet all applicable stormwater, detention, and post-construction control ordinances set forth by regulatory agencies. It will also include a comprehensive and staged erosion control plan to limit site disturbance outside of the project area and to protect critical environmental features within the project area.

Landscaping costs are included in Form F.1a, Capital Cost. For areas that are disturbed during the construction process, replacement materials will use a plant palette of native, low-maintenance, and drought-tolerant plant material, along with turf grass alternatives, to minimize irrigation and maintenance requirements for the site. For example, deciduous and evergreen trees will be installed to allow sun exposure or shade at various times of year, and large, maturing trees will be provided in all parking areas, in compliance with local applicable tree ordinances. Organic mulch material will be provided to build a rich and aerated soil substrate and provide a passive method of weed control. If additional landscaping needs are identified, the contingency funds found in Section Q, Form F.1a Capital Cost will cover landscaping.

Building materials with recycled content will be specified, and the design team will seek to use materials and products extracted and manufactured locally. Based on NH's experience, buildings constructed with structural steel can achieve 25–90% recycled content. Concrete, asphalt, metal framing, drywall, aluminum, lay-in ceiling panels, ceramic tile, and glass can also contribute significantly to recycled content value.

NH will specify materials containing low-emitting levels of volatile organic compounds (VOCs). The roof will have a high solar heat reflectance index so it will reduce cooling costs and will not contribute to a heat island effect. The insulation values for the building envelope will be coordinated with other building systems so the net effect will be to optimize energy usage. Natural daylight will contribute to lighting the patient rooms, work areas, and other spaces frequented by staff and patients.

The engineered systems will be designed to meet the ASHRAE 90.1 standard and the 2018 North Carolina Energy Conservation Code. As part of the design of NH Cabarrus, NH aims to balance the reliability, availability, and cost advantages of traditional infrastructure systems with forward-looking sustainability goals. In the design of NH Cabarrus, the following approaches will be implemented to move NH toward a net zero carbon future, implement sound water conservation measures, and prepare for the future evolution of infrastructure system technologies:

- 15-degree delta T chilled water system design to reduce pumping energy and provide more
- efficient chiller performance
- Variable primary chilled water system to reduce pumping energy
- A heat recovery chiller to provide a portion of the hot water for reheat loads and to preheat domestic hot water
- High-efficiency, dual-fuel condensing boilers with O2 trim
- Heating, ventilation, air conditioning (HVAC) setback for offices and conference rooms
- Airflow setback for operating rooms (ORs) and procedure rooms
- Dual flush-valve toilets for water conservation
- Additional Building Automation Systems (BAS) points for energy and water measurement and verification (include dashboards to evaluate individual system performance and total building performance)
- Photovoltaic (PV) panels for electric vehicle (EV) charging or building loads (will be evaluated during design process)
- EV charging stations (will be evaluated during design process)
- Daylight harvesting and nighttime quiet mode lighting control systems will be evaluated
- Design features to allow for future electrification and decarbonization.
    - The lower temperature hot water heating system (130-degree supply) will allow for conversion to heat pump boilers in the future as this technology improves.
    - The incorporation of electric water heaters for domestic hot water and electric steam generators for humidification and sterilizers eliminates the need for fossil fuels to serve any other loads in the future.
- Building Design Features:
    - Design the building orientation to minimize fenestrations on the west-facing façade, reducing solar heat gain
    - Use of daylight harvesting to minimize lighting loads
    - Loading dock and support spaces designed to accommodate recyclables and compostables

These design approaches will meet or exceed the North Carolina Energy Code.

All new air-handling systems will operate with 100% outdoor air at the completion of construction activities. Operation at 100% outside air will continue until enough time (estimated at 2 weeks) has passed to lower emitted contamination concentrations to near-background levels. Existing recirculating air system flushing will conform to the same procedure as new units, as long as it does not degrade performance to existing or renovated areas.

In all projects, NH considers energy efficiency and water conservation opportunities consistent with the NH Sustainable Energy Management Plan (SEMP). The "written statement" referenced in paragraph 1 of Policy GEN-4 in the 2025 SMFP is articulated in the broader framework of the 2025 SEMP. Exhibit B-21 contains a copy of the 2025 SEMP.

Subsequent to approval of this CON application, NH Cabarrus will submit an Energy Efficiency and Sustainability Plan to the Agency's Construction Section that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan will not adversely affect patient or resident health, safety, or infection control.

Policy GEN-5: Access to Culturally Competent Healthcare:

"A certificate of need (CON) applicant applying to offer or develop a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will provide culturally competent healthcare that integrates principles to increase health equity and reduce health disparities in underserved communities. The delivery of culturally competent healthcare requires the implementation of systems and training to provide responsive, personalized care to individuals with diverse backgrounds, values, beliefs, customs, and languages. A certificate of need applicant shall identify the underserved populations and communities it will serve, including any disparities or unmet needs of either, document its strategies to provide culturally competent programs and services, and articulate how these strategies will reduce existing disparities as well as increase health equity."

20. If the applicant is applying to develop or offer a new institutional health service based on a need determination in the SMFP the applicant shall:

    a. Describe the demographics of the relevant service area with a specific focus on the medically underserved communities within that service area. These communities shall be described in terms including, but not limited to: age, gender, racial composition; ethnicity; languages spoken; disability; education; household income; geographic location and payor type.

The table on the following page describes the demographics of the acute care service area, i.e., Cabarrus County.

Fact	Cabarrus County
Population estimates, July 1, 2023, (V2023)	240,016
Persons 65 years and over, percent	13.90%
Female persons, percent	50.90%
White alone, percent	67.10%
Black alone, percent (a)	22.30%
American Indian and Alaska Native alone, percent (a)	0.80%
Asian alone, percent (a)	7.00%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.10%
Two or More Races, percent	2.70%
Hispanic or Latino, percent (b)	13.00%
White alone, not Hispanic or Latino, percent	56.80%
Veterans, 2019-2023	11,366
Foreign-born persons, percent, 2019-2023	9.80%
Language other than English spoken at home, % of persons age 5 years+, 2019-2023	15.10%
High school graduate or higher, percent of persons age 25 years+, 2019-2023	91.80%
Bachelor's degree or higher, percent of persons age 25 years+, 2019-2023	37.70%
With a disability, under age 65 years, percent, 2019-2023	7.50%
Persons without health insurance, under age 65 years, percent	8.80%
Per capita income in past 12 months (in 2023 dollars), 2019-2023	$40,652
Persons in poverty, percent	9.10%
Population per square mile, 2020	625.1
Land area in square miles, 2020	361.23
Medicaid Enrollment, January 2025	57,485
Medicaid Enrollment % of Population, January 2025	22.7%

(a) Includes persons reporting only one race
Source: US Census Bureau Quick Facts, https://medicaid.ncdhhs.gov/reports/dashboards/enrollment-dashboard

Please also refer to Section C.4 for additional discussion of the demographics for the acute care service area.

b. Describe strategies it will implement to provide culturally competent services to members of the medically underserved community described in a. above.

Novant Health recognizes that historically marginalized groups—including those historically underrepresented by race, ethnicity, sexual orientation, gender identity, geographic location, language proficiency, health literacy, and disability status—often face significant health disparities. These disparities can manifest as poorer health outcomes, reduced access to healthcare, and lower quality of care compared to other populations.

To confront these challenges, Novant Health integrates a health equity perspective into all of its clinical interventions and community outreach initiatives. This approach is data-driven and evidence-based, ensuring that each of its facilities and clinics sets and pursues health equity goals that are customized to the needs of their specific communities. Novant Health utilizes several strategies, including:

- Cultural Ambassador Program: Novant Health's Cultural Ambassador Program was created to enhance the experience of Hispanic and Latino patients. These ambassador team members:

    - Serve as medical interpreters to help patients overcome language barriers.
    - Assist with referrals to services and community programs beyond our Novant Health network.
    - Help patients navigate the healthcare system.
    - Connect patients with primary care physicians and providers.
- Inclusive Spiritual Care
    - All Novant Health patients can have access to a professional spiritual care provider relevant to their religion, spirituality, faith tradition or value system.
    - The spiritual care team also offers a range of services, from helping patients and families through difficult decisions to listening to concerns and struggles.
    - Novant Health recognizes that all people are entitled to their own belief system.
    - Novant Health cares for everyone, regardless of any or no religious affiliation.
    - Novant Health's chapels – also called "rooms of reflection" or "sacred spaces" – provide support to all who are seeking peace, comfort and hope.
- Language and Communication Services
    - Novant Health provides culturally and linguistically appropriate services for individuals who have limited proficiency in English, are deaf or hearing-impaired.
    - Foreign language interpreters and sign language interpreters are available to patients free of charge.
    - In-person, remote video and over-the-phone interpreters are available.
    - Educational materials and discharge instructions are available in multiple languages relevant to the population.
- Diverse Workforce Recruitment and Training
    - Novant Health prioritizes hiring healthcare providers and staff who reflect the cultural and linguistic diversity of the community.
    - Regular training for staff is provided on topics such as implicit bias, health disparities, and culturally sensitive communication.
- Access to Care
    - Novant Health deploys mobile units to bring acute care services directly to underserved neighborhoods.
    - Novant Health extends clinic hours and establishes satellite clinics in areas with limited access to healthcare facilities.
- Health Equity
    - Novant Health identifies health equity challenges, such as housing instability, food insecurity, and transportation barriers, and connects patients with resources.
    - Social services are offered alongside acute care to address holistic patient needs.
- Data-Driven Approaches
    - Novant Health regularly analyzes demographic and health data to identify gaps in care and track improvements.
    - Surveys and focus groups are used to evaluate patient satisfaction and adapt services as needed.
- Telehealth and Digital Inclusion
    - Novant Health expands virtual care options for acute care to reduce transportation and scheduling barriers.
    - Resources are provided to help patients navigate telehealth platforms effectively.

By implementing these strategies, Novant Health endeavors to improve the accessibility, quality, and cultural relevance of acute care services for underserved populations in Cabarrus County and beyond.

c. Document how the strategies described in b. above reflect cultural competence.

The strategies described in b. above prioritize understanding, respecting, and addressing the unique cultural, social, and linguistic needs of diverse populations. Cultural competence involves adapting healthcare delivery to ensure it is effective, equitable, and respectful for individuals from all backgrounds.

Actively listening to and collaborating with community members ensures that care aligns with their specific cultural values, beliefs, and needs. Engaging trusted organizations builds trust and demonstrates respect for local cultures. Employing a diverse workforce ensures that patients can interact with providers who understand their cultural backgrounds. Training staff in cultural competency fosters empathy, reduces bias, and enhances the ability to address patients' unique needs.

Providing interpretation services and translated materials helps eliminate language barriers, ensuring patients fully understand their diagnoses and treatments. These strategies respect linguistic diversity and empower patients to make informed healthcare decisions.

Mobile health units and flexible clinic options reduce structural barriers that disproportionately affect underserved communities. These efforts demonstrate a commitment to equity by meeting patients where they are. Customizing health education to align with cultural norms and practices ensures the information is relatable and actionable for diverse populations.

Recognizing and addressing factors like housing, food, and transportation acknowledges the broader context in which patients live. This holistic approach reflects an understanding of how culture and environment impact health. Using data to identify health disparities and measure progress ensures that care is responsive to the specific needs of different cultural groups. Patient feedback helps refine services to better align with their preferences.

Expanding telehealth services increases access for patients who face geographic or transportation barriers, while addressing digital literacy needs ensures equitable access for all, including those unfamiliar with technology.

By addressing language, cultural beliefs, trust, systemic barriers, and social determinants, these strategies embody cultural competence and aim to make healthcare more inclusive, respectful, and effective for medically underserved populations.

d. Provide support (e.g., best-practice methodologies, evidence-based studies with similar communities) that the strategies described in b. and c. above are reasonable pathways for reducing health disparities, increasing health equity and improving the health outcomes to the medically underserved communities within the relevant service area.

Novant Health's efforts to promote health equity and reduce healthcare disparities have been effective methods for increasing health equity and improving the health outcomes to the medically underserved communities. Novant Health has been recognized by organizations such as the Human Rights Campaign (HRC) Foundation and the Centers for Medicare & Medicaid Services. Novant Health has received several awards for its diversity, inclusion and equity efforts, including:

- America's Greatest Workplaces 2024 by Newsweek
- Best Employer for Diversity by *Forbes* (2023, 2022, 2021, 2020, 2019, 2018)
- Best Employer in North Carolina by *Forbes* (2024, 2023, 2022)
- Best Place to Work for Disability Inclusion by Disability:IN and the American Association of People with Disabilities (2023, 2022, 2021, 2020)

- Best Place to Work for Women and Diverse Managers by *DiversityMBA Magazine* (2024, 2023, 2022, 2021, 2020, 2019, 2018, 2017)
- Diversity Impact Award by Talent Dimensions and the Global ERG Network (2023, 2022, 2021, 2020, 2019)
- Health Equity Accreditation Plus by National Committee for Quality Assurance (2022)
- Health Equity Action Gold Award by The Cigna Group (2023)
- Health Equity Award by Centers for Medicare and Medicaid Services (CMS) (2018)
- Leader in LGBTQ Healthcare Equality by Human Rights Campaign Foundation (2022, 2020, 2019, 2018, 2017)
- National Association of Corporate Directors (NACD) NXT Recognition honoring Novant Health's board of trustees (2019)
- Supplier Diversity Excellence Award by Vizient (2024, 2022, 2019)

e. Describe how the applicant will measure and periodically assess increased equitable access to healthcare services and reduction in health disparities in underserved communities.

Novant Health continuously evaluates and monitors its strategies to improve the quality of culturally competent care. Novant Health collects feedback from patients and families about their experiences, establishes performance metrics related to cultural sensitivity and inclusivity, and conducts periodic reviews to assess the effectiveness of cultural competency initiatives.

Section C - Criterion (3)

G.S. 131E-183(a)(3)

"The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, … persons [with disabilities]*, the elderly, and other underserved groups are likely to have access to the services proposed."*

For change of scope or cost overrun proposals, skip to Section C, Question 8.

Scope of the Project

1. Identify and describe each service component included in this proposal. Your response should include but not be limited to describing the type and number of existing, approved, and proposed health service facility beds, health services, hospital services, or medical equipment included in this proposal.

Overview

The proposed project involves the development of a new acute care hospital in Cabarrus County. The applicants are Novant Health Cabarrus Medical Center, LLC (NH Cabarrus), and its parent company, Novant Health Inc.[5] Pursuant to the need determination in the 2025 SMFP, NH Cabarrus proposes to develop 50 acute care beds at 2401 Trinity Church Road, Concord, NC. This project will allow Novant Health to meet the growing demand for acute care services, increase access to acute care services, and also enhance competition in Cabarrus County.

Service Components

The proposed project involves three service components:

- **Inpatient Services**—Includes nursing units for all inpatients. Includes inpatient surgical services, ED services provided to an admitted patient, and imaging provided during an inpatient stay. Includes all services to intensive care unit (ICU) patients. This service component includes all ancillary services, including but not limited to pharmacy, therapy, radiology, and laboratory, that an inpatient receives. Administrative and overhead costs are allocated to this service component on Form F.3b.

- **Outpatient Surgical Services**—Includes all services for patients receiving outpatient surgical procedures, including observation, ED, and imaging services. This service component includes all ancillary services, including but not limited to pharmacy, therapy, and laboratory, that an outpatient surgical patient receives. Administrative and overhead costs are allocated to this service component.

- **Other Outpatient Services**—Includes ED services, observation, outpatient imaging, outpatient nuclear medicine, and any other outpatient services not included in the above service components. This service component includes all ancillary services, including but not limited to pharmacy, therapy, and laboratory, that a non-surgical outpatient receives. Administrative and overhead costs are allocated to this service component.

The revenues and expenses for the total facility are the sums of the revenues and expenses of the three service components. See also Forms F.2b and F.3b.

[5] Herein after, "Novant Health" refers to the parent company, Novant Health Inc., its subsidiaries, and their collective experience.

Capital Cost

The capital for the proposed project is $336,434,895.

Timetable

Novant Health projects the new acute care hospital will become operational on January 1, 2030. Novant Health's fiscal year is January-December; thus, the first full project year is CY2030.

Community Hospital Acute Care Services

NH Cabarrus has been designed and staffed to deliver comprehensive community hospital services, addressing the majority of inpatient and outpatient needs typically provided by hospitals. Its scope of services aligns with those offered at other NH community hospitals in neighboring Mecklenburg County, including NH Huntersville, NH Mint Hill, NH Ballantyne, and NH Matthews. Further, as the Agency is aware, Novant Health operates community hospitals in Forsyth County, NH Kernersville and NH Clemmons. Beginning with NH Matthews in 1994, Novant Health has been a leader and an innovator in bringing high-quality care closer to where patients live. While large, tertiary medical centers play a very important role in health care delivery, these complex facilities are not always the optimal site of care for every patient. Many medical conditions can be treated effectively in community hospitals. Moreover, some patients and visitors find large, tertiary facilities extremely challenging with respect to way-finding and parking. Novant Health firmly believes in providing high-quality, geographically accessible care for all. Based on more than 30 years' experience of developing community hospitals in many different locations in North Carolina, Novant Health's community hospitals offer an important option for increasing access across North Carolina. These hospitals also serve as cornerstones in the communities they serve, providing not only high-quality health care but also well-paying employment opportunities.

With a commitment to delivering exceptional care, NH Cabarrus will provide high-quality care for every patient who seeks its services. The hospital will feature a fully equipped Emergency Department (ED) to manage all clinically appropriate cases. For patients requiring specialized or higher-level care, seamless transfer arrangements will be in place to ensure their needs are met.

All acute care inpatients are assigned to a Medical Severity Diagnosis-Related Group (MSDRG), which is further categorized under a Major Diagnostic Category (MDC). Each MSDRG and MDC corresponds to specific diagnoses and procedures. Novant Health anticipates that during the first three years of operation, NH Cabarrus will primarily serve inpatients within a focused subset of MSDRGs, referred to as Core Acute Care (CAC) MSDRGs. Exhibit C.1 provides a detailed list of these CAC MSDRGs, including their descriptions. Additionally, NH Cabarrus is committed to offering emergency services to all patients who present at its ED, ensuring access to high-quality care for all who seek it.

The CAC MSDRG list reflects the services routinely provided at Novant Health community hospitals in Mecklenburg County. Novant Health developed the list of MSDRGs appropriate for treatment at NH Cabarrus during its first three years of operation by analyzing utilization data from NH community hospitals and consulting with NH physicians and hospital managers. Exclusions were made for MSDRGs related to psychiatric services, substance use disorder services, normal newborns[6], cardiac catheterization, bariatric surgery, invasive cardiology, electrophysiology, and transplant services. These exclusions consider patient acuity, equipment requirements (e.g., cardiac catheterization laboratories), and the services appropriate for a 50-bed community hospital.

[6] MSDRGs for normal newborns are excluded to avoid double counting obstetrics utilization. NH Cabarrus proposes to serve normal newborns.

The list of CAC MSDRGs is expected to expand in subsequent years as the hospital invests in additional equipment, hires more technicians, and recruits subspecialists to the medical staff. While Novant Health cannot precisely predict which subspecialists will join or the specific services that will emerge, the criteria used to define the initial scope of services at NH Cabarrus are sound and produce a reasonable foundation of CAC MSDRGs for projecting inpatient discharges. NH Cabarrus will adapt to meet the evolving needs of its community, ensuring the medical staff and services grow accordingly.

The CAC MSDRGs span at least five Major Diagnostic Categories (MDCs) as required by Section B.1.b.3. Exhibit C.1 outlines the MDCs that NH Cabarrus expects to treat within its first three years of operation. NH Cabarrus will stabilize all patients presenting at its ED and transfer those whose conditions require services beyond the hospital's scope.

NH Cabarrus Bed Complement

This application seeks to develop 50 acute care beds. The initial bed complement at NH Cabarrus will consist of:

- 36 general medical/surgical acute inpatient beds;
- 8 LDRPs;
- 6 ICU beds; and
- 12 unlicensed observation beds.

To maximize operational flexibility, all bed spaces will be built to acute-care licensure standards. ICU rooms will be available for non-ICU patients when not needed for ICU patients. This design increases the daily census the hospital can manage without exceeding the number of licensed beds.

Emergency Department

NH Cabarrus will have a full-service ED with 16 treatment rooms. These 16 treatment rooms include 9 standard treatment rooms, one resuscitation room, two isolation treatment rooms for patients with infectious diseases, one double-occupancy treatment room, and three rooms that can also serve as behavioral health holding spaces. The ED will be staffed 24/7 by emergency physicians, nurses, and other clinicians. Mid-Atlantic Emergency Medical Associates (MEMA) has offered their support for this application. See Exhibit I.1 for a letter of support that indicates their willingness to partner with NH Cabarrus to provide emergency medicine coverage. The ED is not limited to treating patients suitable for inpatient care at NH Cabarrus. The medical staff, on site and through telemedicine, can stabilize patients with almost any diagnosis before admitting them for further treatment at NH Cabarrus, transferring them to another hospital that offers a higher level of care, or discharging them home.

Three of the 16 ED treatment rooms at NH Cabarrus can also serve as behavioral health holding spaces. NH Cabarrus does not propose to provide inpatient behavioral health or substance use disorder treatment. However, NH understands that many individuals in a behavioral health crisis present at the ED of a general acute care hospital. NH Cabarrus will assess, stabilize, and provide appropriate ED treatment for these patients. For those patients requiring more care, the behavioral health ED room will serve as a space where they can await transfer to another, more appropriate facility.

The Cabarrus County Department of Emergency Medical Services (EMS) or NH Critical Care Transport will transport patients requiring a higher level of care than NH Cabarrus can provide to an appropriate facility. See Exhibit I.1 for a letter from Novant Health Critical Care Transportation.

Surgical Services

Surgical services can be provided in operating rooms (OR) and in properly configured procedure rooms.[7] The 2025 SMFP does not include a need determination for additional ORs in the Cabarrus County service area. Therefore, NH Cabarrus will develop four procedure rooms for the provision of the proposed surgical services. All procedure rooms will be constructed to OR standards and will be designed and equipped to satisfy recognized standards for major surgeries. NH Cabarrus will comply with all applicable state licensure requirements related to surgical services.

The surgical services area will have pre- and postoperative bays, prep and recovery rooms, a pharmacy, an anesthesia supply area, a work room, equipment storage rooms, and team support and break spaces.

NH Cabarrus will also develop one dedicated operating room (OR) exclusively for C-Section procedures to meet the needs of its obstetric patients. Dedicated C-Section ORs are not subject to need determinations. This proposal is driven by the commitment to ensuring the health and safety of the projected obstetric patients at NH Cabarrus. The dedicated C-Section OR will ensure that surgical services are readily available for patients requiring cesarean births.

Novant Health Surgical Services will provide sterile processing services. See Exhibit I.1.

Minor Procedure Rooms

NH Cabarrus will also develop two minor procedure rooms that will be located outside the sterile core. The minor procedure rooms will be used for non-surgical procedures, including but not limited to pain management, cystoscopy, and eye procedures. Surgical cases will not be performed in procedure rooms located outside of the surgical suite.

Imaging Services

Initially, NH Cabarrus will host the following equipment:

- 2 CT scanners;
- 2 fixed x-ray units (including a combination x-ray/fluoroscopy unit);
- 2 portable x-ray units;
- 1 nuclear medicine camera;
- 3 portable ultrasound units;
- Pad space and utility connections for a mobile MRI unit.

NH Cabarrus will have mobile MRI service immediately available 24/7/365. Mobile MRI providers will rotate multiple mobile scanners to provide MRI services at all times while complying with the definition of mobile MRI scanner at 10A NCAC 14C.2701(8) and Chapter 15 of the 2025 SMFP. See Exhibit I.1 for a letter from Chris Murphy at Foundation Health Mobile Imaging committing to provide 24/7/365 mobile MRI services at NH Cabarrus. Once it is operational, NH Cabarrus will apply for a fixed MRI under Policy TE-3: Plan Exemption for Fixed Magnetic Resonance Imaging Scanners. This will allow NH Cabarrus to offer fixed MRI services at the hospital in future years. The facility includes space for a future fixed MRI.

Therapy Services

NH Cabarrus will provide respiratory therapy, speech therapy, occupational therapy, physical therapy, and other therapies for inpatients and outpatients. NH Cabarrus will employ therapists in respiratory, speech, occupational, and

[7] As Judge Byrne's Final Decision in 23 DHR 03681 recognizes, a hospital is not required to have an OR. It is only required to offer surgical services, which can be performed in an operating room or a procedure room.

physical therapy. The therapy staff will be sufficient to support the needs of a 50-bed hospital with a large outpatient component. NH Cabarrus will provide therapy to all clinically appropriate patients. Respiratory therapy services will be available 24/7. Other services will be regularly available on weekdays and on weekends as needed.

Laboratory Services

NH Cabarrus will have a clinical laboratory sufficient to support the needs of a 50-bed community hospital, its outpatient services, and its ED. The laboratory will be on the first floor. The NH Cabarrus laboratory will be staffed, equipped, and operated 24/7. Presbyterian Pathology Group will provide pathologists and related clinicians. Onsite laboratory services will be augmented by service agreements with LabCorp. Both organizations have existing relationships with NH hospitals. See Exhibit I.2 for letters regarding the availability of these services at NH Cabarrus.

Pharmacy Services

NH Cabarrus will have a pharmacy sufficient to support the needs of a 50-bed community hospital, its outpatient services, and its ED. The pharmacy will be on the second floor. The NH Cabarrus pharmacy will be staffed, equipped, and operated 24/7.

Contracted Clinical & Non-Clinical Services

NH Cabarrus will contract with qualified professional providers to offer:

- Mobile MRI (Exhibit I.1);
- Pathology services (Exhibit I.1);
- Anesthesiology services (Exhibit I.1);
- Radiology services (Exhibit I.1);
- ED physician services (Exhibit I.1); and
- Neonatal physician coverage (for any unexpected or unplanned deliveries) (Exhibit I.1).

NH Cabarrus will have contracts for laundry, linen, environmental services, and food/nutrition. See Exhibit I.1.

Telemedicine

Telemedicine facilitates collaboration with Novant Health physicians and hospitals. Novant Health uses technology to enhance patient care and ensure that expert specialist consultation is available to physicians at all Novant Health hospitals. NH Cabarrus will have carts equipped with a video camera, video screen, and a computer, to allow onsite physicians and providers and patients to videoconference with an expert Novant Health specialist. The specialist will be able to interview the patient, review imaging, laboratory, and other test results, and collaborate with the local medical team to make diagnosis and treatment decisions. Patients will also be able to talk directly with the specialist to ask questions or provide information about their medical history and current symptoms. Novant Health's formal telehealth programs include neurology, stroke, behavioral health services, and tele-ICU. However, physicians in any specialty can participate. As NH Cabarrus is developed, Novant Health will evaluate additional telemedicine programs that may benefit patients in Wake County and the surrounding communities.

Telestroke and Teleneurology

Novant Health's telestroke program makes a neurologist available 24/7 to assess any patients with emergent neurological symptoms. Telestroke physicians can view scans, interview the patient and family, and consult the treating physician. Telestroke allows the specialist to recommend thrombolytic agents (TPAs) so they can be given timely. This improves patient outcomes by allowing them to receive care more quickly than they would if they had to

be transferred to another hospital. While NH Cabarrus does not expect to become a designated stroke center in its initial years of operations, the telestroke program will allow NH Cabarrus physicians to appropriately assess, treat, and stabilize stroke patients who presented at the hospital. Novant Health's teleneurology program also provides 24/7 coverage. It also allows a board-certified neurologist to virtually round on appropriate inpatients on a daily basis if the hospital does not have an available neurologist on site. NH Cabarrus plans to offer telestroke and teleneurology.

Telebehavioral Health

Through its Telebehavioral Health program, Novant Health's psychiatrists and licensed therapists can provide patient assessments, medication recommendations, therapy, and counseling. When a patient is at risk in the ED, Novant Health telebehavioral health specialists can offer virtual consultations for depression, anxiety disorders, schizophrenia, substance abuse disorders, and other behavioral health conditions. Novant Health's telebehavioral health specialists can provide:

- Risk assessment to determine whether someone may cause harm to themselves or others
- Diagnosis of mental and behavioral health disorders
- Referral to appropriate levels of care
- Medication prescription and management
- Assistance communicating with family members, in an emergency or as needed
- Follow-up care during an extended hospital stay
- Inpatient psychiatric evaluations before discharge from the hospital

NH Cabarrus does not propose to provide inpatient behavioral health or substance use disorder treatment. However, NH understands that many individuals in a behavioral health crisis present at the ED of a general acute care hospital. Novant Health's telebehavioral specialists will enable NH Cabarrus to assess, stabilize, and provide appropriate ED treatment for these patients.

Tele-ICU

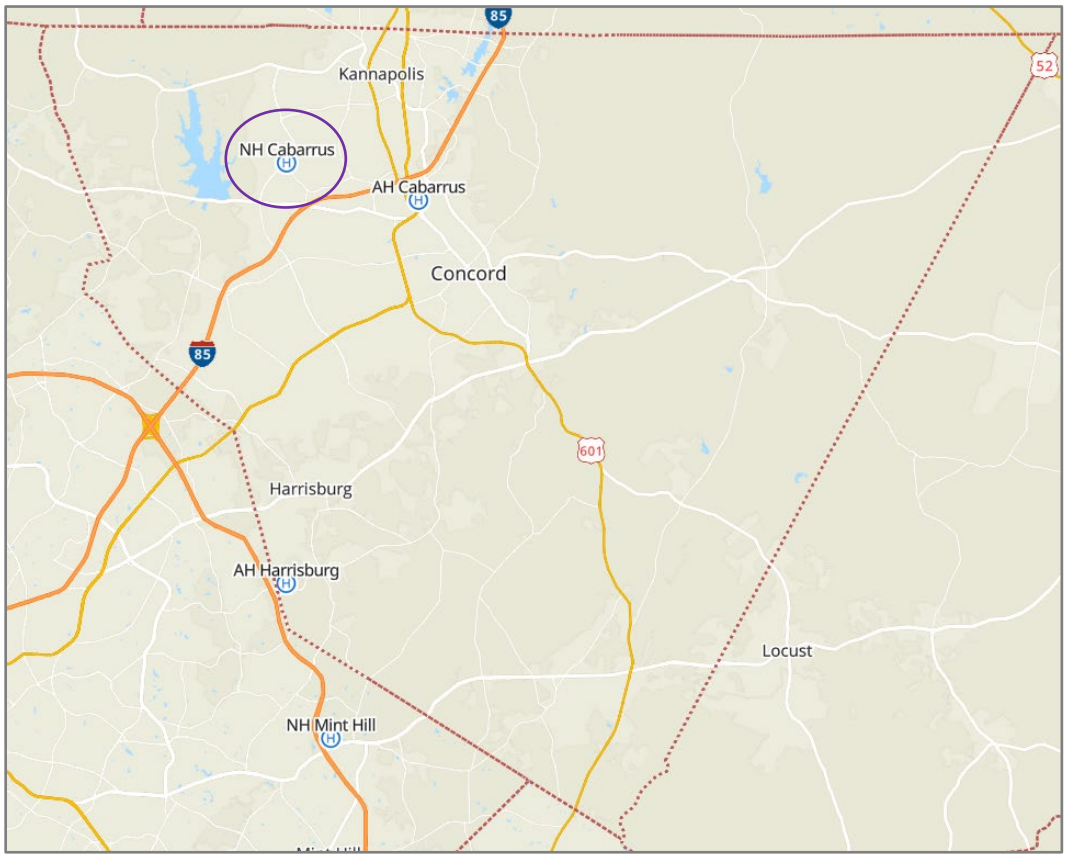
Novant Health's tele-ICU program provides 24/7 intensivist coverage. Novant Health expects to recruit intensivists to provide care at NH Cabarrus. Even with an onsite intensivist, the tele-ICU program can improve patient care as it allows hospital staff to immediately contact a specialist 24/7/365, if a patient is deteriorating or needs additional assessment or treatment authorization. Tele-ICU coverage also improves care in the general medical/surgical floor and ED. Using telehealth, intensivists can consult onsite physicians for patients anywhere in the hospital.

NH Cabarrus Service Area

The service area for acute care beds per 10A NCAC 14C .3801 (4) means the single or multi-county area as used in the development of the acute care bed need determination in the applicable State Medical Facilities Plan. This project is in response to the acute care bed need determination in Cabarrus County set forth in the 2025 SMFP. NH Cabarrus will treat all patients who arrive at the hospital for care, regardless of where they live. NH Cabarrus expects the majority of its patients will come from Cabarrus, Rowan, and Stanly counties.

NH Cabarrus's proposed location in Cabarrus County is proximate to major highways and other arterial roads, enabling access from throughout the county.

NH Cabarrus Proposed Location

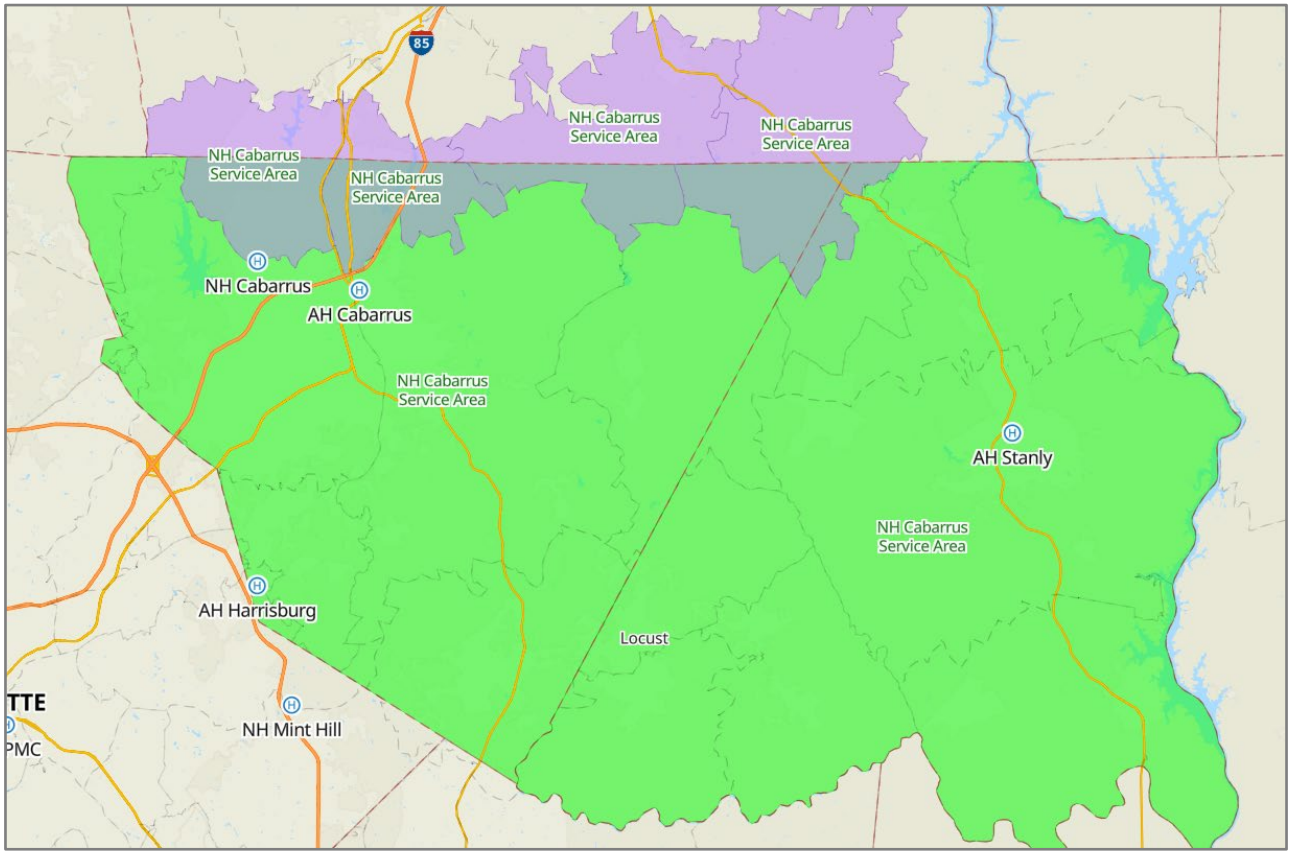


Cabarrus County hosts one existing and one approved acute care hospital, both controlled by Atrium Health (AH). Currently residents from Cabarrus County and surrounding communities must travel to Mecklenburg County or Rowan County for acute care services within the Novant Health system. The proposed new hospital will enhance access for Novant Health patients residing in Cabarrus County, Stanly County, and portions of Rowan County. NH Cabarrus will create a new point of access for Novant Health patients and reduce drive times for many individuals from Cabarrus, Rowan, and Stanly counties that currently utilize Novant Health's acute care services. Additionally, NH Cabarrus will establish a new acute care provider in Cabarrus County, which will stimulate competition and enhance patient choice for area residents. Competition improves choice and quality and also lowers cost.

The service area for the proposed project includes Cabarrus County, Stanly County, and select ZIP codes along the shared border of Cabarrus and Rowan County, specifically: 28071, 28081, 28082, 28083, 28138. The selected Rowan County service area zip codes consider current patient destination patterns for general acute care services and the proximity of the proposed NH Cabarrus facility.

For clarification purposes, inpatient discharge data, sourced from the Hospital Industry Data Institute (HIDI) inpatient database, categorizes patients within ZIP codes based on their respective county of residence. For example, the 2023 inpatient discharge figures for ZIP code 28071 are distinctly recorded for Cabarrus County and separately for Rowan County. The selected Rowan County ZIP codes include only those patients who were confirmed as Rowan County residents, ensuring no duplication of patient counts across counties.

NH Cabarrus Service Area Map



Population to be Served

2. **Historical Patient Origin**

   a. **Service Component(s)** – Complete the following table for each service component included in this proposal for:

   - The facility or campus identified in Section A, Question 4; and
   - Each facility from which existing service components will be relocated as part of this proposal.

   b. **Entire Facility or Campus**

   - **Facilities with more than one campus on the same license**: Complete the following table for: 1) the entire facility if the proposal involves relocating the entire facility to another site or developing a new satellite campus; or 2) the campus identified in Section A, Question 4, if the proposal involves relocating an existing campus of a facility with multiple campuses to another site.
   - **All other applicants**: Complete the following table for the entire facility. If historical patient origin for the service component and the entire facility are the same, the applicant **should explain why that is the case** and is not required to complete the following table.

NH Cabarrus is the facility identified in Section A., Question 4. NH Cabarrus is not an existing facility and does not have historical patient origin.

3. **Projected Patient Origin**

a. Describe the **assumptions and methodology used** to project the number of patients by county or other geographic area of origin. Provide any supporting documentation in an Exhibit.

The projected patient origin for NH Cabarrus inpatient discharges is based on the assumptions and methodology included in Section Q. The projected patient origin for acute care beds is based on the number of patients projected to originate from the service area as identified in Section Q, Form C.1b, C.2b, C.3b, and C.4b Assumptions and Methodology.

Projected utilization for surgical cases, ED visits, imaging, and other ancillary and support services is based on projected inpatient discharges. Therefore, the projected patient origin for surgical cases, ED visits, imaging and other ancillary and support services is reasonably assumed to be consistent with projected patient origin for acute care beds.

c. **Service Component(s)** – Complete the following table for each service component included in this proposal for the facility or campus identified in Section A, Question 4.

Inpatient Services	**Novant Health Cabarrus Medical Center ***					
	1st Full FY		**2nd Full FY**		**3rd Full FY**	
	01/01/2030 to 12/31/2030		**01/01/2031 to 12/31/2031**		**01/01/2032 to 12/31/2032**	
County or other geographic area such as ZIP code	**Number of Patients ****	**% of Total**	**Number of Patients ****	**% of Total**	**Number of Patients ****	**% of Total**
Cabarrus	832	65.4%	1,426	69.1%	2,494	73.7%
Rowan	160	12.5%	219	10.6%	280	8.3%
Stanly	154	12.1%	212	10.3%	271	8.0%
Other^	127	10.0%	206	10.0%	338	10.0%
Total	**1,272**	**100.0%**	**2,063**	**100.0%**	**3,384**	**100.0%**

^Other includes <1 percent patient origin from the remaining counties in North Carolina and other states.

* This should match the name provided in Section A, Question 4.

** Home health agencies should report the number of unduplicated clients.

Outpatient Surgical Services	Novant Health Cabarrus Medical Center *					
	1st Full FY		2nd Full FY		3rd Full FY	
	01/01/2030 to 12/31/2030		01/01/2031 to 12/31/2031		01/01/2032 to 12/31/2032	
County or other geographic area such as ZIP code	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**
Cabarrus	342	65.4%	587	69.1%	1,027	73.7%
Rowan	66	12.5%	90	10.6%	115	8.3%
Stanly	63	12.1%	87	10.3%	112	8.0%
Other^	52	10.0%	85	10.0%	139	10.0%
Total	**524**	**100.0%**	**849**	**100.0%**	**1,393**	**100.0%**

^ Other includes <1 percent patient origin from the remaining counties in North Carolina and other states.

* This should match the name provided in Section A, Question 4.

Other Outpatient Services	Novant Health Cabarrus Medical Center *					
	1st Full FY		2nd Full FY		3rd Full FY	
	01/01/2030 to 12/31/2030		01/01/2031 to 12/31/2031		01/01/2032 to 12/31/2032	
County or other geographic area such as ZIP code	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**
Cabarrus	8,240	65.4%	14,123	69.1%	24,704	73.7%
Rowan	1,581	12.5%	2,169	10.6%	2,772	8.3%
Stanly	1,521	12.1%	2,100	10.3%	2,684	8.0%
Other^	1,260	10.0%	2,044	10.0%	3,351	10.0%
Total	**12,602**	**100.0%**	**20,436**	**100.0%**	**33,512**	**100.0%**

^ Other includes <1 percent patient origin from the remaining counties in North Carolina and other states.

* This should match the name provided in Section A, Question 4.

c. **Entire Facility or Campus**

- **Facilities with more than one campus on the same license**: Complete the following table for: 1) the entire facility if the proposal involves developing a new facility or relocating the entire facility to another site; or 2) the campus identified in Section A, Question 4 if the proposal involves developing a new campus of an existing facility or relocating an existing campus of a facility with multiple campuses to another site.
- **All other applicants**: Complete the following table for the entire facility. If projected patient origin for the service component and the entire facility is the same, the applicant **should explain why that is the case** and is not required to complete the following table.

Entire Facility: Acute Care Beds, Surgical Cases, Emergency Department	Novant Health Cabarrus Medical Center *					
	1st Full FY		2nd Full FY		3rd Full FY	
	01/01/2030 to 12/31/2030		01/01/2031 to 12/31/2031		01/01/2032 to 12/31/2032	
County or other geographic area such as ZIP code	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**
Cabarrus	9,414	65.4%	16,136	69.1%	28,225	73.7%
Rowan	1,806	12.5%	2,478	10.6%	3,167	8.3%
Stanly	1,738	12.1%	2,400	10.3%	3,067	8.0%
Other^	1,440	10.0%	2,335	10.0%	3,829	10.0%
Total	**14,398**	**100.0%**	**23,349**	**100.0%**	**38,288**	**100.0%**

* This should match the name provided in Section A, Question 4, and includes mobile health services

^ Other includes >1 percent patient origin from the remaining counties in North Carolina and other states.

The projected patient origin for the entire NH Cabarrus facility is assumed to be consistent with the projected patient origin for acute care beds. The total number of patients reflects the combined patient total of the service components identified in Section C, Question 3.b. This sum includes some duplication of patients as a single patient may utilize any number of the services proposed.

Demonstration of Need

4. Explain why the patients projected to be served by the health service, facility or campus identified in Section A, Question 4, need the proposal. If the proposal involves multiple service components, explain why those patients need each proposed service component.

   Provide any supporting documentation in an Exhibit.

   The response should include but not be limited to the following as applicable:

   Developing a New Facility or Campus? Include an explanation of why the patients projected to be served: 1) need a new facility or campus; and 2) why the proposed site was selected as compared to other sites in the service area.

   Relocating Existing Service Components? Include: 1) the identify of each facility that would lose service components as part of this proposal; 2) a description of each service component (i.e., specific type and number if applicable) that will be relocated as part of this proposal; and 3) an explanation of why the patients projected to be served need the service components at the facility identified in Section A, Question 4, as opposed to where they are currently located.

   Replacing and Relocating the Entire Facility? Include an explanation of why the patients projected to be served: 1) need the facility to be replaced and relocated; and 2) why the proposed site was selected as compared to other sites in the service area.

   Developing or Expanding a Special Care Unit (nursing home facilities or adult care home facilities)? Include an explanation of why the patients projected to be served need the new or expanded SCU.

   Acquiring Major Medical Equipment or Developing or Expanding a Diagnostic Center (excluding CT scanners, MRI scanners, PET scanners, and cardiac catheterization equipment)? Include: a description of: 1) the annual maximum capacity per unit for each type of major medical equipment included in the proposal; and 2) the assumptions and methodology used to determine maximum capacity per unit.

Acquiring Mobile Medical Equipment? Include: 1) the identity of the proposed host sites by name, owner, type (e.g., hospital, physician office, diagnostic center, etc.) and physical location (i.e., street address, city and county) and 2) a description of the applicant's efforts to contact the proposed host sites.

NH Cabarrus proposes to develop a new 50-bed acute care hospital in Cabarrus County. The need for the proposed project is supported by the following:

- The need for acute care beds in the 2025 SMFP;
- Growth of service area acute care discharges;
- Projected population growth in the service area;
- Need to enhance geographic access to acute care beds in Cabarrus County;
- Need to enhance competition for acute care services in Cabarrus County; and
- Support from area physicians and residents

2025 SMFP Acute Bed Methodology

Chapter 5 of the 2025 SMFP identifies a need for 126 additional acute care beds in the Cabarrus County service area. The methodology used to determine the need for additional acute care beds is summarized below.

The need for additional acute care beds in the 2025 SMFP is triggered by the utilization of the total number of existing and approved acute care beds within a given service area. The number of acute inpatient days of care (exclusive of days of care provided as Level II, III and IV NICU services) is determined for each service area based on utilization data from HIDI, a collector of hospital patient discharge information.

To project inpatient days of care in 2027, the total annual percentage of change over each of the last five fiscal years are divided by four to determine the historical percentage change for the county. For positive annual percentages of change, add one to determine the county growth rate multiplier. For counties with a positive county growth rate multiplier, 2027 projected days of care are calculated by compounding the growth rate multiplier over the next four years. The Cabarrus County service area growth rate multiplier is 1.0759 which is applied to project days of care through 2027. The projected average daily census (ADC) is then calculated by dividing the projected number of inpatient acute care days of care in 2027 by 365 days.

Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	FY2023 IP DOC	County Growth Rate Multiplier	Projected Days of Care	2027 Projected ADC
Atrium Health Cabarrus	427	87	142,904	1.0759	191,478	524

Source: 2025 SMFP, Table 5A: Acute Care Bed Need Projections

The ADC is then multiplied by the appropriate target occupancy factor, listed in the table below, to determine the number of beds needed to meet the projected demand.

ADC	Occupancy Factor
ADC <100	1.5
ADC 100-200	1.4
ADC >200 and ≤400	1.33
ADC >400	1.28

Source: 2025 SMFP

Facility Name	2025 Acute Care Beds (Existing & Approved)	2024 Acute Care Bed Need Determination*	2027 Projected ADC	2027 Beds Adjusted for Target Occupancy	Projected 2027 Deficit or (Surplus)
Atrium Health Cabarrus	514	31	524	671	**126**

*Atrium Health Cabarrus was awarded 31 acute care beds per the 2024 acute care bed need determination, Project ID F-012505-24
Source: 2025 SMFP

Based on the acute care bed methodology in the 2025 SMFP, Cabarrus County service area has a need for an additional 126 acute care beds by 2027. This application is filed in response to the respective need determination. Novant Health is applying for 50 of the 126 acute care beds, which equates to approximately 40 percent of the 126 acute care beds available for Cabarrus County. Approval of the NH Cabarrus application will not preclude awarding the remaining beds to other approvable applicants, should they apply. This project will allow Novant Health to meet growing demand for acute care services and also enhance competition between it and the other health system in Cabarrus County. Enhanced competition benefits patients and insurers by increasing choice, lowering prices, and improving quality. The Agency has recognized these benefits in other reviews, including the 2022 and 2024 Buncombe County acute care bed reviews, in which it has twice approved AdventHealth's efforts to develop another hospital in Buncombe County.

Acute Care Utilization

The following table summarizes historical acute care days (exclusive of DOC provided as Level II, III and IV NICU services) provided in Cabarrus County during recent years.

Historical Acute Care Days, FFY2019-FFY2023

	2019	2020	2021	2022	2023	CAGR
Atrium Health Cabarrus	107,184	107,606	123,397	135,962	142,904	7.5%
State Totals	4,372,987	4,385,376	4,687,557	4,729,618	4,765,963	2.2%

Source: 2021 SMFP-2025 SMFP, Healthcare Planning Section

Acute care days in Cabarrus County have increased by a compound annual growth rate (CAGR) of 7.5 percent from 2019 through 2023. In stark contrast, the statewide CAGR during the same time is only 2.2 percent.

AH Cabarrus is the only existing acute care hospital in Cabarrus County; thus, its utilization triggered the need determination in the 2025 SMFP. However, any person can apply for a CON to meet the need, not just the health service facility or facilities that generated the need.[8]

Growth in Acute Care Days for NH Cabarrus Service Area Residents

NH Cabarrus's service area is explained in Section C.1. The following table summarizes historical acute care discharges for the identified service area.

NH Cabarrus Service Area
Acute Care Discharges

	CY2019	CY2023	4-YR CAGR	CY2024 Ann.*	23-24 Change
Cabarrus County	17,856	19,065	1.7%	20,062	5.2%
Rowan Co. Selected Zip Codes	1,696	3,222	17.4%	3,274	1.6%
Stanly County	6,254	6,403	0.6%	6,710	4.8%
Service Area Total	**25,806**	**28,690**	**2.7%**	**30,046**	**4.7%**

*Annualized based on 6 months data (Jan-June)
Source: HIDI Inpatient Database

Overall, acute care discharges in the service area increased by a CAGR of 2.7 percent from CY 2019 to 2023. Based on six months of available CY2024 data, the service area is expected to increase 4.7 percent compared to CY2023. Therefore, there is continued growth of acute care utilization for the service area.

The following table summarizes historical discharges for the CAC MSDRGs NH Cabarrus expects to serve in its first three project years (see Exhibit C.1 for the complete list).

NH Cabarrus Service Area
Acute Care Discharges Based on CAC DRGs

	CY2019	CY2023	4-YR CAGR	CY2024 Ann.*	23-24 Change
Cabarrus County	10,177	11,018	2.0%	11,748	6.6%
Rowan Co. Selected Zip Codes	938	1,867	18.8%	1,964	5.2%
Stanly County	3,510	3,671	1.1%	3,968	8.1%
Service Area Total	**14,625**	**16,556**	**3.1%**	**17,680**	**6.8%**

*Annualized based on 6 months data (Jan-June)
Source: HIDI Inpatient Database

[8] Even though AH Cabarrus' utilization generated the need, all applicants must demonstrate the need the population has for the services the applicant proposes. See N.C. Gen. Stat. § 131E-183(a)(3).

As illustrated in the previous table, acute care discharges for the CAC DRGs in the service area have grown at a CAGR of 3.1 percent from CY 2019 to 2023, outpacing the 2.7 percent CAGR observed for all acute care discharges. Based on six months of available CY2024 data, the service area is projected to experience an increase in acute care discharges of 6.8 percent compared to CY2023. This trend underscores the robust growth in acute care utilization for CAC MSDRGs within the service area. In fact, as shown in the comparison below, the growth in acute care discharges for CAC DRGs is significantly higher than the growth in acute care discharges in non-CAC DRGs.

NH Cabarrus Service Area
Acute Care Discharges

	CY2019	CY2023	4-YR CAGR	CY2024 Ann.*	23-24 Change
CAC DRGs	14,625	16,556	3.1%	17,680	6.8%
Other DRGs	11,181	12,134	2.1%	12,366	1.9%
Service Area Total	**25,806**	**28,690**	**2.7%**	**30,046**	**4.7%**

*Annualized based on 6 months data (Jan-June)
Source: HIDI Inpatient Database

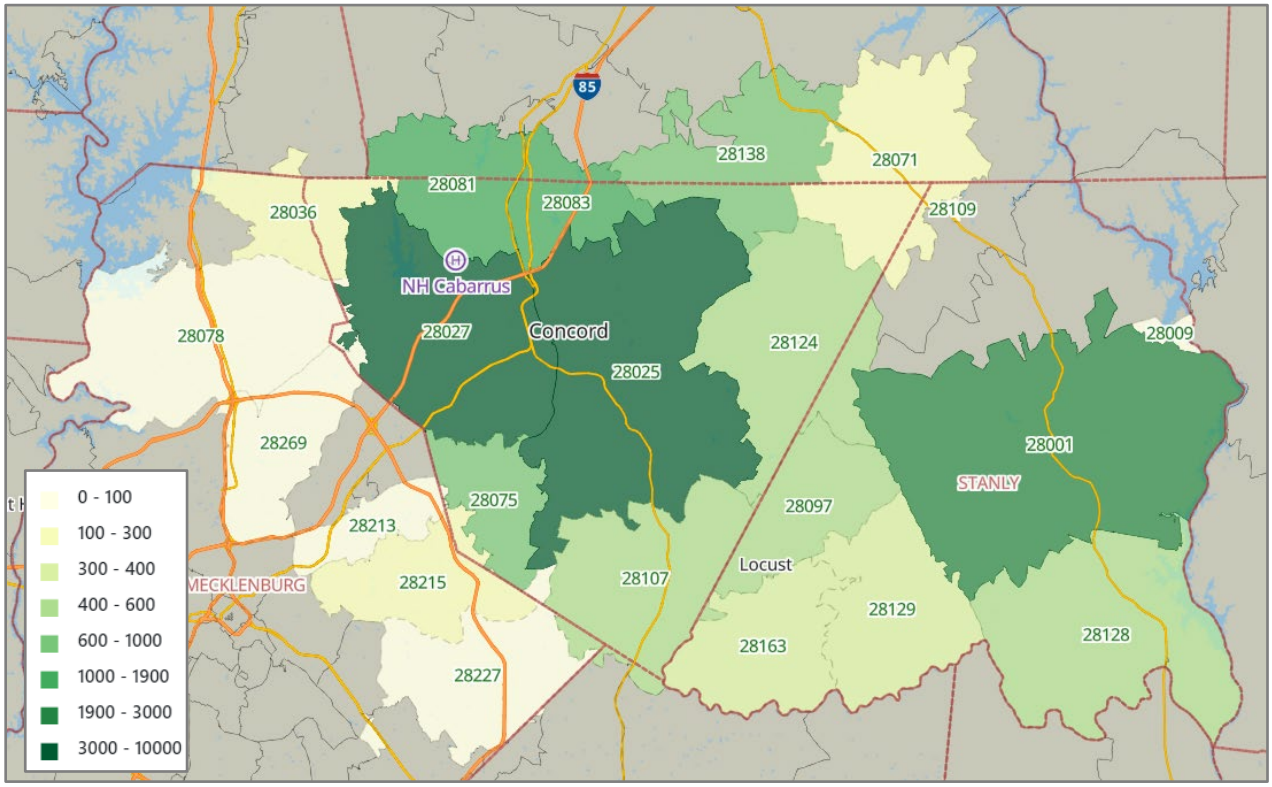
This data indicates that while there is strong overall acute care discharge growth in the NH Cabarrus service area, there is even higher growth for patients with CAC DRGs that can be served at the proposed community hospital.

To address this increasing demand, NH Cabarrus plans to develop a new 50-bed community hospital, enabling service-area residents to access a new provider of acute care services in Cabarrus County. The NH Cabarrus service area is expected to experience significant population growth and aging in the near term, further driving demand for acute care services. By providing localized, high-quality acute care, NH Cabarrus will play a pivotal role in meeting the healthcare needs of this expanding and aging population.

Access For Service Area Residents

The following map illustrates the distribution of 2023 acute care CAC MSDRG discharges by zip code within the NH Cabarrus service area.

NH Cabarrus Service Area
CAC MSDRG Discharges By Zip Code, CY2023



Source: HIDI Inpatient Database

As previously described, inpatient discharge data from the HIDI inpatient database categorizes patients by ZIP code based on their county of residence. For instance, 2023 inpatient discharge figures for ZIP code 28036 are separately recorded for Cabarrus County and Mecklenburg County. The service area CAC MSDRG discharges for 28036 include only residents of Cabarrus County. This same approach applies to ZIP codes 28078, 28269, 28213, 28215, and 28227. The NH Cabarrus service area does not include the portions of the respective zip codes that are in Mecklenburg County.

As shown in the previous map, the proposed location is proximate to the highest volume of CAC MSDRG discharges within the service area, i.e., zip codes 28087 and 28025. Therefore, the proposed location is an effective alternative for enhancing access to acute care services for Cabarrus County residents. Additionally, the proposed location is proximate to major thoroughfares including I-85, Hwy 73, Hwy 29, and Kannapolis Parkway enabling access for residents from throughout the service area.

According to the FY2023 Acute Care Patient Origin Report, 34.2 percent of Stanly County discharges travel to Cabarrus County for acute care services, and 18.4 percent travel to Mecklenburg County—with a notable number of these patients receiving care at Novant Health facilities. In response, NH Cabarrus will serve as a new, community-based provider of acute care services for Stanly County residents. By establishing this new point of access in Cabarrus County, NH Cabarrus aims to enhance the availability and timeliness of care for residents of the identified service area.

Service Area Demographics

Population Growth & Aging

The service area for acute care beds per 10A NCAC 14C .3801 (4) means the single or multi-county area as used in the development of the acute care bed need determination in the applicable State Medical Facilities Plan. This project is in response to the acute care bed need determination in Cabarrus County set forth in the 2025 SMFP. The North Carolina Office of State Budget and Management (NCOSBM) projects the following population for Cabarrus County.

Cabarrus County
Projected Population, 2025-2032

Year	Population
2025	250,391
2026	254,634
2027	259,508
2028	264,881
2029	270,420
2030	275,787
2031	280,768
2032	285,352
CAGR	1.9%

Source: North Carolina Office of State Budget & Management, Vintage 2024

NCOSBM projects Cabarrus County will experience a CAGR of 1.9 percent over the next eight years, adding approximately 35,000 new residents between 2025 and 2032. This growth rate surpasses the projected statewide growth rate of 1.1 percent during the same period.

The service area for NH Cabarrus also includes Stanly County and the zip codes that overlap Cabarrus and Rowan counties. The following table summarizes population projections for the respective areas.

Stanly County
Projected Population, 2025-2032

Year	Population
2025	65,587
2026	65,884
2027	66,177
2028	66,472
2029	66,767
2030	67,060
2031	67,356
2032	67,650
CAGR	0.4%

Source: North Carolina Office of State Budget & Management, Vintage 2024

Zip Code Population Projections, 2024-2029

	2024	2029	CAGR
28071	3,083	3,166	0.5%
28081	30,432	32,279	1.2%
28082	18,535	20,932	2.5%
28083	27,191	28,632	1.0%
28138	11,076	11,302	0.4%

Source: Sg2

Acute healthcare encounters differ across age groups, with older adults being the predominant users of medical services. This increased utilization stems from their heightened vulnerability to acute stress, driven by age-related declines in physiological reserves.[9] Compounding this susceptibility is the higher prevalence of chronic conditions such as hypertension, chronic kidney disease, and heart failure among older adults. The following table summarizes the rate of acute care discharges across various age cohorts in North Carolina, emphasizing the disproportionate reliance of older adults on healthcare services.

[9] Mattison, M. (2021). Hospital management of older adults. UpToDate. Retrieved October 10, 2022, from https://www.uptodate.com/contents/hospital-management-of-older-adults#disclaimerContent

Inpatient Stays by Age Cohort, 2018-2020
Rate of Discharges per 100,000 Population

Age Cohort	Cabarrus Co.	Rowan Co.	Stanly Co.	State
1-17	1,366.3	1,516.5	1,551.7	1,409.9
18-44	7,277.7	8,377.0	7,260.2	6,916.8
45-64	8,791.4	12,197.0	11,459.0	9,727.6
65+	**24,032.5**	**24,482.0**	**26,452.8**	**22,791.5**

Source: HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcupnet.

The following table summarizes Cabarrus County's projected population growth by age cohort.

Cabarrus County
Projected Population by Age Cohort

	2025		2032		
Age Cohort	**Population**	**% of Total**	**Population**	**% of Total**	***CAGR***
<18	59,316	23.7%	62,689	22.0%	*0.8%*
18-64	154,748	61.8%	176,360	61.8%	*1.9%*
65+	36,327	14.5%	46,303	16.2%	*3.5%*
Total	**250,391**	**100.0%**	**285,352**	**100.0%**	***1.9%***

Source: North Carolina Office of State Budget & Management

Novant Health would note that although the 65+ age group accounts for approximately 14.5 percent of Cabarrus County's population in 2025, it accounted for a disproportionate 44.4 percent of Cabarrus County acute care discharges within CAC MSDRGs in calendar year 2023.[10] As this age cohort is projected to increase by a CAGR of 3.5 percent during the next seven years, the demand for acute care services is expected to increase significantly. Therefore, NH Cabarrus's proposal to develop a new acute care hospital will ensure sufficient capacity and access to care for this rapidly growing demographic within the service area.

Socioeconomic Factors

Lack of financial resources and inadequate health insurance coverage can create access barriers to healthcare services, which can have an adverse impact on an individual's health status. In Cabarrus County, 9.1 percent of the population live below the poverty line.[11] It is estimated that 22.7 percent of the population in Cabarrus County is enrolled in Medicaid. Novant Health's existing acute care facilities provide substantial access to Medicaid patients. During CY2023, Medicaid patients accounted for 15 percent of Novant Health's Cabarrus County discharges within the CAC MSDRGs.

The U.S. Census Bureau estimates that 8.8 percent of Cabarrus County residents (under age 65 years) are without health insurance. Novant Health offers a generous financial assistance program to patients who are unable to meet

[10]HIDI Inpatient Database
[11] https://datausa.io/profile/geo/cabarrus-county-nc#health

their financial obligation, including low-income, uninsured, underinsured, or medically indigent. Novant Health's eligibility criteria for charity care apply to patients with annual household incomes up to 300 percent of the Federal Poverty Level. For example, based on the government's 2025 Federal Poverty Levels, a qualified family of four with an annual income of $96,450 (3 x $32,150 = $96,450) or less is eligible for a full Charity Care write-off of all charges incurred at a Novant Health facility in North Carolina. These patients will get no bill from NH Cabarrus, a Novant Health facility, or a Novant Health physician for services rendered.

Additionally, Section B.20 provides an extensive discussion of Novant Health's efforts to improve the accessibility, quality, and cultural relevance of acute care services for underserved populations. Novant Health will extend these efforts in Cabarrus County via development of NH Cabarrus. The proposed project will enhance Novant Health's ability to enhance access to culturally competent healthcare care services for medically underserved individuals in Cabarrus County and surrounding communities.

Enhanced Competition

Competition in healthcare markets benefits consumers by helping to contain costs, improve quality, and drive innovation. Similarly, the 2025 SMFP states the State Health Coordinating Council recognizes the importance of balanced competition and market dynamics in fostering innovation—provided that these advancements enhance safety, quality, access, and value in healthcare delivery.

Currently, Atrium Health is the sole provider of acute care services located within Cabarrus County and maintains 87.6 percent share of Cabarrus County CAC MSDRGs discharges.

Share of Cabarrus County CAC MSDRG Discharges, CY2023

Health System	CAC MSDRG Discharges	Share
Atrium Health	9,651	87.6%
Novant Health	1,161	10.5%
Other	206	1.9%
Total	11,018	100.0%

Source: HIDI Inpatient Database

Novant Health does not provide acute care services within Cabarrus County. As a result, the share of discharges presented in the previous table represents Cabarrus County patients who have chosen to receive care from Novant Health outside the county, primarily in Mecklenburg County.

For context, Novant Health's share of 1,959 discharges in the NH Cabarrus service area (1,161 Cabarrus County; 424 selected Rowan zip codes; 374 Stanly County = 1,959 discharges) accounted for a total of 7,427 days of care during CY2023, equating to an ADC of 20.3 (7,427 ÷ 365 = 20.3). When adjusted for the target occupancy rate of 66.7%, this ADC translates to a demand capable of filling 30 acute care beds. This is a compelling indicator of patient preference and need, particularly considering Novant Health does not currently operate an acute care hospital within Cabarrus County.

Expanding acute care options in Cabarrus County is essential to fostering a patient-centered healthcare system. Increased provider choices empower individuals to select healthcare services based on quality, convenience, specialized care, and personal preferences. Additionally, a more diverse acute care landscape:

- Ensures timely, high-quality medical services for patients, reducing the need for travel and minimizing delays in critical care.
- Strengthens care coordination by improving integration with primary care providers, specialists, and post-acute services, leading to better health outcomes.
- Encourages a competitive healthcare environment, which promotes cost-effectiveness, service innovation, and higher standards of care.
- Enhances local economic growth by creating new opportunities for healthcare professionals to serve the community while retaining medical talent within the county.

The proposed project will introduce a new access point for hospital services in Cabarrus County, fostering greater competition while expanding patient choice. By enhancing cost-effectiveness, quality, and access, the project ensures that more Cabarrus County residents can receive high-quality healthcare close to home. For further discussion on the proposal's effect on competition, see Section N.2.

Novant Health Physician Network

Novant Health's Physician Network is an integrated system of healthcare providers, including physician clinics, outpatient centers, and hospitals, serving communities across North Carolina, South Carolina, and Georgia. The network comprises more than 2,000 physicians and over 40,000 employees operating in over 850 locations, including 19 medical centers and numerous outpatient facilities and clinics.

Novant Health operates 15 medical clinics in Cabarrus County, including primary care and specialty care services. Novant Health also operates numerous physician clinics in Rowan County and provides primary care services in Stanly County. The extent of Novant Health's existing operations in Cabarrus and Rowan Counties supports the reasonableness of NH Cabarrus' projections in Section Q.

Key referral sources such as OB/GYN and Brain & Spine Surgery can experience significant benefits from a local Novant Health hospital in Cabarrus County, enhancing both patient care and provider collaboration. For example, a local Novant Health hospital would provide expecting mothers and gynecological patients with convenient access to high-quality care, reducing the need to travel outside the county for labor and delivery, prenatal care, and specialized gynecological procedures. This proximity fosters stronger continuity of care between OB/GYN providers and hospital-based services, streamlining referrals, and improving patient outcomes. Neurosurgical and orthopedic spine specialists would greatly benefit from having a nearby Novant Health facility equipped with advanced surgical suites and inpatient recovery services. Patients requiring surgical intervention for conditions such as herniated discs, spinal stenosis, or neurological disorders would have access to high-quality care close to home, minimizing travel burdens and expediting post-operative recovery. A local hospital would also facilitate multidisciplinary coordination with neurologists, pain management specialists, and rehabilitation services, enhancing long-term patient outcomes.

Novant Health Physician Clinics
Cabarrus/Rowan/Stanly Counties

County	Novant Health Clinic Name	Address	City	State
Cabarrus	Novant Health Brain & Spine Surgery - Concord	311 Coddle Market Dr NW	Concord	NC
Cabarrus	Novant Health GoHealth Urgent Care - Poplar Tent	5303 Poplar Tent Rd	Concord	NC
Cabarrus	Novant Health Harbor Pointe OB/GYN - Poplar Tent	9955 Poplar Tent Rd	Concord	NC
Cabarrus	Novant Health Harrisburg Family Medicine	6555 Kee Lane	Harrisburg	NC
Cabarrus	Novant Health Kannapolis Family Medicine	1035 Dale Earnhardt Blvd	Kannapolis	NC
Cabarrus	Novant Health Lakeside Primary Care - Afton	5325 Vining St NW	Concord	NC
Cabarrus	Novant Health Lakeside Primary Care - Speedway	7752 Gateway Ln	Concord	NC
Cabarrus	Novant Health Mint Hill OB/GYN - Harrisburg	6555 Kee Ln	Harrisburg	NC
Cabarrus	Novant Health OB/GYN Urgent Care - Poplar Tent	9955 Poplar Tent Rd	Concord	NC
Cabarrus	Novant Health Pediatric After Hours Care - Poplar Tent	9955 Poplar Tent Rd	Concord	NC
Cabarrus	Novant Health Pediatrics Concord	311 Coddle Market Dr NW	Concord	NC
Cabarrus	Novant Health Pediatrics Harrisburg	6555 Kee Lane	Harrisburg	NC
Cabarrus	Novant Health Primary Care Poplar Tent	9955 Poplar Tent Rd	Concord	NC
Cabarrus	Novant Health Psychiatry - Concord	845 Church St N	Concord	NC
Cabarrus	Novant Health Rehabilitation Center - Poplar Tent	9955 Poplar Tent Rd	Concord	NC
Stanly	Novant Health Lakeside Primary Care - Locust	236 Market St	Locust	NC
Rowan	Novant Health Primary Care East Rowan	316 W Main St	Rockwell	NC
Rowan	CoreLife Novant Health - Salisbury	501 N Main St	Salisbury	NC
Rowan	NH Rowan Cancer Clinics	631 Mocksville Ave	Salisbury	NC
Rowan	Novant Health Bariatric Solutions - Salisbury	1910 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Cancer Institute - Rowan	631 Mocksville Ave	Salisbury	NC
Rowan	Novant Health Carolina Women's Health Associates-China Grove	1955 S US 29 Hwy	China Grove	NC
Rowan	Novant Health Carolina Women's Health Associates-Salisbury	911 West Henderson St	Salisbury	NC
Rowan	Novant Health Fulton Heights Family Medicine	860 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health GoHealth Urgent Care - Salisbury	910 E Innes St	Salisbury	NC
Rowan	Novant Health Heart & Vascular Institute - Salisbury	401 Mocksville Ave	Salisbury	NC
Rowan	Novant Health Infectious Disease Specialists - Rowan	911 West Henderson St	Salisbury	NC
Rowan	Novant Health Inpatient Care Specialists - Rowan	612 Mocksville Ave	Salisbury	NC
Rowan	Novant Health Inpatient Stroke and Neurosciences - Rowan	612 Mocksville Ave	Salisbury	NC
Rowan	Novant Health Milestone Family Medicine	825 W Henderson St	Salisbury	NC
Rowan	Novant Health Neurology & Sleep - Rowan	1910 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Orthopedics & Sports Medicine - Manning Park	1910 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Orthopedics & Sports Medicine - Salisbury Annex	1035 Lincolnton Rd	Salisbury	NC
Rowan	Novant Health Orthopedics & Sports Medicine - Salisbury Main	810 Mitchell Ave	Salisbury	NC
Rowan	Novant Health Palliative Care - Rowan	612 Mocksville Ave	Salisbury	NC
Rowan	Novant Health Piedmont Neurosurgery & Spine	330 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Pinnacle Ear, Nose, Throat & Allergy-Salisbury	330 Jake Alexander Blvd W	Salisbury	NC

Rowan	Novant Health Primary Care East Rowan	316 W Main St	Rockwell	NC
Rowan	Novant Health Primary Care Salisbury	1904 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Primary Care South Rowan	1965 South US 29 Hwy	China Grove	NC
Rowan	Novant Health Psychiatric Medicine - Salisbury	612 Mocksville Ave	Salisbury	NC
Rowan	Novant Health Rehabilitation Center - China Grove	950 Kimball Rd	China Grove	NC
Rowan	Novant Health Rehabilitation Center - Rowan	1910 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Rehabilitation Center - Salisbury	1035 Lincolnton Rd	Salisbury	NC
Rowan	Novant Health Rehabilitation Center - Salisbury YMCA	828 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Rehabilitation Medicine - Salisbury	1910 Jake Alexander Blvd W	Salisbury	NC
Rowan	Novant Health Rowan Family Physicians	650 Julian Rd	Salisbury	NC
Rowan	Novant Health Salisbury Medical	201 Woodson St	Salisbury	NC
Rowan	Novant Health Salisbury Surgical Associates	911 West Henderson St	Salisbury	NC
Rowan	Novant Health Salisbury Urology	911 W Henderson St	Salisbury	NC
Rowan	Novant Health Sleep Center - Rowan	1910 Jake Alexander Blvd West	Salisbury	NC
Rowan	Novant Health West Rowan Family Medicine	335 School St	Cleveland	NC

A key component of Novant Health's Physician Network is the Novant Health Clinically Integrated Network (NHCIN), the first of its kind in North Carolina. NHCIN is a collaborative alliance between Novant Health and independent physicians, established to enhance patient care through improved quality, increased efficiency, and reduced healthcare costs. As the first Clinically Integrated Network in North Carolina, NHCIN enables providers to work together toward common goals, delivering value-driven, accountable care to patients.

In 2021, Novant Health partnered with Privia Health to form Privia Medical Group – North Carolina, a joint venture designed to support independent providers across the state. This partnership facilitates the transition to value-based care through the NHCIN model, offering an alternative for community physicians and provider groups.

By participating in NHCIN, providers benefit from shared resources, best practices, and a unified approach to patient care, ultimately leading to better health outcomes and a more efficient healthcare system.

Through these initiatives, Novant Health's Physician Network strives to offer a seamless and patient-centered healthcare experience, ensuring high-quality care across its service areas.

The existing Novant Health provider base in Cabarrus County and strategic efforts of the Novant Health Physician Network support the development of NH Cabarrus and its projected utilization. This project enables Novant Health to add inpatient services to the continuum of care and provide a community-based and efficient point of care for patients in a convenient location. Please see Exhibit I.2 for letters of support for the proposed project.

Community Hospital Experience

Novant Health has a proven track record of successfully developing and operating community hospitals that deliver high-quality, patient-centered care tailored to the unique needs of each region. With decades of experience, Novant Health has strategically expanded access to acute care services, integrating advanced medical technology, specialized care teams, and innovative treatment approaches to enhance healthcare delivery in growing communities.

Novant Health has established and expanded multiple community hospitals across North Carolina, ensuring residents have access to essential medical services close to home. This includes the development of full-service hospitals

offering emergency care, surgical services, women's health, orthopedics, cardiology, and more. Novant Health's de novo community hospitals include:

- Novant Health Ballantyne Medical Center
- Novant Health Clemmons Medical Center
- Novant Health Huntersville Medical Center
- Novant Health Kernersville Medical Center
- Novant Health Matthews Medical Center
- Novant Health Mint Hill Medical Center

Two additional community hospitals will open in the near future:

- Novant Health Steele Creek Medical Center
- Novant Health Scotts Hill Medical Center

Novant Health collaborates closely with local physicians, healthcare providers, and community stakeholders to design hospitals that align with the specific healthcare needs of the population. By fostering strong partnerships, Novant Health ensures seamless care coordination and continuity across outpatient clinics, specialty practices, and hospital services. Novant Health invests in state-of-the-art medical technology and digital health solutions to enhance patient care. This includes telemedicine capabilities, AI-driven diagnostics, and electronic health record systems that improve efficiency and patient outcomes.

Novant Health hospitals are recognized for their high standards of care, patient safety, and commitment to improving health outcomes. With a focus on personalized care, Novant Health ensures that community hospitals provide the same level of excellence as larger medical centers while maintaining a more intimate, patient-friendly environment.

With its deep expertise and commitment to expanding access to high-quality care, Novant Health continues to be a leader in developing community hospitals that serve as vital healthcare hubs for the communities they support. These hospitals also serve as vital economic hubs, offering well-paying jobs, and attracting other businesses. Novant Health will leverage this experience and success for the benefit of service area residents through the development of NH Cabarrus.

Summary

In summary, Novant Health demonstrates the need the population has for the proposed project based on:

- Benefits of competition for hospital services in the service area;
- Population growth and aging in the service area;
- Historical acute care discharges in the service area;
- Rate of Discharges per 100,000 Population by age cohort;
- Qualitative benefits of a new 50-bed community hospital; and
- Support of the local provider and business community for NH Cabarrus.

5. **Utilization**

a. **Complete the applicable forms listed below**. The forms are found in Section Q.

Health Service Facility Bed Utilization
Form C.1a (Prior Full FY and up to 7 Interim Full FYs)

Form C.1b (Partial FY and 1st 3 Full FYs)

Health Service Facility Bed Utilization
Form C.1a (Prior Full FY and up to 7 Interim Full FYs)
Form C.1b (Partial FY and 1st 3 Full FYs)

Facilities with more than one campus on the same license: Provide utilization for the campus identified in Section A, Question 4. However, also provide utilization for the entire facility if a CON rule or SMFP policy applies and requires utilization for the entire facility. If the proposal includes adding neonatal beds (Levels II, III, or IV), provide neonatal utilization for all three levels for the entire facility.

All other health service facilities with licensed beds: Provide utilization for the entire facility.

All applicants: Also provide utilization for the entire facility for the other facilities owned by the applicant or a related entity located in the same service area if a CON rule is applicable and requires historical or projected utilization for those other facilities.

Medical Equipment Utilization
Form C.2a (Prior Full FY and up to 7 Interim Full FYs)
Form C.2b (Partial FY and 1st 3 Full FYs)

Diagnostic centers: Provide utilization for all the types medical equipment (existing, approved, and proposed) operated by the facility.

All other facilities or health services proposing to acquire medical equipment: Provide utilization for each type of medical equipment (existing, approved, and proposed) included in the proposal for the campus identified in Section A, Question 4. However, also provide utilization for the entire facility if a CON rule or SMFP policy requires utilization for the entire facility.

Provide utilization for all the types of medical equipment (existing, approved, and proposed) operated by the facility if the proposal involves: 1) developing a new facility; 2) developing a new campus of an existing facility and the new campus will be on the same license; or 3) relocating a facility to a new campus.

All applicants: Also provide utilization for the entire facility for the other facilities owned by the applicant or a related entity located in the same service area if a CON rule is applicable and requires historical or projected utilization for those other facilities.

OR and GI Endo Room Utilization
Form C.3a (Prior Full FY and up to 7 Interim Full FYs)
Form C.3b (Partial FY and 1st 3 Full FYs)

Ambulatory Surgical Facilities: Provide utilization for the entire facility.

Hospitals: Provide utilization for the campus identified in Section A, Question 4. However, also provide utilization for the entire facility if: 1) a CON rule requires utilization for the entire facility; or 2) developing a new facility.

All applicants: Also provide utilization for the entire facility for the other facilities owned by the applicant or a related entity located in the same service area if a CON rule is applicable and requires historical or projected utilization for those other facilities.

Other Hospital Services Utilization
Form C.4a (Prior Full FY and up to 7 Interim Full FYs)
Form C.4b (Partial FY and 1st 3 Full FYs)

Provide utilization for those Other Hospital Services included in the proposal for the campus identified in Section A, Question 4. However, if the proposal includes developing a new facility, provide utilization for all Other Hospital Services for the entire facility. If the proposal includes developing a new campus of an existing facility and the new campus will be on the same license, provide utilization for all Other Hospital Services for the campus identified in Section A, Question 4.

Home health agencies should use Form C.5, not Forms C.4a and C.4b.

Home Health Utilization
Form C.5 (Partial FY and 1st 3 Full FYs)

Hospice Utilization
Form C.6 (Partial FY and 1st 3 Full FYs)

Instructions for All Forms:

- **DO NOT CHANGE** the font, font size, row height, column width, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. If the applicant must copy a form (original) and paste it into a new blank spreadsheet, the applicant should use Paste Special All and then format the new spreadsheet as follows:

  Font: Calibri
  Font Size: 10 pt
  Row Height: as close to the original as possible
  Column Width: as close to the original as possible
  Top Margin: 1
  Bottom Margin: 0.5
  Left Margin: 0.5
  Right Margin: 0.5
  Orientation: Landscape
  Left footnote: Calibri (body), 9 pt, type: "CON Application Form"
  Center footnote: Calibri (body), 9 pt, type: "Page," then select "Insert Page Number"
  Right footnote: Calibri (body), 9 pt, type: "Date of Last Revision" (use the date on the original)
  Scaling: Fit all columns on one page

- **Historical** – Provide actual annual utilization data for the last full fiscal year prior to the submission of the application. If a full year of utilization data is not available, annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.

- **Interim** – Provide projected annual utilization data for each full fiscal year starting with the first full fiscal year following the last full fiscal year prior to submission of the application until the project is complete. One year of annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include one year of annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.

- **Projected** – Provide projected annual utilization data for the first three full fiscal years after completion of the proposed project. A partial fiscal year of projected utilization data following

completion of the project may be necessary and is permissible. If it is necessary to include a partial fiscal year of projected utilization data, specify the number of months included in the partial fiscal year. Then include three full fiscal years of projected annual utilization data.

b. **Describe the assumptions and the methodology used to complete the forms in 5.a**. The description should be done in Microsoft Word or similar software and placed in Section Q, immediately following the completed form to which it relates. The applicant has the burden to demonstrate in the application as submitted that projected utilization is based on reasonable and adequately supported assumptions. Forms C.1a, C.2a, C.3a, and C.4a only request one year of historical data. However, an applicant may need to provide more years of historical data in its assumptions and methodology in order to meet its burden. If the applicant does provide more years of historical data in its assumptions and methodology, do **not** add those earlier years to the forms. Provide any supporting documentation in an Exhibit.

Please see Section Q for projected utilization. The assumptions and methodology for projecting utilization at NH Cabarrus are also included in Section Q.

c. 1) **Operating Room Proposals –** Complete **only one** of the following tables.

Existing Facility to be Expanded *	
<Insert name of facility here>	
Group Assignment	
Provide the Group Assignment as reported in Table 6A in the SMFP in effect on the application deadline	
Are you proposing that the Group Assignment will change as a result of this project?	
If you answered yes, what is the new Group Assignment?	
Explain why it is appropriate in the cell below and provide any supporting documentation in an Exhibit	
Standard hours per OR per year **	
Case Times ***	
Final inpatient case time	
Final outpatient case time	

* Includes a new proposed campus of an existing facility if the new campus will be on the same license with other campuses.

** **Standard Hours per OR per Year** – Based on the Group Assignment and Step 3 in the OR Need Methodology in Chapter 6 of the SMFP.

*** **Case Times** – From Table 6B in the SMFP. Use these case times to project surgical hours for this facility.

New Facility *
<Insert name of facility here>
Group Assignment

Provide the proposed Group Assignment	
Explain why it is appropriate in the cell below and provide any supporting documentation in an Exhibit	
Standard hours per OR per year **	
Case Times ***	
Average final inpatient case time	
Average final outpatient case time	

* Does not include a new proposed campus of an existing facility if the new campus will be on the same license with other campuses.

** **Standard Hours per OR per Year** – Based on the Group Assignment and Step 3 in the OR Need Methodology in Chapter 6 of the SMFP.

*** **Case Times** – Based on the Group Assignment and Step 4 in the OR Need Methodology in Chapter 6 of the SMFP. Use these case times to project surgical hours for this facility.

2) **Health System** – Identify all licensed or approved facilities with ORs **located in the same service area** as the facility or campus identified in response to Section A, Question 4 that are or would be part of the applicant's health system, as that term is defined in Chapter 6 of the signed SMFP in effect as of the application deadline, by completing the following tables.

- Use the facility's final case times as reported in Chapter 6 of the signed SMFP in effect as of the application deadline to project estimated surgical hours in Form C.3. If the facility does not have final case times in Chapter 6, use the average final case times for the Group.
- All campuses on one hospital license should be reported on one line as they are in Tables 6A and 6B in Chapter 6 in the SMFP.

Not applicable.

Access by Medically Underserved Groups

6. For the facility or campus identified in Section A, Question 4:

a. Briefly describe how the groups listed below will access the service components proposed in this application form:

- Low-income persons;
- Racial and ethnic minorities;
- Women;
- Persons with disabilities;
- Persons 65 and older;
- Medicare beneficiaries; and
- Medicaid recipients.

Novant Health has been recognized by organizations such as the Human Rights Campaign (HRC) Foundation and the Centers for Medicare & Medicaid Services (CMS) for its efforts to promote health equity and reduce healthcare disparities. Novant Health's Department of Equity and Inclusion is committed to ensuring equity such that each person has the appropriate access to opportunities and resources to attain their highest quality of life. Novant Health has earned accreditation in the first cohort of the National Committee for Quality Assurance's (NCQA) Health Equity

Accreditation Plus program. Novant Health is only one of two health systems in the country to receive the NCQA Health Equity Accreditation Plus status.

Existing Novant Health facilities and NH Cabarrus will continue to provide services in a manner that is consistent with:

- Title VI of the Civil Rights Act of 1963 (and any applicable amendments)
- Section 504 of the Rehabilitation Act of 1973 (and any applicable amendments); and
- The Age Discrimination Act of 1975 (and any applicable amendments)

NH Cabarrus will follow the Novant Health Financial Assistance (formerly called Charity Care) policies and Business Office policies. See Exhibit L.4 for copies of these policies. These policies do not require any financial payment for individuals requiring an urgent or emergent admission for care as determined to be medically necessary by an admitting physician. Novant Health adheres to a series of Financial Assistance and related policies that create the framework for access to services by patients with limited financial means (Financial Assistance, Uninsured Discount, and Catastrophic Settlement Policies). Uninsured patients with an annual family income less than or equal to 300 percent of the Federal Poverty Level will not get a bill. For example, based on the government's 2025 Federal Poverty Levels, a qualified family of four with an annual income of $96,450 ($32,150 x 3 = $96,450) or less is eligible for a full write-off of all charges incurred at a Novant Health facility. These patients will get no bill from NH Cabarrus, a Novant Health facility, or a Novant Health physician for services rendered.

In 2025, Novant Health expanded the Financial Assistance program to include Insured Patients who are North Carolina residents and meet certain requirements. Now Insured North Carolina resident patients whose income is below 200 percent of the Federal Poverty Guidelines may qualify for a 100 percent write off of their patient responsibility. Those whose income is between 200 – 250 percent may receive a 75 percent write off and those who are within 250 – 300 percent may receive a 50 percent write off of their patient responsibility amounts. Refer to the Financial Assistance Policy included in Exhibit L.4 for more detail.

The following demonstrates how each of the groups listed below will have access to NH Cabarrus's proposed services.

Low-income persons

Low-income persons will have access to NH Cabarrus. Novant Health is committed to assisting patients to obtain coverage from various programs as well as providing financial assistance to every person in need of medically necessary acute care services. Patients will receive the appropriate medical services, regardless of their ability to pay. Policies to provide access to services by low income, medically indigent, uninsured, or underinsured patients are described and provided in Exhibit C.6 and L.4

Racial and ethnic minorities

Racial and ethnic minorities will have access to NH Cabarrus. Novant Health will not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin.

Women

Women will have access to NH Cabarrus. Novant Health does not discriminate on the basis of gender.

Disabled persons

Disabled persons will have access to NH Cabarrus. Novant Health does not discriminate on the basis of disability. NH Cabarrus will be accessible to persons with disabilities, as required by the Americans with Disabilities Act.

Persons 65 and older

Persons 65 and older will have access to NH Cabarrus. Novant Health does not discriminate on the basis of age.

Medicare beneficiaries

Medicare beneficiaries will have access to NH Cabarrus. Novant Health does not discriminate on the basis of payor.

Medicaid recipients

Medicaid beneficiaries will have access to NH Cabarrus. Novant Health does not discriminate on the basis of payor.

b. Provide an estimated percentage of total patients for each group listed in the following table. If an applicant is unable to provide an estimate for any group, explain.

Group	Estimated Percentage of Total Patients during the Third Full Fiscal Year
Low income persons	19.0%
Racial and ethnic minorities	33.7%
Women	51.7%
Persons with disabilities	*
Persons 65 and older	44.0%
Medicare beneficiaries	31.0%
Medicaid recipients	15.0%

*Novant Health does not maintain data regarding the number of disabled persons it serves. However, as previously described, disabled persons will not be denied access to NH Cabarrus. NH Cabarrus will continue to be accessible to persons with disabilities, as required by the Americans with Disabilities Act.

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

7. a. The CON Rules which may be applicable are listed below. Check each one that applies to this proposal. Copies of the rules may be obtained online at: http://reports.oah.state.nc.us/ncac.asp.

	10A NCAC 14C .1102	Criteria and Standards for Nursing Facility or Adult Care Home Services
	10A NCAC 14C .1403	Criteria and Standards for Neonatal Services
	10A NCAC 14C .1603	Criteria and Standards for Cardiac Catheterization Equipment and Cardiac Angioplasty Equipment
	10A NCAC 14C .1703	Criteria and Standards for Open-Heart Surgery Services and Heart-Lung Bypass Machines
	10A NCAC 14C .1903	Criteria and Standards for Radiation Therapy Equipment
	10A NCAC 14C .2003	Criteria and Standards for Home Health Services
	10A NCAC 14C .2103	Criteria and Standards for Surgical Services and Operating Rooms
	10A NCAC 14C .2403	Criteria and Standards for Intermediate Care Facilities for Individuals with Intellectual Disabilities
	10A NCAC 14C .2703	Criteria and Standards for Magnetic Resonance Imaging Scanner
	10A NCAC 14C .2803	Criteria and Standards for Rehabilitation Services
	10A NCAC 14C .3703	Criteria and Standards for Positron Emission Tomography Scanner
X	10A NCAC 14C .3803	Criteria and Standards for Acute Care Beds
	10A NCAC 14C .3903	Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities
	10A NCAC 14C .4003	Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Care Facilities

b. Insert the rule here and document that the proposal is consistent with that rule.

It is permissible to state that the response can be found in another part of Section C or Section Q. In that case, identify the specific Question or Form where the response to the CON rule can be found. **However, be sure that the response in that section is consistent with the requirements of the CON rule**.

Applicants may delete any of the following subparts that are **not applicable**. However, if any of the subsequent subparts are applicable, do **not** change the number for the applicable subpart.

SECTION .3800 - CRITERIA AND STANDARDS FOR ACUTE CARE BEDS

10A NCAC 14C .3801 DEFINITIONS

The following definitions shall apply to all Rules in this Section:

(1) "Applicant hospital" means the hospital where the applicant proposes to develop the new acute care beds and includes all campuses on one license.

(2) "Approved beds" means acute care beds in a hospital that were issued a certificate of need but are not licensed as of the application deadline for the review period.

(3) "Average daily census (ADC)" means the total number of acute care days of care provided during a full fiscal year of operation divided by 365 days.

(4) "Existing beds" means acute care beds in a hospital that are licensed as of the application deadline for the review period.

(5) "Hospital system" means all hospitals in the proposed service area owned or operated by the applicant or a related entity.

(6) "Occupancy rate" means the ADC divided by the total number of existing, approved, and proposed acute care hospital beds expressed as a percentage.

(7) "Proposed beds" means the acute care beds proposed to be developed in a hospital in the application under review.

(8) "Qualified applicant" shall have the same meaning as defined in the annual State Medical Facilities Plan in effect as of the first day of the review period.

(9) "Service area" shall have the same meaning as defined in the annual State Medical Facilities Plan in effect as of the first day of the review period.

Novant Health recognizes these definitions.

10A NCAC 14C .3803 PERFORMANCE STANDARDS

An applicant proposing to develop new acute care beds in a hospital pursuant to a need determination in the annual State Medical Facilities Plan in effect as of the first day of the review period shall:

(1) document that it is a qualified applicant;

NH Cabarrus is a qualified applicant. NH Cabarrus will develop and operate a 24-hour emergency department. NH Cabarrus will provide inpatient medical services to both surgical and non-surgical patients daily within at least five of the major diagnostic categories recognized by CMS appearing on page 37 of the 2025 SMFP. Please also refer to the Applicants' responses to Section B, Question 1.b. and Section C, Question 1.

(2) provide projected utilization of the existing, approved, and proposed acute care beds for the applicant hospital during each of the first three full fiscal years of operation following completion of the project;

Novant Health does not operate any existing or approved acute care beds in Cabarrus County. See Section Q, Form C.1.b. for projected utilization at NH Cabarrus.

(3) project an occupancy rate of the existing, approved, and proposed acute care beds for the applicant hospital during the third full fiscal year of operation following completion of the project that equals or exceeds the target occupancy percentage;

See Section Q, Form C.1.b. The projected occupancy rate for NH Cabarrus in the third full fiscal year of operation exceeds the target occupancy rate of 66.7 percent for hospitals with an average daily census (ADC) of less than 100.

(4) provide projected utilization of the existing, approved, and proposed acute care beds for the hospital system during each of the first three full fiscal years of operation following completion of the project;

Novant Health does not operate any existing or approved acute care beds in Cabarrus County. See Section Q, Form C.1.b. for projected utilization at NH Cabarrus.

(5) project an average occupancy rate of the existing, approved, and proposed acute care beds for the hospital system during the third full fiscal year of operation following completion of the project that equals or exceeds the target occupancy percentage of:

(a) 66.7 percent if the ADC is less than 100;

(b) 71.4 percent if the ADC is 100 to 200;

(c) 75.2 percent if the ADC is 201 to 399; or

(d) 78.0 percent if the ADC is greater than 400; and

See Section Q, Form C.1.b. The projected occupancy rate for NH Cabarrus in the third full fiscal year of operation exceeds the target occupancy rate of 66.7 percent for hospitals with an average daily census (ADC) of less than 100.

(6) provide the assumptions and methodology used to project the utilization and occupancy rates required in Items (2), (3), (4), and (5) of this Rule.

The assumptions and methodology used to project acute care discharges and days of care at NH Cabarrus are included in Section Q.

Change of Scope and Cost Overrun Applications

8. a. Does this proposal involve a **change of scope** for a previously approved proposal(s)?

No

If you answered yes:

1) Compare the scope of this proposal with the scope of the previously approved proposal(s), identify each proposed change, and explain the need the patients to be served have for each proposed change; and
2) Provide any supporting documentation in an Exhibit.

b. Does this proposal involve a **cost overrun** for a previously approved proposal(s)?

No

If you answered yes:

1) Complete Form F.1b Capital Cost for Cost Overrun, which is found in Section Q;.
2) Compare the new capital cost with the previously approved capital cost, identify each line item that has increased or decreased, and explain why each change is necessary; and
3) Provide any supporting documentation in an Exhibit.

c. **Projected Patient Origin** – Is projected patient origin expected to be different from what was projected in the previously approved application(s) as a result of this proposal?

N/A

1) If you answered yes:
   a) Copy the tables in Question 3 above, insert them below, and provide the responses;
   b) Describe the assumptions and methodology used to project the new patient origin, including but not limited to explaining why it is expected to change as a result of this proposal; and
   c) Provide any supporting documentation in an Exhibit.
2) If you answered no, explain why not.

d. **Projected Utilization** – Is projected utilization expected to be different from what was projected in the previously approved application(s) as a result of this proposal?

N/A

1) If you answered yes, provide the new projected utilization in Section Q, including the assumptions and methodology used (see Question 5 above).

2) If you answered no, explain why not.

e. **Access by Medically Underserved Groups** – Is access by medically underserved groups expected to be different from what was projected in the previously approved application(s) as a result of this proposal?

N/A

1) If you answered yes:

   a) Copy the table in Question 6, insert it below, and provide the response;
   b) Describe the changes and explain why access by medically underserved groups is expected to change as a result of this proposal; and
   c) Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

f. **CON Rules**

1) Are there any CON rules applicable to **this** proposal that were **not** applicable to the previously approved application(s)?

N/A

2) If you answered yes, identify the CON rule(s) applicable to **this** proposal, copy each rule, insert it below, and document that this proposal is consistent with that rule.
3) Provide any supporting documentation in an Exhibit.

Section D - Criterion (3a)

G.S. 131E-183(a)(3a)

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

For cost overrun and change of scope applications, skip to Section D, Question 3.

1. a. Does the proposal in this application involve **relocating the entire facility** to another location or campus?

   No

   b. If you answered yes:

   1) Explain how the needs of the patients currently using the facility will be met following the relocation of the facility;
   2) Provide any supporting documentation in an Exhibit; and
   3) Describe the effect of the relocation of the facility on the ability of each group listed below to obtain the services provided by the facility:

      - Low income persons;
      - Racial and ethnic minorities;
      - Women;
      - Persons with disabilities;
      - Persons 65 and older;
      - Medicare beneficiaries; and
      - Medicaid recipients.

2. a. Does the proposal in this application involve **reducing or eliminating** [12] **some but not all** the service components at a health service facility?

   No

   b. If you answered yes, provide a **separate response** to this subpart for **each** facility that will lose service components as a result of this proposal.

   1) Complete the following table. Add more rows if needed.

<Insert name of facility here>		
Service Component to be Reduced or Eliminated	**Number to be Reduced or Eliminated ***	**Number Remaining**

* Provide the number of health service facility beds by type, ORs by type (shared, dedicated outpatient, dedicated C-section, or other dedicated inpatient), GI endo rooms, or medical equipment by type to be reduced or eliminated. For some health services or hospital services, there would not be a number.

[12] Reducing or eliminating includes relocating health service facility beds, health services, hospital services, or medical equipment to a different facility or campus.

2) Explain how the needs of the patients continuing to use the facility will be met following the reduction or elimination of the existing service components. Your response should include but not be limited to discussion regarding the type and number of health service facility beds, health services, hospital services, or medical equipment that will remain where they are.

3) Describe the effect of the reduction or elimination of the existing service components on the ability of each group listed below to obtain services:

- Low income persons;
- Racial and ethnic minorities;
- Women;
- Persons with disabilities;
- Persons 65 and older;
- Medicare beneficiaries; and
- Medicaid recipients.

4) If the proposal involves reducing or eliminating **Operating Rooms,** complete the following table.

<Insert name of facility here> *	
Group Assignment	
Provide the Group Assignment as reported in Table 6A in the SMFP in effect at the time the review begins	
Are you proposing that the Group Assignment will change as a result of this project?	
If you answered yes, what is the new Group Assignment?	
Explain why it is appropriate in the cell below and provide any supporting documentation in an Exhibit.	
**Standard hours per OR per year ** **	
Case Times * **	
Final inpatient case time	
Final outpatient case time	

* Includes all campuses on one license.

** **Standard Hours per OR per Year** – Based on the Group Assignment and Step 3 in the OR Need Methodology in Chapter 6 of the SMFP.

*** **Case Times** – Based on Step 4 in the OR Need Methodology in Chapter 6 of the SMFP. Use these case times to project surgical hours for this facility.

5) Complete the applicable forms listed below for the facility that will lose existing health service facility beds, health services, hospital services, or medical equipment. The forms can be found in Section Q

Form D.1 Historical and Projected Health Service Facility Bed Utilization
Form D.2 Historical and Projected Medical Equipment Utilization
Form D.3 Historical and Projected ORs and GI Endo Room Utilization
Form D.4 Historical and Projected Other Hospital Services Utilization

Describe the assumptions and the methodology used to complete the forms. The description should be done in Microsoft Word or similar software and placed in Section Q, immediately following the completed form to which it relates. Provide any supporting documentation in an Exhibit.

Instructions for All Forms:

- **DO NOT CHANGE** the font, font size, row height, column width, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. If the applicant must copy a form (original) and paste it into a new blank spreadsheet, the applicant should use Paste Special All and then format the new spreadsheet as follows:

  Font: Calibri
  Font Size: 10 pt
  Row Height: as close to the original as possible
  Column Width: as close to the original as possible
  Top Margin: 1
  Bottom Margin: 0.5
  Left Margin: 0.5
  Right Margin: 0.5
  Orientation: Landscape
  Left footnote: Calibri (body), 9 pt, type: "CON Application Form"
  Center footnote: Calibri (body), 9 pt, type: "Page," then select "Insert Page Number"
  Right footnote: Calibri (body, 9 pt, type: "Date of Last Revision" (use the date on the original)
  Scaling: Fit all columns on one page

- **Historical** – Provide actual annual utilization data for the last full fiscal year prior to the submission of the application. If a full year of utilization data is not available, annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.

- **Interim** – Provide projected annual utilization data for each full fiscal year starting with the first full fiscal year following the last full fiscal year prior to submission of the application until the project is complete. One year of annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include one year of annualized utilization data, specify the number of months for which actual utilization data is available, provide the total actual utilization data for those months and describe the method used to annualize the partial year of actual utilization data.

- **Projected** – Provide projected annual utilization data for the first full fiscal year after completion of the proposed project. A partial fiscal year of projected utilization data following completion of the project may be necessary and is permissible. If it is necessary to include a partial fiscal year of projected utilization data, specify the number of months included in the partial fiscal year. Then include the first full fiscal year of projected annual utilization data.

Cost Overrun and Change of Scope Applications

3. a. Do the changes proposed in this application now include relocating the entire health service facility to another location or campus which was **not** proposed in the previously approved application(s)?

N/A

If you answered yes, copy Question 1.b, insert it below, and provide a response.

b. Do the changes proposed in this application now include reducing or eliminating service components at an existing health service facility which were **not** proposed to be reduced or eliminated in the previously approved application(s)?

N/A

If you answered yes, copy Question 2.b, insert it below, and provide a response for the service components that will be reduced or eliminated as a result of this proposal.

Section E - Criterion (4)

G.S. 131E-183(a)(4)

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

1. Are there any alternative methods of meeting the need for the proposal available to the applicant?

   Yes

2. If you answered yes:

   a. Describe each alternative method available to the applicant to meet the need for the proposal;

      1. Do not apply for acute care beds and maintain the status quo.
      2. Develop a different number of acute care beds at NH Cabarrus,
      3. Develop the hospital at another location.

   b. For each alternative method **not** selected, explain how that alternative would be more costly or less effective for the applicant than the selected alternative; and

Maintain the Status Quo

Under the current status quo, Novant Health would not seek approval to develop a new acute care hospital in Cabarrus County. However, this approach is not the most effective option, as it would fail to enhance competition within the acute care service area and deny patients the benefits of greater choice. As outlined in Section C.4, increased hospital competition leads to numerous positive effects, including improved quality, accessibility, and affordability of care.

Furthermore, Novant Health has identified the need for the proposed services within the service area. Maintaining the status quo would leave this need unmet, depriving residents of expanded access to essential inpatient, emergency and surgical services. This outcome would not align with the goal of optimizing healthcare availability and efficiency in the region.

For these reasons, maintaining the status quo is not the most effective or beneficial alternative at this time.

Develop a Different Number of Acute Care Beds at NH Cabarrus

As an alternative to the proposed project, Novant Health could have applied for a different number of acute care beds at NH Cabarrus. However, after careful evaluation, Novant Health determined that applying for a smaller number of acute care beds would be insufficient to adequately address the growing healthcare needs of service area residents. As outlined in Section C.4, Novant Health has identified over 16,556 patient discharges from the acute care service area that could be appropriately served by the proposed hospital. In CY2023, these patients required 74,952 days of care, translating to an average daily census of 205. While a larger hospital could be supported by this patient volume, the 2025 State Medical Facilities Plan (SMFP) has identified a need for 126 additional acute care beds in the service area.

Novant Health is applying for 50 of the 126 acute care beds, representing approximately 40 percent of the total acute care beds available for Cabarrus County. The proposed complement of 50 beds was determined to be adequate to

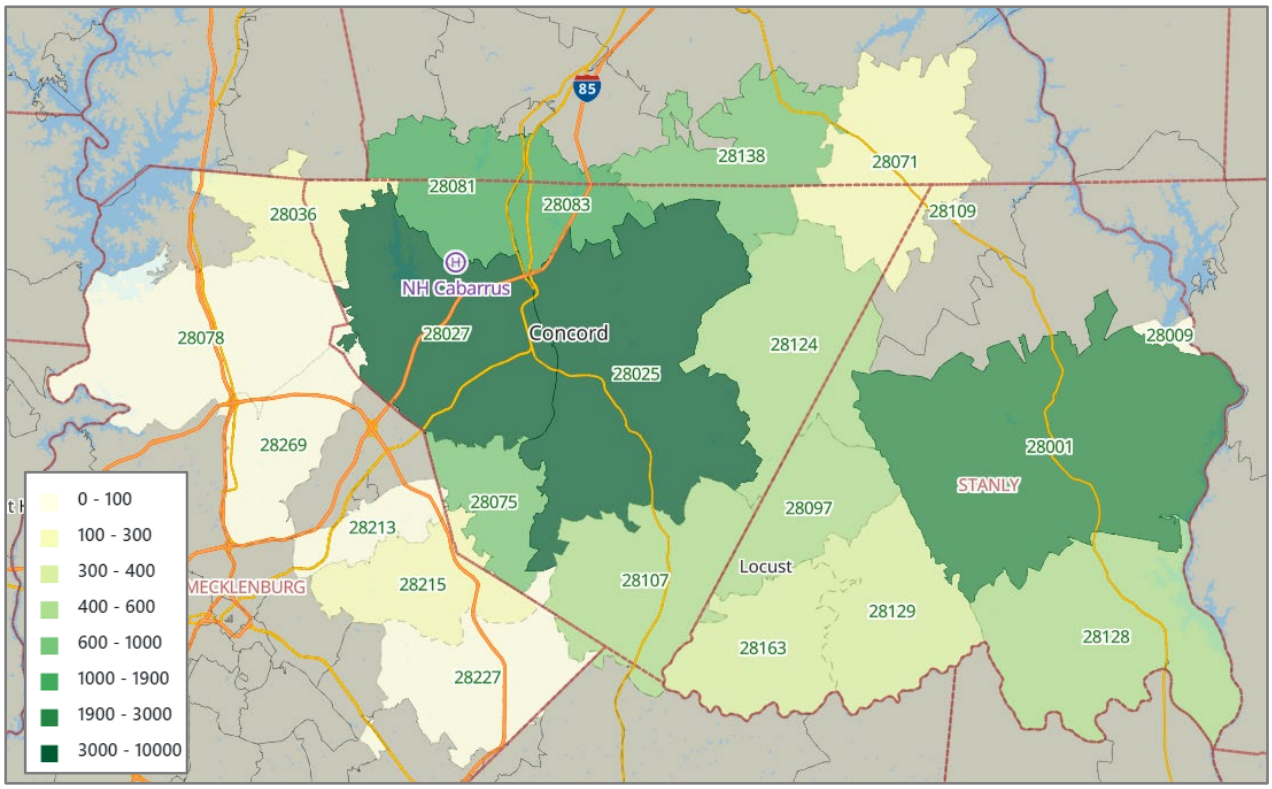
promote operational efficiencies and economies of scale. The proposed complement of beds also enables the existing health system to expand its acute care capacity as needed.

This project will allow Novant Health to meet growing demand for acute care services and also enhance competition between it and the other health system in Cabarrus County. Therefore, the proposed project is the most effective alternative available to Novant Health at this time.

Develop NH Cabarrus at a Different Location in the Service Area

Another alternative is to develop NH Cabarrus at a different location in the service area. The following map illustrates the distribution of acute care discharges by zip code within the service area.

NH Cabarrus Service Area
Acute Care CAC MSDRG Discharges By Zip Code, CY2023



As shown in the previous map, the proposed location is proximate to the highest volume of CAC MSDRG discharges within the service area, i.e., zip codes 28087 and 28025. Therefore, the proposed location is an effective alternative for enhancing access to acute care services for Cabarrus County residents. Additionally, the proposed location is proximate to major thoroughfares including I-85, Hwy 73, Hwy 29, and Kannapolis Parkway enabling access for residents from throughout the service area.

For these reasons, Novant Health determined the alternative to develop NH Cabarrus at a different location is not the most effective alternative at this time.

c. Provide any supporting documentation in an Exhibit.

Not applicable.

3. If you answered no:

a. Explain why there is no alternative method available to the applicant of meeting the need for the proposal; and

b. Provide any supporting documentation in an Exhibit.

Section E, Question 3 is not applicable. Novant Health has described in the alternatives in Section E, Question 2.

Section F - Criterion (5)

G.S. 131E-183(a)(5)

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

For cost overrun and change of scope applications, skip to Section F, Question 5.

Capital Cost and Availability of Funds for the Capital Cost

1. a. Complete Form F.1a Capital Cost, which is found in Section Q.

   b. Describe the **assumptions** used to project the capital cost.

   - The description should be done in Word or similar software.
   - Include it in Section Q immediately following the completed form to which it relates.
   - Provide any supporting documentation in an Exhibit.

Please refer to Section Q for Form F.1a. and the assumptions used to project the capital cost. Please see Exhibit F.1 for the project's cost certification letter.

2. a. All applicants complete the following table(s).

   - Add the name of each applicant in the blank cell in the first row of each table. The name should match the name in Section A, Question 1.
   - Add additional tables if there are more than 3 applicants that will incur an obligation for any portion of the capital cost.
   - The sum of the dollar amounts in the row labeled "**Total to be Incurred by Applicant …**" in each table should equal Line 14 on Form F.1a or Form F.1b.

Applicant 1	**Novant Health Cabarrus Medical Center, LLC**
Loans	$
Cash and Cash Equivalents, Accumulated Reserves, or Owner's Equity	$
Bonds	$
Other (**Describe**)	$
Total to be Incurred by Applicant 1	**$**

Applicant 2	**Novant Health, Inc.**
Loans	$
Cash and Cash Equivalents, Accumulated Reserves, or Owner's Equity	$336,434,895
Bonds	$
Other (**Describe**)	$
Total to be Incurred by Applicant 2	**$336,434,895**

b. Loans – If financing any portion of the capital cost with a loan, document that the prospective lending institution(s) would consider financing the proposed project. The documentation for each loan should be provided in an Exhibit and should include the:

- Proposed borrower;
  - Note: if the borrower is **not** the applicant, document that the borrower is willing to commit the proceeds of the loan for the capital cost of the project.
- Purpose of the loan;
- Proposed interest rate;
- Proposed term (period of the loan);
- Proposed amount of the loan; and
- Amortization schedule.

Not applicable. Novant Health will not fund this project using a commercial loan.

c. Cash and Cash Equivalents, Accumulated Reserves, or Owner's Equity – If financing any portion of the capital cost with cash and cash equivalents, accumulated reserves, or owner's equity:

1) Identify each legal entity that will provide cash and cash equivalents, accumulated reserves, or owner's equity for any portion of the capital cost of the project;

Novant Health, Inc.

2) Document that each legal entity is willing to commit cash and cash equivalents, accumulated reserves, or owner's equity for the capital cost of the project; and

Please see Exhibit F.2 for a letter from Alice Pope, Executive Vice President and Chief Financial Officer, Novant Health, Inc., documenting the availability of accumulated reserves for this project.

3) For each legal entity identified in response to Question 2.a, document that the cash and cash equivalents, accumulated reserves, or owner's equity that will be used to finance the capital cost are reasonably likely to be available when needed.

Please see Exhibit F.2 for a letter from Alice Pope, Executive Vice President and Chief Financial Officer, Novant Health, Inc., documenting the availability of accumulated reserves for this project and for a copy of Novant Health's most recent audited financial statements.

d. Other Forms of Financing – If financing any portion of the capital cost through bonds or some other form of financing:

1) Describe the source of the financing; and
2) Document that the source of the financing is reasonably likely to make the funds available for the project.

Not applicable. Novant Health will not fund this project with bonds or other financing.

Working Capital and Availability of Funds for Working Capital

3. a. **All applicants**

Start-up Costs *	Will the applicant incur any start-up costs?	Yes
Initial Operating Costs *	Will the applicant incur any initial operating costs?	Yes

* The term is defined in the Definitions Section of the application form.

1) If you answered no to either question, explain why not.

2) If you answered yes to either question, respond to the remainder of Question 3.

b. **Start-up costs**

Total estimated start-up costs	$4,799,992

Identify the types of costs included in the total estimated start-up costs by checking **all** that apply in the following table.

X	Utilities	X	Hiring Staff
	Mortgage or Rent	X	Training Staff
	Purchasing Equipment	X	Fees
X	Purchasing Supplies	X	Other (**Insurance; Building & Grounds Maintenance**)
X	Marketing or Advertising		

c. **Initial operating costs**

Initial operating period *	15 months
Total estimated initial operating costs during the initial operating period	$22,117,557

* The term is defined in the Definitions Section of the application form.

d. **Total working capital** *

$26,917,549

* Should equal the sum of the total estimated start-up costs in Question 3.b and the total estimated initial operating costs in Question 3.c.

e. Describe the **assumptions** used to estimate the:

1) Initial operating period;

The initial operating period is the time for cash in-flow to exceed cash out-flow. Based on the financials for this project, that period is 15 months. This time period accounts for the time required to obtain Medicare certification .

2) Start-up costs; and

Start-up expenses include staffing salaries and benefits for training. Executive level positions will start 9 months prior to opening, Director, Manager, Supervisor positions will start 3 months prior to opening, and all other positions will start one month prior to opening. Start-up costs also include Medical/Surgical and Other Supplies to

bring the facility to par levels (3 months). Independent contractors (1 month), building and grounds maintenance (3 months), insurance (3 months), and rental expenses (3 months) will also be incurred during the nine-month startup period.

Startup Expense	Amount
Salaries (from Form H Staffing)	$2,855,384
Taxes and Benefits	$686,490
Independent Contractors	$127,794
Medical Supplies	$511,515
Other Supplies	$461,355
Building & Grounds Maintenance	$100,593
Insurance	$53,565
Rental Expense	$3,296
Total	**$4,799,992**

3) Initial operating costs.

The initial operating costs calculate the amount of cash required to cover the loss during the period before cash in-flow exceeds cash out-flow.

f. **Sources of Financing for Working Capital**

- Add the name of each applicant in the blank cell in the first row of each table. The name should match the name in Section A, Question 1.
- Add additional tables if there are more than 3 applicants that will incur an obligation for any portion of the working capital.
- The sum of the dollar amounts in the row labeled "**Total to be Incurred by Applicant …**" in each table should equal the amount reported in Question 3.d.

Applicant 1	**Novant Health Cabarrus Medical Center, LLC**
Loans	$
Cash or Cash Equivalents, Accumulated Reserves or Owner's Equity	$
Lines of credit	$
Bonds	$
Total to be incurred by Applicant 1	$

Applicant 2	**Novant Health, Inc.**
Loans	$
Cash or Cash Equivalents, Accumulated Reserves or Owner's Equity	$26,917,549
Lines of credit	$
Bonds	$
Total to be incurred by Applicant 2	$

g. Loans – If financing any portion of the working capital with a loan, document that the prospective lending institution(s) would consider financing the working capital. The documentation for each loan should be provided in an Exhibit and should include the:

- Proposed borrower;
  - Note: if the borrower is **not** the applicant, document that the borrower is willing to commit the proceeds of the loan for the working capital.
- Purpose of the loan(s);
- Proposed interest rate(s);
- Proposed term (period of the loan(s));
- Proposed amount of the loan(s); and
- Amortization schedule.

h. Cash or Cash Equivalents, Accumulated Reserves or Owner's Equity – If financing any portion of the working capital with cash or cash equivalents, accumulated reserves or owner's equity:

1) Identify each legal entity that will provide cash or cash equivalents, accumulated reserves or owner's equity for any portion of the working capital;

Novant Health, Inc.

2) Document that each legal entity is willing to commit cash or cash equivalents, accumulated reserves or owner's equity for the working capital; and

Please see Exhibit F.2 for a letter from Alice Pope, Executive Vice President and Chief Financial Officer, Novant Health, Inc., documenting the availability of accumulated reserves for this project.

3) For each legal entity identified in response to Question 2.a, document that the cash or cash equivalents, accumulated reserves or owner's equity that will be used to finance the working capital are reasonably likely to be available when needed.

Please see Exhibit F.2 for a letter from Alice Pope, Executive Vice President and Chief Financial Officer, Novant Health, Inc., documenting the availability of accumulated reserves for this project and for a copy of the most recent audited financial statements.

i. Other Forms of Financing – If financing any portion of the working capital through a line of credit, bonds or some other form of financing:

1) Describe the source of the financing; and
2) Document that the source of the financing is reasonably likely to make the funds available for the working capital.

Not applicable.

Financial Feasibility – Availability of Funds for Operating Needs and Projected Costs and Charges

4. a. **Describe the assumptions and methodology used to complete each form in 4.b**. The forms are found in Section Q.

The description of the assumptions and methodology used for each form should be done in Microsoft Word or similar software and should address each line item on that form. Include the description in Section Q, immediately following the completed form to which it relates.

The assumptions and methodology used to complete each applicable form identified in Section F, Question 4.b are included in Section Q.

b. **All Applicants** should complete the following Revenues and Operating Costs forms as instructed below.

- Form F.2a Historical and Interim Revenues and Net Income
- Form F.2b Projected Revenues and Net Income upon Project Completion
- Form F.3a Historical and Interim Operating Costs
- Form F.3b Projected Operating Costs upon Project Completion

ASFs should complete the revenues and operating costs forms for ORs, GI endo rooms, procedure rooms, and the entire facility.

Combination nursing home facilities should complete the revenues and operating costs forms for NF beds, ACH beds, and the entire facility.

CCRCs should complete the revenues and operating costs forms for NF beds, ACH beds, and the entire health service facility. Provide projected revenues and operating costs for the independent living units only if required to demonstrate the financial feasibility of the proposal.

Diagnostic Centers should complete the revenues and operating costs forms for each service component and the entire facility.

Hospice inpatient facilities that also have hospice residential care beds should complete the revenues and operating costs forms for hospice inpatient beds, hospice residential care beds, and the entire facility.

Hospitals should complete the revenues and operating costs forms for each hospital service included in this proposal. Also complete these forms for the entire facility **if** the proposal involves:

- Developing a new facility;
- Developing a new campus of an existing facility; and
- Projected revenues and operating costs for the entire facility are necessary to demonstrate financial feasibility of the proposal.

All other applicants should complete the revenues and operating costs forms for the entire facility, i.e. mobile services not part of a facility.

General Instructions for the Revenues and Operating Costs forms

- **Historical** – Provide actual revenues and operating costs for the last full fiscal year prior to the submission of the application. If a full year of data is not available, annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include annualized data, specify the number of months for which actual data is available,

provide the total actual data for those months and describe the method used to annualize the partial year of actual data.

- **Interim** – Provide projected annual revenues and operating costs for each full fiscal year starting with the first full fiscal year following the last full fiscal year prior to submission of the application until the project is complete. One year of annualized data may be necessary to complete the form as requested and is permissible. If it is necessary to include one year of annualized data, specify the number of months for which actual data is available, provide the total actual data for those months and describe the method used to annualize the partial year of actual data.
- **Projected** – Provide projected annual revenues and operating costs for the first three full fiscal years after completion of the proposed project. A partial fiscal year of projected data following completion of the project may be necessary and is permissible. If it is necessary to include a partial fiscal year of projected data, specify the number of months included in the partial fiscal year. Then include three full fiscal years of projected annual data.

NFs and ACHs should also complete Form F.4 Charges and Reimbursement Rates (Partial FY and 1st 3 Full FYs).

Home Health Agencies should also complete Form F.5 Charges, Costs, and Reimbursement Rates per Visit (Partial FY and 1st 3 Full FYs).

Hospice Home Care Agencies should also complete Form F.6 Charges and Reimbursement Rates per Visit (Partial FY and 1st 3 Full FYs).

General Instructions for All Forms

DO NOT CHANGE the font, font size, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. If the applicant must copy a form (original) and paste it into a new blank spreadsheet, the applicant should use Paste Special All and then format the new spreadsheet as follows:

Font: Calibri
Font Size: 10 pt
Row Height: as close to the original as possible
Column Width: as close to the original as possible
Top Margin: 1
Bottom Margin: 0.5
Left Margin: 0.5
Right Margin: 0.5
Orientation: Landscape
Left footnote: Calibri (body), 9 pt, type: “CON Application Form”
Center footnote: Calibri (body), 9 pt, type: “Page,” then select “Insert Page Number”
Right footnote: Calibri (body, 9 pt, type: “Date of Last Revision” (use the date on the original)
Scaling: Fit all columns on one page

Each applicable form identified in Section F, Question 4.b is included in Section Q.

c. **Professional Fees**

Will the facility identified in Section A, Question 4, bill the patient for any professional fees such as interpretation of radiological studies by a radiologist or review of specimens by a pathologist?

No

If you answered yes, include the cost of professional fees in Form F.3. Each type of professional fee should be on its own separate line and should not be combined with other professional fees (additional rows may be inserted). For example, do not combine professional fees for interpretation of radiological studies on the same line with professional fees for review of specimens by a pathologist.

Cost Overrun and Change of Scope Applications

5. a. **Cost Overrun Proposals** – Copy Question 2, insert it below, and provide a response for the difference between the previously approved capital cost and the new projected capital cost.

b. **Change of Scope or Cost Overrun Proposals**

1) Do the proposed changes to the scope or the cost overrun result in changes to **total working capital** from the previously approved application(s)?

☐

a) If you answered yes:

i) Complete the following table;

Line 1	New total estimated start-up costs	$
Line 2	New total estimated initial operating costs during initial operating period	$
Line 3 (Line 1 + Line 2)	New total working capital	$
Line 4	Previously approved total working capital	$
Line 5 (Line 3 – Line 4)	Difference	$

ii) Explain why total working capital is expected to change as a result of this proposal; and

iii) If total working capital has **increased**, provide documentation of the availability of the additional funds needed in an Exhibit.

b) If you answered no, explain why not.

2) Do the proposed changes to the scope or the cost overrun result in different **revenue and operating cost** projections from the previously approved application?

☐

a) If you answered yes:

i) Describe the changes and explain why projected revenues are expected to change during the first three full fiscal years of operation as a result of this proposal;

ii) Describe the changes and explain why projected operating costs are expected to change during the first three full fiscal years of operation as a result of this proposal; and

iii) Provide new proformas in Section Q (see Question 4 above).

b) If you answered no, explain why not.

Not applicable. The project does not involve a cost overrun or change in scope.

Section G - Criterion (6)

G.S. 131E-183(a)(6)

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

For cost overrun and change of scope applications, skip to Section G, Question 3.

a. a. Identify all existing and approved health service facilities located in the proposed service area that provide the same service components proposed in this application.

The service area for acute care beds per 10A NCAC 14C .3801 (4) means the single or multi-county area as used in the development of the acute care bed need determination in the applicable State Medical Facilities Plan. This project is in response to the acute care bed need determination in Cabarrus County set forth in the 2025 SMFP. Atrium Health Cabarrus (H0031) is the only licensed acute care hospital in the service area. Atrium Health is approved to develop 44 acute care beds at Atrium Health Harrisburg by relocating 13 acute care beds from AH Cabarrus and developing 31 pursuant to the need determination in the 2024 SMFP (CON Project ID # F-12505-24; CON Project ID # F-12255-22).

a. If available from the SMFP or license renewal application forms on file with the Division of Health Service Regulation, for each existing facility identified above, provide the total annual utilization for each service component proposed in this application during the last full fiscal year prior to the application deadline.

The following provides publicly available FY2023 days of care data obtained from the 2025 SMFP.

Facility Name	FY2023 IP Days of Care
Atrium Health Cabarrus	142,902

Source: 2025 SMFP, Table 5A

2. a. Explain why the proposed project will not result in an unnecessary duplication of the existing or approved health service facilities located in the proposed service area that provide the same service components proposed in this application.

b. Provide any supporting documentation for your response in an Exhibit.

The proposed project will not result in unnecessary duplication of existing or approved facilities in Cabarrus County. The 2025 SMFP has identified a need for 126 additional acute care beds in the service area because acute care utilization in the service area is projected to exceed the capacity of the existing and approved acute care beds in Cabarrus County. Novant Health does not operate any hospitals in Cabarrus County.

As described in Section C.4, Novant Health demonstrates the need the population has for the proposed project based on demographic data, historical service area utilization, and qualitative benefits, including hospital competition. Please see Section Q for projected utilization for the proposed project.

Currently, there is only one acute care hospital provider in the service area; therefore, the Cabarrus County service area lacks competition. Section C.3 describes many of the benefits of healthcare competition.

While Atrium Health operates two freestanding emergency rooms (FSERs) in Cabarrus County, the respective FSERs do not offer inpatient services; thus, they are not comparable in scope to the services proposed at NH Cabarrus and

will not result in any unnecessary duplication. Furthermore, Novant Health's ED visit projections are conservative in nature and considered the presence of the FSERs in the service area. See Exhibit Q for additional information.

Sections C.4 and E.2 describe in detail why alternative scopes are not the most effective means of developing the proposed project.

The response to Section C, Question 12 (Performance Standards) demonstrates that by CY2032, the third full project year, NH Cabarrus will exceed the minimum occupancy threshold identified in 10A NCAC 13C .3803(5).

Cost Overrun and Change of Scope Applications

3. a. Do the proposed changes to the scope or the cost overrun include adding service components that were **not** included in the previously approved applications(s)?

N/A

b. If you answered yes:

1) Identify the new service components included in this proposal that were **not** included in the previously approved application(s); and

2) For each new service component included in this proposal, explain why this proposal will not result in an unnecessary duplication of the same existing or approved service component located in the service area.

c. If you answered no, explain why not.

Section H - Criterion (7)

G.S. 131E-183(a)(7)

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

For cost overrun and change of scope applications, skip to Section H, Question 4.

1. **Staffing** – Complete Form H Staffing, which is found in Section Q, as follows:

   - Acute care hospitals should complete the form for the service components included in this proposal. However, if the proposal involves developing a new hospital or developing a new campus of an existing hospital, the applicant should complete the form for the entire facility or new campus.
   - All other applicants should complete the form for the entire facility or health service (mobile health service).

   Instructions:

   - **DO NOT CHANGE** the font, font size, margins, borders, shading, footnotes, or the orientation from landscape to portrait. The spreadsheets are set up to fit all columns on one page. Applicants may add rows for position types not listed and may delete rows for position types that are not relevant to the type of facility identified in Section A, Question 4.b.
   - For each staff position, which **includes employees, contract employees and temporary employees**, provide the **average annual salary** for one full-time equivalent (FTE) position (2,080 hours per year per FTE).
   - For current staffing, identify the position types and the number of FTEs as of a specific date as close as possible to the date the application is expected to be submitted.
   - For projected staffing, **describe the assumptions and methodology used to project:**
     - The type of positions included;
     - The number of FTE positions for each type; and
     - The average annual salary for each position type.
   - The description of the assumptions should be done in Microsoft Word or similar software and placed in Section Q, immediately following the completed spreadsheet to which they relate.

Please see Form H in Section Q.

The Form H Staffing is based on Novant Health's experience providing inpatient acute care services at comparable facilities. Projected staffing levels at NH Cabarrus each year are based on the utilization projections described in Section Q. Salaries are based on Novant Health experience for each job title.

2. **Staff Recruitment** – Describe the methods used or to be used by the facility identified in response to Section A, Question 4, to recruit or fill vacant or new positions.

Novant Health is a major employer in North Carolina and has historically been able to recruit and retain clinical and non-clinical personnel for its healthcare facilities. Novant Health will recruit through its established regional and corporate Human Resources Departments should any recruitment be necessary. Novant Health corporate and regional human resources personnel will be available to recruit needed team members for the proposed project. Positions are filled through a combination of advertisements in local newspapers, trade journals, and on the Novant Health website. Periodic job fairs and open houses also help in attracting staff. Recruitment ads run in the regional newspapers where Novant Health has facilities and in national professional journals to fill a wide variety of clinical

hospital personnel positions. Based on Novant Health's past experience, the management team does not foresee any major difficulty or significant challenges in recruiting personnel. It is Novant Health's practice to recruit and hire qualified personnel who live in the community hospital services area whenever possible.

While Novant Health is not immune to the healthcare workforce challenges that have affected facilities in North Carolina and nationwide, Novant Health is aggressively working to attract and retain qualified staff and believes it is well positioned to do so. There are several measures in place to ensure the availability of qualified staff for the proposed project.

Novant Health is strengthening its relationships with area universities and colleges. Novant Health recently hosted a networking event at Queens University of Charlotte, which offers a baccalaureate degree program in nursing and a Master of Science in Nursing program. Novant Health also uses scholarship programs to recruit personnel. Novant Health also connects program alumni with students and potential students, e.g., CNAs desiring to transition to a registered nurse. See the Novant Health list of Clinical Education Programs with which Novant Health has established relationships (Exhibit M.1). Many students rotate through Novant Health hospitals and physician practices, and often apply for jobs at Novant Health upon graduation. Novant Health's long-standing relationships with area Universities and colleges creates a consistent pipeline of new nursing hires.

Novant Health offers competitive salaries and benefits to attract and retain qualified personnel. Salaries and benefits are periodically reviewed for all positions at Novant Health's facilities in each market and compared to those offered by competitors. Novant Health offers various recognition and bonus programs to clinical and non-clinical staff at its facilities. Novant Health recently announced an adjustment to its minimum wage from $12.50 per hour to $15 per hour. This change, effective January 2021, benefits over 2,000 additional clinical and non-clinical team members.

Novant Health recognizes the importance of providing team members who are new parents an opportunity to bond with a newborn or newly adopted child. Effective January 1, 2020, Novant Health offered eligible full-time and part-time team members paid parental leave for bonding with a newborn or newly adopted child. Parental leave applies to both maternity and paternity leave.

Novant Health takes a family-friendly approach to benefits, flexible schedules, and its support of a healthy work-life balance among its employees. This focus on building an innovative and employee-centric work environment has resulted in substantial recognition within the human resources sphere: Novant Health has received multiple awards and recognitions for its employee development programs and its efforts to create an inclusive and supportive workplace. In 2016, Becker's Hospital Review recognized Novant Health as one of the 150 best places to work in healthcare. In 2021, Diversity MBA magazine named Novant Health the #1 Best Place to Work for women and diverse managers, after it had included Novant Health on its list of award recipients in the five years from 2016 to 2020. Forbes magazine has also recognized Novant Health as a leading employer in supporting diversity in the workforce and named Novant Health to its annual Best Employers for Women and Diversity lists in 2017–2020. In 2019, Forbes names Novant Health the sixth best sixth-best employer in North Carolina. Novant Health has long been a promoter of cultural awareness, and its Employee Resource Groups ("ERGs") and Business Resource Groups ("BRGs") have ranked highly on several lists published by the Association of ERGs and Councils. Novant Health has been recognized as a best place to work for LGBTQ employees, employees with disabilities, and military veterans. In 2017, the Human Rights Campaign Foundation, the educational arm of the country's largest LGBTQ civil rights organization, recognized Novant Health's acute care hospitals as leaders in LGBTQ healthcare equity.

The following table highlights NH's recent achievements:

2015 – 2025 Achievements
America's Greatest Places to Work for Diversity by Newsweek (2024) – Rated 5 of 5 Stars
America's Greatest Places to Work for Women by Newsweek (2024) – Rated 4.5 of 5 Stars
America's Greatest Places to Work for Job Starters by Newsweek (2024) – Rated 4.5 of 5 Stars
Leaders in LGBTQ+ Healthcare Equality" by the Human Rights Campaign Foundation (HRC) (2024)
#17 of 50 Out Front Best Places to Work for Women & Diverse Managers by Diversity MBA Magazine (2023)
#38 in NC - Americas Best Employers by State by Forbes (2023)
Healthiest Employer for Greater Charlotte & Triad Region per Charlotte &Triad Business Journals (2023)
America's Best Employers for Diversity by Forbes - (2022–2023)
20 Best Employers in North Carolina by Forbes (2022)
Diversity Impact Award from Association of Employee Resource Groups (2022)
Diversity MBA Magazine #1 Best Places for Women & Diverse Managers to Work (2021)
LinkedIn Top Companies: Charlotte #6 (2021)
Best Place to Work for Disability Inclusion through the Disability Equality Index by Disability: IN (2020-2023)
Diversity MBA's 50 Out Front: Best Places to Work for Women & Diverse Managers (2016–2020)
The Best Employers for Women by Forbes (2017, 2020)
The Best Employers for Diversity by Forbes (2017–2020)
Leaders in LGBTQ Healthcare Equality through the Healthcare Equality Index by the Human Rights Campaign (2017– 2020)
7 BRGs have received Top 25 ERG Category (2016–2020)
Health Equity Council received Top 10 Diversity Action Award (2020)
Cross Cultural Communications Program received Top 10 Diversity Action Award (2020)
Board of Trustees awarded NACD NXT, No. 1 Diversity Innovator in America (2019)
North Carolina Vet Biz Corporate Supporter Award (2019)
Supplier Diversity Excellence Award from Vizient (2019)
Best Overall Project by the Disparities Leadership Program faculty (2017)
CMS Inaugural Award for Health Equity (2017)
HIMSSS Davies Award of Excellence (2017)
Becker's Hospital Review 150 Best Places to Work (2016)
Mechanics and Farmers Bank Founders Award — for principles that include diversity (2015)

Novant Health recently began coordinating with an agency to recruit qualified international nurses. The agency coordinates housing, banking, and language services to ensure a smooth transition into the community. Novant Health will leverage the language and cultural competencies of the international staff to promote inclusivity while meeting the clinical needs of its diverse populations.

Novant Health is dedicated to providing outstanding and compassionate care and service as well as finding team members who are dedicated to the same goal. Novant Health's philosophy is that it is easier to recruit and retain employees when they know that patients, families, and co-workers appreciate the work they do. This philosophy will continue to apply to the employees and staff at NH Cabarrus.

Novant Health is an equal opportunity employer. Novant Health is committed to the principles of excellence, fairness, and respect for all people. As part of this commitment, Novant Health actively values diversity in the workplace and seeks to take advantage of the rich backgrounds and abilities of everyone.

It is Novant Health's policy to consider all applicants for employment equally, regardless of race, color, religion, sex, national origin, age, disability, veteran's status, genetic information, sexual orientation, or gender identity, and to give them opportunities to progress in the organization consistent with their skills and interests.

3. **Staff Training** – Describe the training programs and continuing education programs currently in place or to be used in the facility identified in response to Section A, Question 4.

Novant Health will continue to require all clinical employees to complete orientation, as well as training specific to their position. Novant Health will continue to require clinical staff members to maintain current licensure and certification, and to annually provide evidence of continued competency, either through direct observation, testing, or chart audit. Further, Novant Health will continue to require all clinical staff members to attend continuing education programs and to receive regular in-services on HIPAA, Medicare Compliance, and safety requirement.

In-service education, continuing education seminars, and individual training of staff will continue to be required of all clinical staff. Novant Health maintains an annual education budget at the corporate level to support employees in attending appropriate regional and state seminars.

NH Cabarrus will have an annual budget for staff training to maintain licenses and certifications. At the corporate level, Novant Health has an annual education budget to allow employees to attend appropriate regional and state conferences and seminars.

Novant Health's employee education department offers a wide variety of classes for its employees, including computer and software skills, HIPAA requirements, continuous improvement techniques, customer service skills, basic cardiac life support and advanced cardiac life support, new employee orientation, clinical orientation, annual reviews of required safety and care environment features, and other continuing education programs. Many of Novant Health's training programs are also available online.

The Novant Health Acute Care Nursing Clinical Ladder provides clinical advancement opportunities. The process helps an RN advance from an RN1/Novice to RN2/Advanced Beginner, to RN3/Competent, to RN4/Proficient, to RN5/Expert. The program also improves quality of care for patients and increases job satisfaction for Novant Health's RNs. This program is in place at NH Cabarrus.

Please see Exhibit H.3 for documentation related to employee training and continuing education.

Cost Overrun and Change of Scope Applications

4. a. Do the proposed changes to the scope or the cost overrun result in changes to projected staffing during the first three full fiscal years of operation?

☐

b. If you answered yes:

1) Describe the changes and explain why staffing is projected to change during the first three full fiscal years of operation as a result of this proposal; and
2) Complete a new Form H in Section Q (See Question 1 above).

c. If you answered no, explain why not.

Not applicable. The project does not involve a cost overrun or change in scope.

Section I - Criterion (8)

G.S. 131E-183(a)(8)

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

For cost overrun and change of scope applications, skip to Section I, Question 3.

1. **Ancillary and Support Services**

a. Check each ancillary and support service in the table below that the applicant would need to provide or contract for in order to be able to offer the health services proposed in this application.

X	Administration / Management
X	Billing / Finance Office / Insurance Claims Filing
X	Marketing
X	Human Resources / Staff Recruitment and Retention
X	Staff Training / Continuing Education
X	Information Technology
X	Building Maintenance / Grounds Keeping
X	Equipment Maintenance
X	Purchasing / Materials Management / Central Sterile Supply
X	Dietary
X	Housekeeping / Linen
X	Medical Records
X	Social Services
X	Discharge Planning
	Other (**describe**)

b. 1) For each ancillary or support service checked in the table above, briefly explain why it is necessary and how it is or will be made available.
2) For each ancillary or support service **not** checked in the table above, briefly explain why it is not necessary.
3) Provide any supporting documentation in an Exhibit.

The services above are all related to the provision of inpatient acute care services at NH Cabarrus and will be provided in the proposed project. See also Exhibit I.1.

Administration / Management: Necessary to ensure the responsibilities are fulfilled. This service will be provided through facility staff and/or corporate staff.

Billing / Finance Office / Insurance Claims Filing: Necessary for the charging and reimbursing for the service. This service will be provided through facility staff and/or corporate staff.

Marketing: Necessary for patient referrals to the service. This service will be provided through facility staff and/or corporate staff.

Human Resources / Staff Recruitment and Retention: Necessary for staffing the service. This service will be provided through facility staff and/or corporate staff.

Staff Training / Continuing Education: Necessary for providing training to staff. This service will be provided through facility staff and/or corporate staff.

Information Technology: Necessary for providing clinical and administrative services. This service will be provided through facility staff and/or corporate staff.

Building Maintenance / Grounds Keeping: Necessary to maintain services. This service will be provided through facility staff and/or corporate staff.

Equipment Maintenance: Necessary to provide equipment maintenance. This service will be provided through facility staff and/or regional contracts.

Purchasing / Materials Management / Central Sterile Supply: Necessary for providing medical and non-medical supplies. This service will be provided through facility staff and/or corporate staff.

Dietary: Necessary for providing nutritious meals for patients and staff. This service will be provided through facility staff and/or contract services.

Housekeeping / Linen: Necessary for the provision of service. This service will be provided through facility staff and/or contract services.

Medical Records: Necessary to record the provision of service. This service will be provided through facility staff.

Social Services: Necessary for the wellbeing of patients. This service will be provided through facility staff.

Discharge Planning: Necessary for the safe discharge of patients. This service will be provided through facility staff.

2. **Coordination with Existing Health Care System**

   a. **Existing Facilities** – Describe the facility's existing and proposed relationships with other local health care and social service providers and provide any supporting documentation in an Exhibit.

Not applicable. NH Cabarrus is not an existing facility.

   b. **New Facilities** – Describe the efforts made by the applicant(s) to develop relationships with other local health care and social service providers and provide any supporting documentation in an Exhibit.

NH Cabarrus will be part of Novant Health which is a longstanding existing healthcare system in North Carolina and collaborates with other local health care and social service providers in the service area and surrounding communities. Novant Health has significantly invested in the communities it serves by offering quality healthcare services, products, and community outreach programs to community members and businesses. As a not-for-profit organization that generates significant economic activity, Novant Health seeks to ensure its strategies are making a difference in local communities.

One of the most important aspects of Novant Health's mission is to improve its community through dedicated outreach, including partnering with multiple agencies and organizations to extend health and wellness services to the community, sponsoring health and wellness-focused events and offering free health fairs and events.

Not having enough food, dependable transportation, or a safe place to live makes it very difficult to stay healthy. When these and other social issues go unsolved, visits to the doctor's office only scratch the surface of what patients need. Addressing this very challenge is what Novant Health and the Michael Jordan Foundation envisioned when they built two medical clinics for underserved communities in Charlotte. By providing comprehensive primary care, behavioral health services and social support connections, all under one roof, the clinics bring much-needed services to Charlotte-metro area patients, regardless of their insurance status.

Novant Health has a partnership with UNC Health and UNC School of Medicine to expand medical education, research, and clinical services to Novant Health facilities in North Carolina. This partnership will expand the relationship between these organizations to include Cabarrus County and other counties, with an additional focus on finding innovative solutions to enhance care in rural areas.

The partnership located a UNC School of Medicine branch campus at Novant Health Presbyterian in Charlotte, and serves as an important training site for learners. It also gives more students access to learn at the best medical school for primary care in the country, according to U.S. News & World Report, and expands the pipeline for high-quality physicians available to serve North Carolinians. In addition, expansion of UNC School of Medicine's Kenan Primary Care Medical Scholars Program will train more students to work in rural and under-resourced communities, with enhanced training for care in those communities across North Carolina.

Additionally, clinical trials and studies from UNC School of Medicine's world-renowned researchers will provide new treatment options for patients in Novant Health facilities. Collaboration on population health has the potential to make a tremendous impact on the health of North Carolina. Together, through advanced analytics and proven population health strategies, more data will allow these partners to address community health challenges, such as COVID-19, opioid addiction, social determinants of health, and health equity.

Novant Health's relationships with other local healthcare and social service providers are well established and will continue following completion of the proposed project. Exhibit I.2 includes letters of support for the proposed project.

Cost Overrun and Change of Scope Applications

3. a. **Ancillary and Support Services** – Do the proposed changes to the scope or the cost overrun result in changes to the provision of necessary ancillary and support services?

☐

1) If you answered yes:

- Describe the changes to provision of necessary ancillary and support services and explain why each change is necessary; and
- Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

b. **Coordination with Existing Health Care System** – Do the proposed changes to the scope or the cost overrun result in changes to coordination with the existing health care system?

☐

1) If you answered yes:

- Describe the changes to coordination with the existing health care system and explain why each change is necessary; and
- Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

Not applicable. The project does not involve a cost overrun or change in scope.

Section J - Criterion (9)

G.S. 131E-183(a)(9)

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

Note: Criterion (9) applies only if a "substantial portion" of the patients expected to utilize the service components proposed in this application reside in a "health service area" (i.e., HSA) that is not adjacent to the HSA where the facility is located. The following table identifies the non-adjacent HSAs for each HSA.

HSA	Non-adjacent HSAs
I	IV, V and VI
II	VI
III	IV and VI
IV	I and III
V	I
VI	I, II and III

"Substantial portion" is not defined in the CON Law but some of the synonyms for "substantial" are big, considerable, large and sizable. Thus, it would have to be a relatively large percentage of the total number of patients projected to utilize the service components proposed in this application in order to be considered a "substantial portion."

1. What portion of each service component proposed in this application does the applicant project will be utilized by individuals **not** residing in the Health Service Area (HSA) in which the project is located **or** in **adjacent** HSAs?

2. If a **substantial** portion of any of the service components proposed in this application will be utilized by individuals **not** residing in the HSA in which the project is located **or** in **adjacent** HSAs, document the special needs and circumstances that warrant service to these individuals.

Not Applicable. Novant Health is not proposing to provide a substantial portion of the project's services to individuals not residing in HSA III or adjacent HSAs. Please see Section C.3 for projected patient origin. Nevertheless, as described in Section C.4, Novant Health demonstrates the need the population has for the services proposed.

Section K - Criterion (12)

G.S. 131E-183(a)(12)

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

For cost overrun and change of scope applications, skip to Section K, Question 5.

1. **Construction of New Space**

Does the proposal include construction of new space?	Yes
If yes, provide the total number of square feet to be constructed:	210,045
Briefly describe the proposed construction in the cell below	
The proposed project involves the construction of a new 50-bed acute care hospital facility. The proposed new construction square footage is representative of the necessary spaces to support the project as proposed.	

Provide legible line drawings (no larger than 11" x 17") that identify all new construction in an Exhibit. The use of each room or space should be labeled.

See Exhibit K.1.

2. **Renovation of Existing Space**

Does the proposal include renovation of existing space?	No
If yes, provide the total number of square feet to be renovated:	
Briefly describe the proposed renovation in the cell below	

Provide legible line drawings (no larger than 11" x 17") that identify all existing spaces to be renovated in an Exhibit. Include drawings that show the "before" and "after" renovation. The use of each room or space should be labeled.

Not applicable.

3. a. Explain how the cost, design and means of construction (including renovating space) represents the most reasonable alternative for the proposal and provide any supporting documentation in an Exhibit.

   b. Explain why the project will not unduly increase the costs to the applicant of providing the proposed services or the costs and charges to the public for the proposed services and provide any supporting documentation in an Exhibit.

The project architect has reviewed the necessary construction for the proposed project and has estimated project costs to total $336,434,895. Exhibit F.1 includes a letter from Novant Health's architect that estimates costs for the construction to be $207,431,040.

Please refer to the discussion in Section E.2., which identifies the alternatives considered by Novant Health before determining the proposed project to be the most reasonable alternative to develop acute care services in Cabarrus County.

The project costs incurred by Novant Health will be spread over the projected utilization and across the larger healthcare system. The costs and charges to the public should not increase due to this project because no major payor bases payment on the costs of a specific hospital. Medicare bases payment on changes in national average hospital costs, but realistically, NH Cabarrus's project costs could not affect the national average. Commercial payors base payment on adjusted Medicare rates, on usual, customary, and reasonable (UCR) charges in the market, or on negotiated rates. Commercial payors do not have access to data on the current costs of individual hospitals and would likely not afford them great weight if they did.

c. Identify any applicable energy saving features incorporated into the construction / renovation plans and provide any supporting documentation in an Exhibit.

Novant Health will ensure NH Cabarrus complies with applicable local, state, and federal requirements for energy efficiency and consumption. Novant Health will use and enforce engineering standards that mandate state-of-the-art components and systems. Novant Health will strive to ensure that energy-efficient systems are part of the project. NH Cabarrus will continue to utilize Novant Health's Sustainable Energy Management Plan and the Novant Health Utility Management Plan. Please see Exhibit K.3.

New Facilities, Relocation of the Entire Existing Facility, or a New Campus of an Existing Acute Care Hospital

G.S. 131E-181(a) states:

*"A certificate of need shall be valid only for the defined scope, **physical location**, and person named in the application."* (Emphasis added)

Thus, assuming a certificate of need is issued for this project, it will be valid only for the physical location of the proposed site as described below.

4. **Proposed Site**

a. **Site Address** *

Street Address (be as specific as possible)	2401 Trinity Church Road
City	Concord
State	North Carolina
ZIP Code	28027
County	Cabarrus

* This should be the same as the address provided in Section A, Question 4.

For information purposes, the mailing address for the proposed site identifies Concord, NC, the physical address is located in the city of Kannapolis.

b. **Ownership**

1) Identify the legal entity that currently holds fee simple title to the proposed site (this is usually available on the county's website).
2) If the applicant is not the current owner in fee simple, provide documentation that the site is available for acquisition by purchase or lease.

The site is owned by Mr & Mrs. William Austin. Novant Health has placed the site under a non-binding letter of intent (LOI) to purchase, including Parcel Numbers: 56022237180000, 56022251730000, and 56022176520000. A copy of the LOI is included in Exhibit K.4.

c. **Zoning and Special Use Permits**

1) Describe the current zoning at the proposed site and provide any supporting documentation in an Exhibit.

Tax Parcel 56022237180000, with an address of 2610 Kannapolis Parkway, Kannapolis, North Carolina, is currently zoned Light Commercial and Office District (C-1). The C-1 District is an established legacy district.

Tax Parcels 56022251730000 and 56022176520000, with addresses of 2401 Trinity Church Road, Kannapolis, North Carolina and 2425 Trinity Church Road, Kannapolis, North Carolina, respectively, are currently zoned Residential 18 District (R18).

Descriptions of the current zoning for each of the parcels for the site are included in Exhibit K.4.

2) If the proposed site will require rezoning, describe how the applicant anticipates having it rezoned and provide any supporting documentation in an Exhibit.
3) If the proposed site will require a special use permit, describe how the applicant anticipates obtaining the special use permit and provide any supporting documentation in an Exhibit.

The current zoning designations, coupled with plans for developing the Parcels for use as a medical center, will require a rezoning with the City of Kannapolis. Accordingly, Novant Health will submit the appropriate rezoning applications. See also Exhibit K.4

Novant Health has had a tremendous amount of success in recent years with obtaining local municipality approval on several rezoning petitions that were filed, with all recent filings and approvals taking place in Charlotte, North Carolina with Charlotte City Council. Although this rezoning petition will be in a different jurisdiction from Charlotte, Novant Health is confident that it will be successful with receiving the desired rezoning needed for the Parcels based on its demonstrated need to develop a new medical center in this portion of Cabarrus County and prior experience working on other, similar rezoning petitions in the state.

The proposed site will not require a special use permit.

d. **Water** – Describe how water will be provided at the proposed site and include any supporting documentation in an Exhibit.

e. **Sewer and Waste Disposal** – Describe how sewer and waste disposal services will be provided at the proposed site and include any supporting documentation in an Exhibit.

f. **Power** – Describe how power will be provided at the proposed site and include any supporting documentation in an Exhibit.

Water, sewer and waste disposal, and power are available and will be provided at the proposed site via public utilities. See Exhibit K.4 for additional information.

Cost Overrun and Change of Scope Applications

5. a. Do the changes to the scope or the cost overrun result in changes to the cost, design, and means of construction?

N/A

1) If you answered yes:

i) Copy Questions 1 through 3, insert them below, and provide responses;
ii) Identify each proposed change and explain the need for each proposed change; and
iii) Provide any supporting documentation in an Exhibit.

2) If you answered no, explain why not.

b. If proposing to change the site, copy Question 4, insert it below, and provide a response.

Not applicable. The proposed project does not involve a change of scope or cost overrun.

Section L - Criterion (13)

G.S. 131E-183(a)(13)

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

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

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

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

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

For change of scope applications, skip to Section L, Question 6.

1. a. **Historical Payor Sources during the Last Full FY before Submission of Application**

Complete the following tables for:

- The health service (mobile), facility or campus identified in Section A, Question 4; and
- Each facility from which service components will be relocated to the facility or campus identified in Section A, Question 4.

Last Full FY before Submission of Application
mm/dd/yyyy to mm/dd/yyyy

<Insert the name of the facility here>	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	%
Charity Care	%
Medicare *	%
Medicaid *	%
Insurance *	%
Workers Compensation	%
TRICARE	%
Other (**describe**)	%
Total	100.0%

* Including any managed care plans.

Last Full FY before Submission of Application
mm/dd/yyyy to mm/dd/yyyy

<Insert the name of the facility from which service components will be relocated here>	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	%
Charity Care	%
Medicare *	%
Medicaid *	%
Insurance *	%
Workers Compensation	%
TRICARE	%
Other (describe)	%
Total	100.0%

* Including any managed care plans.

b. **Comparison with the Percentages of the Population of the Service Area**

Complete the following tables for:

- The health service (mobile), facility or campus identified in Section A, Question 4; and
- Each facility from which service components will be relocated to the facility or campus identified in Section A, Question 4.

<Insert the name of the facility here>	Last Full FY before Submission of the Application	
	Percentage of Total Patients Served	**Percentage of the Population of the Service Area ***
Female		
Male		
Unknown		
64 and Younger		
65 and Older		
American Indian		
Asian		
Black or African-American		
Native Hawaiian or Pacific Islander		
White or Caucasian		
Other Race		
Declined / Unavailable		

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

<Insert the name of the facility from which service components will be relocated here>	Last Full FY before Submission of the Application	
	Percentage of Total Patients Served	Percentage of the Population of the Service Area *
Female		
Male		
Unknown		
64 and Younger		
65 and Older		
American Indian		
Asian		
Black or African-American		
Native Hawaiian or Pacific Islander		
White or Caucasian		
Other Race		
Declined / Unavailable		

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

Not applicable. NH Cabarrus is not an existing facility.

2. **Uncompensated Care, Community Service, Access by Minorities & Persons with Disabilities, and Patient Civil Rights Complaints**

a. For the health service (mobile), facility or campus identified in Section A, Question 4 **and** each facility from which existing health services will be relocated to that facility, respond to the following:

1) Is the health service (mobile), facility or campus obligated under any applicable federal regulations to provide uncompensated care, community service, or access by minorities and persons with disabilities?

No

2) If you answered yes, describe how the health service (mobile), facility or campus has fulfilled or is fulfilling its requirement.

Not applicable.

b. Identify each **patient** civil rights equal access complaint filed in the 18 months immediately preceding the application deadline against the health service (mobile), facility or campus identified in Section A, Question 4, **and** each facility from which existing health services will be relocated to that facility or campus. Describe the current status of each complaint.

Not applicable. There have been no patient civil rights equal access complaints filed against any Novant Health facilities in North Carolina in the last 18 months.

3. **Projected Payor Sources during the Third Full FY of Operation following Completion of the Project.**

a. Complete the following tables for:

- The health service (mobile), facility or campus identified in response to Section A, Question 4; and
- Each service component included in the proposal.

Projected Payor Mix during the 3rd Full FY
01/01/2032 to 12/31/2032

NH Cabarrus: Facility	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	6.9%
Charity Care	
Medicare *	44.3%
Medicaid *	13.9%
Insurance *	32.3%
Other ^	2.5%
Total	100.0%

* Including any managed care plans.
^ Other includes Other Govt, Institutional, Workers Comp

Projected Payor Mix during the 3rd Full FY
01/01/2032 to 12/31/2032

NH Cabarrus: Inpatient Services	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	6.9%
Charity Care	
Medicare *	51.5%
Medicaid *	13.7%
Insurance *	25.1%
Other ^	2.8%
Total	100.0%

* Including any managed care plans.
^ Other includes Other Govt, Institutional, Workers Comp

Projected Payor Mix during the 3rd Full FY
01/01/2032 to 12/31/2032

NH Cabarrus: Outpatient Surgical Services	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	7.0%
Charity Care	
Medicare *	40.6%
Medicaid *	14.6%
Insurance *	35.4%
Other ^	2.5%
Total	100.0%

* Including any managed care plans.
^ Other includes Other Govt, Institutional, Workers Comp

Projected Payor Mix during the 3rd Full FY
01/01/2032 to 12/31/2032

NH Cabarrus: Other Outpatient Services	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	7.0%
Charity Care	
Medicare *	40.6%
Medicaid *	14.6%
Insurance *	35.4%
Other ^	2.5%
Total	100.0%

* Including any managed care plans.
^ Other includes Other Govt, Institutional, Workers Comp

b. **Describe the assumptions used to project each payor source**.

For total facility and each of the three service components, the payor mix data source is HIDI for CY 2023. HIDI does not have an indication of charity care. Therefore, charity care is not reported as a payor in the tables above.

The charity care assumptions are described in response to the question below. NH Cabarrus has based its payor mix on service area patients seen at area hospitals and expects the patients who in-migrate from outside of the service area will have a similar payor mix. NH Cabarrus expects the payor mix for its patients to remain the same in future years as they have been historically.

Inpatient payor mix was determined by calculating the payor mix of service area residents' discharges from the CAC MSDRG set. Outpatient surgical payor mix was determined by calculating the payor mix of outpatient visits with an OR flag in the CY2023 HIDI data by payor among service area residents. The analysis excluded services that are not projected to be served at NH Cabarrus. These excluded services include mammography, infusion, physician office visits, pre- and post-natal visits, cardiac rehab, sleep study, athletic training, PET scans, cardiac catheterization, eye surgery and hospital-based outpatient rehabilitation.

Outpatient non-surgical payor mix was determined using the same method as described in the paragraph above, but for outpatients without an OR flag in the HIDI data.

Total hospital payor mix is a weighted average of the payor mix for the three service components, using year three (CY 2032) patients as the weighting factor. It was calculated by multiplying the number of year three patients by service line by payor for each service line to determine total patients by payor in each service line. Next, patients across all three service lines were summed by payor to arrive at total facility patients by payor. Finally, the number of total facility patients in each payor category was divided by total patients to arrive at total facility payor mix.

4. **Charity and Reduced Cost Care**

a. Will the health service (mobile), facility or campus identified in Section A, Question 4, provide care to medically indigent or low-income patients at no cost to the patient (i.e., charity care)?

Yes

If you answered yes, provide estimates of the total number of charity care patients to be served by the entire health service (mobile) or facility in the each of the first three full FYs of operation. **Describe how the number was estimated**.

	1st Full FY	2nd Full FY	3rd Full FY
Estimated # of Charity Care Patients	993	1,611	2,642

Charity care patients are based on the projected payor mix in Section L.3 applied to total NH Cabarrus facility patients.

b. Will the health service (mobile), facility or campus identified in Section A, Question 4, provide care to medically indigent or low-income patients at a reduced cost to the patient?

Yes

If you answered yes, provide estimates of the total number of patients to be served by the entire facility at a reduced cost to the patient in the each of the first three full FYs of operation. **Describe how the number was estimated**.

	1st Full FY	2nd Full FY	3rd Full FY
Estimated # of Patients to be Served at a Reduced Cost to the Patient	*	*	*

*Novant Health makes no differentiation between charity care and reduced-cost care patients. The patients estimated in response to Section L.4.a. include patients who will receive care at a reduced cost.

Please refer to Exhibit L.4. for the following copies: the Novant Health Financial Assistance (formerly called Charity Care) and related policies ("Financial Assistance, Uninsured Discount, Catastrophic Settlement") which apply to all existing Novant Health hospitals.

c. Provide copies of the health service's (mobile) or facility's existing or proposed policies regarding charity and reduced cost care.

NH Cabarrus will follow the Novant Health Financial Assistance (formerly Charity Care) policies and Business Office policies. See Exhibit L.4 for copies of these policies.

These policies do not require any financial payment for individuals requiring an urgent or emergent admission for care as determined to be medically necessary by an admitting physician. Novant Health adheres to a series of Financial Assistance and related policies that create the framework for access to services by patients with limited financial means (Financial Assistance, Uninsured Discount, and Catastrophic Settlement Policies).

Financial Assistance (formerly Charity Care) Policy

The Novant Health Medical Group physicians and surgeons also adhere to the Novant Health Financial Assistance (formerly called Charity Care) policies and Business Office policies. See Exhibit L.4 for copies of these policies. These policies do not require any financial payment for individuals requiring an urgent or emergent admission for care as determined to be medically necessary by an admitting physician. Novant Health adheres to a series of Financial Assistance and related policies that create the framework for access to services by patients with limited financial means (Financial Assistance, Uninsured Discount, and Catastrophic Settlement Policies). Uninsured patients with an annual family income less than or equal to 300 percent of the Federal Poverty Level will not get a bill. For example, based on the government's 2025 Federal Poverty Levels, a qualified family of four with an annual income of $96,450

($32,150 x 3 = $96,450) or less is eligible for a full write-off of all charges incurred at a North Carolina Novant Health facility. These patients will get no bill from NH Cabarrus, a Novant Health facility, or a Novant Health physician for services rendered.

In 2025, Novant Health expanded the Financial Assistance program to include insured patients who are North Carolina residents and meet certain requirements. Now insured North Carolina resident patients whose income is below 200 percent of the Federal Poverty Guidelines may qualify for a 100 percent write off of their patient responsibility. Those whose income is between 200 – 250 percent may receive a 75 percent write off and those who are within 250 – 300 percent may receive a 50 percent write off of their patient responsibility amounts. Refer to the Financial Assistance Policy included in Exhibit L.4 for more detail.

Novant Health uses a simple one-page form to be filled out by the patient and their family in order to determine eligibility for Charity Care. Novant Health also has Financial Navigators available Monday-Friday to assist patients with the Charity Care paperwork.

Uninsured Discount Policy

Novant Health's "Uninsured Discount" policy works to identify circumstances in which Novant Health Acute and Outpatient Services may discount care to patients who are not eligible for or not currently covered by insurance. Novant Health realizes that the uninsured population continues to rise and Novant Health is aiming to ensure a fair and consistent discount to accommodate patients' financial needs. Novant Health is committed to establishing the appropriate guidelines and procedures for communicating our discount guidelines to patients, their families, and team members. Novant Health's goal is to better educate team members, so they can better assist patients who are struggling to pay their bills. The eligibility criteria for an Uninsured Discount include:

- The patient or responsible party does not have any health insurance coverage, nor is eligible for any other medical coverage, including but not limited to Medicaid, COBRA, or Health Exchange Plan.
- The discounted amounts will be determined based on the average discount given to contracted Managed Care payers. The amount will be approved annually by Novant Health's Business Development and Sales staff and approved by the Novant Health Executive Team.
- The Uninsured Discount will not apply to elective health procedures or those not normally covered by health insurance.
- The Uninsured Discount cannot be used in conjunction with any other plan.

Catastrophic Settlement Policy

The purpose of the Novant Health "Catastrophic Settlement" policy is to identify circumstances in which Novant Health affiliates may work with patients to meet their financial obligations when they have large out-of-pocket expenses related to visits that are not covered by financial assistance. A Catastrophic Settlement will be provided to uninsured patients or those covered by insurance who have a catastrophic balance, defined as a remaining balance after insurance payments of at least 20 percent of their annual household income. The eligibility criteria for this program include:

- The remaining balance after insurance payments must be at least 20 percent of their annual household income.
- The account has received the expected payment from the insurance company (if applicable).
- The patient or responsible party must provide all supporting documentation required to verify household income.

- The individual does not meet financial assistance requirements as defined in the Novant Health Financial Assistance (formerly Charity Care) policy.
- Catastrophic Settlements will apply to only medically urgent and emergent, non-elective services.
- Any account submitted to Bad Debt for collection purposes will be reviewed on a case-by-case basis.
- The settlement amounts will be calculated based on amounts generally billed to Medicare patients not to exceed the Catastrophic amount.
- Potential outcomes include full payment, and/or partial write-off with an agreed upon payment plan.

Novant Health's set of three interrelated Financial Assistance policies provide financial assistance to those in need, supporting its mission of improving the health of communities, one person at a time. Novant Health supports each person's physical and mental health needs, as well as their financial health related to the consumption of healthcare services provided at one of its facilities. Every year, Novant Health treats thousands of patients who cannot pay for services and offers financial counseling, in addition to its charity care and financial policies, to assist patients who are unable to pay.

All these policies and processes are fully described in Novant Health's Financial Assistance (formerly called Charity Care) and related policies (Financial Assistance, Uninsured Discount, and Catastrophic Settlement) are included in CON application Exhibit L.4. These policies illustrate that Novant Health also has processes and policies that facilitate access to Financial Assistance in addition to the community benefit data below that quantifies Novant Health's commitment to financial assistance for the medically underserved populations, including the medically indigent, the uninsured, and the underinsured.

5. Indicate the means by which a person will continue to have access to the services proposed in this application (e.g., physician referral, self-admission, etc.).

Patients may be admitted by a physician on the facility's medical staff or through the emergency department. Novant Health does not discriminate against any person on the basis of race, color, national origin, religion, disability, sex, veteran status, sexual orientation, gender identity or age with regard to admission, treatment or participation in its programs, services and activities, or in employment. Free foreign language interpreters are available for individuals with limited English proficiency.

Please refer to Exhibit I.2 for letters from physicians who support NH Cabarrus's project.

Cost Overrun and Change of Scope Applications

6. Do the proposed changes to the scope or the cost overrun result in changes to projected access by medically underserved groups?

☐

a. If you answered yes:

   1) Copy Questions 3 and 4, insert them below, and provide responses;
   2) Explain what would change and why; and
   3) Provide any supporting documentation in an Exhibit.

b. If you answered no, explain why not.

Not applicable. The proposed project does not involve a change of scope or cost overrun.

Section M - Criterion (14)

G.S. 131E-183(a)(14)

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

For cost overrun and change of scope applications, skip to Section M, Question 3.

1. a. If applicable to the proposed service components, describe the extent to which health professional training programs **in the area** have or will continue to have access to the facility or campus identified in Section A, Question 4, for health professional training purposes.

   b. Document the efforts made by the applicant to establish relationships with these training programs.

Novant Health has many established clinical education agreements with area health education programs in Cabarrus County. These agreements will be extended to NH Cabarrus. Novant Health's clinical education agreements include many educational institutions in Novant Health's Charlotte-metro market and beyond such as: UNC School of Medicine, the University of North Carolina at Charlotte, Charlotte, NC; Queens University of Charlotte, Charlotte, NC; Central Piedmont Community College, Charlotte, NC; and Cabarrus College of Health Sciences, Concord, NC. As part of Novant Health, NH Cabarrus will work collaboratively with any interested health professional program to establish or expand clinical training programs at its facility.

To enhance experiential learning, health professional training requires opportunities to participate in realistic patient care situations. This enhances the diffusion of knowledge and accelerates the adoption of best practices regarding patient care and nursing training. Novant Health provides learning opportunities for medical and health sciences students from a variety of schools, colleges, and training programs.

All educational programs with clinical agreements with Novant Health will have the same access to NH Cabarrus upon completion of the proposed project. Novant Health is always open to considering new clinical education training programs and institutions.

2. If not applicable to the proposed service components, briefly explain why not.

Section M, Question 2 is not applicable. Novant Health has existing relationships with health professional training programs, which include NH Cabarrus.

Cost Overrun and Change of Scope Applications

3. Do the changes proposed to the scope or the cost overrun result in changes to accommodating the clinical needs of area health professional training programs?

a. If you answered yes:
   1) Explain what would change and why; and
   2) Provide any supporting documentation in an Exhibit.

b. If you answered no, explain why not.

Not applicable. The proposed project does not involve a change of scope or cost overrun.

Section N - Criterion (18a)

G.S. 131E-183(a)(18a)

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

For cost overrun and change of scope applications, skip to Section N, Question 3.

1. Describe the expected effects of the proposal on competition in the proposed service area.

The project will promote cost-effectiveness, quality, and access to services and therefore will promote competition in Cabarrus County because it will allow Novant Health to expand access to hospital services, to better meet the needs of service area residents.

Currently, Atrium Health is the sole provider of acute care services located within Cabarrus County and maintains an 87.6 percent share of Cabarrus County CAC MSDRGs discharges.

Share of Cabarrus County CAC MSDRG Discharges, CY2023

Health System	CAC MSDRG Discharges	Share
Atrium Health	9,651	87.6%
Novant Health	1,161	10.5%
Other	206	1.9%
Total	11,018	100.0%

Source: HIDI Inpatient Database

Novant Health does not provide acute care services within Cabarrus County. As a result, the share of discharges presented in the previous table represents Cabarrus County patients who have chosen to receive care from Novant Health outside the county, primarily in Mecklenburg County.

Expanding acute care options in Cabarrus County is essential to fostering a patient-centered healthcare system. Increased provider choices empower individuals to select healthcare services based on quality, convenience, specialized care, and personal preferences. Additionally, a more diverse acute care landscape:

- Ensures timely, high-quality medical services for patients, reducing the need for travel and minimizing delays in critical care.
- Strengthens care coordination by improving integration with primary care providers, specialists, and post-acute services, leading to better health outcomes.
- Encourages a competitive healthcare environment, which promotes cost-effectiveness, service innovation, and higher standards of care.
- Enhances local economic growth by creating new opportunities for healthcare professionals to serve the community while retaining medical talent within the county.

The proposed project will introduce a new access point for hospital services in Cabarrus County, fostering greater competition while expanding patient choice. By enhancing cost-effectiveness, quality, and access, the project ensures

that more Cabarrus County residents can receive high-quality healthcare close to home. For further discussion on the proposal's effect on competition, see Section N.2.

2. Will the proposal have a positive impact on cost-effectiveness, quality, and access by medically underserved groups to the proposed services?

Yes

a. If your answer was **yes**, discuss how the proposal will have a positive impact on:

1) Cost-effectiveness of the proposed services;

NH Cabarrus will be a community hospital designed to effectively and efficiently deliver high frequency services and will not need to duplicate and bear the cost of more specialized, high acuity tertiary services which are already available at hospitals in the area. Without these costs, NH Cabarrus will deliver community hospital services at a lower cost. The hospital will be cost-effective for physicians performing surgical and non-surgical procedures and attending medical patients. They will not have to navigate a large, congested hospital and will be better able to schedule block time and avoid being bumped by unscheduled procedures. By having hospitalists, intensivists, and telemedicine access to specialists, Novant Health will increase the efficiency of on-site physicians and improve their ability to have continuity of care, which reduces the total cost of care.

Novant Health has financial assistance and uninsured discount policies that will improve access to healthcare for service area residents. NH Cabarrus will operate under NH's Financial Assistance (formerly Charity Care) policy and other policies that promote equitable access to care. Uninsured patients with an annual family income less than or equal to 300 percent of the Federal Poverty level will not get a bill. See Question 6 in this Section for more detail on Novant Health's Financial Assistance and Uninsured Discount policies, which will be in place at NH Cabarrus.

This project will not increase the cost to patients or payors for the inpatient services provided by Novant Health because reimbursement rates are set by the federal government and commercial insurers. The capital expenditure for this project is necessary to ensure that NH Cabarrus will have the capacity to continue to provide high-quality services that are accessible to patients.

Novant Health Value

Novant Health is delivering value and quality in outcomes through its value-based care delivery model. This approach encourages wellness and preventive care and manages existing conditions to slow or reverse the progression of disease, all while lowering the overall cost of care. The key to value-based care is a coordinated effort with physicians, nurses, pharmacists, dieticians, social workers, referral coordinators, and others working together to give patients the customized care they want and need. Ultimately, this type of care provides high-quality and safe, more-affordable care with better outcomes, and is centered on patients' unique needs.

With a focus on keeping people healthy, some traditional fee-for-service payments have been replaced by newly negotiated agreements focusing on value, where quality and outcomes factor into how much providers and facilities are paid. Novant Health is continuing to collaborate with payors and partners to identify payment models that match Novant Health's value-based care delivery. Getting the right care in the right setting at the right price is the future of health care. It is what makes health care affordable and more sustainable.

Novant Health has a value-based strategy team that was launched to accelerate strategies for assuming risk and shifting further towards value-based care and payment models to demonstrate greater value for patients served. The

organizational aim is to generate growth and assume greater accountability for outcomes and their associated financial risk for the patients Novant Health serves.

Novant Health's value-based priorities include:

- Participation in Medicare Shared Savings Program in North Carolina and Virginia
- Novant Health Clinically Integrated Network
- Episodes of Care
- Set Up of Value-Based Strategy Business Unit

Novant Health also uses the latest consumer relationship management tools to deliver fully integrated, data-driven, personalized, patient-centric marketing to drive deep, dynamic engagement that guides the patient-specific health care journey. Nearly ten years ago, Novant Health entered into an agreement that assigned financial value to clinical quality and invited patients to partner with us in their care. That early effort built momentum around clinical quality leading to better patient outcomes and lower cost. Today, Novant Health is accountable through Value-Based Care arrangements for the clinical outcomes of over 550,000 attributed lives. Novant Health has seen a 90% growth of actively managed lives since 2016 and is delivering top decile quality performance across all programs. Consumers have a choice when seeking care and these results show the trust patients have in Novant Health's primary care as advisors and partners in their healthcare decisions.

In 2019, Novant Health reduced the cost of care by $50 million for the populations served across all value-based care agreements and has saved over $200 million over five years. Those efficiencies translate directly to reduced patient and employer premiums and reduced patient out-of-pocket costs.

Novant Health's Collaborative Accountable Care program now includes independent physicians in North Carolina and comprises the Novant Health Clinically Integrated Network ("NHCIN"). The goal of the NHCIN is to provide participating providers with the opportunity to collectively develop clinical pathways and protocols, create improved systems for care, share and analyze clinical outcomes data, and determine the most efficient way to deliver high-quality, affordable care to more patients.

As previously established, NH Cabarrus will be part of the Novant Health system which provides many system-wide policies and initiatives which will support the proposed project, including revenue cycle process improvements, value-based care programs, and tactics to save money in a way that will not impact patients.

2) Quality of the proposed services; and

In today's world, patients have choices – especially when it comes to healthcare. Having reliable and understandable information about the quality of care Novant Health hospitals and outpatient centers provide can help patients make the best healthcare decisions possible.

There are several national organizations that define the best ways to measure quality. These organizations use research and expert calculations to decide what data to gather, how to analyze it, and how to display the information. They set standards to ensure that any hospital that participates has reliable and accurate data. This information will help patients determine what level of care they are receiving and will help us identify areas where we can grow and improve.

Novant Health's quality measures were chosen because they meet these goals:

- Transparency - we want measures to be up-front and easy to understand.
- Public methodology - the methods of collecting and analyzing data are available for study.
- Validity - we want measures to be validated by reputable research or expertise.
- Comparisons - we want measures that can be compared to a national average so you can compare us with the high standards set for hospitals across the nation.
- Expertise - we choose measures that have been developed and tested by the most well-respected, independent national experts.
- Relevance - we choose measures that are relevant to our patients to help you understand, select and plan for high-quality healthcare.

Novant Health displays information in a way that is understandable and useful to patients because that is what is most valuable. Results are shared consistently over time. Novant Health believes patients and families need the facts in order to make an informed decision about their healthcare as reflected on the Novant Health website at: https://www.novanthealth.org/home/quality--safety.aspx.

Novant Health has received many awards and designations for its commitment to quality. By twice awarding Novant Health the prestigious Ernest A. Codman Award, The Joint Commission has recognized Novant Health's effort in improving the quality and safety of care provided to patients systemwide. Novant Health also received the Team Approaches in Quality Improvement Award from the Society of Hospital Medicine. This award recognized Novant Health's multidisciplinary team approach to improve medication safety within its acute care facilities. The National Committee for Quality Assurance recognized Novant Health Medical Group physicians for excellent diabetes, heart disease, and stroke care.

Novant Health is committed to delivering high-quality care at all of its facilities. Novant Health has quality-related policies and procedures that will be applicable to NH Cabarrus. NH Cabarrus will participate in Novant Health's Performance Improvement Philosophy. Novant Health leaders embrace a philosophy for organizational performance improvement based on the work of Drs. Deming, Langley, and Nolan. The model is based on the theory that improvement comes from applying knowledge, and it is used to test and implement ideas for change at the process and system levels.

NH Cabarrus will also participate in the Clinical Improvement Plan, the Infection Prevention Plan, and the Risk Management Plan, and will work with the NH Clinical Improvement Department to facilitate the improvement of clinical performance across Novant Health. Please see Exhibit O.2 for quality-related policies and procedures.

NH Cabarrus will provide the highest possible quality of care to patients, including those who traditionally encounter barriers when receiving care. NH Cabarrus will utilize Novant Health's Language Access Services policy for patients and other individuals. This policy complies with Title VI of the Civil Rights Act of 1964 and other applicable federal and state laws and regulations on the needs of individuals who are blind, deaf, hearing impaired, limited English proficient (LEP), and/or functionally illiterate. It also aids patients whose primary language is not English.

Novant Health's Interpreter Services Department provides methods of communicating in the patient's preferred language. This includes providing American Sign Language interpreters for the deaf, foreign-language interpreters, and auxiliary aids for individuals with special communication needs. Since 2017, Novant Health has utilized Remarkable On- Demand Language Liaison (ROLL). ROLL is a video remote interpretation device using iPads. It enables all NH acute care facilities to provide interpreter services in many languages when and where needed.

NH Cabarrus will seek accreditation by The Joint Commission.

NH Cabarrus will adhere to medical staff credentialing policies and procedures to ensure credentialed staff are qualified to deliver care in their area of specialty. All clinical and technical staff are required to maintain appropriate and current licensure and continuing education.

3) Access by medically underserved groups to the proposed services.

As previously stated, Novant Health will continue to have a policy to provide services to all patients regardless of income, racial/ethnic origin, gender, physical or mental conditions, age, ability to pay, or any other factor that would classify a patient as underserved. Novant Health's financial assistance policy will apply to the proposed services.

Section L.3 includes payor mix projections that demonstrate Novant Health's commitment to ensuring access for medically underserved patients at NH Cabarrus.

b. If your answer was **no**, explain why the proposal is a service on which competition will not have a favorable impact on cost-effectiveness, quality and access by medically underserved groups.

Not applicable. Novant Health has described how the project will positively impact cost-effectiveness, quality, and access by medically underserved groups.

Cost Overrun and Change of Scope Applications

3. a. Do the changes proposed to the scope or the cost overrun result in changes to the expected effects of the proposal on competition in the proposed service area from what was stated in the previously approved application(s)?

☐

1) If you answered yes, explain why and provide any supporting documentation in an exhibit.

2) If you answered no, explain why not.

b. Do the changes proposed to the scope or the cost overrun result in changes to the impact of enhanced competition on the cost effectiveness, quality and access by medically underserved groups from what was stated in the previously approved application(s)?

☐

1) If you answered yes, explain why and provide any supporting documentation in an exhibit.

2) If you answered no, explain why not.

Not applicable. The proposed project does not involve a change of scope or cost overrun.

Section O - Criterion (20)

G.S. 131E-183(a)(20)

"An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past."

1. Identify all existing and approved health services (mobile) and/or facilities providing the same service components included in this proposal that are owned, operated or managed by the applicant or a related entity in North Carolina by completing Form O Health Services (mobile) or Facilities, which is found in Section Q.

Please see Form O Facilities included in Section Q. Form O identifies the existing and approved facilities with acute care beds that are owned, managed, or operated by Novant Health in North Carolina.

2. Describe the methods used or to be used by the health service (mobile) or facility identified in response to Section A, Question 4 to ensure and maintain quality of care.

At Novant Health, safety and quality are embedded into every service line, alongside a commitment to identify opportunities for improvement, set goals to accomplish change, and work together in an inclusive manner to make a measurable difference. At Novant Health, patient safety is about keeping patients safe and free from harm when they are in Novant Health's care. Novant Health applies evidence-based best practice methods to prevent medical errors by building accountability for finding and fixing system problems.

Novant Health Patient Safety Program: First Do No Harm

All Novant Health facilities participate in the organization-wide patient safety program called "First Do No Harm" ("FDNH"). Patient Safety via the FDNH program is a priority for Novant Health facilities and services. Safety processes have been put into place to identify and prevent negative patient outcomes based on high-risk or high-volume issues. The staff is encouraged to report not only actual occurrences but also "near misses" so that problematic processes and interfaces can be identified, and efforts can be focused on the improvement of those processes/interfaces. Facility leaders provide a non-punitive environment for reporting errors and "near misses" and support education of staff related to their role in patient safety and maintaining a safe environment. The staff records patient safety issues (errors and "near misses") promptly in the Electronic Reporting Liaison (eRL) database. The ERL promotes patient safety by providing one source for incident and claims management and one source for feedback related to complaints and grievances across the Novant Health system. The eRL reports are reviewed by facility leaders as well as the Novant Health Risk Management department for further follow-up and trending.

Examples of focus areas are:

- Applying professionally recognized standards for the performance and interpretation of scans
- Monitoring medication issues, staff turnover rates, staff injuries/exposure to blood and body fluids
- Hand Hygiene
- Patient identification and transport/transfer
- Patient History and physical and allergy status documented on chart prior to the scan procedure
- Staff education on actual as well as potential safety concerns for patients
- Ongoing staff in-services and training related to safety practices for self and patients

Novant Health Infection Prevention Plan

The purpose of the Novant Health Infection Prevention ("IP") Plan (Exhibit O.2) is to reduce the risk of transmission of infection for patients, employees, and others in the healthcare setting. The Novant Health Infection Prevention Plan will encompass NH Cabarrus. The IP Plan includes surveillance and prevention of infections for inpatients, outpatients, visitors, and employees of all diagnostic/clinical services and support departments.

Infection Prevention services are provided by Novant Health's IP Department, Novant Health's Employee Occupational Health program, the Novant Health Medical Director of Clinical Improvement, and the Novant Health Director of Infection Prevention. The objectives of the IP Plan are to reduce/eliminate the risk of infection, establish a surveillance program, develop IP-related policies and IP-related educational materials for staff/patients, and promptly comply with established/recognized regulations, guidelines, and accreditation requirements. IP goals are developed by review of:

- IP risk assessment
- Previous year infection data
- Community risk factors (demographics)
- New services/procedures
- Regulatory/mandating agency requirements

Novant Health is dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. Novant Health will continue to maintain the highest standards and quality of care, consistent with the high standard that it has sustained throughout its history of providing patient care, including at the proposed new facility. Please see Exhibit O.2 for policies that will be utilized by NH Cabarrus.

All clinical and technical staff will be required to maintain appropriate and current licensure and continuing education.

NH Cabarrus will adhere to medical staff credentialing policies and procedures to ensure credentialed staff are qualified to deliver care in their area of specialty.

3. If the facility or health service (mobile) identified in Section A, Question 4 is an existing facility or health service (mobile), provide supporting documentation in an Exhibit to document that the facility or health service (mobile) is currently:

   - Licensed;
   - Certified for participation in the Medicare Program;
   - Certified for participation in the Medicaid Program; and
   - Accredited (identify the accrediting body).

   If any of the above are not applicable to the existing facility, briefly explain why it is not applicable.

Not applicable. NH Cabarrus is not an existing facility.

4. **All Applicants** – Document that the health service facilities or health services (mobile) identified in Form O have provided quality care during the 18 months immediately preceding submission of the application (18 month look-back period).

The Novant Health facilities identified in Form O have provided high-quality care during the eighteen months preceding this CON application submission. Section O.2 describes the methods, plans, and processes used by Novant Health and related providers to ensure and maintain quality care in the past and going forward. NH Cabarrus will use these same methods, plans, and processes. Exhibit O.2 includes copies of the quality-related policies and procedures that will continue to be utilized by Novant Health facilities.

5. **Hospitals, LTCHs, Inpatient Rehabilitation Hospitals, ASFs, Home Health Agencies, Hospice Home Care Agencies, and Hospice Inpatient or Hospice Residential Care Facilities**

   a. Of the facilities identified in Form O, identify each facility that was determined by the Division of Health Service Regulation to have had any situations resulting in a finding of immediate jeopardy during the 18 month look-back period (determination). Include only those facilities that did not challenge the determination or where a challenged determination was subsequently upheld.

   b. For each facility identified in response to Question 5.a:

   - Briefly summarize each situation that resulted in the determination;
   - Indicate the number of patients, if any, affected by each situation;
   - State whether the facility is now back in compliance; and
   - If the facility is not back in compliance as of the application deadline, estimate when it will be back in compliance.

Not applicable. No hospital identified in Form O had any situations resulting in a finding of immediate jeopardy during the eighteen-month look-back period.

6. **Nursing Facilities**

   a. Of the facilities identified in Form O, identify each facility that was found by the Division of Health Service Regulation or CMS to have had any situations resulting in a finding of substandard quality of care (Level 4) during the 18 month look-back period (determination). Include only those facilities that did not challenge the determination or where a challenged determination was subsequently upheld.

On May 1, 2024, Novant Health Pender Medical Center's hospital-based skilled nursing unit had a finding of immediate jeopardy that was removed by the North Carolina State Survey Agency by May 4, 2024, and validated on May 6, 2024.

   b. For each facility identified in response to Question 6.a:

   - Briefly summarize each situation that resulted in the determination.
   - Indicate the number of patients, if any, affected by each situation.
   - State whether the facility is now back in compliance.
   - If the facility is not back in compliance as of the application deadline, estimate when it will be back in compliance.

On May 1, 2024, Novant Health Pender Medical Center's hospital-based skilled nursing unit had a finding of immediate jeopardy that was removed by the North Carolina State Survey Agency by May 4, 2024, and validated on May 6, 2024.

The finding related to not immediately implementing the emergency management plans when a resident showed a knife to another resident.

7. **Adult Care Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities**

a. Of the facilities identified in Form O, identify each facility that had a situation which resulted in any of the following during the 18 month look-back period. Do not include facilities where an appeal of any associated fine due to the violation, the summary suspension of license, the revocation of license is pending, or was rescinded or reversed.

State Administrative Action:

- Imposition of a Type A or an unabated violation;
- Summary suspension of license; or
- Revocation of license.

b. For each facility identified in response to Question 7.a:

- Briefly summarize each situation that resulted in the state administrative action.
- Indicate the number of patients, if any, affected by each state administrative action.
- State whether the facility is now back in compliance.
- If the facility is not back in compliance as of the application deadline, estimate when it will be back in compliance.

Not applicable. The project does not involve Adult Care Homes, Substance Use Disorder Facilities, or Intermediate Care Facilities for Individuals with Intellectual Disabilities.

Section P – Proposed Timetable

The proposed timetable determines:

- The deadline by which the project must be developed.
- The times at which the Agency will request the progress reports.

Therefore, the dates provided in Section P should reflect the date each milestone is anticipated to be completed. Please note:

- Dates **MUST** be provided in the following format: **mm/dd/yyyy;**
- A date **MUST** be provided for **#14 Services Offered**;
- Use **ONLY** the milestones listed below;
- Do **NOT** change the descriptions;
- Do **NOT** add other milestones; and
- Do **NOT** change the order in which the milestones appear.

Assume for the purposes of projecting milestone completion dates that the date of the decision will be 150 days from the first date of the review and that the certificate of need will be issued 35 days from the projected decision date. Projected milestone completion dates should be calculated from the 1st date the certificate may be issued.

1st Day of Review Cycle (this is always the 1st Day of the Month)	March 1, 2025
150 Days from 1st Day of Review (Projected Decision Date)	July 29, 2025
35 Days from Projected Decision Date (1st date certificate may be issued)	September 2, 2025

Fiscal Year for the Facility Identified in Section A, Question 4	**01/01** to **12/31**

Milestone		**Date mm/dd/yyyy**
1	Financing Obtained	
2	Drawings Completed	05/26/2027
3	Land Acquired	
4	Construction / Renovation Contract(s) Executed	07/12/2027
5	25% of Construction / Renovation Completed (25% of the cost is in place)	01/31/2028
6	50% of Construction / Renovation Completed	08/21/2028
7	75% of Construction / Renovation Completed	03/12/2029
8	Construction / Renovation Completed	09/14/2029
9	Equipment Ordered	09/08/2028
10	Equipment Installed	10/19/2029
11	Equipment Operational	11/09/2029
12	Building / Space Occupied	11/09/2029
13	Licensure Obtained	11/27/2029
14	**Services Offered** *	**01/01/2030**
15	Medicare and / or Medicaid Certification Obtained	05/01/2030
16	Facility or Service Accredited	

* Required

Section Q – Excel Workbook

Form C.1.b Projected Health Service Facility Bed Utilization upon Project Completion

Form C.1b Projected Health Service Facility Bed Utilization Upon Project Completion Novant Health Cabarrus Medical Center	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Acute Care Hospital - All Beds			
Total # of Beds, including all types of beds	50	50	50
# of Admissions or Discharges (Discharges)	1,272	2,063	3,384
# of Patient Days	4,824	7,823	12,828
Average Length of Stay	3.8	3.8	3.8
Occupancy Rate	26.4%	42.9%	70.3%

Form C.2b Projected Medical Equipment Utilization upon Project Completion

Form C.2b Projected Medical Equipment Utilization upon Project Completion Novant Health Cabarrus Medical Center	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
CT Scanner			
# of Units	2	2	2
# of Scans	3,524	5,715	9,371
Fixed X-ray (including a combination x-ray/fluoroscopy unit)			
# of Units	2	2	2
# of Procedures*	2,130	3,454	5,665
MRI Scanner			
# of Units	Mobile Service Provider	Mobile Service Provider	Mobile Service Provider
# of Procedures	821	1,332	2,184
# of Adjusted Procedures	1,104	1,791	2,936
Nuclear Medicine			
# of Units	1	1	1
# of Procedures	174	282	462
Ultrasound			
# of Units	3	3	3
# of Procedures	1,029	1,669	2,737
Other Medical Equipment (Portable X-ray)			
# of Units	2	2	2
# of Procedures*	2,130	3,454	5,665
Other Medical Equipment (Echocardiogram)			
# of Units	1	1	1
# of Procedures	570	924	1,516

*Note projected X-ray procedures in Section Q. Assumptions and Methodology are distributed evenly between fixed X-ray and portable X-ray.

Form C.3b Projected OR and GI Endo Room Utilization upon Project Completion

Form C.3b Projected OR and GI Endo Room Utilization upon Project Completion Novant Health Cabarrus Medical Center	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Operating Rooms - Number of Rooms by Type			
Open Heart ORs			
Dedicated C-Section ORs	1	1	1
Other Dedicated Inpatient ORs			
Shared ORs			
Dedicated Ambulatory ORs			
Total # of ORs	1	1	1
# of Excluded ORs	1	1	1
Adjusted Planning Inventory (1)	0	0	0
Surgical Cases			
# of C-Sections Performed in Dedicated C-Section ORs	97	158	259
# of Inpatient Surgical Cases (2)			
# of Outpatient Surgical Cases			
Total # of Surgical Cases (2)	0	0	0
Case Times (from Section C, Question 5(c))			
Inpatient			
Outpatient			
Surgical Hours			
Inpatient (3)			
Outpatient (4)			
Total Surgical Hours			
# of ORs Needed			
Group Assignment (5)			
Standard Hours per OR per Year (6)			
Total Surgical Hours / Standard Hours per OR per Year			
Surgical Cases Performed in Procedure Rooms			
# of Inpatient Surgical Cases Performed in Procedure Rooms	321	521	855
# of Outpatient Surgical Cases Performed in Procedure Rooms	524	849	1,393
Total # of Surgical Cases Performed in Procedure Rooms	845	1,371	2,247

(1) Total # of ORs - # of Excluded ORs
(2) Exclude C-Sections performed in dedicated C-Section ORs
(3) Inpatient Cases (exclude C-Sections performed in dedicated C-Section ORs) X Inpatient Case Time
(4) Outpatient Cases X Outpatient Case Time
(5) From Section C, Question 5(c)
(6) From Section C, Question 5(c)

Form C.4b Projected Other Hospital Services Utilization upon Project Completion

Form C.4b Projected Other Hospital Services Utilization upon Project Completion Novant Health Cabarrus Medical Center	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Emergency Department			
# of Treatment Rooms	16	16	16
# of Visits	4,556	7,389	12,116
Observation Beds (unlicensed)			
# of Beds	12	12	12
Days of Care	400	648	1,063
Laboratory			
Tests	25,529	41,399	67,886
Pharmacy			
Units	135,324	219,449	359,857
Physical Therapy			
Treatments	474	769	1,261
Speech Therapy			
Treatments	143	231	379
Occupational Therapy			
Treatments	416	674	1,105

Forms C.1b, C.2b, C.3b, and C.4b - Assumptions and Methodology

Overview

Pursuant to the need identified in the 2025 SMFP, Novant Health is submitting this CON application proposing to develop a new 50-bed hospital in Cabarrus County. NH Cabarrus will offer inpatient, outpatient, and emergency care, specifically:

- 50 licensed acute care beds;
- 12 observation beds;
- One (1) dedicated C-Section OR;
- Four surgical procedure rooms;
- 16 Emergency Department bays; and,
- Imaging and ancillary services including CT, X-ray/fluoroscopy, ultrasound, nuclear medicine, echocardiogram, lab, and physical/speech/occupational therapy.

Novant Health has projected utilization at NH Cabarrus for acute care beds, observation beds, emergency department, surgery, imaging, and ancillary services. These assumptions are contained in the following pages.

Project Years

Novant Health uses the calendar year (CY) as its fiscal year. NH Cabarrus is expected to open January 1, 2030. The first three project years (full fiscal years) for the project are CY2030, CY2031, and CY2032.

Scope of Inpatient Services

To conservatively project utilization, the Applicants assumed NH Cabarrus will normally see inpatients in a core range of Medical Severity Diagnosis-Related Groups (MSDRGs) during the first three years of operation, the Core Acute Care (CAC) MSDRGs. Exhibit C.1 includes the CAC MSDRGs along with their descriptions. NH Cabarrus will provide emergency services to all patients who come to its ED.

Each MSDRG covers certain diagnoses and procedures. Novant Health created the list of MSDRGs appropriate to be treated at NH Cabarrus in its first three years of operations by consulting Novant Health physician leadership and hospital administrators. Novant Health excluded all MSDRGs normal newborns[13], NICU, cardiac catheterization, bariatric surgery, invasive cardiology, electrophysiology, and transplant services. The limits during the first three years of operation consider patient acuity, equipment requirements (e.g., cardiac catheterization laboratories), and the services appropriate for a 50-bed community hospital.

The list reflects the services routinely offered at Novant Health community hospitals in North Carolina, including Novant Health's community hospitals. The list of MSDRGs will likely expand in later years as the hospital adds equipment, adds technicians, and adds subspecialties to the medical staff. Novant Health cannot predict exactly what subspecialists will be on staff and exactly which patients will use the hospital. However, the criteria used to determine the initial scope of services at NH Cabarrus are reasonable and produce a reasonable list of MSDRGs with which to project inpatient discharges.

[13] MSDRGs for normal newborns are excluded to avoid double counting obstetrics utilization. NH Cabarrus proposes to serve normal newborns.

Due to rounding, numbers presented throughout this document may not add up precisely to the totals provided and percentages may not precisely reflect the absolute figures.

A. Acute Care Bed Utilization

The service area for the proposed project includes Cabarrus County, Stanly County, and select ZIP codes along the shared border of Cabarrus and Rowan County, specifically: 28071, 28081, 28082, 28083, 28138. The selected Rowan County service area zip codes consider current patient destination patterns for general acute care services and the proximity of the proposed NH Cabarrus facility.

As explained in Section C.1, inpatient discharge data, sourced from the HIDI inpatient database, categorizes patients within ZIP codes based on their respective county of residence. For example, the 2023 inpatient discharge figures for ZIP code 28071 are distinctly recorded for Cabarrus County and separately for Rowan County. The selected Rowan County ZIP codes include only those patients who were confirmed as Rowan County residents, ensuring no duplication of patient counts across counties.

Step 1: Determine Base Year Volume for Projections

Novant Health used HIDI data to analyze the inpatient volume at area hospitals within the CAC MSDRGs. The analysis included discharges for patients residing in the identified service area. Calendar Year (CY) 2023 was the basis for projecting future volume. This year was chosen because it is the most recent complete fiscal year, and it was after the peak of COVID hospital admissions, which disrupted or delayed care for some patients.[14]

The table below summarizes all acute care discharges (not limited to CAC MSDRGs) within the identified service area in the base year (CY2023).[15]

Table Q.1 NH Cabarrus Service Area Acute Care Discharges, CY2023

Area	2023
Cabarrus County	19,065
Rowan Co. Selected Zip Codes	3,222
Stanly County	6,403
Total	**28,690**

Source: HIDI Inpatient Database

The following table summarizes the acute care discharges within the CAC MSDRGs in the identified service area during CY2023.

[14] Autumn Gerz, Catherine C. Pollack, Marinanicole D. Schultheiss, and John S. Brownstein, "Delayed Medical Care and Underlying Health in the United States During the COVID-19 Pandemic: A Cross-Sectional Study," Preventive Medicine Reports. 28 (2022): 101882, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9254505/pdf/main.pdf.

[15] Service area acute care discharges exclude behavioral health, inpatient rehabilitation, substance abuse, normal newborns, and acute neonates

Table Q.2 NH Cabarrus Service Area Discharges Within CAC MSDRGs, CY2023

Area	2023
Cabarrus County	11,018
Rowan Co. Selected Zip Codes	1,867
Stanly County	3,671
Total	**16,556**

Source: HIDI Inpatient Database

Service area discharges within the CAC MSDRGs equate to approximately 58 percent of all acute care discharges (16,556 ÷ 28,690 = .58). Novant Health has identified over 16,500 acute care discharges from the service area that could be appropriately served at NH Cabarrus.

Step 2: Project Service Area Discharges Within CAC MSDRGs

To project acute care discharges within the CAC MSDRGs, Novant Health applied the respective population growth rates to Cabarrus County and Stanly County, and the weighted average population growth rate for the selected Rowan County zip codes. Novant Health assumes the annual population growth rates will extend forward through the third year of the project. This assumption is reasonable and conservative in consideration that the population aged 65 and older is projected to increase for service area residents in excess of the overall population growth rate. See discussion in Section C.4.

Table Q.3a: Projected Population Growth: Cabarrus County & Stanly County

Year	Cabarrus Co.	Stanly Co.
2023	242,880	64,999
2024	246,620	65,293
2025	250,391	65,587
2026	254,634	65,884
2027	259,508	66,177
2028	264,881	66,472
2029	270,420	66,767
2030	275,787	67,060
2031	280,768	67,356
2032	285,352	67,650
CAGR	**1.8%**	**0.4%**

Source: North Carolina Office of State Budget & Management, Vintage 2024

Table Q.3b: Projected Population Growth: Selected Rowan County Zip Codes

Zip Code	2024	2029	CAGR
28071	3,083	3,166	0.5%
28081	30,432	32,279	1.2%
28082	18,535	20,932	2.5%
28083	27,191	28,632	1.0%
28138	11,076	11,302	0.4%
Total	**90,317**	**96,311**	**1.3%**

Source: Sg2
Note: NCOSBM does not provide zip code population projections. Sg2 only provides zip code population projections for 2024 and 2029. Novant Health reasonably expects the respective zip code populations to continue at comparable rates beyond 2029.

The following table summarizes projected service area CAC MSDRG discharges based on the respective population growth rates applied to 2023 CAC MSDRG discharges.[16]

Table Q.4 Projected Service Area Discharges Within CAC MSDRGs

	2024	2025	2026	2027	2028	2029	2030	2031	2032
Cabarrus Co.	11,217	11,420	11,626	11,836	12,050	12,268	12,489	12,715	12,945
Rowan Zip Codes	1,891	1,916	1,940	1,965	1,991	2,017	2,043	2,069	2,096
Stanly Co.	3,687	3,704	3,720	3,737	3,753	3,770	3,787	3,804	3,821
Total	**16,796**	**17,039**	**17,287**	**17,538**	**17,794**	**18,054**	**18,319**	**18,588**	**18,861**

Step 3: Project Discharges at NH Cabarrus

Novant Health serves patients from throughout the identified service area via its existing acute care hospitals. The following table summarizes Novant Health's CY2023 share of the CAC MSDRG discharges in the service area.

Table Q.5 Novant Health Share Of Service Area CAC MSDRG Discharges

	2023		
	NH Discharges	SA Discharges	NH Share
Cabarrus Co.	1,161	11,018	10.5%
Rowan Zip Codes	424	1,867	22.7%
Stanly Co.	374	3,671	10.2%

Source: HIDI Inpatient Database and Table Q.2

[16]While partial year 2024 data is available for CAC MSDRGs in the service area, Novant Health projects 2024 service area discharges based on the respective population growth rates, which is more conservative compared to annualized 2024 market data.

As previously described, Novant Health does not provide acute care services in Cabarrus County. As a result, the share of discharges presented in the previous table represents Cabarrus County patients who have chosen to receive care from Novant Health outside the county, primarily in Mecklenburg County.

To project share of discharges for NH Cabarrus, Novant Health anticipates that a portion of its current share in the service area will shift to the new hospital. This projection is based, in part, on the enhanced geographic access NH Cabarrus will offer to residents who have historically relied on Novant Health facilities. By providing a more conveniently located care option, NH Cabarrus will not only improve patient access but also enable Novant Health to optimize its system-wide resources. Lower-acuity patients can be efficiently reallocated to NH Cabarrus, thereby freeing capacity at other facilities to better accommodate higher-acuity and specialized cases.

Novant Health also anticipates that many patients will be drawn to the proposed hospital's welcoming community setting and state-of-the-art, modern facilities. The hospital's design will prioritize patient comfort, accessibility, and efficiency, creating an environment that enhances the overall care experience. With contemporary amenities, advanced technology, and a patient-centered approach, NH Cabarrus will offer an attractive alternative for individuals seeking high-quality care in a more convenient and less complex setting than larger regional hospitals.

Novant Health conservatively projects that 30 percent of its existing share of discharges in the service area will shift to NH Cabarrus in project year one, with a gradual increase of 10 percent in years two and three, respectively. Novant Health believes these assumptions are reasonable for the reasons previously described and consider its own experience developing new community hospitals, existing provider relationships, and time for patients and providers to adapt to a new facility. The following table summarizes the projected percentage of share shifts for the proposed project.

For clarification purposes, the following annual projections are based on a percentage of 2023 share of discharges. Example: 2030 Cabarrus County [30.0% x 10.5% share of discharges = 3.15% x 12,489 = 395]. The effective shift of Novant Health Cabarrus County share of discharges during 2030 is **3.15%** (not 30.0%).

Table Q.6 Percentage Shift of Novant Health Share of Discharges to NH Cabarrus

	Current Share	% of Existing Share That Will Shift To NH Cabarrus			Projected Discharges Based on % of Share Shift		
	2023	2030	2031	2032	2030	2031	2032
Cabarrus Co.	10.5%	30.0%	40.0%	50.0%	395	536	682
Rowan Zip Codes	22.7%	30.0%	40.0%	50.0%	139	188	238
Stanly Co.	10.2%	30.0%	40.0%	50.0%	116	155	195

For information purposes, Exhibit Q includes a summary of projected shifts from Novant Health facility.

Consistent with its historical experience developing de novo community hospitals, Novant Health also projects that NH Cabarrus will capture an incremental share of discharges, i.e., share not based on a shift of existing Novant Health acute care share of discharges. Novant Health projects the following incremental share of discharges to be served at NH Cabarrus during the first three project years.

Table Q.7 Incremental Share of Discharges To Be Served at NH Cabarrus

	Incremental Share			Projected Discharges Based on Incremental Share		
	2030	2031	2032	2030	2031	2032
Cabarrus Co.	3.5%	7.0%	14.0%	437	890	1,812
Rowan Zip Codes	1.0%	1.5%	2.0%	20	31	42
Stanly Co.	1.0%	1.5%	2.0%	38	57	76

The annual projected share of discharges and resulting discharges are reasonable and well-supported by several factors, including but not limited to:

- Novant Health already operates several clinics in Cabarrus and Rowan Counties.
- Physicians currently serving patients in the service area, along with other medical professionals who are expected to seek privileges at NH Cabarrus, strongly support the proposed project. Letters of intent from these physicians (see Exhibit I.2) provide tangible evidence of their commitment to the hospital and underscore their readiness to align their practice with NH Cabarrus.
- The establishment of NH Cabarrus offers a vital alternative to Atrium Health for both patients and physicians. This diversification increases competition, which can drive improvements in patient care, enhance service delivery, and address the preferences of those seeking varied healthcare options within Cabarrus County.
- Novant Health has a long-standing reputation for delivering high-quality acute care services across North Carolina. This track record not only inspires confidence among patients but also strengthens the case for NH Cabarrus to successfully attract patients in the service area.
- The new hospital will feature state-of-the-art facilities, thoughtfully designed to optimize patient care, safety, and operational efficiency. These modern amenities enhance patient and physician experiences, distinguishing NH Cabarrus from older facilities in the region.
- NH Cabarrus will be strategically located to ensure accessibility for patients and physicians. The hospital's design and location aim to minimize travel barriers, providing convenience for residents across the service area.
- Cabarrus County and its surrounding areas are experiencing significant population growth. NH Cabarrus is positioned to serve this expanding community, offering a geographically convenient and alternative healthcare option that aligns with the evolving needs of the region.

For information purposes, Novant Health considered the possibility of projecting its share of discharges at a more granular level, such as individual zip codes. However, for the proposed project, it was determined that county-based discharge share projections are reasonable and appropriate. First, county-level projections provide a comprehensive view of the service area, capturing both demographic and geographic variations, which ensures a balanced and inclusive methodology. Additionally, healthcare access patterns indicate that patients often seek care beyond their immediate zip code, especially in suburban and rural areas where facilities may be less concentrated. A county-level analysis accounts for this patient movement across zip codes, reflecting real-world patterns of healthcare access and

utilization. A county-level approach allows Novant Health to project utilization based on the overall healthcare needs of the service area.

The following tables summarize projected patient discharges based on the shift of existing discharge share and the projected incremental share of discharges.

Table Q.8 Projected NH Cabarrus Discharges Based on Share of Discharges

Area	Shift of Existing NH Share			Incremental Share		
	2030	2031	2032	2030	2031	2032
Cabarrus Co.	395	536	682	437	890	1,812
Rowan Co. Selected Zip Codes	139	188	238	20	31	42
Stanly Co.	116	155	195	38	57	76
Total	**650**	**879**	**1,115**	**495**	**978**	**1,931**

Table Q.9 Projected NH Cabarrus Discharges Based on Share of Discharges

Area	2030	2031	2032
Cabarrus Co.	832	1,426	2,494
Rowan Co. Selected Zip Codes	160	219	280
Stanly Co.	154	212	271

The projected discharges based on share of discharges result in the following projected share of CAC MSDRGs in the identified service area.

Table Q.10 NH Cabarrus Projected Share of CAC MSDRGs

Area	2030	2031	2032
Cabarrus Co.	6.7%	11.2%	19.3%
Rowan Co. Selected Zip Codes	7.8%	10.6%	13.4%
Stanly Co.	4.1%	5.6%	7.1%
Service Area Total	**6.3%**	**10.0%**	**16.1%**

The previously described methodology results in projected discharges that are equivalent to approximately 16 percent of projected CAC MSDRG acute care discharges. Note the projected shares of discharges in Table Q.10 are representative only of the CAC MSDRGs in the market and not all acute care discharges. As stated previously, CAC MSDRGs in the identified service area equate to approximately 58 percent of all acute care discharges.

Assuming total acute care discharges (Table Q.1) increase by the same population growth rates identified in Step 2 of this methodology, the following table summarizes NH Cabarrus's effective projected share of all acute care discharges in the service area.

Table Q.11 NH Cabarrus Projected Share of All Acute Care Discharges

Area	2030	2031	2032
Cabarrus Co.	3.8%	6.5%	11.1%
Rowan Co. Selected Zip Codes	4.5%	6.1%	7.7%
Stanly Co.	2.3%	3.2%	4.1%
Service Area Total	**3.6%**	**5.8%**	**9.3%**

The previously described methodology results in projected discharges that are equivalent to less than 10 percent of projected acute care discharges.

Step 4: Project In-Migration

Drawing from its extensive experience in providing acute care services across North Carolina, Novant Health anticipates that NH Cabarrus will serve a portion of patients originating from outside of the identified service area. In FY2024, 35 percent of acute care discharges at Novant Health Mint Hill Medical Center came from outside Mecklenburg County. Similarly, at NH Ballantyne Medical Center, 51 percent of discharges originated beyond Mecklenburg County. To project in-migration for discharges, Novant Health conservatively projects 10 percent of total discharges will originate from outside the identified service area. This in-migration is expected to primarily consist of patients from the remaining counties within HSA III and adjacent HSAs.

Table Q.12 NH Cabarrus Total Discharges During First Three Project Years

Area	2030	2031	2032
Cabarrus Co.	832	1,426	2,494
Rowan Co. Selected Zip Codes	160	219	280
Stanly Co.	154	212	271
In-Migration	127	206	338
Total Discharges	**1,272**	**2,063**	**3,384**

Step 5: Project Inpatient Days of Care at NH Cabarrus

To project inpatient days of care, Novant Health reviewed discharges and days of care within the CAC MSDRGs served at its acute care hospitals during CY2023 and applied the respective average length of stay (ALOS) to the projected acute care discharges. This assumption is reasonable because it is representative of the scope of discharges that will be served at NH Cabarrus.

Table Q.13 Service Area CAC MSDRG Discharges and Days of Care Served at Novant Health Hospitals

Area	Discharges	Days of Care
Cabarrus Co.	1,161	4,145
Rowan Co. Selected Zip Codes	424	2,008
Stanly Co.	374	1,274
Total	1,959	7,427
Average Length of Stay	**3.8**	

The following table applies the projected ALOS to projected discharges at NH Cabarrus.

Table Q.14 NH Cabarrus Projected Discharges and Days of Care

	2030	2031	2032
Acute Care Discharges	1,272	2,063	3,384
Days of Care	4,824	7,823	12,828
Average Daily Census (ADC)	13.2	21.4	35.1
% Occupancy	26.4%	42.9%	70.3%

ICU Bed Utilization

As previously described, NH Cabarrus will initially develop six (6) ICU beds.

Novant Health reviewed historical ICU days of care at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill. These facilities were identified as reasonable proxies for the proposed project due to their alignment in scope of services, location, and operational experience. This analysis ensures that projections for the proposed project are grounded in reliable and relevant data from facilities with similar characteristics and service delivery models. Additionally, a portion of the respective facilities' existing share of discharges will shift to NH Cabarrus as part of the shift described in Step 3; therefore, the NH facilities' historical experience is a reasonable reflection of the utilization patterns that can be expected at NH Cabarrus.

Table Q.15 Novant Health ICU Days of Care, FY2024

	NH Mint Hill	NH Matthews*	NH Ballantyne[17]	NH Huntersville	Total
ICU Days	1,163	2,057	767	1,835	5,822
Total Days	8,061	40,959	6,170	36,670	91,860
ICU % of Total Days	14.4%	5.0%	12.4%	5.0%	**6.3%**

*Total days of care excludes NICU days
Source: 2025 Hospital License Renewal Applications

Notably, the smaller community hospitals, such as Novant Health Mint Hill (36 beds) and Novant Health Ballantyne (36 beds), exhibit a comparatively higher percentage of total ICU days than their larger counterparts. To be conservative, Novant Health applied the average ICU experience of the identified facilities (6.3 percent of total acute care days) to project ICU utilization at NH Cabarrus.

Table Q.16: NH Cabarrus ICU Days of Care

	2030	2031	2032
ICU Days	306	496	813
Total Days	4,824	7,823	12,828
ICU % of Total Days	6.3%	6.3%	6.3%

As noted previously, to maximize operational flexibility, all bed spaces will be built to acute-care licensure standards. ICU rooms will be available for non-ICU patients when not needed for ICU patients.

LDRP Bed Utilization

As previously described, NH Cabarrus will initially develop eight (8) LDRP beds.

Novant Health reviewed historical obstetrics days of care at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill. These facilities were identified as reasonable proxies for the proposed project due to their alignment in scope of services, location, and operational experience. This analysis ensures that projections for the proposed project are grounded in reliable and relevant data from facilities with similar characteristics and service delivery models. Additionally, a portion of the respective facilities' existing share will shift to NH Cabarrus as part of the shift described in Step 3; therefore, the facilities' historical experience is a reasonable reflection of the utilization patterns that can be expected at NH Cabarrus.

[17]NH Ballantyne does not have licensed ICU beds; however, it operates four intermediate acute care beds that provide an elevated level of care beyond standard medical/surgical beds. In assessing ICU days of care, Novant Health determined that including NH Ballantyne's intermediate acute care days in the analysis was appropriate, as these beds offer a higher level of care than general med/surg and more closely align with the intensity of ICU-level services.

Table Q.17 Novant Health Obstetrics Days of Care, FY2024

	NH Mint Hill	NH Matthews	NH Ballantyne	NH Huntersville	Total
Obstetrics	1,193	5,387	901	5,623	13,104
Total Days	8,061	40,959*	6,170	36,670	91,860
Obstetrics % of Total Days	14.8%	13.2%	14.6%	15.3%	**14.3%**

* Total days of care excludes NICU days

Source: 2025 Hospital License Renewal Applications

Novant Health applied the average obstetrics experience of the identified facilities (14.3 percent of total acute care days) to project obstetrics utilization at NH Cabarrus.

Table Q.18: NH Cabarrus Obstetrics Days of Care

	2030	2031	2032
Obstetrics Days	688	1,116	1,830
Total Days	4,824	7,823	12,828
Obstetrics % of Total Days	14.3%	14.3%	14.3%

There is no rule or statute that requires an applicant to project discharges based on level of care. However, Novant Health projected obstetric discharges for the purpose of projecting the number of C-Section cases to be performed in the dedicated C-Section operating room. To determine projected obstetric discharges, Novant Health reviewed the average length of stay for service area obstetric discharges in the CAC MSDRGs that were served at NH Ballantyne, NH Matthews, and NH Mint Hill.

Table Q.19: Service Area Obstetrics Discharges & Days of Care Within CAC MSDRGs Served at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill, CY2023

	2023
Obstetrics Discharges	349
Obstetric Days of Care	774
Average Length of Stay	2.2

Source: HIDI Inpatient Database

To project obstetrics discharges at NH Cabarrus, Novant Health divided projected days of care by the average length of stay (2.2).

Table Q.20: NH Cabarrus Obstetrics Discharges & Days of Care

	2030	2031	2032
Obstetric Days	688	1,116	1,830
Obstetric Discharges	310	503	825

NH Cabarrus will develop one dedicated C-Section operating room. To project C-Section cases, Novant Health reviewed historical utilization at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill.

Table Q.21: Historical Birth Utilization By Type, FFY2024

	Total	% of Total
Live Births - Vaginal Deliveries	3,764	68.1%
Live Births – C-Section	1,734	**31.4%**
Stillbirths	28	0.5%
Total	5,526	100.0%

Source: 2025 License Renewal Applications

During FFY2024, approximately 31.4 percent of births were delivered via Cesarian Section. Novant Health reasonably projects NH Cabarrus will experience similar utilization. The following table provides projected utilization for the dedicated C-Section OR.

Table Q.22: NH Cabarrus C-Section OR Cases

	2030	2031	2032
Obstetrics Discharges	310	503	825
C-Section OR Cases	97	158	259

Conclusion

The projection of inpatient days uses reasonable and supported assumptions to project patient days through the third project year. The projections result in 12,828 inpatient days in the third year (CY 2032), which equates to 70.3 percent occupancy of the proposed 50 beds. This exceeds the performance standard of 66.7 percent occupancy for hospitals with an average daily census of fewer than 100 patients.

B. Observation Bed Utilization

NH Cabarrus will include 12 observation beds. Novant Health reviewed historical observation experience at NH Ballantyne, NH Matthews, and NH Mint Hill. These facilities were identified as reasonable proxies for the proposed project due to their alignment in scope of services, comparable size, location, and operational experience. Additionally, a portion of the respective facilities' existing share will shift to NH Cabarrus as part of the shift described

in Step 3; therefore, the facilities' historical experience is a reasonable reflection of the utilization patterns that can be expected at NH Cabarrus.

Table Q.23: Novant Health Observation Experience, FFY2024

	Discharges	Observations	Ratio to Discharges
NH Mint Hill	2,937	1,739	0.59
NH Ballantyne	1,974	951	0.48
NH Huntersville	9,877	2,778	0.28
NH Matthews	9,875	2,984	0.30
Total	14,786	5,674	**0.34**

Source: 2025 Hospital License Renewal Applications

During FFY2024, the ratio of observation patients to discharges at NH Ballantyne, NH Matthews, and NH Mint Hill was 0.34. The respective observation patients had an ALOS of 22 hours. Novant Health projects the same ratio for NH Cabarrus based on this historical experience. The following table provides projected observation bed utilization based on this assumption.

Table Q.24: NH Cabarrus Observation Utilization

	Ratio To Discharges	2030	2031	2032
IP Discharges	1.00	1,272	2,063	3,384
Observation Cases	0.34	436	707	1,160
Observation Hours (22 Hours Per Case)		10,742	9,593	15,557
Observation Days (Observation Hours ÷ 24)		473	400	648

Novant Health anticipates a continued shift toward observation care, with the ratio of observation days to acute care days expected to rise as more patients are admitted under observation status rather than as inpatients. This trend reflects evolving healthcare practices aimed at providing cost-effective, high-quality care while optimizing hospital resources.

Beyond the projected utilization for observation patients, these beds will play a vital role in enhancing patient flow and care coordination. They will accommodate individuals requiring extended recovery time following procedures and provide critical monitoring for emergency department patients. This includes those awaiting diagnostic test results during peak ED demand or undergoing evaluation to determine the necessity of inpatient admission, ensuring timely and appropriate care decisions.

Furthermore, the development of the proposed observation beds is designed to support long-term growth and adaptability. By proactively establishing sufficient capacity from the outset, Novant Health can meet future demand without the immediate need for expansion, fostering operational efficiency and sustained excellence in patient care.

C. Surgical Utilization

To project inpatient surgical utilization at NH Cabarrus, Novant Health reviewed the distribution of non-surgical vs. surgical inpatient discharges for the service area patients within the CAC MSDRGs.

Table Q.25: Service Area Surgical & Non-Surgical Discharges

	2023	% of Total
Non-Surgical Discharges	12,374	74.7%
Surgical Discharges	4,182	**25.3%**
Total	16,556	100.0%

Source: HIDI Inpatient Database

Based on HIDI CY2023 HIDI data, approximately 25.3 percent of discharges were attributable to surgical inpatients and approximately 74.7 percent of discharges were attributable to medical, non-surgical inpatients. Novant Health projects the distribution of medical and surgical patients at NH Cabarrus based on the CY2023 utilization of medical and surgical patients for the identified service area patients within the CAC MSDRGs.

Table Q.26: NH Cabarrus Med/Surg Discharges

	2030	2031	2032
Medical Inpatients (74.7%)	951	1,542	2,529
Surgical Inpatients (25.3%)	321	521	855
Total Med/Surg Discharges	**1,272**	**2,063**	**3,384**

Novant Health projects NH Cabarrus will perform one inpatient surgical case for each surgical inpatient discharge.

Table Q.27: NH Cabarrus Inpatient Surgical Cases

	2030	2031	2032
Inpatient Surgical Cases	321	521	855

To project outpatient surgical cases at NH Cabarrus, Novant Health reviewed the FFY2024 ratio of outpatient surgical cases to discharges at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill.

Table Q.28: Ratio of Outpatient to Inpatient Discharges, FFY2024

	NH Mint Hill	NH Matthews	NH Ballantyne	NH Huntersville	Total
Discharges	2,937	9,864	1,974	9,877	24,652
Ambulatory Surgery	1,408	4,490	1,471	2,778	10,147
Ratio Amb Surg to Discharges	0.479	0.455	0.745	0.281	**0.412**

Source: 2025 Hospital License Renewal Applications

During FFY2024, the ratio of outpatient surgeries to discharges at NH Ballantyne, NH Matthews, and NH Mint Hill was 0.412. Novant Health projects the same ratio for NH Cabarrus based on this historical experience. The following table provides projected outpatient surgical cases based on this assumption.

Table Q.29: NH Cabarrus Outpatient Surgical Cases

	2030	2031	2032
Discharges	1,272	2,063	3,384
Ratio of OP Surgical Cases to Discharges	0.412	0.412	0.412
Outpatient Surgical Cases	524	849	1,393

D. Emergency Department Utilization

To project emergency department utilization at NH Cabarrus, Novant Health reviewed the distribution of inpatient discharges that were admitted through the emergency department for the service area patients within the CAC MSDRGs. The following table relies on the ER Flag in the HIDI data to identify inpatients who came through the ED.

Table Q.30: Service Area Emergency Department Admissions

	2023	% of Total
Non-ED	4,147	25.0%
ED Admission	12,409	**75.0%**
Total	16,556	100.0%

Source: HIDI Inpatient Database

Based on CY2023 HIDI data, approximately 75 percent of discharges were admitted via the emergency department. Novant Health assumes the percentage of discharges in the CAC MSDRG set who come through the ED will remain stable through the first three years of operation. The table below applies these percentages to the projected inpatient discharges at NH Cabarrus.

Table Q.31: NH Cabarrus Inpatient Emergency Department Visits

	Ratio To Discharges	2030	2031	2032
IP Discharges	1.00	1,272	2,063	3,384
IP ED Visit	0.75	954	1,547	2,536

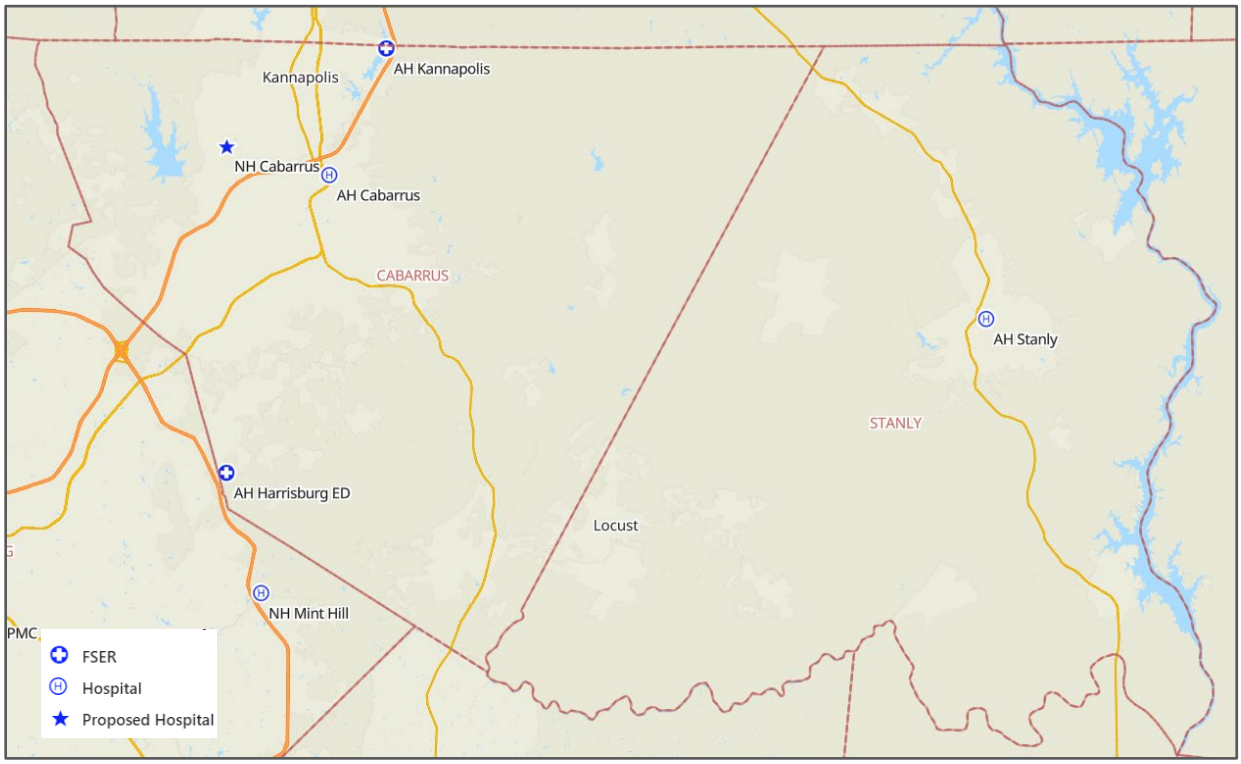
To project outpatient emergency department visits, Novant Health reviewed the ratio of outpatient emergency department visits to inpatient discharges at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill.

Table Q.32: Ratio of Outpatient Emergency Department Visits to Inpatient Discharges, FFY2024

Novant Health Facility	Discharges	A ED Visits	B ED Visits Admitted	C=A-B OP ED Visits	Ratio OP ED Visits: Discharges
NH Mint Hill	2,937	30,549	2,267	28,282	9.63
NH Ballantyne	1,974	16,894	1,522	15,372	7.79
NH Matthews	9,877	2,778	41,125	6,369	3.52
NH Huntersville	9,875	2,984	32,460	6,125	2.67
Total	24,663	8,452	121,028	16,283	**4.25**

Source: 2025 Hospital License Renewal Applications

During FFY2024, the ratio of outpatient emergency department visits to discharges at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill was 4.25. In projecting future ED volumes, Novant Health carefully considered the presence of both existing and approved hospitals, as well as FSERs in Cabarrus County, which are illustrated on the following map.



Atrium Health currently operates an ED at AH Cabarrus and two FSERs—one in Harrisburg and another in Kannapolis. The AH Harrisburg FSER is located 15 miles (~ 20 minutes) from the proposed NH Cabarrus site and the AH Kannapolis FSER is located approximately nine miles (~15 minutes) from the proposed NH Cabarrus site. For information purposes, Atrium Health has received approval to develop a new acute care hospital at its Harrisburg FSER site.

Despite the presence of existing emergency care facilities in Cabarrus County, Novant Health highlights that NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill operate in a highly competitive market, where multiple

hospitals and FSERs provide emergency services within the acute care service area, *i.e.,* Mecklenburg County. Given this competitive landscape, Novant Health believes that the historical ratio of outpatient ED visits to discharges observed at NH Ballantyne, NH Matthews, and NH Mint Hill serves as a reasonable benchmark for projecting emergency department visits at NH Cabarrus. Moreover, NH Cabarrus will establish a new access point in the service area, offering residents an additional choice for high-quality emergency services.

To ensure a prudent approach to forecasting ED utilization, Novant Health has adopted a conservative methodology. The historical ratio of outpatient ED visits to discharges at NH Ballantyne, NH Matthews, and NH Mint Hill serves as a benchmark for projecting patient volume at NH Cabarrus. However, in an effort to maintain conservative projections, Novant Health has reduced this ratio by one-third when estimating utilization at NH Cabarrus. Please see the following table.

Table Q.33: NH Cabarrus Outpatient Emergency Department Visits

	Ratio To Discharges	2030	2031	2032
IP Discharges	1.00	1,272	2,063	3,384
OP ED Visits	2.83	3,603	5,842	9,580

Novant Health highlights that the NH Cabarrus inpatient discharges presented in Table Q.33 account for less than 10 percent of the projected acute care discharges in the service area (see also Table Q.11). This reinforces the inherently conservative nature of the projected emergency department utilization, which is further supported by Novant Health's prudent ED visit methodology.

The following table combines projected inpatient and outpatient emergency department utilization.

Table Q.34: NH Cabarrus Emergency Department Visits

	2030	2031	2032
IP ED Visits	954	1,547	2,536
OP ED Visit	3,603	5,842	9,580
Total ED Visits	**4,556**	**7,389**	**12,116**

There is no utilization threshold or performance standard for emergency departments. After consulting with its architect and leveraging its extensive experience in operating emergency departments nationwide, Novant Health concluded that the proposed 16 ED bays will adequately support the expected ED utilization in the initial years of the project and into the future.

E. Imaging & Ancillary Utilization

An acute care hospital must provide imaging and other ancillary services to support its projected inpatients, emergency patients, and outpatients. These services are essential for patient care and must be readily available onsite, regardless of utilization, to support the proposed inpatient and emergency services in this project. To project utilization for imaging services, Novant Health reviewed utilization of the respective services at NH Ballantyne, NH Huntersville, NH Matthews, and NH Mint Hill.

Table Q.35: Inpatient Imaging Services, CY2024*

NH Ballantyne, NH Huntersville, NH Mint Hill, NH Matthews	IP		OP	
	Volume	Per Patient Day	Volume	Per Patient Day
Total Inpatient Days	97,803	1.000	97,803	1.000
X-Ray Procedures	12,872	0.132	73,504	0.752
Nuclear Medicine Procedures	602	0.006	2,921	0.030
Ultrasound Procedures	3,051	0.031	17,820	0.182
CT Scans	11,652	0.119	59,797	0.611
MRI Procedures (unweighted)	2,509	0.026	14,141	0.145
Echocardiogram	6,120	0.063	5,435	0.056

*Reflects 11 months data (January-November)
Source: Novant Health internal data

For imaging services, Novant Health reasonably assumes that the CY2024 ratio of imaging procedures to inpatient days of care will be comparable to that of NH Cabarrus patients.

Table Q.36: NH Cabarrus Inpatient Imaging Procedures

	Ratio to IP Days	2030	2031	2032
Total Inpatient Days	1.000	4,824	7,823	12,828
X-Ray Procedures	0.132	635	1,030	1,688
Nuclear Medicine Procedures	0.006	30	48	79
Ultrasound Procedures	0.031	150	244	400
CT Scans	0.119	575	932	1,528
MRI Procedures (unweighted)	0.026	124	201	329
Echocardiogram	0.063	302	490	803

Table Q.37: NH Cabarrus Outpatient Imaging Procedures

	Ratio to IP Days	2030	2031	2032
Total Inpatient Days	1.000	4,824	7,823	12,828
X-Ray Procedures	0.752	3,625	5,879	9,641
Nuclear Medicine Procedures	0.030	144	234	383
Ultrasound Procedures	0.182	879	1,425	2,337
CT Scans	0.611	2,949	4,783	7,843
MRI Procedures (unweighted)	0.145	697	1,131	1,855
Echocardiogram	0.056	268	435	713

Table Q.38: NH Cabarrus Total Imaging Procedures

	2030	2031	2032
X-Ray Procedures	4,260	6,909	11,329
Nuclear Medicine Procedures	174	282	462
Ultrasound Procedures	1,029	1,669	2,737
CT Scans	3,524	5,715	9,371
MRI Procedures (unweighted)	821	1,332	2,184
Echocardiogram	570	924	1,516

To project adjusted MRI procedures at NH Cabarrus, Novant Health reviewed mobile MRI utilization at NH Ballantyne.

Table Q.39: NH Ballantyne Mobile MRI Utilization By Type

MRI Procedure Type	NH Ballantyne	% of Total
Base IP	441	19.7%
Complex IP	222	9.9%
Total IP	663	
Base OP	816	36.5%
Complex OP	757	33.9%
Total OP	1,573	
Total MRI Procedures	**2,236**	**100.0%**

Source: 2025 License Renewal Application

NH Cabarrus reasonably assumes MRI utilization by scan type will be comparable to NH Ballantyne. NH Ballantyne is geographically proximate to the proposed service area, comparable in size, and it is also a new hospital with only mobile MRI access. The following table provides adjusted mobile MRI procedures at NH Cabarrus.

Table Q.40: NH Cabarrus Mobile MRI Utilization By Type

MRI Procedure Type	% of Total	2030	2031	2032
Base IP	19.7%	162	263	431
Complex IP	9.9%	82	132	217
Total IP		244	395	648
Base OP	36.5%	300	486	797
Complex OP	33.9%	278	451	739
Total OP		578	937	1,536
Total MRI Procedures		**821**	**1,332**	**2,184**

The following table calculates adjusted mobile MRI procedures based on the weight by procedure type described in Chapter 15 of the 2025 SMFP.

Table Q.41: NH Cabarrus Mobile MRI Utilization Adjusted Procedures

MRI Procedure Type	Weight	2030	2031	2032
Base IP	1.82	294	478	783
Complex IP	2.12	173	280	460
Total IP		467	758	1,243
Base OP	1.00	300	486	797
Complex OP	1.21	337	547	896
Total OP		637	1,033	1,693
Total MRI Adjusted Procedures		**1,104**	**1,791**	**2,936**

The following table provides historical ancillary service volume at NH Ballantyne, NH Matthews, and NH Mint Hill.

Table Q.42: Ancillary Services, CY2024*

NH Ballantyne, NH Huntersville NH Mint Hill, NH Matthews	Volume	Per Patient Day
Total Inpatient Days	97,803	1.000
Laboratory	517,581	5.292
Physical Therapy	9,613	0.098
Speech Therapy	2,893	0.030
Occupational Therapy	8,425	0.086

*Reflects 11 months data (January-November)
Source: Novant Health internal data

For ancillary services, Novant Health reasonably assumes that the CY2024 ratio of ancillary service utilization to inpatient days of care will be comparable to that of NH Cabarrus patients.

Table Q.43: NH Cabarrus Ancillary Services

	Ratio to IP Days	2030	2031	2032
Total Inpatient Days	1.000	4,824	7,823	12,828
Laboratory	5.292	25,529	41,399	67,886
Physical Therapy	0.098	474	769	1,261
Speech Therapy	0.030	143	231	379
Occupational Therapy	0.086	416	674	1,105

Novant Health projects pharmacy units based on the CY2024 experience of NH Matthews and NH Ballantyne summarized below.

Table Q.44 Pharmacy Units, CY2024

	Days of Care	Pharmacy Units	Ratio of Units per Day
NH Ballantyne	7,345	279,846	38.1
NH Matthews	47,013	1,245,036	26.5
Total	54,358	1,524,882	**28.1**

Source: Novant Health internal data

Table Q.45 NH Cabarrus Pharmacy Units

	2030	2031	2032
Pharmacy Units	135,324	219,449	359,857

Form F.1a Capital Cost

	NH Cabarrus Capital Cost	Column A Novant Health, Inc. (Applicant & Parent Company)	Column B Novant Health Cabarrus Medical Center, LLC (Applicant)	Column C Total Column A + Column B
1	Purchase Price of Land	$17,484,250		$17,484,250
2	Closing Costs	$150,000		$150,000
3	Site Preparation	$25,441,623		$25,441,623
4	Construction Contract(s)	$207,431,040		$207,431,040
5	Landscaping	$3,361,875		$3,361,875
6	Architect / Engineering Fees	$23,623,454		$23,623,454
7	Medical Equipment	$22,965,770		$22,965,770
8	Non-Medical Equipment	$13,351,277		$13,351,277
9	Furniture	$9,650,802		$9,650,802
10	Consultant Fees (specify)	$35,000		$35,000
11	Financing Costs	$0		$0
12	Interest during Construction	$0		$0
13	Other (Contingency)	$12,939,804		$12,939,804
14	**Total Capital Cost**	**$336,434,895**		**$336,434,895**

Form F.2b Projected Revenues and Net Income upon Project Completion

Form F.2b Projected Revenues and Net Income upon Project Completion	1st Full FY	2nd Full FY	3rd Full FY
	F: 01/01/2030	F: 01/01/2031	F: 01/01/2032
NH Cabarrus: Facility	T: 12/31/2030	T: 12/31/2031	T: 12/31/2032
Patient Services Gross Revenue			
Self-Pay	$8,433,223	$14,084,164	$23,793,753
Insurance *	$39,257,064	$65,560,792	$110,756,967
Medicare *	$53,823,115	$89,890,956	$151,862,687
Medicaid *	$16,860,481	$28,158,132	$47,570,487
Other (Other Govt, Institutional, Tricare)	$3,094,891	$5,168,754	$8,732,159
Total Patient Services Gross Revenue	$121,468,773	$202,862,799	$342,716,054
Other Revenue (1)	$0	$0	$0
Total Gross Revenue (2)	$121,468,773	$202,862,799	$342,716,054
Adjustments to Revenue			
Charity Care	$8,433,223	$14,084,164	$23,793,753
Bad Debt	$1,568,491	$2,619,508	$4,425,393
Contractual Adjustments	$82,987,491	$131,551,877	$222,242,888
Total Adjustments to Revenue	$92,989,205	$148,255,549	$250,462,034
Total Net Revenue (3)	$28,479,568	$54,607,250	$92,254,019
Total Operating Costs (from Form F.3)	$62,617,855	$71,588,654	$85,066,831
Net Income (4)	($34,138,286)	($16,981,405)	$7,187,188

* Including any managed care plans
(1) Identify each type of revenue included on this line and explain how the dollar amount for each type was determined.
(2) Total Gross Revenue = Total Patient Services Gross Revenue + Other Revenue
(3) Total Net Revenue = Total Gross Revenue - Total Adjustments to Revenue
(4) Net Income = Total Net Revenue - Total Operating Costs

Form F.2b Projected Revenues and Net Income upon Project Completion NH Cabarrus: Inpatient Services	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Patient Services Gross Revenue			
Self-Pay	$2,861,984	$4,780,976	$8,077,647
Insurance *	$10,410,985	$17,391,665	$29,383,905
Medicare *	$21,361,184	$35,684,093	$60,289,686
Medicaid *	$5,682,490	$9,492,662	$16,038,227
Other (Other Govt, Institutional, Tricare)	$1,161,385	$1,940,106	$3,277,886
Total Patient Services Gross Revenue	$41,478,028	$69,289,502	$117,067,351
Other Revenue (1)			
Total Gross Revenue (2)	$41,478,028	$69,289,502	$117,067,351
Adjustments to Revenue			
Charity Care	$2,861,984	$4,780,976	$8,077,647
Bad Debt	$535,594	$894,715	$1,511,657
Contractual Adjustments	$28,299,953	$43,624,773	$73,705,778
Total Adjustments to Revenue	$31,697,531	$49,300,464	$83,295,082
Total Net Revenue (3)	$9,780,497	$19,989,038	$33,772,269
Total Operating Costs (from Form F.3)	$32,949,253	$38,119,330	$46,198,398
Net Income (4)	($23,168,756)	($18,130,292)	($12,426,130)

* Including any managed care plans
(1) Identify each type of revenue included on this line and explain how the dollar amount for each type was determined.
(2) Total Gross Revenue = Total Patient Services Gross Revenue + Other Revenue
(3) Total Net Revenue = Total Gross Revenue - Total Adjustments to Revenue
(4) Net Income = Total Net Revenue - Total Operating Costs

Form F.2b Projected Revenues and Net Income upon Project Completion NH Cabarrus: Outpatient Surgical Services	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Patient Services Gross Revenue			
Self-Pay	$1,666,240	$2,780,682	$4,699,286
Insurance *	$8,478,132	$14,148,611	$23,910,819
Medicare *	$9,716,306	$16,214,920	$27,402,833
Medicaid *	$3,485,323	$5,816,432	$9,829,632
Other (Other Govt, Institutional, Tricare)	$602,928	$1,006,187	$1,700,433
Total Patient Services Gross Revenue	$23,948,929	$39,966,831	$67,543,003
Other Revenue (1)			
Total Gross Revenue (2)	$23,948,929	$39,966,831	$67,543,003
Adjustments to Revenue			
Charity Care	$1,666,240	$2,780,682	$4,699,286
Bad Debt	$309,246	$516,080	$872,163
Contractual Adjustments	$16,193,304	$25,944,611	$43,845,781
Total Adjustments to Revenue	$18,168,790	$29,241,373	$49,417,231
Total Net Revenue (3)	$5,780,138	$10,725,459	$18,125,773
Total Operating Costs (from Form F.3)	$16,001,299	$17,818,276	$20,411,320
Net Income (4)	($10,221,160)	($7,092,817)	($2,285,547)

* Including any managed care plans
(1) Identify each type of revenue included on this line and explain how the dollar amount for each type was determined.
(2) Total Gross Revenue = Total Patient Services Gross Revenue + Other Revenue
(3) Total Net Revenue = Total Gross Revenue - Total Adjustments to Revenue
(4) Net Income = Total Net Revenue - Total Operating Costs

Form F.2b Projected Revenues and Net Income upon Project Completion	1st Full FY	2nd Full FY	3rd Full FY
	F: 01/01/2030	F: 01/01/2031	F: 01/01/2032
NH Cabarrus: Other Outpatient Services	T: 12/31/2030	T: 12/31/2031	T: 12/31/2032
Patient Services Gross Revenue			
Self-Pay	$3,904,999	$6,522,507	$11,016,820
Insurance *	$20,367,947	$34,020,516	$57,462,243
Medicare *	$22,745,624	$37,991,943	$64,170,169
Medicaid *	$7,692,668	$12,849,039	$21,702,628
Other (Other Govt, Institutional, Tricare)	$1,330,578	$2,222,461	$3,753,840
Total Patient Services Gross Revenue	$56,041,817	$93,606,466	$158,105,700
Other Revenue (1)			
Total Gross Revenue (2)	$56,041,817	$93,606,466	$158,105,700
Adjustments to Revenue			
Charity Care	$3,904,999	$6,522,507	$11,016,820
Bad Debt	$723,652	$1,208,713	$2,041,573
Contractual Adjustments	$38,494,233	$61,982,492	$104,691,329
Total Adjustments to Revenue	$43,122,884	$69,713,713	$117,749,722
Total Net Revenue (3)	$12,918,933	$23,892,753	$40,355,978
Total Operating Costs (from Form F.3)	$13,667,302	$15,651,049	$18,457,113
Net Income (4)	($748,370)	$8,241,704	$21,898,865

* Including any managed care plans
(1) Identify each type of revenue included on this line and explain how the dollar amount for each type was determined.
(2) Total Gross Revenue = Total Patient Services Gross Revenue + Other Revenue
(3) Total Net Revenue = Total Gross Revenue - Total Adjustments to Revenue
(4) Net Income = Total Net Revenue - Total Operating Costs

Form F.3b Projected Operating Costs upon Project Completion

Form F.3a Projected Operating Costs NH Cabarrus Facility	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Salaries (from Form H Staffing)	$22,051,510	$26,190,918	$31,950,260
Taxes and Benefits	$5,301,616	$6,296,811	$7,681,470
Independent Contractors (1)	$1,533,530	$2,536,655	$4,243,742
Medical Supplies	$2,046,060	$3,382,831	$5,660,437
Other Supplies	$1,845,419	$3,052,284	$5,106,541
Dietary (2)	$0	$0	$0
Housekeeping/Laundry (2)	$0	$0	$0
Equipment Maintenance	$1,104,623	$1,126,715	$1,149,249
Building & Grounds Maintenance (2)	$402,372	$410,420	$418,628
Utilities	$0	$0	$0
Insurance	$214,262	$218,547	$222,918
Professional Fees	$0	$0	$0
Interest Expense	$0	$0	$0
Rental Expense	$118,646	$121,019	$123,439
Depreciation - Buildings	$8,801,058	$8,801,058	$8,801,058
Depreciation - Equipment	$6,566,836	$6,566,836	$6,566,836
Other Expenses (Corporate Overhead Allocation)	$9,236,907	$9,421,645	$9,610,078
Other Expenses (On-Call and Med Dir Payments, IP Hospitalists Allocation)	$3,395,016	$3,462,916	$3,532,174
Total Expenses	$62,617,855	$71,588,654	$85,066,831

(1) Include only the cost of independent contractors on this line. Employees should be included in the Salaries line.

(2) Do not include salaries on this line. Salaries should be included in the Salaries line.

Form F.3a Projected Operating Costs NH Cabarrus Inpatient Services	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Salaries (from Form H Staffing)	$11,443,412	$14,212,384	$18,465,064
Taxes and Benefits	$2,751,221	$3,416,936	$4,439,364
Independent Contractors (1)	$861,991	$1,425,985	$2,385,868
Medical Supplies	$539,858	$893,083	$1,494,250
Other Supplies	$918,151	$1,518,890	$2,541,310
Dietary (2)	$0	$0	$0
Housekeeping/Laundry (2)	$0	$0	$0
Equipment Maintenance	$520,714	$531,128	$541,751
Building & Grounds Maintenance (2)	$290,191	$295,995	$301,915
Utilities	$0	$0	$0
Insurance	$163,569	$166,840	$170,177
Professional Fees	$0	$0	$0
Interest Expense	$0	$0	$0
Rental Expense	$86,411	$88,139	$89,902
Property and Other Taxes (except Income)	$0	$0	$0
Depreciation - Buildings	$3,224,238	$3,225,004	$3,225,048
Depreciation - Equipment	$2,405,738	$2,406,310	$2,406,343
Other Expenses (On-Call and Med Dir Payments, IP Hospitalists Allocation, Indirect Salaries & Benefits)	$6,901,437	$7,039,466	$7,180,255
Other Expenses (Corporate Allocation)	$2,842,322	$2,899,169	$2,957,152
Total Expenses	$32,949,253	$38,119,330	$46,198,398

(1) Include only the cost of independent contractors on this line. Employees should be included in the Salaries line.

(2) Do not include salaries on this line. Salaries should be included in the Salaries line.

Form F.3a Projected Operating Costs NH Cabarrus Outpatient Surgical Services	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Salaries (from Form H Staffing)	$5,864,621	$6,537,361	$7,288,457
Taxes and Benefits	$1,409,970	$1,571,710	$1,752,288
Independent Contractors (1)	$75,164	$124,219	$207,889
Medical Supplies	$1,127,729	$1,863,723	$3,119,069
Other Supplies	$264,541	$437,189	$731,665
Dietary (2)	$0	$0	$0
Housekeeping/Laundry (2)	$0	$0	$0
Equipment Maintenance	$297,485	$303,434	$309,503
Building & Grounds Maintenance (2)	$54,516	$55,606	$56,718
Utilities	$0	$0	$0
Insurance	$14,159	$14,442	$14,731
Professional Fees	$0	$0	$0
Interest Expense	$0	$0	$0
Rental Expense	$17,069	$17,411	$17,759
Property and Other Taxes (except Income)	$0	$0	$0
Depreciation - Buildings	$3,394,798	$3,393,750	$3,394,160
Depreciation - Equipment	$2,533,000	$2,532,218	$2,532,524
Other Expenses (On-Call and Med Dir Payments, IP Hospitalists Allocation, Indirect Salaries & Benefits)	$793,772	$809,648	$825,841
Other Expenses (Corporate Allocation)	$154,475	$157,564	$160,716
Total Expenses	$16,001,299	$17,818,276	$20,411,320

(1) Include only the cost of independent contractors on this line. Employees should be included in the Salaries line.
(2) Do not include salaries on this line. Salaries should be included in the Salaries line.

Form F.3a Projected Operating Costs NH Cabarrus Other Outpatient Services	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Salaries (from Form H Staffing)	$4,743,477	$5,441,173	$6,196,740
Taxes and Benefits	$1,140,425	$1,308,165	$1,489,818
Independent Contractors (1)	$596,374	$986,451	$1,649,985
Medical Supplies	$378,473	$626,024	$1,047,118
Other Supplies	$662,728	$1,096,205	$1,833,566
Dietary (2)	$0	$0	$0
Housekeeping/Laundry (2)	$0	$0	$0
Equipment Maintenance	$286,424	$292,153	$297,996
Building & Grounds Maintenance (2)	$57,665	$58,819	$59,995
Utilities	$0	$0	$0
Insurance	$36,534	$37,264	$38,010
Professional Fees	$0	$0	$0
Interest Expense	$0	$0	$0
Rental Expense	$15,165	$15,468	$15,778
Property and Other Taxes (except Income)	$0	$0	$0
Depreciation - Buildings	$2,182,023	$2,182,303	$2,181,849
Depreciation - Equipment	$1,628,098	$1,628,307	$1,627,969
Other Expenses (On-Call and Med Dir Payments, IP Hospitalists Allocation, Indirect Salaries & Benefits)	$1,541,698	$1,572,532	$1,603,983
Other Expenses (Corporate Allocation)	$398,219	$406,183	$414,307
Total Expenses	$13,667,302	$15,651,049	$18,457,113

(1) Include only the cost of independent contractors on this line. Employees should be included in the Salaries line.
(2) Do not include salaries on this line. Salaries should be included in the Salaries line.

Form H Staffing

Form H Staffing Criterion (7) NH Cabarrus: Facility	Projected Staff								
	First Full Fiscal Year			Second Full Fiscal Year			Third Full Fiscal Year		
	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *
	E	F	G=E*F	H	I	J=H*I	K	L	M=K*L
CRNAs	8.8	272,517	$2,398,152	8.8	280,693	$2,470,097	8.8	289,114	$2,544,200
Registered Nurses	54.7	115,088	$6,300,521	77.4	118,541	$9,178,107	113.0	122,097	$13,790,834
Surgical Technicians	14.0	66,833	$935,657	14.0	68,838	$963,727	14.0	70,903	$992,639
Aides/Orderlies	13.4	55,176	$738,764	18.5	56,831	$1,053,077	27.2	58,536	$1,590,420
Clerical Staff	29.0	51,991	$1,507,749	29.0	53,551	$1,552,981	29.0	55,158	$1,599,571
Laboratory Technicians	14.0	64,823	$907,518	14.0	66,767	$934,743	14.0	68,770	$962,786
Radiology Technologists	19.9	80,512	$1,602,179	22.0	82,793	$1,821,453	22.0	85,277	$1,876,096
Pharmacists	4.0	181,677	$726,710	4.0	187,128	$748,511	4.0	192,742	$770,966
Pharmacy Technicians	8.0	59,408	$475,267	8.0	61,191	$489,525	8.0	63,026	$504,211
Physical Therapists	1.0	100,960	$100,960	2.0	103,988	$207,977	2.0	107,108	$214,216
Speech Therapists	0.8	99,345	$74,509	0.8	102,326	$76,744	0.8	105,395	$79,046
Occupational Therapists	1.0	95,570	$95,570	1.0	98,437	$98,437	1.0	101,390	$101,390
Respiratory Therapists	8.5	67,927	$577,382	8.5	69,965	$594,703	8.5	72,064	$612,544
Social Workers	6.5	87,468	$568,540	6.5	90,092	$585,596	6.5	92,794	$603,164
Medical Records	1.0	54,441	$54,441	1.0	56,074	$56,074	1.0	57,757	$57,757
Central Sterile Supply	18.0	61,321	$1,103,774	18.0	63,160	$1,136,888	18.0	65,055	$1,170,994
Materials Management	5.0	46,146	$230,729	5.0	47,530	$237,651	5.0	48,956	$244,781
Maintenance/Engineering	3.5	74,062	$259,216	3.5	76,284	$266,993	3.5	78,572	$275,003
Administrator	18.3	150,113	$2,739,560	18.3	154,616	$2,821,747	18.3	159,255	$2,906,400
Director of Nursing	0.5	245,979	$122,989	0.5	253,358	$126,679	1.0	260,959	$260,959
Other (Public Safety)	9.0	59,036	$531,323	12.7	60,807	$769,208	12.7	62,631	$792,284
Total	**238.8**		**$22,051,510**	**273.4**		**$26,190,918**	**318.1**		**$31,950,260**

Form H Staffing Criterion (7) Inpatient Services	First Full Fiscal Year			Second Full Fiscal Year			Third Full Fiscal Year		
	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *
	H	I	J=H*I	K	L	M=K*L	K	L	M=K*L
CRNAs	3.4	272,517	$929,055	3.4	280,693	$954,289	3.4	289,114	$982,613
Registered Nurses	36.6	115,088	$4,210,611	51.8	118,541	$6,142,968	76.6	122,097	$9,347,799
Surgical Technicians	5.4	66,833	$362,478	5.4	68,838	$372,323	5.4	70,903	$383,374
Aides/Orderlies	9.9	55,176	$547,916	13.7	56,831	$777,465	19.9	58,536	$1,167,348
Clerical Staff	5.0	48,878	$244,389	5.0	50,344	$251,721	5.0	51,854	$259,272
Respiratory Therapists	8.5	67,927	$577,382	8.5	69,965	$594,703	8.5	72,064	$612,544
Central Sterile Supply	7.0	61,321	$427,607	7.0	63,160	$439,222	7.0	65,055	$452,258
Administrator	4.4	144,323	$633,202	4.4	148,648	$652,019	4.4	153,107	$671,559
Total	**80.2**		**$7,932,640**	**99.2**		**$10,184,711**	**130.1**		**$13,876,767**

Form H Staffing Criterion (7) Outpatient Surgery	Second Full Fiscal Year			Third Full Fiscal Year			Third Full Fiscal Year		
	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *
	H	I	J=H*I	K	L	M=K*L	K	L	M=K*L
CRNAs	5.4	272,517	$1,469,097	5.4	280,693	$1,515,807	5.4	289,114	$1,561,587
Registered Nurses	8.3	115,088	$951,782	10.4	118,541	$1,236,648	12.9	122,097	$1,573,760
Surgical Technicians	8.6	66,833	$573,179	8.6	68,838	$591,404	8.6	70,903	$609,265
Aides/Orderlies	1.2	55,176	$67,601	1.2	56,831	$69,750	1.2	58,536	$71,857
Central Sterile Supply	11.0	61,321	$676,167	11.0	63,160	$697,666	11.0	65,055	$718,737
Administrator	0.6	162,777	$99,716	0.6	167,660	$102,887	0.6	172,690	$105,994
Total	**35.1**		**$3,837,543**	**37.3**		**$4,214,162**	**39.8**		**$4,641,200**

Form H Staffing Criterion (7) Administrative/Clinical Support	Projected Staff								
	First Full Fiscal Year			Second Full Fiscal Year			Third Full Fiscal Year		
	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *
	E	F	G=E*F	H	I	J=H*I	K	L	M=K*L
Registered Nurses	9.9	115,088	$1,138,128	15.2	118,541	$1,798,491	23.5	122,097	$2,869,275
Aides/Orderlies	2.2	55,176	$123,247	3.6	56,831	$205,861	6.0	58,536	$351,215
Clerical Staff	24.0	52,640	$1,263,360	24.0	54,219	$1,301,261	24.0	55,846	$1,340,298
Laboratory Technicians	14.0	64,823	$907,518	14.0	66,767	$934,743	14.0	68,770	$962,786
Radiology Technologists	19.9	80,512	$1,602,179	22.0	82,793	$1,821,453	22.0	85,277	$1,876,096
Pharmacists	4.0	181,677	$726,710	4.0	187,128	$748,511	4.0	192,742	$770,966
Pharmacy Technicians	8.0	59,408	$475,267	8.0	61,191	$489,525	8.0	63,026	$504,211
Physical Therapists	1.0	100,960	$100,960	2.0	103,988	$207,977	2.0	107,108	$214,216
Speech Therapists	0.8	99,345	$74,509	0.8	102,326	$76,744	0.8	105,395	$79,046
Occupational Therapists	1.0	95,570	$95,570	1.0	98,437	$98,437	1.0	101,390	$101,390
Social Workers	6.5	87,468	$568,540	6.5	90,092	$585,596	6.5	92,794	$603,164
Medical Records	1.0	54,441	$54,441	1.0	56,074	$56,074	1.0	57,757	$57,757
Materials Management	5.0	46,146	$230,729	5.0	47,530	$237,651	5.0	48,956	$244,781
Maintenance/Engineering	3.5	74,062	$259,216	3.5	76,284	$266,993	3.5	78,572	$275,003
Administrator	13.3	151,445	$2,006,642	13.3	155,988	$2,066,841	13.3	160,668	$2,128,846
Director of Nursing	0.5	245,979	$122,989	0.5	253,358	$126,679	1.0	260,959	$260,959
Other (Public Safety)	9.0	59,036	$531,323	12.7	60,807	$769,208	12.7	62,631	$792,284
Total	**123.5**		**$10,281,328**	**136.9**		**$11,792,045**	**148.2**		**$13,432,293**

Form O: Acute Care Facilities

	County	Name of Facility	Type of Health Service Facility	Owned by the Applicant(s)?	Provide the Name of the Related Entity if Not Owned by the Applicant
1	Cabarrus	Novant Health Mint Hill Medical Center	Hospital	Yes	
2	Cabarrus	Novant Health Matthews Medical Center	Hospital	Yes	
3	Cabarrus	Novant Health Huntersville Medical Center	Hospital	Yes	
4	Cabarrus	Novant Health Presbyterian Medical Center	Hospital	Yes	
5	Cabarrus	Novant Health Charlotte Orthopedic Hospital	Hospital	Yes	
6	Cabarrus	Novant Health Steele Creek Medical Center*	Hospital	Yes	
7	Cabarrus	Novant Health Ballantyne Medical Center	Hospital	Yes	
8	Rowan	Novant Health Rowan Medical Center	Hospital	Yes	
9	Forsyth	Novant Health Forsyth Medical Center	Hospital	Yes	
10	Forsyth	Novant Health Kernersville Medical Center	Hospital	Yes	
11	Forsyth	Novant Health Clemmons Medical Center	Hospital	Yes	
12	Forsyth	Novant Health Medical Park Hospital	Hospital	Yes	
13	Davidson	Novant Health Thomasville Medical Center	Hospital	Yes	
14	Brunswick	Novant Health Brunswick Medical Center	Hospital	Yes	
15	New Hanover	New Hanover Regional Medical Center	Hospital	Yes	
16	New Hanover	New Hanover Regional Medical Center Orthopedic Hospital	Hospital	Yes	
17	Pender	Pender Memorial Hospital	Hospital	Yes	
18	Ashe	Ashe Memorial Hospital	Hospital	No	Managed by Novant Health

*CON approved but not yet operational

Form F.1a Capital Cost Assumptions

1. Purchase price of parcel in Cabarrus County.
2. Closing costs for land acquisition.
3. Site preparation for hospital portion of the site only.
4. Includes cost of materials, labor, and escalation to proposed construction start date.
5. Landscaping costs.
6. A&E fees, permit, review, and survey fees.
7. Includes cost of medical equipment based on Novant Health experience with similar projects.
8. Includes estimated IT equipment based on Novant Health experience with similar projects.
9. Includes cost for needed furniture, signage, and art.
10. Includes legal fees and permitting/inspection/DHSR fees.
11. N/A
12. N/A
13. Other: Project Contingency added for unforeseen conditions

Form F.2 Revenue Assumptions

Gross Patient Revenue

Gross patient revenue is projected using the CY2024 actual Novant Health gross charge at the case level, weighted for the projected volume at the DRG projected volume. The gross patient revenue also incorporates price increases of 3% annually.

The gross patient revenue for each service component includes the following grow revenue for the following:

- Inpatient Services – Includes nursing units for all inpatients. Includes inpatient surgery, emergency department services provided to an admitted patient, and imaging revenue provided during an inpatient stay. Includes all ancillary services, including pharmacy, therapy, and laboratory that an inpatient receives.
- Outpatient Surgery – Includes all revenue for a patient with an outpatient surgery or procedure in the procedure rooms, including observation, emergency department, and imaging services revenue. All ancillary service revenue, including pharmacy, therapy, and laboratory that an outpatient surgical patient receives are included in this service component.
- Other Outpatient Services – Includes emergency department services, observation, outpatient imaging, outpatient nuclear medicine, and any other outpatient services revenue not included in the above service components. All ancillary service revenue, including pharmacy, therapy, and laboratory that a non-surgical outpatient receives are included in this service component.

Deduction from Gross Patient Revenue

Contractual adjustments are derived from the actual contractual adjustments experienced during the CY 2024 at Novant Health facilities in the Charlotte and Rowan region for the specific DRG, adjusted for the proposed payor mix. To be conservative, the charity care at NH Cabarrus is based on the projected self-pay volume, estimated to be 6.9% of total gross charges. By service component, 6.9% for inpatient services, 7.0% for outpatient surgery, and 7.0% for other outpatient services.

Bad debt is estimated to remain at 1.29% of gross patient revenue, which reflects the CY 2023 bad debt percent across all Novant Health acute care facilities. Due to timing, the CY 2024 bad debt was not available. Contractual adjustments, charity care, and bad debt percentages are assumed to remain consistent during the course of this project for each service component, through Project Year 3.

Net Patient Revenue

Net patient revenue is equal to gross patient revenue minus total deductions from gross patient revenue including contractual adjustments, charity care, and bad debt as detailed above.

Payor Mix

The payor mix is based on the historical payor mix of patients originating from the defined NH Cabarrus service area, limited to DRGs and services proposed at NH Cabarrus. NH Cabarrus assumes the payor mix for these patients to remain the same in future years as they have been historically.

To determine payor mix for the total facility, the year three patients in each service line and payor category were summed to determine the total number of patients in each payor category that would receive care at NH Cabarrus in its third year of operations. Each payor category was divided by total patients receiving care at the hospital to arrive at total facility payor mix.

Form F.3 Expense Assumptions

Salaries

See Form H for staffing detail regarding the current and expected FTEs by position and the respective current and projected average annual salaries. There is a Form H for each service component (inpatient services, outpatient surgery services, and other outpatient services). A fourth Form H reflects the administrative/clinical positions that serve two or more of the service components. The allocation of these salaries is captured in the Salary line for each service component. Salary costs for the three project years listed on a Form H are based on projected staffing for the new medical center. There is also a Form H for each service component. To be conservative, Novant Health expects the average annual salary to increase 3.0% per FTE for all positions annually during the course of this project. The actual, Novant Health 2024 weighted-average salary for each position was used.

Taxes and Benefits

Taxes and benefits are assumed to be 24.0% of total salary expenses, which is based on the NH Ballantyne and NH Mint Hill CY 2024 average tax and benefit expense for non-physician personnel. This expense category includes the employer portions of payroll taxes, medical, dental and life benefits, as well as the employer contribution related to retirement benefits. This percent will remain constant during the course of this project.

Independent Contractors

Projected contract labor is based on the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation, at the case level and adjusted for volume, for the projected DRGs and service lines for NH Cabarrus. This is then adjusted case volume and an expected increase of 2.0% each year.

Medical and Other Supplies

Medical and other supply expenses are based on the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation, at the case level and adjusted for volume, for the projected DRGs and service line cases for NH Cabarrus. Pharmacy expenses are included in other supply expenses. To be conservative, the historical expense amounts are inflated by 2.0% annually and adjusted for cases.

Dietary, Housekeeping/Laundry

Dietary, Housekeeping/Laundry services are a contracted service and is included in Independent Contractors.

Equipment Maintenance

Equipment maintenance is based on the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation and inflated 2.0% per year.

Building & Grounds Maintenance

Building and grounds maintenance is based on the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation and inflated 2.0% per year.

Utilities

Utilities expense includes electricity, water, and connectivity costs. These costs are included in Building & Grounds Maintenance.

Insurance

Insurance includes direct malpractice, general, and property insurance based on the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation and inflated 2.0% per year.

Rental Expense

Rental costs are related to leased space, equipment and off-site storage costs. These expenses are based on the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation and inflated 2.0% per year.

Property and Other Taxes (except Income)

Included in Other Expenses (Corporate Overhead Allocation).

Depreciation – Buildings

The building depreciation is based on the full cost of construction depreciated annually, using straight-line methodology, over thirty-one years, which is consistent with standard Novant Health depreciation methodology. Each service component is allocated a portion of this depreciation based on gross charges and the square footage of each area specific to the service component.

Depreciation – Equipment

Equipment depreciation is allocated annually using straight-line methodology, over seven years. Each service component is allocated a portion of this depreciation based on gross charges specific to the service component.

Other Expenses (Corporate Allocation)

This category includes a corporate overhead allocation based on the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation and inflated 2.0% per year. This allocation includes, but is not limited to, the following

corporate services: human resources, information technology, business development and sales, data analytics, business strategic planning, financial planning and analysis, billing central business office, general accounting, facility services design and construction, materials management, strategic sourcing, government relations, legal affairs, CON, and population management. This category also includes indirect insurance.

Other Expenses (On-Call and Med Dir Payments, IP Hospitalists Allocation

This includes, but are not limited to On-Call payments, Medical Director pay, and inpatient hospitalist allocation. This total expense is based the actual NH Ballantyne and NH Mint Hill CY 2024 cost accounting allocation and inflated 2.0% per year.

Form H Assumptions

Staffing reflects the estimated full-time staffing equivalents necessary to provide services in the project periods. Staffing is based on expected volume with minimum staffing requirements per discussions with clinical operations.

The actual and/or estimated 2024 hourly rate was used for each position. In addition, average salaries are projected to increase 3.0% annually for all positions. Taxes and benefits are estimated to be 24.0% of salaries, which is based on the CY 2024 ratio for non-physician personnel at NH Ballantyne and NH Mint Hill.

Below is a description of the staffing and salaries provided in each individual Form H:

- Inpatient Services Form H – Includes all staffing associated directly and only with inpatient acute care services
- Outpatient Surgery Form H – Includes all staffing associated directly and only with outpatient surgical services
- Other Outpatient Services Form H – There are no positions that are solely dedicated to other outpatient services. Support services like lab, imaging, pharmacy, etc. support all inpatient services, outpatient surgery services, and other outpatient services. These positions are captured on the Administrative/Clinical Support Form H and are allocated between the three service components based on gross charges, as seen in the table below.
- Administrative/Clinical Support Form H – Includes all staffing that provides administrative or clinical support services to two or more of the three service components. The salary expense is allocated to the appropriate service component based on gross charges and is reflected in the Salary line on form F.3.

Salary Allocation from Administrative/Clinical Support Departments to CON Service Components

	2030	2031	2032
Admininistrative/Clinical Support Salaries	10,057,965	11,608,459	13,131,338
CON Service Components % Gross Charge			
Other OP Services	46.1%	46.1%	46.1%
OP Surgery	19.7%	19.7%	19.7%
IP Acute Care Services	34.1%	34.2%	34.2%
Allocation			
Other OP Services	4,640,424	5,356,462	6,057,899
OP Surgery	1,983,040	2,287,030	2,587,944
IP Acute Care Services	3,434,500	3,964,967	4,485,494