Atrium Health Cabarrus

Acute Care Beds

Certificate of Need

Application & Exhibits

February 17, 2025

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

Certificate of Need Application Fee Sheet

N.C. Gen. Stat. § 131E-182(c)

Office Use Only

Project ID #: _____

Date Received: _____

Applicant(s) The Charlotte-Mecklenburg Hospital Authority

Total Projected Capital Expenditure: $ 208,468,290

(1) If the Total Projected Capital Expenditure is less than or equal to $1,000,000, the application fee is **$5,000.00**

(2) If the Projected Capital Expenditure is more than $1,000,000, the application fee will is calculated as follows:

a	Total Projected Capital Expenditure	$	208,468,290
b	Subtract $1,000,000	$	(1,000,000)
c	Subtotal	$	207,468,290
d	Multiply the Subtotal by $0.003 and round to the nearest whole dollar	$	622,405
e	Add $5,000	$	5,000
f	Total Fee Due*	**$**	**50,000**

*Pursuant to N.C. Gen. Stat. § 131E-182(c), the maximum certificate of need application fee is **$50,000.00**

Make checks payable to:
Healthcare Planning and Certificate of Need Section, DHSR, DHHS

All data in this document was produced by computer and may not add exactly due to computer rounding.

A	Identification of Applicant(s)
B	Criterion (1)
C	Criterion (3) and Rules
D	Criterion (3a)
E	Criterion (4)
F	Criterion (5)
G	Criterion (6)
H	Criterion (7)
I	Criterion (8)
J	Criterion (9)
K	Criterion (12)
L	Criterion (13)
M	Criterion (14)
N	Criterion (18a)
O	Criterion (20)
P	Proposed Timetable
Q	Excel Workbook / Assumptions for Workbook
R	
S	
T	
U	
V	
W	
X	
Y	
Z	

CERTIFICATE OF NEED APPLICATION

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

Project ID #: _____
(Internal Use Only)

FID #: _____
(Internal Use Only)

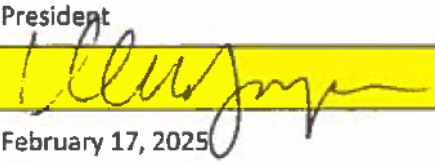
Internal Use Only
Stamp Date Agency Received Application Here

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 *	The Charlotte-Mecklenburg Hospital Authority
Name of the Person Certifying for Applicant 1 (print/type name)	Kenneth D. Haynes
Title	President
Signature **	
Date Signed	February 17, 2025

* 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** *	
Name of the Person Certifying for Applicant 2 (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.

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. Is the review competitive? Yes No

b. Is the total projected capital cost $5,000,000 or more? Yes No

c. Has the CON Section determined that a public hearing is in the public interest? Yes No

If **ALL** the answers above are **NO**, 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. All pages should be one-sided versus double-sided. **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.

[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.

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., 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.

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)		The Charlotte-Mecklenburg Hospital Authority[4]
Street or Post Office Box		1000 Blythe Boulevard
City		Charlotte
State		North Carolina
ZIP Code		28203
Name of parent or holding company		Not applicable.
Is this an existing legal entity?	Yes*	If not an existing legal entity, briefly explain in the cell below
Not applicable.		

*Please see Exhibit A.1 for a copy of the organizing documents for The Charlotte-Mecklenburg Hospital Authority (CMHA).

Applicant 2		
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

Not applicable. The proposed project involves only one applicant.

[4] Advocate Aurora Health, Inc. ("AAH") and Atrium Health, Inc. ("Atrium Health") formed Advocate Health, Inc. ("Advocate Health"), a nonprofit corporation, to manage and oversee AAH, Atrium Health, and their respective subsidiaries and affiliates. As part of Atrium Health, The Charlotte-Mecklenburg Hospital Authority and Wake Forest University Baptist Medical Center are now part of the Advocate Health enterprise and are managed and overseen by Advocate Health.

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

Not applicable. The proposed project involves only one applicant.

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) *	Elizabeth Kirkman, Atrium/Advocate
Title	Assistant Vice President
Street or Post Office Box * ^	AH Cabarrus-Administration, 920 Church Street N.
City *	Concord
State *	North Carolina
ZIP Code *	28025
Direct Telephone Number *	(980) 622-7049
Email Address *	Elizabeth.kirkman@atriumhealth.org

* Required

^ Provide the address where mail is received.

3. **Total Projected Capital Cost** *

$ 208,468,290

* 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.

The total projected capital cost is equal to the total capital cost reported in Form F.1a Capital Cost 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 *	Atrium Health Cabarrus
Street Address ^	920 Church Street North
City ^	Concord
State	North Carolina
ZIP Code ^	28025
County	Cabarrus
FID # **	943049
License Number	H0031
Provider Number	340001 (CMS Certification Number)

* 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 or 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 proposed project does not involve an ambulatory surgical facility (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?		Yes
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?**
Atrium Health Cabarrus	Existing	Yes
Atrium Health Harrisburg Emergency Department^	Existing	No
Atrium Health Kannapolis Emergency Department	Existing	No
Atrium Health Cabarrus Imaging (Copperfield)	Existing	No
Atrium Health Cabarrus Pain Management	Existing	No
Atrium Health MRI^^	Existing	No
Atrium Health Concord Emergency Department	Approved	No

*The existing campuses identified in this table also are identified in Atrium Health Cabarrus's 2024 Hospital License Renewal Application (HLRA) as all campuses (as defined in N.C. Gen. Stat. § 131E-176(2c)) under the hospital license.
^ Pursuant to Project ID # F-012255-22 and subsequent change of scope, Project ID # F-012505-24, CMHA was approved to develop a total of 31 additional acute care beds at Atrium Health Harrisburg and to relocate 13 existing licensed acute care beds and two ORs from Atrium Health Cabarrus to Atrium Health Harrisburg where they will remain licensed as part of Atrium Health Cabarrus.
^^Project ID # F-012255-22 also involved the replacement and relocation of the existing fixed MRI scanner from Atrium Health MRI to Atrium Health Harrisburg. Upon relocation of the fixed MRI scanner to Atrium Health Harrisburg, Atrium Health MRI will cease operation and all MRI utilization associated with the MRI scanner will shift to Atrium Health Harrisburg.

e. **Ownership and Operation**

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

5. **Proposal**

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

CMHA proposes to develop 126 additional acute care beds at Atrium Health Cabarrus in response to a need determination in the *2025 State Medical Facilities Plan* (*2025 SMFP*) for Cabarrus County.

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

	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 *		
	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 *		
X	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 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
	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 (general med/surg, intensive care, neonatal, pediatric, obstetric, etc.)
	Emergency
	Laboratory
	Radiology (imaging and interventional)
	Pharmacy
	Physical therapy
	Occupational therapy
	Speech therapy
	Cardiopulmonary therapy
	GI endoscopy
	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	427**	118***	126	671
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				

**In response to a petition filed in 2022 for an adjustment to the need methodology, the State Health Coordinating Council (SHCC) removed Level II, III and IV neonatal beds and days of care from the acute care bed need methodology beginning with the *2023 SMFP*. Thus, CMHA excluded Atrium Health Cabarrus's 20 neonatal beds from this count. Per its 2024 HLRA, Atrium Health Cabarrus is currently licensed for 427 acute care beds (447 general acute care beds minus 20 neonatal beds).

***Pursuant to Project ID # F-012116-21, Atrium Health Cabarrus was approved to develop a total of 22 additional acute care beds. Pursuant to Project ID # F-012367-23, Atrium Health Cabarrus was approved to develop a total of 65 additional acute care beds. Pursuant to Project ID # F-012255-22 and subsequent change of scope, Project ID # F-012505-24, CMHA was approved to develop a total of 31 additional acute care beds at Atrium Health Harrisburg and to relocate 13 existing licensed acute care beds from Atrium Health Cabarrus to Atrium Health Harrisburg where they will remain licensed as part of Atrium Health Cabarrus.

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				
Gamma knife				
Heart-lung bypass machine				
Linear accelerator				
Lithotriptor				
Major medical equipment *				
MRI scanner				
PET scanner				
Simulator				
Other (describe) **				

* 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).

Not applicable. The proposed project does not involve medical equipment.

6. **Experience**

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

24

A total of 24 existing and approved acute care hospitals are owned, operated, or managed by CMHA or related entities in North Carolina.[5]

[5] As noted previously, Advocate Aurora Health, Inc. ("AAH") and Atrium Health, Inc. ("Atrium Health") formed Advocate Health, Inc. ("Advocate Health"), a nonprofit corporation, to manage and oversee AAH, Atrium Health, and their respective subsidiaries and affiliates. As part of Atrium Health, The Charlotte-Mecklenburg Hospital Authority and Wake Forest University Baptist Medical Center are now part of the Advocate Health enterprise and are managed and overseen by Advocate Health.

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

Atrium Health Cabarrus is an existing acute care hospital that operates 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

Atrium Health Cabarrus is an existing acute care hospital that provides 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?

Not applicable. The proposed project does not involve a new hospital.

4) Provide supporting documentation in an Exhibit.

Not applicable.

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

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

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

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

19. 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.

    CMHA is committed to energy efficiency and sustainability that balances the need for healthcare services and environmental sustainability in the communities it serves.

    <u>Guiding Principles</u>

    1. Implement environmental sustainability to improve and reduce our environmental impact.
    2. Integrate sustainable operational and facility best practices into existing and new facilities.
    3. Encourage partners to engage in environmentally responsible practices.
    4. Promote environmental sustainability in work, home, and community.
    5. Deliver improved performance to provide a long-term return on investment that supports our mission and values.

    CMHA employs experienced, highly trained, and qualified architects, engineers, project managers, tradesmen, and technicians, who oversee the design, construction, operation, and maintenance of CMHA's facilities.

    CMHA has demonstrated its commitment to a higher standard of excellence and will continue to do so relative to the proposed project. CMHA has engaged experienced architects and engineers to ensure energy efficient systems are an inherent part of the proposed project. The design team has Energy Star and Hospitals for a Healthy Environment Green Guide for HealthCare (GGHC) experience. Together the team seeks to deliver the following:

    - Meet or exceed the requirements of the North Carolina Building Code in effect when line drawings are submitted for review to the DHSR Construction Section.
    - Use Environmental Protection Agency (EPA) Energy Star for Hospitals rating system to compare performance across CMHA, North Carolina, and the United States for benchmarking performance following 12 months of operation.

- Use CMHA's Standard Control Sequences to optimize energy efficiency in the BAS and HVAC systems. When fully utilized, these sequences help to make CMHA's acute care hospitals some of the most energy efficient hospitals in the nation. Reducing energy consumption per square foot reduces water consumption used for cooling tower and boiler make-up.
- Select new plumbing fixtures to optimize water efficiency and life cycle benefits.
- Design new HVAC systems and select equipment that optimize water efficiency and life cycle benefits.

As a result of these efforts, CMHA was recognized as an Energy Star Partner of the Year by the EPA for the seventh year in a row. This prestigious award is the highest level of recognition that a corporate energy management program can receive from the EPA. Energy Star Partners must perform at a superior level of energy management and meet the following criteria:

- Demonstrate best practices across the organization,
- Prove organization-wide energy savings, and
- Participate actively and communicate the benefits of ENERGY STAR.

Additionally, CMHA has established ambitious sustainability goals, with commitments to reduce emissions by 50 percent by 2030 and achieve net zero emissions by 2050. Recent sustainability-focused technologies considered for incorporation into CMHA facilities include but are not limited to:

- Solar power systems
- Variable frequency chillers, air handlers, and other equipment
- Bipolar ionization filtration
- Geothermal heat pumps
- High efficiency transformers
- Peak shaving generators

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.

Policy GEN-5: Access to Culturally Competent Healthcare states:

"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.

Cabarrus County Demographics

	Cabarrus County	*North Carolina*	*Difference*
Age			
Under 5 years	6.0%	5.6%	+0.4%
Under 18 years	24.9%	21.6%	+3.3%
65 years and over	13.9%	17.6%	-3.7%
Gender			
Male persons	49.1%	48.9%	+0.2%
Female persons	50.9%	51.1%	-0.2%
Racial Composition			
White	67.1%	69.8%	-2.7%
Black/African American	22.3%	22.1%	+-0.2%
American Indian and Alaska Native	0.8%	1.6%	-0.8%
Asian	7.0%	3.7%	+3.3%
Native Hawaiian and other Pacific Islander	0.1%	0.2%	-0.1%
Two or More Races	2.7%	2.7%	0.0%
Ethnicity			
Hispanic or Latino	13.0%	11.4%	+1.6%
Languages Spoken			
Language other than English at home	15.1%	13.0%	+2.1%
Disability			
Persons with disability (under 65)	7.5%	9.3%	-1.8%
Education			
High school graduate or higher	91.8%	89.7%	+2.1%
Bachelor's degree or higher	37.7%	34.7%	+3.0%
Household Income			

Median household income	$86,084	$69,904	+$16,180
Per capita income	$40,652	39,616	+$1,036
Persons in poverty	9.1%	12.8%	-3.7%
Geographic Location			
Population density (per square mile)	625.1	214.7	+410.4
Mean travel time to work (minutes)	28.0	25.1	+2.9
Payor			
Without health insurance (under 65)	8.8%	11.0%	-2.2%
Medicaid Enrollment^	21.8%	27.7%	-5.9%
Medicare Enrollment^	15.4%	20.2%	-4.8%

Sources: U.S. Census Bureau QuickFacts (January 2025), Centers for Medicare & Medicaid Services (CMS) Monthly Medicare Enrollment Data (August 2024), NC Medicaid Monthly Enrollment Report (December 2024), and NC Office of State Budget and Management (NC OSBM) Population Estimates (updated January 15, 2025).
^Medicare and Medicaid enrollment percentages calculated using raw enrollment numbers from CMS and NC Medicaid reports, divided by total population estimates from NC OSBM.
Note: These figures represent the service area population and do not reflect the percentages of underserved populations served by Atrium Health Cabarrus.

In Cabarrus County (the service area), there are cultural, linguistic, economic and physical challenges that may prevent some community members from accessing adequate medical care. Understanding and addressing these barriers is essential for ensuring equitable healthcare services for all residents. As demonstrated in the table above, compared to North Carolina, Cabarrus County has:

- A significantly higher Asian population (7.0%, nearly double the state average)
- A slightly higher proportion of Black/African American residents (22.3% vs. 22.1% in NC)
- A larger Hispanic community (13.0% vs. 11.4% in NC)
- A higher percentage of non-English speakers (15.1% speak another language at home vs. 13.0% in NC)

While Cabarrus County's rates of uninsured residents (8.8%), poverty (9.1%), and disability (7.5%) fall below state averages, these figures still represent thousands of vulnerable individuals who may face barriers to healthcare access.

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

CMHA is committed to ensuring equitable healthcare access for all, implementing a variety of strategies to provide culturally competent services to medically underserved communities. While this list is not comprehensive, some system strategies include:

Language Access Services: Free language assistance is provided to Limited English Proficient (LEP) patients 24 hours per day, seven days per week. This includes qualified medical interpreters, translation of written materials, and multiple interpretation options (in-person, video, phone). See CMHA's Language Assistance Plan included with its Non-Discrimination Policies, Exhibit C.6. Further, CMHA prioritizes the recruitment and retention of bilingual staff by offering financial incentives both to employees who utilize their language skills and to those who successfully refer bilingual candidates.

Disability Accommodations: All CMHA facilities comply with regulations as described in the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) to reasonably accommodate individuals with disabilities. CMHA also ensures that individuals with special hearing needs are provided with a qualified medical interpreter and auxiliary aids at no cost. See CMHA's Non-Discrimination Policy included in Exhibit B.2.

Access and Opportunity Programs: At CMHA, access and opportunity are central to business and culture. CMHA is also taking a firm stake in advancing healthcare access for ALL by pledging to disrupt the root causes of health inequities and improving the life expectancy and overall well-being of underserved communities by addressing disparities in access to care, clinical outcomes, and social drivers of health. To do this, CMHA is prioritizing eliminating disparities in three clinical priority areas (cardiometabolic diseases, infant and maternal health and violence driven injuries) and three social drivers of health priority areas (affordable housing, food security and meaningful employment). Healthcare access and outcome goals for the Greater Charlotte region include AMI Mortality, 30-Day Readmissions, Venous Thromboembolism (VTE)/Pulmonary Thromboembolism (PTE), Colorectal Cancer Screening, CLASBI, and Diabetic A1C Control. In addition, the Office of Access and Opportunity provides educational events and activities throughout the year. CMHA's signature learning event, The FOR ALL Conference, is a cultural mainstay of CMHA. By hosting educational programming like this, CMHA aims to elevate cultural competency across the enterprise, enhance care delivery, cultivate an inclusive workplace and learning environment, and uplift the communities it serves.

Social Drivers of Health Screening and Referral: CMHA conducts comprehensive screenings for social drivers of health across all patient touchpoints – including emergency departments, primary care offices, and inpatient facilities – in alignment with guidelines from the Centers for Medicare and Medicaid Services (CMS). The screenings assess six essential categories: food security, interpersonal violence, utilities, housing, and transportation. To transform these screenings into meaningful action, CMHA leverages the Community Resource Hub (CRH), an innovative web-based platform that connects patients directly with local community partners. Through the CRH, patients gain immediate access to vital resources addressing both urgent and long-term needs. For patients requiring additional support, dedicated Community Health Workers (discussed in the following section) provide personalized assistance by navigating the CRH platform on patients' behalf; coordinating directly with community partners; and ensuring patients receive timely access to essential services.

Community Health Worker Program: CMHA's Community Health Workers serve as trusted bridges between healthcare and social services, operating across six counties: Mecklenburg, Cabarrus, Union, Stanly, York, and Lancaster. Through mobile primary care units, community clinics, and inpatient settings, these professionals meet patients where they are to ensure comprehensive care that extends beyond traditional medical services.

Project Boost (Hospital Violence Intervention Program): Housed in CMC, a Level I Trauma Center, Project Boost utilizes a trauma-informed approach to reduce trauma recidivism among patients (*ages 15 – 24*) who are victims of community and interpersonal violence. The Hospital-Based Violence Intervention Program (HVIP) utilizes innovative tools to work with patients to identify social and healthcare needs, set responsive personal goals, and make connections to tailored support from clinical and community-based organizations (CBOs). In 2024, with the advocacy of NC State Representative Alma Adams, Project Boost received a grant of over $900M through the Office for Victims of Crime FY24 Byrne Discretionary Community Project Grants/Byrne Discretionary Grants Program to expand and fund the HVIP program.

Social Drivers of Health Priority Areas: CMHA utilizes strong strategic partnerships with community organizations to advance health access for ALL. Through these partnerships, CMHA creates and implements innovative programs focused on affordable housing, food security, and employment. These initiatives aim to address social drivers of health and create sustainable impact in the communities CMHA serves.

Innovative Care Delivery: As CMHA looks across the communities it serves, it understands that some residents experience difficulty accessing basic primary care or other services needed to stay healthy due to a variety of barriers, such as lack of health insurance, lack of transportation, or other challenges associated with low-income status. Learnings from the COVID-19 pandemic have transformed CMHA's traditional care access points from brick and mortar to virtual care, mobile primary care and localized community care for all ages that also treat social drivers of health needs on site. It has become more important than ever to ensure equitable access to primary and specialty care across CMHA's geographic footprint, meeting people where they live, work, play, and worship. CMHA is committed to providing equitable, convenient, and accessible care across all of the communities it serves. CMHA has made significant investments in physical clinic locations, mobile clinic operations, and enhanced virtual primary and behavioral health care options for all patients.

Atrium Health Cabarrus Specific Initiatives

In addition to these system-wide endeavors, Atrium Health Cabarrus has implemented several strategies to support health access for ALL efforts in the Cabarrus community, including those in traditionally underserved populations. These include:

- **Age Friendly:** Atrium Health Cabarrus stands at the forefront of age-friendly healthcare initiatives, serving as the leading provider for Medicare-eligible patients among CMHA hospitals in the greater Charlotte region. The demographic shift in Cabarrus County is particularly striking, with NC OSBM projections showing the 65+ population is expected to grow by 19.9 percent between 2025 and 2030, far exceeding North Carolina's projected statewide growth of 14.2 percent (see Section C.4). In response to these demographic changes, Atrium Health Cabarrus launched comprehensive age-friendly initiatives in 2021. These efforts resulted in a dramatic improvement in key quality indicators and recognition as a Level 2 Age-Friendly Hospital. In 2023, the family medicine unit at Atrium Health Cabarrus was converted into a specialized 28-bed age-friendly unit and, by mid-2023, the unit earned the Platinum Sneakers Award for increasing patient mobility. Additionally, emergency departments in Cabarrus, Harrisburg, and Kannapolis have achieved Bronze Geriatric Emergency Department Accreditation (GEDA) from the American College of Emergency Physicians. Lastly, geriatric advanced practice provider (APP) consult services have expanded from two to five days weekly, yielding impressive results including a 52 percent reduction in fall incidents, 27 percent increase in patient experience scores, 20 percent increase in patient mobility, and decreased length of stay and mortality rates.
- **Housing Partnerships:** Atrium Health Cabarrus invests in We Build Concord, Habitat for Humanity, and Cooperative Christian Ministries to create affordable housing and provide critical home repairs in the community.
- **ThriveLink:** Atrium Health Cabarrus has partnered with ThriveLink to help patients enroll in government assistance and other social programs after discharge, achieving 558 approved applications in the first six months, with patients predominantly enrolling in programs that provide food delivery, housing, and utilities assistance.

- **School-Based Therapy Program:** In the 2023-2024 school year, Atrium Health Cabarrus launched a comprehensive school-based therapy program across 28 schools in Cabarrus County, dramatically improving access to mental health services. The program has achieved remarkable results, with 81 percent of referred students receiving services within 10 days (compared to historical rates of 55-60 percent with traditional care) and has served 242 students through 2,193 visits since August 2023, including 21 students who were uninsured or underinsured. Students participating in the program have shown an average 30 percent improvement in depression and anxiety symptoms.
- **Community Paramedicine:** Atrium Health Cabarrus partnered with county paramedics to create a comprehensive community paramedicine program that continues to provide in-home follow-up care, medication management, and preventive services to patients, with a special focus on addressing social determinants of health.
- **Key Community Partners:** Atrium Health Cabarrus supports organizations committed to improving social determinants of health: the Cabarrus Health Alliance (which provides a wide range of community health programs), the Cabarrus Partnership for Children (a 501c3 nonprofit focused on child well-being through health, early education, and family outreach programs), and Cooperative Christian Ministries (which provides financial counseling and support, food security through pantries and meal programs, and transitional housing and support services).

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

While cultural competence is not specifically defined, CMHA believes that the awards and recognition it has received by organizations focused on improving healthcare access for ALL, including through culturally competent care, are an indication that its strategies are reflective of culture competence. CMHA continues to be recognized locally and nationally for its commitment to culturally competent care. Awards and recognitions related to its efforts include, but are not limited to, the following:

- In 2024, 35 CMHA hospitals achieved "LGBTQ+ Healthcare Equity High Performer" status, and Atrium Health Wake Forest Baptist achieved "LGBTQ+ Healthcare Equity Leader" status.
- In 2024, CMHA was scored 100 on the Disability Index by The American Association of People with Disabilities and Disability.
- In 2024, Atrium Health Pineville, a CMHA facility in Mecklenburg County, earned national recognition when *U.S. News* distinguished it as one of just 26 hospitals nationwide for delivering outstanding care to Black patients, specifically for achieving excellent outcomes in cesarean sections and managing unexpected newborn complications.
- In 2023, CMHA was included in *Forbes*' list of "Best Employers for Diversity."
- In 2022, CMHA was named "The Top Place to Work for Women and Diverse Managers" by *Diversity MBA Magazine*.
- In 2022, CMHA was awarded the American Organization for Nursing Leadership (AONL) Prism Award which recognizes excellence in diversity efforts. Among its accomplishments, CMHA offers a variety of programs and tools such as diversity certification classes, a leadership speaker series, and a Racial Justice Toolkit. Since signing the American Hospital Association's Equity of Care Pledge in 2016, CMHA has transformed how it collects and uses data pertaining to race, ethnicity, language preferences, and sexual orientation to identify and drive change to eliminate disparities in healthcare access and outcomes.
- CMHA was named the 2021 AHA Carolyn Boone Lewis Equity of Care Award winner for its success in applying data and an equity focus to its COVID-19 response. This included

testing 25,323 community members for COVID-19 through roving mobile units and leveraging community relationships to partner with 55 sites in underserved neighborhoods with high infection rates. CMHA used its data-driven approach to close gaps in COVID-19 testing and bring thousands of vaccinations to underserved communities.

- In 2021, CMHA was recognized as a finalist for the Bernard J. Tyson National Award for Excellence in Pursuit of Healthcare Equity.
- In 2021, CMHA was named one of America's Best Employers for Veterans by *Forbes.*
- In 2020, CMHA was recognized as one of two CMS Health Equity Award winners for demonstrating an exceptional commitment to healthcare access for ALL. To address racial and ethnic disparities in colorectal cancer screening rates, CMHA strengthened its data and collaboration with community partners. Through a redesign of its electronic medical record (EMR), CMHA transformed the way it collects demographic data – adding or improving questions on race, ethnicity, language preference, assigned sex at birth, and gender identity – and created a tool that stratifies data related to mortality, diabetes, hypertension, colorectal cancer screening, and high-risk medications by race and ethnicity, gender, and location. These data were used to implement a number of culturally appropriate interventions at the primary care practice and community levels, including a phone call campaign and working with a Spanish-language newspaper, which resulted in an additional 200 screenings and the detection of some cancers at earlier stages. As a result, from 2018 to 2019, CMHA closed the disparity of colorectal screenings for Hispanic males compared to the overall screening rate for males from 9.4 percentage points to 3.5 percentage points, reducing the disparity by 62.7 percent.

Although these examples do not detail every initiative and award, they demonstrate CMHA's drive to ensure equity in access, care delivery, and outcomes, to which the proposed project will provide necessary inpatient capacity to support the underserved seeking care at CMHA.

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.

While there is no "one size fits all" approach to reducing health disparities, healthcare leaders agree that cultural competency leads to delivering the highest quality care to every patient.[6] Although published literature on reasonable pathways for reducing health disparities, increasing healthcare access for ALL, and improving the health outcomes of the medically underserved remains limited (and specific to individual facilities and communities), some known strategies for building cultural competence within healthcare systems include:[7,8]

1. Provide interpreter services
2. Provide training to increase cultural awareness, knowledge, and skills
3. Coordinate with traditional healers

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6 Doherty, J. A., Johnson, M., & McPheron, H. (2022). Advancing health equity through organizational change: Perspectives from health care leaders. Health Care Management Review, 47(3), 263-270.

7 Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Medical care research and review: MCRR, 57 Suppl 1(Suppl 1), 181–217.

8 Georgetown University, Health Policy Institute. (n.d.). Cultural competency in health care. Georgetown University. Retrieved December 18, 2024, from https://hpi.georgetown.edu/cultural/

4. Use community health workers
5. Incorporate culture-specific attitudes and values into health promotion tools
6. Include family and community members in health care decision making
7. Locate clinics in geographic areas that are easily accessible for certain populations
8. Expand hours of operation
9. Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials

Guidelines from professional organizations may also help promote cultural competence and provide support for many of these strategies. For example, The Joint Commission and CMS outline several interconnected strategies for improving healthcare access for ALL in healthcare organizations. These recommendations emphasize the importance of systematic data collection and analysis of patient demographics and outcomes, coupled with leadership engagement and a specific action plan for improving healthcare access for ALL.

As detailed above, CMHA, including Atrium Health Cabarrus, have integrated many strategies for building cultural competence and reducing health disparities with these best practices and evidence-based studies in mind. CMHA remains deeply committed to implementing proven strategies across all levels of the organization to advance healthcare access for ALL through culturally competent care in the communities it serves.

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

CMHA will continue to measure and periodically assess increased access to healthcare services for all and reduction in health disparities in underserved communities through program and initiative specific evaluations. As detailed above through the program specific outcome metrics provided, CMHA and Atrium Health Cabarrus's healthcare access for ALL initiatives involve mechanisms for program evaluation, monitoring of metrics, and periodic reporting of outcomes. Additionally, at the system-wide level, the Safety/Health Outcomes Committee of the Advocate Health Board of Directors provides oversight and monitors access to health services and reduction in health disparities in underserved communities per its charter. As noted earlier, Advocate Health is comprised of Atrium Health, which includes CMHA, and Advocate Aurora Health. Reports on access and health disparities are provided to the Committee quarterly through an outcomes and patient experience performance report, along with strategies for improvement, as needed. The most recent set of healthcare access for ALL measures included hypertension control; diabetes control; nulliparous, term, singleton, vertex (NTSV) cesarean sections; and social drivers of health screening.

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.

INTRODUCTION

CMHA proposes to develop 126 licensed acute care beds at Atrium Health Cabarrus pursuant to a need determination in the *2025 SMFP* for 126 licensed acute care beds in Cabarrus County. The following is a description of the components of the proposed project.

BACKGROUND

Atrium Health Cabarrus is a growing tertiary care facility providing many types of specialized care, including:

- North of Charlotte, the region's only 24/7 Level IV NICU and a high-risk obstetrics unit for pregnant and post-partum women with special obstetric needs.
- Complete cardiac care including cardiovascular surgery and rehabilitation at the Cannon Heart Center.
- Comprehensive cancer treatment, including chemotherapy, radiation oncology, integrative therapies, and a rejuvenation center through the Levine Cancer Institute.
- General and specialized surgeries such as bariatric surgery through CMHA's Surgical Weight Management Program.
- Family-centered pediatric care, including subspecialist care, at the Levine Children's Jeff Gordon Children's Center.

According to its 2024 HLRA, Atrium Health Cabarrus is licensed for 427 acute care beds.[9] Pursuant to Project ID # F-012116-21, which was filed in August 2021, CMHA was approved to develop 22 additional acute care beds at Atrium Health Cabarrus. Pursuant to Project ID # F-012367-23, CMHA was approved to develop 65 additional acute care beds at Atrium Health Cabarrus. Pursuant to Project ID # F-012255-22 and subsequent change of scope, Project ID # F-012505-24, CMHA was approved to develop a total of 31 additional acute care beds at Atrium Health Harrisburg and to relocate 13 existing acute care beds from Atrium Health Cabarrus to Atrium Health Harrisburg where they will remain licensed as part of Atrium Health Cabarrus. As such, upon completion of the proposed project, Atrium Health Cabarrus will operate a total of 671 existing and approved acute care beds (671 = 427 existing acute care beds + 118 previously

[9] Per Atrium Health Cabarrus's 2024 HLRA. As noted in response to Section A.5(e), this count excludes the 20 neonatal beds at Atrium Health Cabarrus. Given the State Health Coordinating Council (SHCC) removed Level II, III and IV neonatal beds and days of care from the acute care bed need methodology beginning with the *2023 SMFP*, this application excludes neonatal beds as well as neonatal patient days unless otherwise indicated.

approved beds + 126 beds proposed in this application). Of these beds, 627 will be located on the main campus and 44 beds will be located at Atrium Health Harrisburg.

PROPOSED PROJECT

The proposed project involves the development of 126 additional acute care beds at Atrium Health Cabarrus. As discussed in detail below, these acute care beds will be developed across three floors of a new patient tower planned for Atrium Health Cabarrus's main campus. The proposed project is expected to become operational on May 1, 2031.

New Patient Tower

All 126 additional acute care beds proposed in this application will be developed across Levels 02, 03, and 04 of a new patient tower planned for Atrium Health Cabarrus's main campus, located adjacent and connected to the existing hospital building. The development of the new patient tower is a CON-exempt project that includes the following:

- Basement – Shell
- Level 01 – Emergency Department and Public Space
- Level 02 – Public Space and Shell
- Level 03 – Shell
- Level 04 – Shell
- Level 05 – Mechanical

Please see Exhibit C.1-1 for a copy of the exemption notice that was filed on January 13, 2025. In this application, CMHA proposes to develop the 126 proposed acute care beds as follows: 30 acute care beds on Level 02, 48 acute care beds on Level 03, and 48 acute care beds on Level 04. The proposed project also involves the development of necessary support spaces across all three floors, including waiting rooms, storage space, office space, staff lounges, patient consult rooms, elevators, bathrooms, soiled/clean utility rooms, nurse workstations, and more. Please see Exhibit C.1-2 for detailed project line drawings. Notably, the proposed project involves no changes to other floors of the new patient tower; since other levels of the new patient tower are not involved in the proposed project, the line drawings included in Exhibit C.1-2 do not include these levels.

As previously mentioned, the construction of the new patient tower on Atrium Health Cabarrus's campus is part of a CON-exempt project. In an effort to ensure that all costs attributable to the development of 126 additional acute care beds and associated support space on Levels 02, 03, and 04 are included in this review, CMHA has duplicated costs that were part of the CON-exempt project. Please note that the entire cost of the 126 beds and associated support space is included in the capital cost for the proposed project in Form F.1a. Specifically, the cost includes the allocated core, shell, and full upfit – furniture, fixtures, and equipment – of the portion of Level 02 proposed to be renovated and the entirety of Levels 03 and 04, as well as attributable costs for architect/engineering fees, CON and legal fees, financing costs, interest during construction,[10] and other costs. All of these costs are included in the capital cost for the proposed project in Form F.1a. As such, CMHA has included all costs necessary to develop 126 additional acute care beds on Levels 02, 03 and 04 in the new patient tower planned for development on Atrium Health Cabarrus's main campus. Please see Form F.1a in Section Q for the completed capital cost form.

[10] CMHA expects to fund the project with accumulated reserves but has conservatively included financing costs and interest during construction in the event that the project is funded with bond financing.

SUMMARY

In summary, in response to the need identified in the *2025 SMFP* for Cabarrus County, CMHA proposes to expand inpatient capacity at Atrium Health Cabarrus by developing 126 additional acute care beds. Upon completion of the proposed project, Atrium Health Cabarrus will operate 671 acute care beds. Please see Section C.4 for a discussion of the qualitative need for the proposed project and Form C Assumptions and Methodology for a discussion of the quantitative need for the proposed project.

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 health service, 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.

<Acute Care Beds>	<Atrium Health Cabarrus (Main Campus)> *	
	Last Full FY 01/01/2023 to 12/31/2023	
County or other geographic area such as ZIP code	**Number of Patients**	**% of Total**
Cabarrus	14,970	53.4%
Rowan	3,660	13.1%
Mecklenburg	3,259	11.6%
Stanly	2,601	9.3%
Iredell	608	2.2%
Other^	2,929	10.5%
Total	**28,027**	**100.0%**

* This should match the name provided in Section A, Question 4. If applicable, include mobile health services.
^Other includes Union, Lincoln, Gaston, Montgomery, Cleveland, Catawba, Anson, York SC, Davidson, Caldwell, Other NC Counties, and Other States.

The proposed project does not involve the relocation of existing service components from any other facility.

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.

Entire Facility or Campus	**< Atrium Health Cabarrus (Main Campus)> ***	
	Last Full FY 01/01/2023 to 12/31/2023	
County or other geographic area such as ZIP code	**Number of Patients**	**% of Total**
Cabarrus	170,132	63.2%
Rowan	38,714	14.4%
Mecklenburg	23,094	8.6%
Stanly	18,213	6.8%
Iredell	4,746	1.8%
Union	1,696	0.6%
Other^	12,737	4.7%
Total	**269,332**	**100.0%**

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

^Other includes Gaston, Montgomery, Lincoln, Davidson, Catawba, York SC, Anson, Cleveland, Guilford, Forsyth, Other NC Counties, and Other States.

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.

Service Component Assumptions

The proposed addition of 126 acute care beds to Atrium Health Cabarrus is not expected to have any impact on patient origin. However, as outlined in Form C, CMHA has projected a shift of acute care volume during the projection period to Atrium Health Harrisburg. For additional detail regarding the proposed shifts, please refer to Form C Assumptions and Methodology. Atrium Health Cabarrus's projected patient origin for its acute care beds is based on its existing patient origin, modified to account for projected shifts to Atrium Health Harrisburg. Please note that patients shifting to Atrium Health Harrisburg are assumed to originate from Cabarrus, Mecklenburg, Stanly, and other counties consistent with Project ID # F-012505-24. Please see Form C Assumptions and Methodology for projected utilization of acute care patient days. The subsequent conversion of patient days into total number of patients is based on the projected average length of stay discussed in Form C Assumptions and Methodology.

Entire Facility Assumptions

The proposed project does not involve Atrium Health Cabarrus's entire campus facility. However, to be responsive to Section C.3.c below, Atrium Health Cabarrus's total projected patients by county for its main campus are provided below. These projections of total patients and the distribution by county are provided to be responsive to Section C.3.c only and are not intended to be used for any other purpose. Of note, other than the modifications discussed above relative to shifts of volume to other facilities, the projections of total patients do not consider any potential future projects or initiatives that may impact the number or origin of future patients. Projected patient origin for Atrium Health Cabarrus's entire main campus facility is based on the CY 2023 patient origin for Atrium Health Cabarrus's entire main campus facility, and an assumed growth rate of 2.0 percent per year based on the Cabarrus County projected population growth rate and adjusted for the projected shift to Atrium Health Harrisburg as detailed above with regard to acute care beds. The proposed project is not expected to result in any material change to patient origin for the entire facility.

b. **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.

<Acute Care Beds>	< Atrium Health Cabarrus (Main Campus)> *					
	1st Full FY		2nd Full FY		3rd Full FY	
	01/01/2032 to 12/31/2032		01/01/2033 to 12/31/2033		01/01/2034 to 12/31/2034	
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	18,998	53.8%	19,540	53.9%	20,092	53.9%
Rowan	5,061	14.3%	5,230	14.4%	5,405	14.5%
Stanly	3,374	9.6%	3,475	9.6%	3,578	9.6%
Mecklenburg	3,152	8.9%	3,183	8.8%	3,209	8.6%
Iredell	841	2.4%	869	2.4%	899	2.4%
Other^	3,856	10.9%	3,974	11.0%	4,096	11.0%
Total	**35,283**	**100.0%**	**36,272**	**100.0%**	**37,278**	**100.0%**

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

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

^Other includes Union, Lincoln, Gaston, Montgomery, Cleveland, Catawba, Anson, York SC, Davidson, Caldwell, Other NC Counties, and Other States.

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 or Campus	**< Atrium Health Cabarrus (Main Campus)> ***					
	1st Full FY		**2nd Full FY**		**3rd Full FY**	
	01/01/2032 to 12/31/2032		**01/01/2033 to 12/31/2033**		**01/01/2034 to 12/31/2034**	
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	200,743	63.3%	204,543	63.3%	208,407	63.3%
Rowan	46,067	14.6%	46,966	14.6%	47,881	14.6%
Mecklenburg	26,126	8.2%	26,543	8.2%	26,960	8.2%
Stanly	21,450	6.8%	21,853	6.8%	22,263	6.8%
Iredell	5,647	1.8%	5,758	1.8%	5,870	1.8%
Union	2,018	0.6%	2,057	0.6%	2,098	0.6%
Other^	14,962	4.7%	15,240	4.7%	15,523	4.7%
Total	**317,013**	**100.0%**	**322,960**	**100.0%**	**329,002**	**100.0%**

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

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

^Other includes Gaston, Montgomery, Lincoln, Davidson, Catawba, York SC, Anson, Cleveland, Guilford, Forsyth, Other NC Counties, and Other States.

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.

   OVERVIEW

   The overall need for the proposed project is based on a need determination for 126 additional acute care beds in Cabarrus County as identified in the *2025 SMFP*. The specific need for the project proposed in this application is comprised of the following factors:

   - Population growth and aging of Cabarrus County; and
   - The need for additional acute care bed capacity in Cabarrus County, including the specific need at Atrium Health Cabarrus.

   Each of these factors will be discussed in turn below. A detailed analysis of the quantitative need for the proposed project is discussed in Form C Assumptions and Methodology.

POPULATION GROWTH AND AGING OF CABARRUS COUNTY

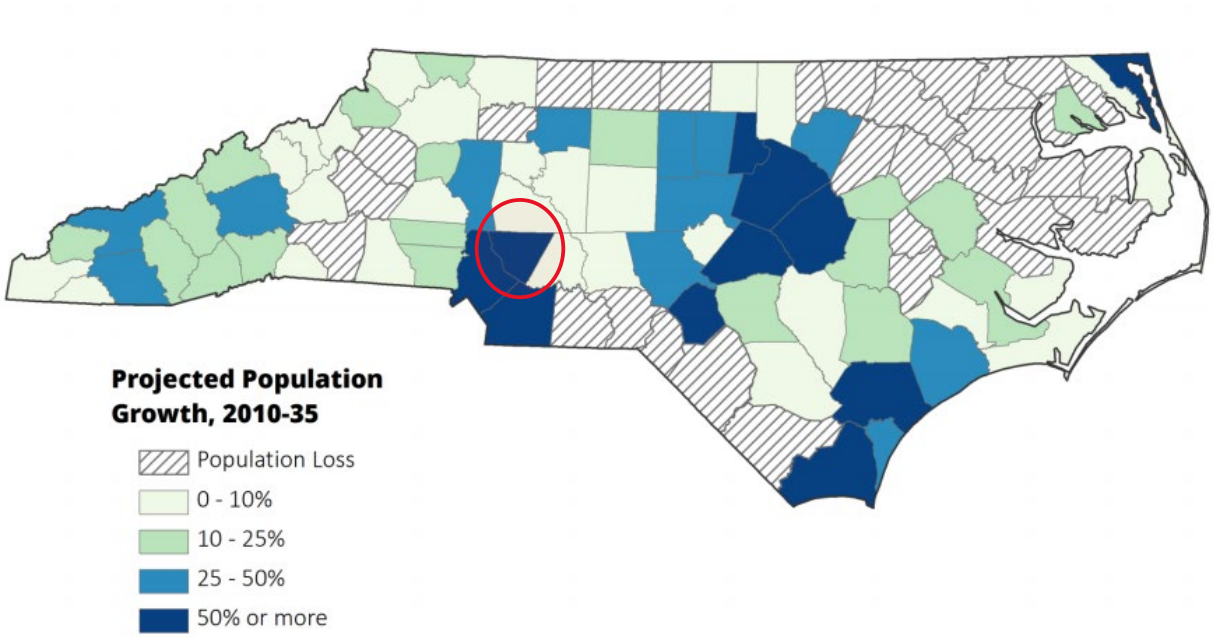
According to data from the North Carolina Office of State Budget and Management (NC OSBM), Cabarrus County's population grew 10 percent between 2020 and 2025, adding roughly 23,000 residents. Only Wake County, Mecklenburg County, Johnston County, Brunswick County, and Union County welcomed more people. Moreover, Cabarrus County's population expanded at a compound annual growth rate (CAGR) of 1.9 percent, outpacing North Carolina's CAGR of 1.2 percent over the same period.

Top Ten NC Counties by Population Change 2020-2025

	2020	*2025*	*Population Change*	*Percent Growth*	*CAGR**
Wake	1,135,576	1,238,879	103,303	9.1%	1.8%
Mecklenburg	1,118,967	1,198,460	79,493	7.1%	1.4%
Johnston	218,141	256,176	38,035	17.4%	3.3%
Brunswick	138,756	175,047	36,291	26.2%	4.8%
Union	239,925	273,432	33,507	14.0%	2.6%
Cabarrus	227,580	250,391	22,811	10.0%	1.9%
Iredell	188,250	209,922	21,672	11.5%	2.2%
New Hanover	226,927	246,073	19,146	8.4%	1.6%
Guilford	542,304	560,760	18,456	3.4%	0.7%
Durham	326,546	344,427	17,881	5.5%	1.1%
North Carolina	**10,472,893**	**11,107,246**	**634,353**	**6.1%**	**1.2%**

Source: NC OSBM
*Compound Annual Growth Rate

As demonstrated in the map below, this growth is expected to continue in the next decade. Further, while the growth in Cabarrus County is significant, the neighboring Mecklenburg and Union counties are also in the highest growth tier. Cabarrus County is part of one of the fastest growing regions in North Carolina and, as a result, will need to expand its healthcare capacity to accommodate current and future population growth.



Source: NC General Assembly, available at https://webservices.ncleg.gov/ViewDocSiteFile/34072.

Cabarrus County's oldest population cohort is also growing rapidly. As demonstrated in the table below, Cabarrus County's population aged 65 and over is projected to grow 3.7 percent annually over the next five years, or 19.9 percent overall [(43,550-36,327) ÷ 36,327 = 19.9 percent].

Growth of Population Aged 65 and Older

	2025	*2030*	*2025-2030 CAGR*
Cabarrus	36,327	43,550	3.7%
North Carolina	2,038,854	2,328,643	2.7%

Source: NC OSBM

This growing population of residents 65 and over will require more access to services in the future, as older residents typically utilize healthcare services more frequently than younger residents.

NEED FOR ADDITIONAL ACUTE CARE BED CAPACITY IN CABARRUS COUNTY

As noted previously, the *2025 SMFP* identifies a need for 126 additional acute care beds to be located in Cabarrus County based on application of the acute care bed need methodology. Notably, the need in the *2025 SMFP* was generated by the highly utilized acute care services at Atrium Health Cabarrus. Over the past five years, Atrium Health Cabarrus has experienced dramatic increases in acute care bed utilization, with current occupancy exceeding 95 percent, as shown in the table below.

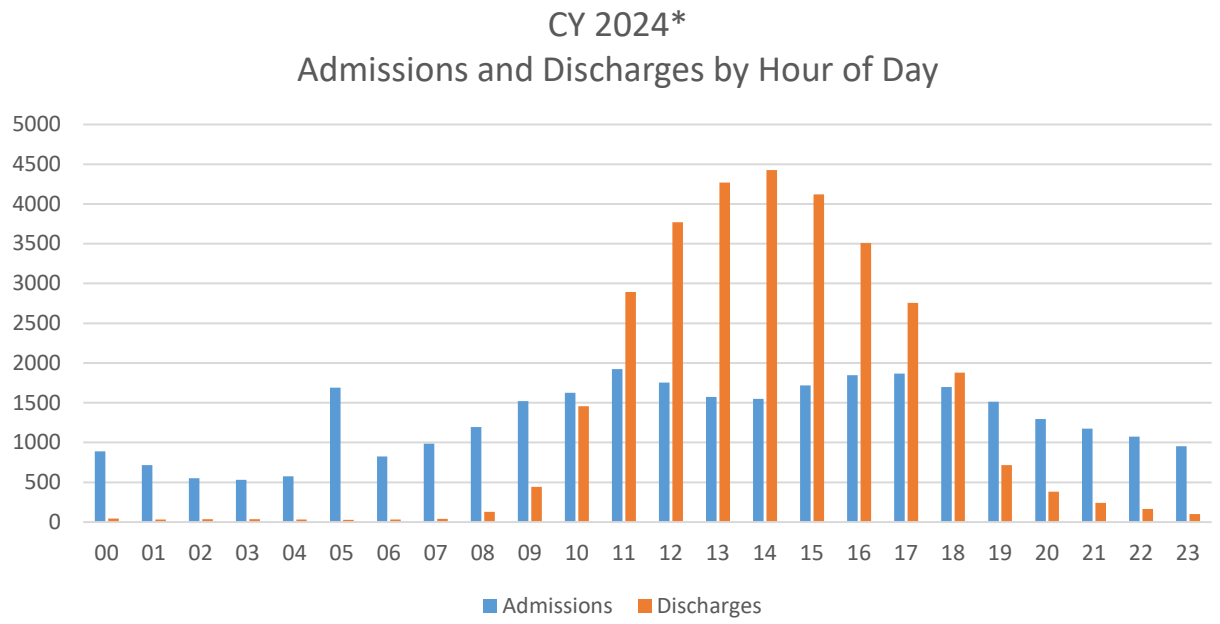
Atrium Health Cabarrus Historical Acute Care Bed Utilization

	CY 2019	*CY 2020*	*CY 2021*	*CY 2022*	*CY 2023*	*Annualized CY 2024^*	*CY19-CY24 CAGR^^*
Patient Days	108,174	107,346	126,417	137,388	139,559	149,482	6.7%
Number of Acute Care Beds in Operation	427	427	427	427	427	427	
Average Daily Census	296	294	346	376	382	410	
% Occupancy	69.4%	68.9%	81.1%	88.2%	89.5%	95.9%	

Source: CMHA internal data.
Note: As discussed previously, the SHCC removed Level II, III and IV neonatal beds and days of care from the acute care bed need methodology beginning with the 2023 SMFP. Thus, all neonatal beds and days of care are excluded from this table.
^CY 2024 acute care days based on actual January – November utilization and annualized using historical seasonal utilization patterns from CY 2023.
^^Compound annual growth rate.

Patient days have grown from approximately 108,000 in CY 2019 to a projected 149,482 in CY 2024, and the average daily census increased from 296 patients to a projected 410 patients during that time. Occupancy rates have also risen substantially from 69.4 percent in CY 2019 to 95.9 percent in CY 2024. Under the performance standards in the Criteria and Standards for Acute Care Beds, Atrium Health Cabarrus's target occupancy rate is now 78.0 percent based on its ADC that is greater than 400 patients. As shown in the table above, Atrium Health Cabarrus is projected to exceed this occupancy rate by **17.9 percentage points** in CY 2024.

Moreover, Atrium Health Cabarrus's annualized CY 2024 occupancy rate of 95.9 percent is based on its average midnight census over the course of a full year, and midnight census does not reflect the actual use of acute care beds throughout the day. Often, patients are not discharged until later in the day, in essence occupying a bed for much of the day though that bed would show up as available under a midnight census count and in the tabulation of total patient days. The chart below provides the variation in the total annual number of 2024 admissions and discharges by hour at Atrium Health Cabarrus.



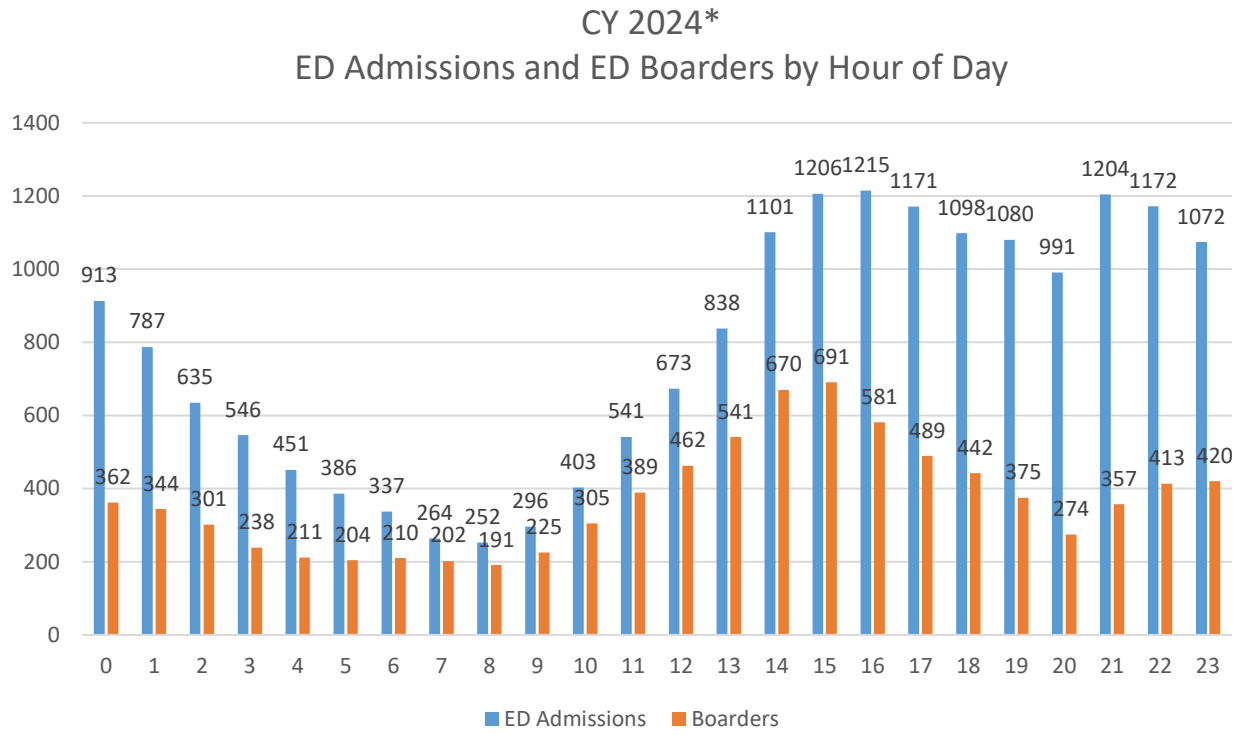
Source: CMHA internal data
*Through November, most recent data available.

As shown above, there is a steady demand for beds at Atrium Health Cabarrus (blue bars) with a slight drop in the early morning hours. Relief in the form of discharges (orange bars) does not even begin until 9 or 10am when there is already a backlog of patients waiting on a bed. Further, during the year, there are periods of higher census related to seasonal patterns for inpatient admissions. Inpatient volume is higher Monday to Friday than on weekends because of patient and physician preference for elective admissions. In addition, not all beds are equally available to any patient; ICU patients cannot be placed in medical/surgical beds, for example. Even with this potential for undercounting bed usage, Atrium Health Cabarrus regularly exceeded 100 percent occupancy in CY 2024. These high occupancy rates are a detriment to the community as Atrium Health Cabarrus is sometimes unable to provide services in a timely manner and is increasingly limited in its ability to accept the transfer of a patient in need of tertiary level care from an outside facility.

In addition, high occupancy rates at Atrium Health Cabarrus have led to a variety of operational challenges. Surgical cases are frequently delayed due to the appropriate level and type of bed not being available for the patient upon completion of the surgery. This complicates not only the bed census and management, but also the flow of the operating room suite and other departments as well, such as anesthesia and nursing. This additional wait time can be frustrating for a patient who does not understand why a bed is not available for them, particularly for a planned procedure. During the time waiting in the PACU, patients have less privacy and are unable to see or be comforted by their loved ones, and it also delays the patient's ability to begin necessary post-surgical therapies, such as physical therapy, which cannot be provided in a PACU setting. This capacity challenge was so apparent that CMHA began tracking the amount of time a patient must wait in a PACU bed for admission to an acute care bed. From January through October CY 2024[11], according to internal data, 854 patients at Atrium Health Cabarrus had to wait in a PACU bed for over two hours, on average, after they were deemed clinically appropriate for transfer to an acute care bed—a total of more than 2,000 hours waiting for a bed.

[11] Most recent data available.

The operational challenges created by insufficient bed capacity are clearly evident in emergency department (ED) metrics. Atrium Health Cabarrus often has no choice but to hold patients in the ED while waiting for acute care beds to become available for admission. ED boarding times at Atrium Health Cabarrus have increased, with the median wait time prior to admission rising from 108 minutes in CY 2023 to 117 minutes in CY 2024 (through November). As shown in the table below, which summarizes total patient admissions from the ED and total patients boarded in the ED waiting for acute care beds by hour from January to November 2024, peak boarding hours (indicated by the smallest distance between the blue and orange bars) occur most frequently in the morning hours before the day's discharges begin. In fact, between 7 AM and 10 AM, over 75 percent of patients to be admitted to Atrium Health Cabarrus's ED are, on average each hour, considered to be boarding or waiting for an inpatient bed (calculated as the number of ED boarders divided by the total number of admissions from the ED). Regardless of the hour of day, this share never drops below 25 percent. These patients occupy emergency department rooms, which greatly reduces the department's efficiency and capacity.



Source: CMHA internal data
*Through November, most recent data available

Patients also are routinely held in the Atrium Health Harrisburg and Atrium Health Kannapolis satellite EDs while waiting for a bed to become available at Atrium Health Cabarrus. With the anticipated opening of the Atrium Health Concord satellite ED in 2025, these capacity challenges may be further strained as additional emergency department patients enter the system seeking inpatient beds.

In March 2020, CMHA launched a new and innovative program – the COVID-19 Virtual Hospital program – with the objective of increasing inpatient bed capacity by caring for patients with mild or moderate symptoms at home. Patients could receive monitoring of vital signs; advanced therapies such as EKG monitoring, X-ray and ultrasound imaging, intravenous (IV) fluids, treatments, respiratory protocols, and labs; 24/7 nurse and physician coverage, daily community paramedic and nurse home visits, daily virtual provider rounds, and other mechanisms for patient engagement and feedback. In March 2021, CMHA

facilities implemented Hospital at Home (H@H) waivers through the H@H program established by the Centers for Medicare and Medicaid Services (CMS) to allow hospital providers to be reimbursed for inpatient care provided to patients in their homes. As such, in March 2021, the COVID-19 Virtual Hospital, which was launched in March 2020, evolved into CMHA's H@H. Notably, the Atrium Health COVID-19 Virtual Hospital provided inpatient-level care without inpatient reimbursement for an entire 12-month period prior to implementing the H@H waivers in March 2021 as yet another way to try to manage census at its facilities. Since implementing the H@H waivers in March 2021, Atrium Health H@H has provided inpatient-level care to almost 10,000 patients from the greater Charlotte region in their own homes; 2,597 of these patients would have otherwise occupied an inpatient bed at Atrium Health Cabarrus. CMHA expects to continue to expand the services provided through Atrium Health H@H, including caring for patients who have exacerbated chronic conditions such as congestive heart failure, chronic obstructive pulmonary disorder (COPD)/asthma, diabetes, and hypertension as well as patients with acute or episodic conditions such as cellulitis, pyelonephritis, deep vein thrombosis (DVT), community-acquired pneumonia (CAP), and pulmonary embolism (PE). The volume of patients served by the Atrium Health COVID-19 Virtual Hospital, now Atrium Health H@H, is not accounted for in any of the CMHA hospitals' reported patient days. Thus, the actual volume of patients that are being cared for by Atrium Health Cabarrus is more significant than what will be reported on its Hospital License Renewal Application (HLRA) or in the *SMFP*. CMS payment has been extended through March 31, 2025, but there is uncertainty regarding the payment mechanism for these patients after that. Long term payment for H@H patients is not guaranteed nor is the ability of CMHA to care for these patients indefinitely at home without any form of payment. Under such circumstances, demand for CMC's inpatient bed capacity would be even more than presented in this application.

Looking to the future, Atrium Health Cabarrus expects its utilization to grow due to many of the same factors that contributed to its historical growth. As noted previously, Cabarrus County is expected to grow in future years and be among the fastest growing regions in the state; the county's aging population is expected to grow even faster. Pursuant to Project ID # F-012255-22 and subsequent change of scope, Project ID # F-012505-24, CMHA was approved to develop a total of 44 additional and relocated acute care beds and two relocated ORs at Atrium Health Harrisburg, a campus of Atrium Health Cabarrus, which will become operational in CY 2028. Atrium Health Cabarrus is expected to continue receiving high-acuity patient transfers from Atrium Health Harrisburg as well as inpatient transfers from Atrium Health Kannapolis satellite ED. Moreover, it is important to note that Atrium Health Cabarrus serves as a regional referral center for Atrium Health Mecklenburg County facilities located in the northern part of the county adjacent to Cabarrus County.

In addition, the continued development of Atrium Health Cabarrus as a tertiary care facility also is expected to result in utilization growth. Examples of such development include:

Provider Recruitment & Specialty Services

- Recent specialist additions include a colorectal surgeon, minimally invasive gynecological surgeon (MIGS physician), ortho-trauma provider, and an interventional pulmonologist, with the latter being supported by advanced ION robot technology.
- Cardiology expansion plans include the anticipated recruitment of five specialists: an interventional cardiologist, general cardiologist, vascular surgeon, cardiac surgeon, and thoracic surgeon.
- Neurological care is expanding with the planned addition of two neurologists and the establishment of a dedicated Stroke/Neurology team based in Cabarrus County.
- Primary care services are growing with nine anticipated new providers in the region at various Cabarrus Family Medicine locations.
- Women's health services will be enhanced through the launch of the Spangler Doula Program in 2025.
- Pediatric surgical care will expand through the planned recruitment of two pediatric surgeons.

Facility & Program Development

- Atrium Health Lake Norman, set to open on July 1, 2025, will initially operate with 30 acute care beds and two operating rooms, with recently approved plans to develop an additional 23 acute care beds by April 1, 2026. The opening of Atrium Health Lake Norman and related expansion of services in northern Mecklenburg County is expected to drive further growth through the resulting transfers of higher acuity cases, including cases that require surgical care. As mentioned previously, Atrium Health Cabarrus serves as the regional referral center for Atrium Health facilities in this area adjacent to Cabarrus County.
- Atrium Health Concord, a satellite emergency department and campus of Atrium Health Cabarrus, is expected to open in 2025, with patients requiring inpatient care being admitted primarily to Atrium Health Cabarrus.
- A DaVinci XI robot is expected to be added to expand general surgery capabilities.
- A pediatric musculoskeletal infection (MSKI) surgery program is anticipated to be launched.
- A new vascular lab is currently under construction on the campus of Atrium Health Cabarrus. Additionally, pursuant to CON Project ID # F-12481-24, Atrium Health Cabarrus is approved to develop a fourth unit of fixed cardiac catheterization equipment.
- A satellite location for Atrium Health Women's Care Copperfield OB/GYN is planned in Kannapolis.

Finally, it is important to note that with the expiration of the COVID-19 bed waiver, Atrium Health Cabarrus faces even more severe capacity challenges. While Atrium Health Cabarrus immediately requested and continues to operate with temporary bed overflow status under 10A NCAC 13B .311, this regulation's 10 percent limit on temporary capacity expansion is insufficient to meet the demand for bed capacity at Atrium Health Cabarrus. Moreover, the regulation does not contemplate use of the temporary licenses as a long-term solution. Although the temporary spaces utilized at Atrium Health Cabarrus have been approved by DHSR's Licensure and Construction Sections as safe for patient care, they are not required to, nor do they, meet the same FGI standards as licensed acute care beds. Caring for inpatients in overflow areas is particularly taxing as these areas are designed for patients with short stays. Many of these areas lack private bathrooms, natural light from windows, and space for patients to ambulate outside of their rooms. Additional permanent acute care beds are needed to meet current and future demand at Atrium Health Cabarrus for all of the reasons discussed above.

SUMMARY

In summary, CMHA is proposing to develop 126 additional acute care beds at Atrium Health Cabarrus in response to a need determination in the *2025 SMFP* for Cabarrus County. Given the increasing demand for Atrium Health Cabarrus's acute care services and the impact on patient care when there is inadequate capacity, Atrium Health Cabarrus more than demonstrates the need for the proposed 126 additional acute care beds. As the only tertiary care facility in Cabarrus County and an important referral hospital, it is imperative that Atrium Health Cabarrus maintain sufficient acute care bed capacity to meet the needs of patients who choose to receive its services.

Please refer to Form C Assumptions and Methodology for a detailed discussion of the quantitative need for the proposed project.

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)

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.

All applicable forms identified in Section C, Question 5.a are included in Section Q.

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 Form C Assumptions and Methodology 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.

Not applicable. The proposed project does not involve licensed operating rooms.

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.

Not applicable. The proposed project does not involve licensed operating rooms.

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.

Number of Operating Rooms

Health Service Facility	**# of Dedicated C-Section ORs**	**# of Inpatient ORs** (excluding dedicated C-Section ORs)	**# of Shared ORs**	**# of Dedicated Ambulatory ORs**	**# of Exclusions** *	**Total # of ORs less Exclusions** *

* Exclude all dedicated C-Section ORs, 1 OR for each Level I or Level II Trauma Center, and 1 additional OR for each designated Burn Intensive Care Unit.

Group Assignments, Standard Hours per OR per Year, and Case Times

Health Service Facility	**Group Assignment**	**Standard Hours per OR per Year**	**Case Times**	
			Inpatient	**Outpatient**

Not applicable. The proposed project does not involve licensed operating rooms.

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.

   Consistent with all CMHA facilities, Atrium Health Cabarrus provides services to all people in need of medical care and will continue to following the proposed project. Please see Exhibit C.6 for CMHA's Non-Discrimination policies. As noted in CMHA's Non-Discrimination Policy Statement, "[n]o individual shall be subject to discrimination or denied the benefits of the services, programs, or activities of Atrium Health on the basis of race, color, religion, national origin, age, sex, sexual orientation, gender identity, gender expression, disability or source of payment." CMHA will continue to serve this population as dictated by the mission of CMHA, which is the foundation for every action taken. The mission is simple, but unique: To improve health, elevate hope, and advance healing – for all. This includes the medically underserved.

   In addition, as noted in Advocate Heath's enterprise-wide Financial Assistance Policy, Exhibit L.4-1, "Atrium Health, Aurora Health Care, Advocate Health Care and affiliates (collectively Advocate Health) are committed to caring for the health and well-being of all patients regardless of their ability to pay. Advocate Health is committed to assisting eligible patients in the communities we serve with obtaining coverage from various programs and extending financial assistance to those in need as outlined in this policy." Patients lacking coverage receive financial counseling to determine eligibility for financial assistance. Patients who do not qualify for financial assistance will be able to establish an installment payment plan. Patients will receive the appropriate medical screening examination and any necessary stabilizing treatment for emergency medical conditions, regardless of ability to pay, in compliance with Federal EMTALA regulations (see Exhibit L.4-2).

   The total measurable community benefit attributable to the Advocate Health Enterprise is more than $6 billion annually, or $16.5 million per day, driven by financial assistance to uninsured patients, professional medical education and research, community-building activities including cash and in-kind contributions to community groups and community health improvement services, bad debt costs, and losses incurred by serving Medicare and Medicaid patients. Further, CMHA has made the recruitment and retention of bilingual staff members a priority. CMHA provides financial incentives to employees who spend their time using a language skill and to employees who refer bilingual new hires. Please see Exhibit C.6 for CMHA's Non-Discrimination policies, which include its Language Assistance Plan Policy regarding patients who do not read or speak English.

   Atrium Health Cabarrus will continue to comply with the standards and provisions of the North Carolina State Building Code Volume 1-C Accessibility Code and the federal guidelines (Americans with Disabilities Act). As noted in the Individuals with Disabilities summary statement of CMHA's

Non-Discrimination Policy, Exhibit C.6, all CMHA facilities will comply with regulations as described in the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 to reasonably accommodate individuals with disabilities.

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	
Racial and ethnic minorities	25.0%
Women	62.7%
Persons with disabilities	
Persons 65 and older	38.9%
Medicare beneficiaries	43.2%
Medicaid recipients	14.3%

The table above provides an estimated percentage for each category of patients to be served at Atrium Health Cabarrus during the third full fiscal year of the project. These percentages are based on CY 2023 patients served at Atrium Health Cabarrus. CMHA does not maintain data that includes the number of low income or disabled persons it serves. As such, CMHA does not have a reasonable basis to estimate the percentage of low income and handicapped patients to be served by the project; however, neither low income nor handicapped persons are denied access to the proposed services.

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.

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;

CMHA is proposing to develop 126 additional acute care beds at Atrium Health Cabarrus pursuant to the need identified in the *2025 SMFP* for Cabarrus County. Please see the responses to Section B.1b for documentation that CMHA meets the requirements of a "qualified applicant."

(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;

Please see Form C Assumptions and Methodology for documentation and projected utilization of the existing, approved, and proposed acute care beds at the applicant campus, Atrium Health Cabarrus. As discussed previously, the SHCC removed Level II, III and IV neonatal beds and days of care from the acute care bed need methodology beginning with the *2023 SMFP*. Thus, CMHA excluded all neonatal beds and days of care from Form C and its assumptions. The table below demonstrates that the Atrium Health Cabarrus campus still exceeds the performance standards when neonatal beds and days of care are included. Of note, CMHA chose to use CY 2023 neonatal days of care and held them constant throughout the projection years. Growing neonatal days of care at a conservative growth rate would have resulted in an even higher occupancy rate of the total acute care beds than shown. Even without accounting for growth in neonatal patient days, Atrium Health Cabarrus still exceeds the performance standards in CY 2034 (Project Year 3).

Atrium Health Cabarrus (Main Campus)
Projected Acute Care Bed Utilization (Including Neonatal Days and Beds)

	CY32	***CY33***	***CY34***
Adult Days	181,555	186,919	192,401
Neonatal Days	5,944	5,944	5,944
Total Acute Care Days	**187,499**	**192,863**	**198,345**
Average Daily Census	514	528	543
Total Number of Acute Care Beds*	647	647	647
Occupancy	**79.4%**	**81.7%**	**84.0%**

Source: CMHA internal data
*Incudes 20 neonatal beds

(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 the table above which demonstrates that Atrium Health Cabarrus exceeds the target occupancy percentage for the existing, approved, and proposed acute care beds during the third full fiscal year of operation following completion of the proposed project. Please also see Form C Assumptions and Methodology.

(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;

The Atrium Health Cabarrus license includes the existing Atrium Health Cabarrus main campus and the Atrium Health Harrisburg campus. Please see Form C Assumptions and Methodology for documentation and projected utilization of the existing, approved, and proposed acute care beds for the hospital system, Atrium Health Cabarrus. As discussed

previously, the SHCC removed Level II, III and IV neonatal beds and days of care from the acute care bed need methodology beginning with the *2023 SMFP*. Thus, CMHA excluded all neonatal beds and days of care from Form C and its assumptions. The table below demonstrates that Atrium Health Cabarrus, the hospital system, exceeds the performance standards with and without neonatal days and beds. Of note, CMHA chose to use CY 2023 neonatal days of care and held them constant throughout the projection years. Growing neonatal days of care at a conservative growth rate would have resulted in an even higher occupancy rate of the total acute care beds than shown. Even without accounting for growth in neonatal patient days, the Atrium Health Cabarrus license still exceeds the performance standards in CY 2034 (Project Year 3).

Atrium Health Cabarrus (License)
Projected Acute Care Bed Utilization (Including Neonatal Days and Beds)

	CY32	***CY33***	***CY34***
Adult Days	194,437	200,933	207,647
Neonatal Days	5,944	5,944	5,944
Total Acute Care Days	**200,381**	**206,877**	**213,591**
Average Daily Census	549	567	585
Total Number of Acute Care Beds*	691	691	691
Occupancy	**79.4%**	**82.0%**	**84.7%**

Source: CMHA internal data
*Includes 20 neonatal beds

(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

Please see Form C Assumptions and Methodology for projected utilization which demonstrates that the Atrium Health Cabarrus license exceeds 78.0 percent target occupancy for the existing, approved, and proposed acute care beds during the third full fiscal year of operation following completion of the proposed project. Also, see the previous table above which demonstrates that the Atrium Health Cabarrus license exceeds the target occupancy percentage even when neonatal beds are included.

(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.

Please see Form C Assumptions and Methodology for documentation of the assumptions and methodology used to project the utilization and occupancy rates required in Items (2), (3), (4), and (5) of this 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.

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.

Not applicable. The proposed project does not involve a change of scope.

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.

Not applicable. The proposed project does not involve a cost overrun.

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?

NA

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.

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

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?

NA

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.

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

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?

NA

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.

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

f. **CON Rules**

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

   NA

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.

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

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;

      Not applicable. The proposed project does not involve the relocation of an entire facility to another location or campus.

   2) Provide any supporting documentation in an Exhibit; and

      Not applicable. The proposed project does not involve the relocation of an entire facility to another location or campus.

   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.

      Not applicable. The proposed project does not involve the relocation of an entire facility to another location or campus.

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

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

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.

Not applicable. The proposed project does not involve the reduction or elimination of any service components at a health service facility.

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.

Not applicable. The proposed project does not involve the reduction or elimination of any service components at a health service facility.

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.

Not applicable. The proposed project does not involve the reduction or elimination of any service components at a health service facility.

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.

Not applicable. The proposed project does not involve the reduction or elimination of any service components at a health service 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.

Not applicable. The proposed project does not involve the reduction or elimination of health service facility beds, health services, hospital services, or medical equipment at a health service facility.

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)?

☐

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

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

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)?

☐

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.

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

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. Develop the proposed additional acute care beds at Atrium Health Harrisburg.
      2. Develop the proposed additional acute care beds at a new location.

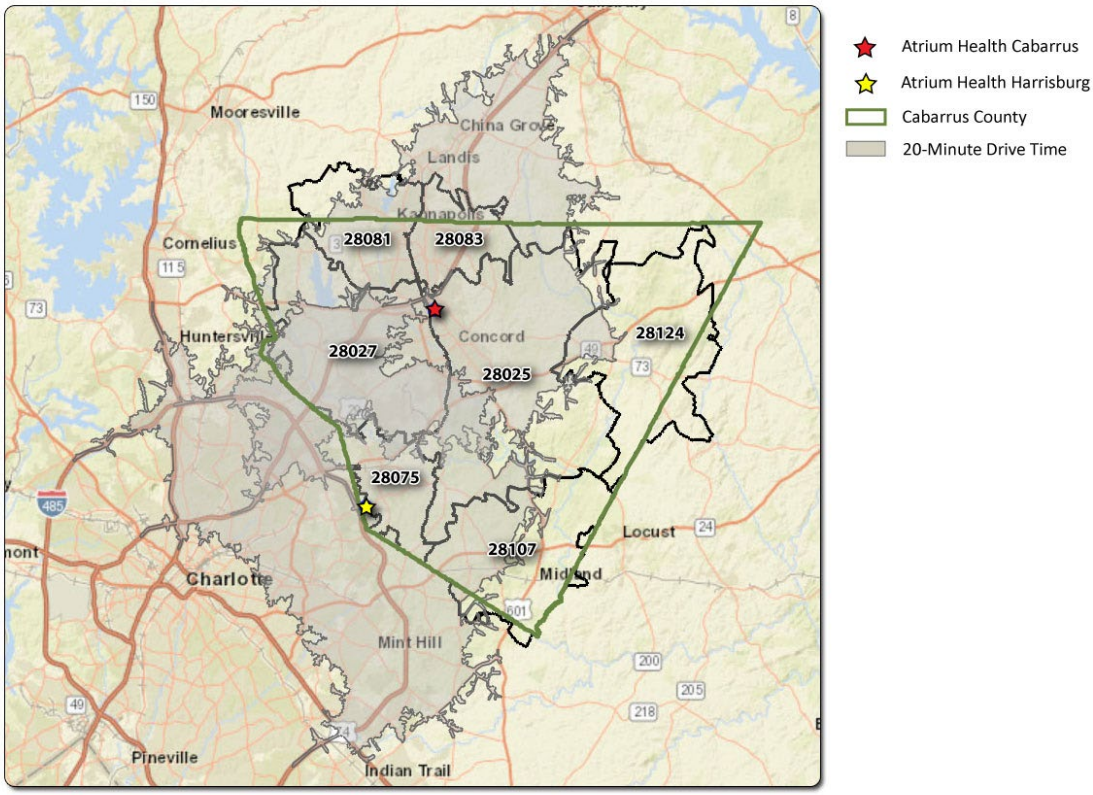
   b. For each alternative method **not** selected, explain how that alternative would be more costly or less effective for the applicant than the selected alternative; and

DEVELOP THE PROPOSED ADDITIONAL ACUTE CARE BEDS AT ATRIUM HEALTH HARRISBURG

CMHA also considered developing beds at Atrium Health Harrisburg, which would result in fewer beds at Atrium Health Cabarrus's main campus. As demonstrated in Section C.4, Atrium Health Cabarrus's CY 2024 annualized occupancy rate of 95.9 percent indicates severe capacity constraints. As discussed in Section C.1, CMHA was recently approved to develop a total of 31 additional acute care beds at Atrium Health Harrisburg and to relocate 13 existing acute care beds from Atrium Health Cabarrus to Atrium Health Harrisburg. While Atrium Health Harrisburg will play an important role in serving the community's acute care needs and decompressing the Atrium Health Cabarrus main campus, CMHA believes that expanding capacity at Atrium Health Cabarrus is the best choice at this time to allow the ongoing expansion of tertiary services in support of the demand from the large and growing population in the region that increasingly depends on Atrium Health Cabarrus for its services. While CMHA may pursue future bed development at Atrium Health Harrisburg as community needs continue to grow, the proposed project is ultimately a result of CMHA's efforts to balance the distribution of assets with the need identified for Cabarrus County in the *2025 SMFP*.

DEVELOP THE PROPOSED ADDITIONAL ACUTE CARE BEDS AT A NEW LOCATION

CMHA determined that developing the proposed acute care beds at a new location in Cabarrus County would be less effective than developing them at an existing location. The drive time map below demonstrates the combined 20-minute drive time areas of Atrium Health Cabarrus and Atrium Health Harrisburg, which shows that these facilities already provide comprehensive coverage of Cabarrus County's core zip codes (28025, 28027, 28075, 28081, and 28083).



According to NC HIDI market data (included in the table below), these five zip codes (shaded in green) generated 92.7 percent of all patient days from Cabarrus County residents in 2023, confirming that the existing and approved hospital locations in Cabarrus County already provide excellent accessibility for the county's population.

2023 Cabarrus County Patient Days by ZIP Code

ZIP Code	*Patient Days*	*% Patient Days*
28025	32,504	27.6%
28027	33,602	28.5%
28075	7,011	6.0%
28081	18,214	15.5%
28083	17,805	15.1%
28107	4,093	3.5%
28124	4,509	3.8%
Total	**117,738**	**100%**

Source: 2023 NC HIDI market data, most recent available.

With such comprehensive coverage of the county's population through these two facilities, CMHA determined an additional hospital site is not needed and would likely result in unnecessary duplication of resources.

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.

Not applicable. The alternative methods considered are discussed above in Section E.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.

   Please see Form F.1a Capital Cost 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 see Section Q, immediately following Form F.1a Capital Cost, for the assumptions used to project the capital cost. In addition, please see Exhibit F.1 for a certified capital cost estimate.

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	The Charlotte-Mecklenburg Hospital Authority
Loans	$
Cash and Cash Equivalents, Accumulated Reserves, or Owner's Equity	$ 208,468,290
Bonds	$
Other (**Describe**)	$
Total to be Incurred by Applicant 1	**$ 208,468,290**

Please note that CMHA expects to fund the proposed project with accumulated reserves but has conservatively included financing costs in the event the proposed project is funded with bond financing.

Applicant 2	
Loans	$
Cash and Cash Equivalents, Accumulated Reserves, or Owner's Equity	$
Bonds	$
Other (**Describe**)	$
Total to be Incurred by Applicant 2	**$**

Not applicable. The proposed project involves only one applicant.

Applicant 3	
Loans	$
Cash and Cash Equivalents, Accumulated Reserves, or Owner's Equity	$
Bonds	$
Other (**Describe**)	$
Total to be Incurred by Applicant 3	**$**

Not applicable. The proposed project involves only one applicant.

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. The proposed project will not be funded with a 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;

   The proposed project will be funded with accumulated reserves of CMHA. Please note that CMHA expects to fund the project with accumulated reserves but has conservatively included financing costs in the event the project is funded with bond financing.

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.2-1 for a letter from Brad Clark, Chief Financial Officer of CMHA, 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.2-2 for the most recent audited financial statements for CMHA, the source of funds for the proposed project. Please refer to the line items "Cash and cash equivalents" and "Assets limited as to use," which indicate sufficient reserves available for the proposed project.

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. The proposed project will be funded with accumulated reserves of CMHA.

Working Capital and Availability of Funds for Working Capital

3. a. **All applicants**

Start-up Costs *	Will the applicant incur any start-up costs?	No
Initial Operating Costs *	Will the applicant incur any initial operating costs?	No

* 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.

Not applicable. The proposed project does not involve a new service or facility and, therefore, will not result in any start-up expenses or initial operating costs.

b. **Start-up costs**

Total estimated start-up costs	$

Not applicable. As noted above, the proposed project does not involve a new service or facility and, therefore, will not result in any start-up expenses.

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

	Utilities		Hiring Staff
	Mortgage or Rent		Training Staff
	Purchasing Equipment		Fees
	Purchasing Supplies		Other (**describe**)
	Marketing or Advertising		Other (**describe**)

Not applicable. As noted above, the proposed project does not involve a new service or facility and, therefore, will not result in any start-up expenses.

c. **Initial operating costs**

Initial operating period *	
Total estimated initial operating costs during the initial operating period	$

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

Not applicable. The proposed project does not involve a new service or facility and, therefore, will not result in any initial operating expenses.

d. **Total working capital** *

$

* 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.

Not applicable. The proposed project does not involve a new service or facility.

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

1) Initial operating period;
2) Start-up costs; and
3) Initial operating costs.

Not applicable. The proposed project does not involve a new service or facility.

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	
Loans	$
Cash or Cash Equivalents, Accumulated Reserves or Owner's Equity	$
Lines of credit	$
Bonds	$
Total to be incurred by Applicant 1	$

Applicant 2	
Loans	$
Cash or Cash Equivalents, Accumulated Reserves or Owner's Equity	$
Lines of credit	$
Bonds	$
Total to be incurred by Applicant 2	$

Applicant 3	
Loans	$
Cash or Cash Equivalents, Accumulated Reserves or Owner's Equity	$
Lines of credit	$
Bonds	$
Total to be incurred by Applicant 3	$

Not applicable. The proposed project does not involve a new service or facility.

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.

Not applicable. The proposed project does not involve a new service or facility and, therefore, will not result in any working capital costs.

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;
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
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.

Not applicable. The proposed project does not involve a new service or facility and, therefore, will not result in any working capital costs.

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. The proposed project does not involve a new service or facility and, therefore, will not result in any working capital costs.

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.

Please see Section Q, immediately following Forms F.2 and F.3, for the assumptions and methodology used to complete each form.

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 or health service, 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

All applicable forms identified in Section F, Question 4.b are included in Section Q.

c. **Professional Fees**

Will the facility or health service 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.

Not applicable. Atrium Health Cabarrus will not bill the patient for any professional fees associated with the proposed project.

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.

Not applicable. The proposed project does not involve a cost overrun.

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)?

NA

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.

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

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?

NA

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 proposed project does not involve a change of scope or cost overrun.

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.

1. a. Identify all existing and approved health service facilities or health services, if applicable (i.e. mobile health services) located in the proposed service area that provide the same service components proposed in this application.

   The service area for the proposed project is Cabarrus County. Please see Exhibit G.1 for an excerpt of Table 5A from the *2025 SMFP* which provides a list of all existing and approved facilities with acute care beds in Cabarrus County.

   b. If available from the SMFP or license renewal application forms, or equipment registration and inventory forms on file with the Division of Health Service Regulation, for each existing facility or health service 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.

   Please see Exhibit G.1, an excerpt of Table 5A from the *2025 SMFP*, for the total annual utilization of acute care services for the existing facilities identified above for the year ending September 30, 2023. Per the question, SMFP data was provided. Please see Form C for more recent internal utilization data.

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.

   The *2025 SMFP* includes a need determination for 126 additional acute care beds in Cabarrus County. Notably, the need in the *2025 SMFP* was generated by the highly utilized acute care services at Atrium Health Cabarrus. Furthermore, even with a conservative projection using just half of Atrium Health Cabarrus's historical growth rate (3.3 percent) for acute care days, as shown in Form C, the facility is expected to reach 84.1 percent occupancy by the third project year. Thus, the proposed project will not result in any unnecessary duplication.

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

   Not applicable.

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)?

NA

   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.

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

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 for the assumptions and methodology used to project types of positions, FTEs, and salaries.

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.

   CMHA's human resources department utilizes several media outlets for recruitment including print, online, and radio. In addition, interactive advertising approaches such as social networking sites, search engine optimization, and e-postcards also are used. CMHA participates in school career fairs, professional job fairs, and offers co-worker referral bonuses. Hard-to-fill positions and strategic initiatives are reviewed annually and supporting recruitment plans are created.

   CMHA has two schools of nursing within the System:

   - Cabarrus College of Health Sciences, and
   - Carolinas College of Health Sciences.

CMHA has a lengthy set of procedures for recruiting nursing and non-nursing staff. Some of these procedures include:

- Employee referral bonuses;
- Hospital website job postings;
- Career fairs;
- Providing facilities as host sites for professional clinical training programs; and,
- Advertising in professional journals and job posting websites.

CMHA has deployed multiple strategies to attract and recruit talent, particularly during the workforce shortage that permeates the industry, both locally and nationally. Some of those strategies include the following:

National Recruitment Strategy via Expansive Digital/Social Marketing

- Facebook/Instagram sponsored ads/campaigns
  - Targeting individuals with healthcare experience noted
- Indeed
  - Branded targeted ads targeting talent in 13 states
- Glassdoor
  - Brand spotlight targeting RNs in North Carolina, South Carolina, and Tennessee
  - Homepage highlight – programmatic marketing targeting Glassdoor users who have engaged with the CMHA company profile
  - Competitor retargeting – programmatic marketing retargeting job seekers who have not engaged with the CMHA profile
- LinkedIn
  - Job posting and employment branding

Competitive Recruitment Incentives

- Signing bonuses
- Relocation assistance
- Referral bonuses for CMHA teammates

Traveler Conversion Initiatives

- Actively recruiting current contingent staff to consider permanent employment with CMHA
- Active traveler conversion bonus

Recruitment Hiring Events

- Virtual and in-person recruitment hiring events where leaders can interview and extend same day offers to candidates

Nursing

- The Cabarrus College of Health Sciences received accreditation for two new nursing programs that began enrollment in Fall of 2023
- Commitment to focus recruitment efforts on nursing and support staff; non-patient care roles are either on hold or deprioritized
- Exploring potential non-nursing roles to support acute care bedside nurses
- International nurse recruitment
- Expanding partnerships with nursing schools

While these expanded efforts will not shield CMHA from industry-wide workforce challenges, they are serving to reduce the impact of national shortages.

Of note, as the second largest employer in North Carolina, CMHA is committed to creating an inclusive workforce made up of teammates from all backgrounds and experiences. Financial stability for teammates is a critical focus for CMHA as an employer of choice; CMHA strives to provide family sustaining income, comprehensive health benefits, and programs for career advancement – all of which, in turn, help drive economic mobility in the communities it serves.

CMHA believes that these initiatives also contribute to its ability to recruit and retain qualified staff to provide patient care, including those services proposed in this application.

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.

All clinical and administrative staff of Atrium Health Cabarrus are required to meet multiple performance standards and competency levels. All new staff are required to attend CMHA New Teammate Orientation. Nursing staff are required to complete needs assessments during orientation and annually. Nurse managers identify learning needs and develop strategies to address them. Multiple strategies and avenues are used to provide updates on various topics, including new policies or service excellence. All clinical staff are required to maintain certification by an appropriate, nationally recognized certification-accrediting body.

In addition, the Office of Access and Opportunity provides educational events and activities throughout the year. CMHA's signature learning event, The FOR ALL Conference, is a cultural mainstay of CMHA. By hosting educational programming like this, CMHA aims to elevate cultural competency across the enterprise, enhance care delivery, cultivate an inclusive workplace and learning environment, and uplift the communities it serves.

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?

NA

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 proposed project does not involve a change of scope or cost overrun.

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.

Atrium Health Cabarrus has all ancillary and support services in place to support hospital operations, including the existing acute care services at Atrium Health Cabarrus. These existing ancillary and support services will also support the additional acute care beds proposed in this application. Patients may require the use of any of Atrium Health Cabarrus's existing ancillary and support services including laboratory, radiology, pharmacy, dietary, housekeeping, maintenance, and administration, among others.

2) For each ancillary or support service **not** checked in the table above, briefly explain why it is not necessary.

Not applicable. As a full-service acute care hospital, all necessary ancillary and support services are in place.

3) Provide any supporting documentation in an Exhibit.

Please see Exhibit I.1 for a letter from Asha Rodriguez, Vice President and Facility Executive of Atrium Health Cabarrus, attesting to the availability of the above ancillary and support services.

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

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

As an existing healthcare facility in the area, Atrium Health Cabarrus has established relationships with area healthcare providers. Atrium Health Cabarrus's relationships with other local healthcare and social service providers are well established and will continue following the completion of the proposed project. Please see Exhibit I.2 for letters of support from physicians and other providers received to date.

b. **New Facilities or health services (mobile)** – 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.

Not applicable. The proposed project does not involve a new facility.

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?

NA

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.

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

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?

NA

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 proposed project does not involve a change of scope or cost overrun.

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?

   Based on its projected patient origin, less than one percent of encounters are projected to be provided to patients that do not reside in the HSA in which the proposed project is located or in adjacent HSAs in North Carolina. Note, as previously advised by the CON Section, this calculation does not include patients in South Carolina or other states, as they do not reside in a North Carolina HSA.

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. As noted above, CMHA does not propose to serve a substantial portion of individuals not residing in the HSA in which the proposed project is located or in adjacent HSAs in North Carolina.

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?	No
If yes, provide the total number of square feet to be constructed:	Not applicable.
Briefly describe the proposed construction in the cell below	
Not applicable.	

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.

Not applicable.

2. **Renovation of Existing Space**

Does the proposal include renovation of existing space?	Yes
If yes, provide the total number of square feet to be renovated:	113,551
Briefly describe the proposed renovation in the cell below	
The 126 additional acute care beds proposed in this application will be developed across Levels 02, 03, and 04 of a new, CON-exempt patient tower planned for Atrium Health Cabarrus's main campus. The proposed project also involves the development of necessary support spaces across all three floors, including waiting rooms, storage space, office space, staff lounges, patient consult rooms, elevators, bathrooms, soiled/clean utility rooms, nurse workstations, and more. See Section C.1 for additional details.	

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.

Please see the previously referenced Exhibit C.1-2 for a copy of the project line drawings.

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.

CMHA believes that the proposed project is indicative of its commitment to containing healthcare costs, even though the addition of 126 licensed acute care beds necessitates the expenditure of capital to upfit space for their development. The overall layout of the new patient tower renovation is based on a configuration that provides the most efficient circulation and throughput

for patients and caregivers. Sizes of spaces are based on best practice methodologies, as well as relationships and adjacencies to support functions while also preventing unnecessary costs. Daylighting is proposed where feasible to reduce energy consumption, as well as other sustainable strategies. The exterior envelope of the new patient tower will be a mixture of materials that provide energy efficiency, low maintenance, and aesthetics complementary of the surrounding buildings. Costs were derived from recent historical cost information using cost modeling tools. Finally, all patient rooms to be constructed for the proposed project will be compliant with current Facility Guidelines Institute (FGI) guidelines. While this project specifically involves the buildout of three floors in the planned patient tower, it must be sequenced after construction begins on the patient tower and coordinated with other previously approved projects at Atrium Health Cabarrus, resulting in a services offering date of May 2031. Given these factors, the cost, design, and means of construction as proposed in this application represent the most reasonable alternative for the project.

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.

CMHA believes the proposed construction costs are necessary to ensure the proposed project can be developed, providing access to essential acute care services for patients at Atrium Health Cabarrus. Through its conservative fiscal management, CMHA has set aside excess revenues from previous years to enable it to pay for projects such as the one proposed in this application, without necessitating an increase in costs or charges to pay for the project. Even if the proposed project were to be funded with debt, CMHA is well-able to service the debt without increasing costs or charges to the public. Please see the previously referenced Exhibit F.2-2 for audited financial statements.

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

Please see Section B.21 for a detailed discussion of the energy saving features incorporated into the construction/renovation plans.

New Facilities or health service (mobile), 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)	
City	
State	North Carolina

ZIP Code	
County	

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

Not applicable. The proposed project involves an existing health service facility – Atrium Health Cabarrus – and not a new facility, a relocation of an existing facility, or a new campus.

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.

Not applicable. The proposed project involves an existing health service facility – Atrium Health Cabarrus – and not a new facility, a relocation of an existing facility, or a new campus.

c. **Zoning and Special Use Permits**

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

Not applicable. The proposed project involves an existing health service facility – Atrium Health Cabarrus – and not a new facility, a relocation of an existing facility, or a new campus.

d. **Water** – Describe how water will be provided at the proposed site and include any supporting documentation in an Exhibit.

Not applicable. The proposed project involves an existing health service facility – Atrium Health Cabarrus – and not a new facility, a relocation of an existing facility, or a new campus.

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.

Not applicable. The proposed project involves an existing health service facility – Atrium Health Cabarrus – and not a new facility, a relocation of an existing facility, or a new campus.

f. **Power** – Describe how power will be provided at the proposed site and include any supporting documentation in an Exhibit.

Not applicable. The proposed project involves an existing health service facility – Atrium Health Cabarrus – and not a new facility, a relocation of an existing facility, or a new campus.

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?

NA

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.

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

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 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
01/01/2023 to 12/31/2023

<Atrium Health Cabarrus (Main Campus)>	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	4.6%
Charity Care^	
Medicare *	43.2%
Medicaid *	14.3%
Insurance *	35.2%
Workers Compensation^^	
TRICARE^^	
Other (Other Govt, Worker's Comp)^^	2.6%
Total	100.0%

* Including any managed care plans.

^CMHA internal data does not include Charity Care as a payor source for patients. Patients in any payor category can and do receive charity care. Please see Form F.2 for charity care projections.

^^Workers Compensation, TRICARE, Department of Corrections, and other payors are included in the Other payor category.

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.

Not applicable. The proposed project does not involve the relocation of any service components from any other facility.

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.

< Atrium Health Cabarrus (Main Campus)>	Last Full FY before Submission of the Application	
	Percentage of Total Patients Served	**Percentage of the Population of the Service Area ***
Female	62.7%	50.9%
Male	37.1%	49.1%
Unknown	0.2%	0.0%
64 and Younger	61.1%	86.1%
65 and Older	38.9%	13.9%
American Indian	0.5%	0.8%
Asian	1.4%	7.0%
Black or African-American	20.6%	22.3%
Native Hawaiian or Pacific Islander	0.1%	0.1%
White or Caucasian	71.9%	67.1%
Other Race	2.4%	2.7%
Declined / Unavailable	3.2%	0.0%

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

The table above shows percentages of populations historically served by Atrium Health Cabarrus. It does not show the percentage of the population in the service area in need of the services offered at Atrium Health Cabarrus. Specifically, the available population data by age, race, and gender does not include information on the number of elderly, minorities, women, or

handicapped persons that need health services provided at the facility. For example, the elderly utilize health services at a higher rate than the younger population, thus the percentage of elderly patients at the facility is higher than the percentage of the population.

<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. The proposed project does not involve the relocation of any service components from any other 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.

Atrium Health Cabarrus has no obligation to provide a specific uncompensated care amount, community service, or access to care by medically underserved, minorities, or handicapped persons. However, as stated earlier, Atrium Health Cabarrus provides and will continue to provide services to all persons in need of medical care, regardless of race, color, religion, national origin, age, sex, sexual orientation, gender identity, gender expression, disability, or source of payment as demonstrated in CMHA's Non-Discrimination policies provided in previously referenced Exhibit C.6.

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. No complaints regarding civil rights equal access have been filed against Atrium Health Cabarrus in the 18 months immediately preceding this application deadline.

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.

b. **Describe the assumptions used to project each payor source**.

Projected payor mix for the Atrium Health Cabarrus campus and the acute care bed service component is based on CY 2023 payor mix for the total facility and acute care bed service component, respectively. With the expansion of Medicaid coverage in North Carolina that began in December 2023, preliminary 2024 data indicates that the anticipated payor mix shift is occurring, with some patients previously classified as Self-Pay transitioning to Medicaid coverage. While this transition is ongoing, CMHA utilizes the historical 2023 payor mix data in this application as it represents the last complete fiscal year of data at the time of preparation of this application and provides a conservative baseline. This approach ensures that CMHA's projections account for the maximum potential volume of Self-Pay patients, who, along with Medicaid patients, are considered underserved population. As both Medicaid and Self-Pay are considered underserved, CMHA demonstrates that patients from both categories will continue to have access to the proposed services in conformity with Criterion (13)c, regardless of the yet-to-be-determined future shift between the two categories. Until there is greater clarity to guide the specific shift between Self-Pay and Medicaid, CMHA has assumed that the payor mix will be consistent with the historical payor mix assumptions above.

Projected Payor Mix during the 3rd Full FY
01/01/2034 to 12/31/2034

<Atrium Health Cabarrus (Main Campus)>	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	4.6%
Charity Care^	
Medicare *	43.2%
Medicaid *	14.3%
Insurance *	35.2%
Workers Compensation^^	
TRICARE^^	
Other (**Other Govt, Worker's Comp**)^^	2.6%
Total	100.0%

* Including any managed care plans.

^CMHA internal data does not include Charity Care as a payor source for patients. Patients in any payor category can and do receive charity care. Please see Form F.2 for charity care projections.

^^Workers Compensation, TRICARE, Department of Corrections, and other payors are included in the Other payor category.

<Acute Care Beds (Atrium Health Cabarrus (Main Campus))>	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	3.6%
Charity Care^	
Medicare *	57.7%
Medicaid *	12.5%
Insurance *	22.5%
Workers Compensation^^	
TRICARE^^	
Other (Other Govt, Worker's Comp)^^	3.7%
Total	100.0%

* Including any managed care plans.

^CMHA internal data does not include Charity Care as a payor source for patients. Patients in any payor category can and do receive charity care. Please see Form F.2 for charity care projections.

^^Workers Compensation, TRICARE, Department of Corrections, and other payors are included in the Other payor category.

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**.

The percent of charity care patients for the Atrium Health Cabarrus campus in CY 2023 was 3.1 percent. The proportion of charity care patients to total patients is assumed to be constant through the project years.

	1st Full FY	**2nd Full FY**	**3rd Full FY**
Estimated # of Charity Care Patients	9,761	9,944	10,130

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**.

The percent of reduced cost patients for the Atrium Health Cabarrus campus in CY 2023 was 0.2 percent. The proportion of reduced cost patients to total patients is assumed to be constant through the project years.

	1st Full FY	2nd Full FY	3rd Full FY
Estimated # of Patients to be Served at a Reduced Cost to the Patient	569	579	590

c. Provide copies of the health service's (mobile) or facility's existing or proposed policies regarding charity and reduced cost care.

As noted in Advocate Heath's enterprise-wide Financial Assistance Policy, Exhibit L.4-1, "Atrium Health, Aurora Health Care, Advocate Health Care and affiliates (collectively Advocate Health) are committed to caring for the health and well-being of all patients regardless of their ability to pay. Advocate Health is committed to assisting eligible patients in the communities we serve with obtaining coverage from various programs and extending financial assistance to those in need as outlined in this policy." Patients lacking coverage receive financial counseling to determine eligibility for financial assistance. CMHA offers financial assistance to patients who are uninsured or who are underinsured. Eligibility is determined using the most current Federal Poverty Guidelines as the basis. Patients who are not eligible for any third-party coverage or CMHA financial assistance and who are unwilling or unable to pay will be able to establish an installment payment plan.

Patients will receive the appropriate medical screening examination and any necessary stabilizing treatment for emergency medical conditions, regardless of ability to pay, in compliance with Federal EMTALA regulations (see Exhibit L.4-2).

5. Indicate the means by which a person will have access to the services proposed in this application (e.g., physician referral, self-admission, etc.).

Persons have access to inpatient services at Atrium Health Cabarrus through referrals from physicians who have admitting privileges at the hospital. Patients of Atrium Health Cabarrus also are admitted through the emergency department.

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?

NA

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 have access to the facility or campus identified in Section A, Question 4, for health professional training purposes.

CMHA has extensive, existing relationships with health professional training programs. CMHA has established relationships with programs including Central Piedmont Community College, Queens University of Charlotte (including Presbyterian School of Nursing), University of North Carolina at Charlotte, and Gardner-Webb University among many others. A complete list is included in Exhibit M.1.

CMHA also has a contractual agreement with the University of North Carolina at Chapel Hill to manage the South Piedmont Area Health Education Center (AHEC). South Piedmont AHEC coordinates various educational programs and produces continuing medical education programming for employees of CMHA and other healthcare providers in an eight-county region. This agreement also deems CMHA facilities as clinical rotation training sites for several advanced practice provider programs including Duke University, UNC at Chapel Hill, and Wake Forest School of Medicine.

CMHA, along with Carolinas College of Health Sciences and Cabarrus College of Health Sciences, provides educational environments for more than 1,000 residents, medical, physician extender, nursing, radiology, and other allied health professional students annually. Carolinas College of Health Sciences awards associate degrees in nursing and radiologic technology, a diploma in surgical technology, and clinical education certificates in medical technology and phlebotomy, as well as a nurse's aide program. The Center for Pre-Hospital Medicine is a regional EMT-paramedic program. The curriculum, designed to last approximately 15 months, is provided in affiliation with Central Piedmont Community College and Mecklenburg Emergency Medical Services Agency. The Clinical Pastoral Education Program is the only hospital-based pastoral education program in Charlotte that is accredited by the Association for Clinical Pastoral Education. It provides interfaith professional training for clergy and lay people. CMHA and the University of North Carolina at Charlotte offer a collaborative program for registered nurses to obtain a Master's degree and professional nurse anesthetist training (CRNA program). All of these health professionals use the facilities of CMHA to meet their clinical training requirements.

Each of the programs listed above will continue to have access to clinical training opportunities at CMHA facilities following the proposed project, including Atrium Health Cabarrus, as appropriate.

b. Document the efforts made by the applicant to establish relationships with these training programs.

Not applicable. Established relationships are already in place.

2. If not applicable to the proposed service components, briefly explain why not.

Not applicable. Please see the response to Section M.1.a above.

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 proposed project is expected to enhance competition in the service area by promoting cost effectiveness, quality, and access to acute care services. As discussed in Section C.4, Atrium Health Cabarrus is operating at extremely high occupancy levels due to increasing demand. The proposed acute care beds will strengthen competition in the region by addressing capacity constraints that increasingly limit Atrium Health Cabarrus's ability to compete for patients. Thus, expanding capacity will enable Atrium Health Cabarrus to effectively compete with other providers serving Cabarrus County residents, who frequently choose from multiple providers for their acute care needs. In short, the proposed expansion of acute care capacity at Atrium Health Cabarrus – a facility that is cost-effective, demonstrates high quality, and provides strong access to the medically underserved – will promote competition in the region.

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;

         The proposed project is indicative of CMHA's commitment to containing healthcare costs and maximizing healthcare benefit per dollar expended, while also ensuring that it develops the services and capacity to meet the needs of the population it serves. As discussed in Section C.1, a new patient tower is planned for Atrium Health Cabarrus's main campus, located adjacent and connected to the existing hospital building. CMHA believes additional acute care capacity can be developed efficiently at a reasonable cost (given the amount of capacity that Atrium Health Cabarrus is proposing to add) as part of the larger patient tower project while also creating the necessary capacity to care for a growing number of patients.

         Further, Atrium Health Cabarrus, as a part of the larger CMHA and Advocate system, benefits from significant cost savings measures through the consolidation of multiple services and large economies of scale. The proposed project will enable Atrium Health Cabarrus to continue to provide its patients with the best care possible, while also being responsive in a healthcare environment that emphasizes cost containment and efficient utilization of existing resources. Through the proposed additional acute care beds at Atrium Health Cabarrus, CMHA will foster competition in the region by pursuing an approach that balances expending capital with developing needed capacity to meet patient demand for additional, high quality acute care services.

2) Quality of the proposed services; and

CMHA believes that the proposed project will promote safety and quality in the delivery of healthcare services by expanding access to the high quality services it provides at Atrium Health Cabarrus.

CMHA is dedicated to providing the highest quality care and is continually recognized locally and nationally for its commitment to delivering efficient, quality care. Each year, CMHA facilities are recognized by many of the top accrediting and ranking organizations in the industry. Awards and recognitions specific to Atrium Health Cabarrus include, but are not limited to, the following:

- In 2024, Atrium Health Cabarrus tied for the third ranking hospital in the Charlotte metro area and twelfth in the state according to *U.S. News & World Report's* Best Hospital rankings. It was also designated high performing in nine adult procedures/conditions.
- In 2024, Atrium Health Cabarrus received Chest Pain Myocardial Infarction (CP-MI) Registry Platinum Recognition, demonstrating exceptional performance in chest pain and myocardial infarction care.
- In 2024, Atrium Health Cabarrus received the American Heart Association's Mission Lifeline Gold Plus Recognition for STEMI care and Gold Recognition for NSTEMI care, demonstrating excellence in treating both types of myocardial infarction patients according to national guidelines.
- In 2024, Atrium Health Cabarrus received the "Pathway to Excellence" designation from the American Nurses Credentialing Center, recognizing its commitment to creating a positive work environment for nurses.
- In 2024, Atrium Health Cabarrus's emergency department was honored with the Lantern Award, acknowledging exceptional and innovative performance in leadership, practice, education, advocacy, and research.
- In 2024, Atrium Health Cabarrus received Bronze Level 3 Accreditation from the American College of Emergency Physicians Geriatric Emergency Department Accreditation (GEDA) program at all three emergency departments (Cabarrus, Harrisburg, and Kannapolis), recognizing excellence in geriatric emergency care.
- In 2024, Atrium Health Cabarrus received a "B" rating in The Leapfrog Group's Spring and Fall Patient Safety Report Card, demonstrating continued commitment to patient safety.
- In 2023, Atrium Health Cabarrus was named an age-friendly health system by the Institute for Healthcare Improvement for its commitment to care excellence for older adults.
- In 2023, Atrium Health Cabarrus was named an Antimicrobial Stewardship Center of Excellence by the Infectious Disease Society of America.
- In 2023, Atrium Health Cabarrus received the American Heart Association's Get With The Guidelines®- Stroke Gold Plus Quality Achievement Award. The designation honors Atrium Health Cabarrus for its commitment to ensuring stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines. Atrium Health Cabarrus also received two other stroke awards and a Type II Diabetes award from the Association.
- In 2022, Atrium Health Cabarrus was awarded The Joint Commission's Gold Seal of Approval® for Advanced Certification in Spine Surgery by demonstrating continuous compliance with its performance standards. Only 15 hospitals in the U.S. currently hold this prestigious designation in spine surgery. Further, CMHA is one of the only health systems

in the nation to have multiple facilities earn The Joint Commission's distinguished Gold Seal designation in spine surgery.

- In 2020, Atrium Health Cabarrus received Platinum Recognition for its National Hospital Organ Donation Campaign from the United States Department of Health and Human Services Health Resources and Services Administration.

CMHA's commitment to providing quality care is further demonstrated by its Performance Improvement, Utilization, and Risk Management Plans included in Exhibits N.2-1 through N.2-3. As CMHA continues to expand its services, these plans will ensure that quality care is provided to all patients.

3) Access by medically underserved groups to the proposed services.

The proposed project will improve equitable access to acute care services in the service area. CMHA has long-promoted economic access to its services as it historically has provided services to all persons in need of medical care, regardless of race, color, religion, national origin, age, sex, sexual orientation, gender identity, gender expression, disability or source of payment as demonstrated in CMHA's Non-Discrimination policies provided in Exhibit C.6. The proposed project will continue to serve this population as dictated by the mission of CMHA, which is the foundation for every action taken. The mission is simple, but unique: *To improve health, elevate hope, and advance healing – for all*. This includes the medically underserved. CMHA's commitment to this mission is borne out not just in words but in service to patients.

The Department of Health and Human Services has recognized the need to ensure access to healthcare in as equitable a manner as possible. As noted on page 2 of the *2025 SMFP*, "[t]*he SHCC assigns the highest priority to a need methodology that favors providers delivering services to a patient population representative of all payer types in need of those services in the service area*." The proposed project seeks to address this principle by developing additional acute care bed capacity at Atrium Health Cabarrus. The total measurable community benefit attributable to the Advocate Health Enterprise is more than $6 billion annually, or $16.5 million per day, driven by financial assistance to uninsured patients, professional medical education and research, community-building activities including cash and in-kind contributions to community groups and community health improvement services, bad debt costs, and losses incurred by serving Medicare and Medicaid patients. Further, CMHA has made the recruitment and retention of bilingual staff members a priority at the medical center. CMHA provides financial incentives to employees who spend their time using a language skill and to employees who refer bilingual new hires. Please see Exhibit C.6 for CMHA's Non-Discrimination Policies, which include its Language Assistance Plan regarding patients who do not read or speak English. By expanding capacity for Atrium Health Cabarrus's acute care patients, the proposed project will enhance equitable access to these services in Cabarrus County. Further details about CMHA's ongoing efforts to promote healthcare access for ALL can be found in response to Gen-5.

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.

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)?

NA

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.

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 in Section Q for a list of all existing and approved facilities providing acute care services that are owned, operated or managed by CMHA or a related entity 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.

   The proposed project is motivated, in part, by the need to continue to provide high quality, efficient services. CMHA always strives to provide quality care; as such, CMHA has in place performance improvement, utilization, and risk management programs and policies as discussed below.

   A Quality Assessment and Performance Improvement Plan, Exhibit N.2-1, is in place to systematically monitor and evaluate patient care and clinical performance. This program is an ongoing, repetitive process involving medical and administrative staff and board members. As noted in its Quality Assessment and Performance Improvement Plan, CMHA's overall strategies for maintaining quality include:

   - Building upon world-class specialty service lines;
   - Delivering the primary care and on-demand services consumers want;
   - Creating the next generation regional network;
   - Improving the health of at-risk populations;
   - Enhancing community health and benefit in partnerships with others;
   - Improving value for teammates, their families, and for employer partners;
   - Delivering effectiveness and efficiency by practicing to the highest clinical standards;
   - Streamlining operations by identifying and minimizing the eight wastes;
   - Strengthening our integration as ONE System by reducing silos; and,
   - Ensuring healthcare access is achieved for ALL.

   In addition, as stated in the Quality Assessment and Performance Improvement Plan, the goals include:

   - Aligning with Enterprise goals and initiatives;
   - Measuring, improving, and sustaining the satisfaction and quality of services provided to all;
   - Identifying and improving systems and processes related to patient care, safety, and clinical processes including stakeholder (patient, staff, and regulatory) requirements, project goals, and improvement activities;
   - Creating effective systems to measure, assess, and improve the processes and outcomes associated with patient care;
   - Analyzing methods for identifying causes of variation and poor performance in the process(es);
   - Improving the overall understanding of continuous quality improvement tools and techniques within the organization; and,

- Analyzing and comparing peer and national benchmark data to internal data over time to identify levels of performance, patterns, trends, and variations;
- Identifying and reducing disparities in health outcomes.

Another tool for monitoring care is CMHA's Utilization Management (UM) Plan, included in Exhibit N.2-2. The purpose of the Utilization Management Plan is to address the operational procedures that will be followed with respect to the review of all patients. The current focus of the plan's scope includes but is not limited to:

- Review of professional services provided to determine medical necessity of those services and promotion of the most efficient use of available facility resources.
- Continuous evaluation of the availability of necessary diagnostic and therapeutic services to ensure timeliness of service delivery with appropriate frequency and intensity.
- Evaluation of over and underutilization of these services to ensure usage is effective and efficient.
- Provision of care and services that are medically necessary and prudent, with an emphasis on maintenance of the patient's rights and dignity.
- Optimize efficient resource utilization through integration and coordination within the interdisciplinary healthcare teams while maintaining optimal patient outcomes.
- Ongoing assessment and analysis to determine efficiency in resource management.
- Foster effective collaboration and communication between all members of the healthcare team to enhance quality in a cost efficient and safe environment.
- Enforce and ensure consistent compliance with all regulatory agencies and contractual agreements.
- Implement and monitor the effectiveness of educational programs provided to inform physicians and other members of the interdisciplinary team concerning optimal UM strategies, including alternative approaches to patient care, treatments, and current healthcare management guidelines.
- Perform specific medical record review audit to include, but not be limited to, determination and verification of the physician(s) intent regarding the patient type status, level of care provided, and review of patient care outcomes including response(s) to treatment.
- The Utilization Management Committee (UM Committee), which is responsible for overseeing processes related to the appropriate use of resources, setting and services, and ensuring compliance with State and Federal regulations. Additionally, the UM Committee provides oversight of policies and processes related to Health Information Management, including complete and accurate documentation, storage, and release of patient health information.

Finally, CMHA's Risk Management Plan, included in Exhibit N.2-3, states, "[t]*he purpose of the Corporate Risk Management program is to prevent and reduce the risk of injury to patients, visitors, team members and medical staff members and to protect the organization's financial resources*." A few of the overall objectives of the Risk Management Plan include:

- To provide a safe environment by:
    - preventing incidents involving patients, visitors, team members, and medical staff; and,
    - conducting risk assessments.
- To ensure the financial stability of the organization and minimize the frequency and severity of incidents by:
    - maintaining a systematic Corporate Risk Management reporting system to track the number of incidents and claims;
    - identifying and correcting in a timely manner any situation which could cause professional and general liability claims and/or lawsuits;
    - promptly investigating, reporting, and ensuring implementation of a plan of corrective action by the appropriate department;

- reducing the insurance costs to the hospital; and,
- maintaining confidentiality of all information.

- To educate staff about Corporate Risk Management and risk prevention by:
  - providing information to new team members about their responsibility in reporting unusual occurrences or incidents and in prevention of incidents;
  - providing Corporate Risk Management education during orientation and annual training; and,
  - offering departmental specific programs regarding relevant Risk Management issues.
- To assist Compliance with accrediting and regulatory agency requirements by:
  - providing assistance in coordinating activities with the Safety Officer, Patient Safety Officer, Corporate Compliance and Regulatory Compliance on compliance with local, state and federal safety regulations pertinent to the organization.
- To integrate Corporate Risk Management activities with performance improvement (PI) activities by:
  - communicating information to and participating in the Environment of Care, PI and Patient Safety Committees;
  - referring issues to administrative and medical staff departments for quality review;
  - communicating information as needed to the Pharmacy & Therapeutics Committee; and,
  - communicating information by reporting to the appropriate oversight committee to the Quality Department.

As demonstrated in the goals and objectives of the Quality Assessment and Performance Improvement Plan, the Utilization Management Plan, and the Risk Management Plan, Atrium Health Cabarrus has methods in place to ensure that quality care is provided to all patients. These plans will continue to guide the services provided by the facility, including the acute care services involved in this project. Please see the previously referenced Exhibit N.2-1 through Exhibit N.2-3 for a copy of each of these plans.

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;

  Please see the previously referenced Exhibit I.1 for a letter from Asha Rodriguez, Vice President and Facility Executive of Atrium Health Cabarrus, documenting that the existing facility currently meets all licensure requirements.

- Certified for participation in the Medicare Program;

  Please see the previously referenced Exhibit I.1 for a letter from Asha Rodriguez, Vice President and Facility Executive of Atrium Health Cabarrus, documenting that the existing facility is certified for participation in the Medicare program and that it currently meets all requirements for certification.

- Certified for participation in the Medicaid Program; and

  Please see the previously referenced Exhibit I.1 for a letter from Asha Rodriguez, Vice President and Facility Executive of Atrium Health Cabarrus, documenting that the existing facility is certified for participation in the Medicaid program and that it currently meets all requirements for certification.

- Accredited (identify the accrediting body).

Please see the previously referenced Exhibit I.1 for a letter from Asha Rodriguez, Vice President and Facility Executive of Atrium Health Cabarrus, documenting that the existing facility is currently accredited by The Joint Commission.

If any of the above are not applicable to the existing facility, briefly explain why it is not applicable.

Not applicable. Please see the response to Section O.3 above.

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).

Each of the facilities identified in Form O has continually maintained all relevant licensure, certification, and accreditation for the 18 months preceding the submission of this application.

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.

Not applicable. None of the facilities identified in Form O have had situations resulting in a finding of immediate jeopardy during the 18 month look-back period.

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. None of the facilities identified in Form O have had situations resulting in a finding of immediate jeopardy during the 18 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.

Not applicable. The proposed project is not a nursing facility project.

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.

Not applicable.

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.

Not applicable. The proposed project is not an adult care home, psychiatric facility, substance abuse disorder facility, or ICF-ID facility project.

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.

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)	03/01/2025
150 Days from 1st Day of Review (Projected Decision Date)	07/29/2025
35 Days from Projected Decision Date (1st date certificate may be issued)	09/02/2025

Fiscal Year for the Facility Identified in Section A, Question 4	**mm/dd** to **mm/dd** 01/01 to 12/31

Milestone		**Date** **mm/dd/yyyy**
1	Financing Obtained	NA
2	Drawings Completed	11/01/2028
3	Land Acquired	NA
4	Construction / Renovation Contract(s) Executed	01/01/2029
5	25% of Construction / Renovation Completed (25% of the cost is in place)	07/03/2029
6	50% of Construction / Renovation Completed	01/02/2030
7	75% of Construction / Renovation Completed	07/04/2030
8	Construction / Renovation Completed	01/03/2031
9	Equipment Ordered	06/03/2030
10	Equipment Installed	02/02/2031
11	Equipment Operational	04/04/2031
12	Building / Space Occupied	04/04/2031
13	Licensure Obtained	NA
14	**Services Offered** *	05/01/2031
15	Medicare and / or Medicaid Certification Obtained	NA
16	Facility or Service Accredited	NA

* Required

Form C.1a Historical and Interim Health Service Facility Bed Utilization Atrium Health Cabarrus (Main Campus)	Last Full FY F: 01/01/2023 T: 12/31/2023	Interim Full FY F: 01/01/2024 T: 12/31/2024	Interim Full FY F: 01/01/2025 T: 12/31/2025	Interim Full FY F: 01/01/2026 T: 12/31/2026	Interim Full FY F: 01/01/2027 T: 12/31/2027	Interim Full FY F: 01/01/2028 T: 12/31/2028	Interim Full FY F: 01/01/2029 T: 12/31/2029	Interim Full FY F: 01/01/2030 T: 12/31/2030
Acute Care Hospital - All Beds*								
Total # of Beds, including all types of beds	427	427	427	427	514	501	501	501
# of Discharges	28,027	29,572	30,790	31,818	32,881	33,154	33,093	33,356
# of Patient Days	139,559	149,482	154,476	159,638	164,972	167,419	168,679	171,186
Average Length of Stay	4.98	5.05	5.02	5.02	5.02	5.05	5.10	5.13
Occupancy Rate	89.5%	95.9%	99.1%	102.4%	87.9%	91.6%	92.2%	93.6%

*Excludes neonatal beds

F: = From

T: = To

Applicants may delete rows for types of beds not included in the proposal.

Applicants may delete Interim Full FY columns if not needed.

Form C.1b Projected Health Service Facility Bed Utilization upon Project Completion Atrium Health Cabarrus (Main Campus)	Partial FY F: 01/01/2031 T: 12/31/2031	1st Full FY F: 01/01/2032 T: 12/31/2032	2nd Full FY F: 01/01/2033 T: 12/31/2033	3rd Full FY F: 01/01/2034 T: 12/31/2034
Acute Care Hospital - All Beds*				
Total # of Beds, including all types of beds	627	627	627	627
# of Discharges	34,310	35,283	36,272	37,278
# of Patient Days	176,310	181,555	186,919	192,401
Average Length of Stay	5.14	5.15	5.15	5.16
Occupancy Rate	77.0%	79.3%	81.7%	84.1%

*Excludes neonatal beds

F: = From

T: = To

Applicants may delete rows for types of beds not included in the proposal.

Applicants may delete the Partial FY column if not needed.

Form C.1a Historical and Interim Health Service Facility Bed Utilization Atrium Health Harrisburg	Last Full FY F: 01/01/2023 T: 12/31/2023	Interim Full FY F: 01/01/2024 T: 12/31/2024	Interim Full FY F: 01/01/2025 T: 12/31/2025	Interim Full FY F: 01/01/2026 T: 12/31/2026	Interim Full FY F: 01/01/2027 T: 12/31/2027	Interim Full FY F: 01/01/2028 T: 12/31/2028	Interim Full FY F: 01/01/2029 T: 12/31/2029	Interim Full FY F: 01/01/2030 T: 12/31/2030
Acute Care Hospital - All Beds*								
Total # of Beds, including all types of beds						44	44	44
# of Discharges						826	2,022	2,933
# of Patient Days						3,065	7,501	10,881
Average Length of Stay						3.71	3.71	3.71
Occupancy Rate						19.1%	46.7%	67.8%

*Excludes neonatal beds

F: = From

T: = To

Applicants may delete rows for types of beds not included in the proposal.

Applicants may delete Interim Full FY columns if not needed.

Form C.1b Projected Health Service Facility Bed Utilization upon Project Completion Atrium Health Harrisburg	Partial FY F: 01/01/2031 T: 12/31/2031	1st Full FY F: 01/01/2032 T: 12/31/2032	2nd Full FY F: 01/01/2033 T: 12/31/2033	3rd Full FY F: 01/01/2034 T: 12/31/2034
Acute Care Hospital - All Beds*				
Total # of Beds, including all types of beds	44	44	44	44
# of Discharges	3,191	3,472	3,777	4,109
# of Patient Days	11,840	12,881	14,014	15,246
Average Length of Stay	3.71	3.71	3.71	3.71
Occupancy Rate	73.7%	80.2%	87.3%	94.9%

*Excludes neonatal beds

F: = From

T: = To

Applicants may delete rows for types of beds not included in the proposal.

Applicants may delete the Partial FY column if not needed.

Form C.1a Historical and Interim Health Service Facility Bed Utilization Atrium Health Cabarrus (License)	Last Full FY F: 01/01/2023 T: 12/31/2023	Interim Full FY F: 01/01/2024 T: 12/31/2024	Interim Full FY F: 01/01/2025 T: 12/31/2025	Interim Full FY F: 01/01/2026 T: 12/31/2026	Interim Full FY F: 01/01/2027 T: 12/31/2027	Interim Full FY F: 01/01/2028 T: 12/31/2028	Interim Full FY F: 01/01/2029 T: 12/31/2029	Interim Full FY F: 01/01/2030 T: 12/31/2030
Acute Care Hospital - All Beds*								
Total # of Beds, including all types of beds	427	427	427	427	514	545	545	545
# of Discharges	28,027	29,572	30,790	31,818	32,881	33,980	35,115	36,289
# of Patient Days	139,559	149,482	154,476	159,638	164,972	170,484	176,180	182,067
Average Length of Stay	4.98	5.05	5.02	5.02	5.02	5.02	5.02	5.02
Occupancy Rate	89.5%	95.9%	99.1%	102.4%	87.9%	85.7%	88.6%	91.5%

*Excludes neonatal beds

F: = From

T: = To

Applicants may delete rows for types of beds not included in the proposal.

Applicants may delete Interim Full FY columns if not needed.

Form C.1b Projected Health Service Facility Bed Utilization upon Project Completion Atrium Health Cabarrus (License)	Partial FY F: 01/01/2031 T: 12/31/2031	1st Full FY F: 01/01/2032 T: 12/31/2032	2nd Full FY F: 01/01/2033 T: 12/31/2033	3rd Full FY F: 01/01/2034 T: 12/31/2034
Acute Care Hospital - All Beds*				
Total # of Beds, including all types of beds	671	671	671	671
# of Discharges	37,501	38,754	40,049	41,387
# of Patient Days	188,150	194,437	200,933	207,647
Average Length of Stay	5.02	5.02	5.02	5.02
Occupancy Rate	76.8%	79.4%	82.0%	84.8%

*Excludes neonatal beds

F: = From

T: = To

Applicants may delete rows for types of beds not included in the proposal.

Applicants may delete the Partial FY column if not needed.

Form C Utilization – Assumptions and Methodology

As discussed in Section C.1, CMHA is proposing to develop 126 additional acute care beds at Atrium Health Cabarrus in response to a need determination for Cabarrus County in the *2025 State Medical Facilities Plan* (*2025 SMFP*). To be responsive to the performance standards in the Criteria and Standards for Acute Care Beds, CMHA is providing historical and projected utilization for Atrium Health Cabarrus as well as Atrium Health Harrisburg, an existing campus of Atrium Health Cabarrus, which was previously approved to develop 44 acute care beds – 31 new and 13 relocated from Atrium Health Cabarrus. As mentioned previously, given the State Health Coordinating Council (SHCC) removed Level II, III and IV neonatal beds and days of care from the acute care bed need methodology beginning with the *2023 SMFP*, this methodology excludes neonatal beds and patient days.

The proposed project is scheduled to be operational on May 1, 2031. CMHA's fiscal year corresponds to the Calendar Year. Therefore, the first three full fiscal years of the proposed project will be CY 2032, CY 2033, and CY 2034.

HISTORICAL UTILIZATION

According to internal data, acute care days at Atrium Health Cabarrus grew rapidly from CY 2019 to CY 2024 – at a compound annual growth rate (CAGR) of 6.7 percent – as shown in the table below.

Atrium Health Cabarrus (License) Historical Acute Care Bed Utilization

	CY19	*CY20*	*CY21*	*CY22*	*CY23*	*CY24**	*CY19-CY24 CAGR^*
Acute Care Days	108,174	107,346	126,417	137,388	139,559	149,482	6.7%
Average Daily Census	296	294	346	376	382	410	
Number of Acute Care Beds in Operation	427	427	427	427	427	427	
Occupancy	69.4%	68.9%	81.1%	88.2%	89.5%	95.9%	

Source: CMHA internal data
*CY 2024 acute care days are based on actual January – November utilization and annualized using historical seasonal utilization patterns from CY 2023.
^Compound annual growth rate

As a result, the occupancy rate of acute care beds at Atrium Health Cabarrus has grown substantially in recent years – from 69.4 percent in CY 2019 to 95.9 percent in CY 2024 – representing a total increase of **26.5 percentage points** over the five-year period.

PROJECTED UTILIZATION

<u>Atrium Health Cabarrus License</u>

CMHA conservatively projects that total acute care days on the Atrium Health Cabarrus license will grow at a compound annual growth rate of 3.3 percent, representing half of the historical 6.7 percent CAGR demonstrated previously. CMHA believes this growth rate is reasonable for several reasons. First, the *2025 SMFP* establishes a significantly higher growth rate multiplier of 7.58 percent for Cabarrus County, which is based solely on Atrium Health Cabarrus's acute care utilization. Second, historical projections based on population growth have proven overly conservative for this facility. For example, current

volumes at Atrium Health Cabarrus are already nearing levels originally projected for CY 2027 in the 2024 Atrium Health Harrisburg acute care bed application (Project ID # F-012505-24). Lastly, the proposed addition of 126 beds will provide the necessary capacity to support even more growth in the future. For all of these reasons, CMHA decided that half of the CY 2019 to CY 2024 historical CAGR would strike an appropriate balance between conservative forecasting and reasonable growth expectations.

The table below summarizes the projected acute care utilization for the entire Atrium Health Cabarrus License which includes the main campus and the Atrium Health Harrisburg campus.

Atrium Health Cabarrus (License)
Projected Acute Care Bed Utilization

	CY24*	***CY25***	***CY26***	***CY27***	***CY28***	***CY29***	***CY30***	***CY31***	***CY32***	***CY33***	***CY34***
Acute Care Days	149,482	154,476	159,638	164,972	170,484	176,180	182,067	188,150	194,437	200,933	207,647
Average Daily Census	410	423	437	452	467	483	499	515	533	551	569
Acute Care Beds	427	427	427	514^	545^^	545	545	671^^^	671	671	671
Occupancy	95.9%	99.1%	102.4%	87.9%	85.7%	88.6%	91.5%	76.8%	79.4%	82.0%	84.8%

*CY 2024 acute care days are based on actual January – November utilization and annualized using historical seasonal utilization patterns from CY 2023.
^Includes the addition of 22 acute care beds approved pursuant to Project ID # F-012116-21 (operational July 1, 2027) and 65 acute care beds approved pursuant to Project ID # F-012367-23 (operational July 1, 2027) at the main campus.
^^Includes the addition of 31 acute care beds approved pursuant to Project ID # F-012505-24 (operational May 1, 2028) at the Atrium Health Harrisburg campus.
^^^Includes the addition of 126 acute care beds proposed in this application (projected operational May 1, 2031).

As shown above, the 671 acute care beds included on the Atrium Health Cabarrus license are expected to operate at 84.8 percent occupancy in CY 2034 (the third full fiscal year for the proposed project). Under the performance standards in the Criteria and Standards for Acute Care Beds, the total license will have a target occupancy rate of 78.0 percent in CY 2034 based on an ADC that is greater than 400 patients. The license is projected to exceed this target occupancy rate in CY 2032, the first full fiscal year of the proposed project, through CY 2034, the third full fiscal year of the proposed project.

Atrium Health Harrisburg Campus

The Atrium Health Harrisburg campus will expand its existing services through the addition of 44 acute care beds beginning May 1, 2028. The acute care days projected to shift to the Atrium Health Harrisburg campus from the Atrium Health Cabarrus main campus are based on the shifts projected in the 2024 Atrium Health Harrisburg acute care bed change of scope application (Project ID # F-012505-24). That application, which included forecasts through CY 2031, recently received Agency approval, with the Agency specifically noting that the projections were "reasonable and adequately supported." CMHA extended these projections through CY 2034 by applying a compound annual growth rate of 8.8 percent, which represents the effective growth rate in acute care days at Atrium Health Harrisburg based on the methodology to shift appropriate patients as outlined in that application. Projected acute care utilization at the Atrium Health Harrisburg campus is included in the table below.

Atrium Health Harrisburg
Projected Acute Care Bed Utilization

	*CY28**	*CY29*	*CY30*	*CY31*	*CY32*	*CY33*	*CY34*
Acute Care Days	3,065	7,501	10,881	11,840	12,881	14,014	15,246
Average Daily Census	8	21	30	32	35	38	42
Acute Care Beds	44	44	44	44	44	44	44
Occupancy	19.1%	46.7%	67.8%	73.7%	80.2%	87.3%	94.9%

Source: Project ID # F-012505-24
*Atrium Health Harrisburg will open 44 acute care beds on May 1, 2028 (partial year of operation).

Please note that 100 percent of the acute care days at Atrium Health Harrisburg are projected to shift from Atrium Health Cabarrus's main campus. Thus, the 8.8 percent growth rate represents the continued growth in shifted days from the main campus and has no impact on the growth of total acute care days at Atrium Health Cabarrus. In fact, a higher growth rate at Atrium Health Harrisburg is more conservative in terms of the main campus projections as it implies a greater shift and less days overall at the main campus. This growing shift of acuity-appropriate patients to Atrium Health Harrisburg is in line with CMHA's goal to provide more convenient access to care in the Harrisburg service area.

Atrium Health Cabarrus Main Campus

To determine the projected number of days to be served at the main campus, CMHA subtracted the total number of acute care days projected at Atrium Health Harrisburg from the total number of acute care days projected for the Atrium Health Cabarrus license overall. The following table summarizes projected acute care bed utilization at Atrium Health Cabarrus's main campus.

Atrium Health Cabarrus (Main Campus)
Projected Acute Care Bed Utilization

	*CY24**	*CY25*	*CY26*	*CY27*	*CY28*	*CY29*	*CY30*	*CY31*	*CY32*	*CY33*	*CY34*
Acute Care Days	149,482	154,476	159,638	164,972	167,419	168,679	171,186	176,310	181,555	186,919	192,401
Average Daily Census	410	423	437	452	459	462	469	483	497	512	527
Acute Care Beds	427	427	427	514^	501^^	501	501	627^^^	627	627	627
Occupancy	95.9%	99.1%	102.4%	87.9%	91.6%	92.2%	93.6%	77.0%	79.3%	81.7%	84.1%

*CY 2024 acute care days are based on actual January – November utilization and annualized using historical seasonal utilization patterns from CY 2023.
^Includes the addition of 22 acute care beds approved pursuant to Project ID # F-012116-21 (operational July 1, 2027) and 65 acute care beds approved pursuant to Project ID # F-012367-23 (operational July 1, 2027) at Atrium Health Cabarrus (Main Campus).
^^Excludes the 13 acute care beds approved to relocate from the main campus to the Atrium Health Harrisburg campus pursuant to Project ID # F-012505-24 (on May 1, 2028).
^^^Includes the addition of 126 acute care beds proposed in this application (projected operational May 1, 2031).

As shown above, Atrium Health Cabarrus's main campus is expected to operate at 84.1 percent occupancy in CY 2034 (the third full fiscal year of the proposed project). Under the performance standards in the Criteria and Standards for Acute Care Beds, the main campus will have a target occupancy rate of 78.0 percent in CY 2034 based on an ADC that is greater than 400 patients. The main campus is projected to exceed this target occupancy rate in CY 2032, the first full fiscal year of the proposed project, through CY

2034, the third full fiscal year of the proposed project. Notably, even with the additional acute care bed capacity that will be developed in CY 2027 and CY 2028, the main campus is projected to maintain occupancy rates above 90 percent through CY 2029. By CY 2032, the first full fiscal year of the proposed project, the main campus is expected to operate at 79.3 percent occupancy, already exceeding the target occupancy rate of 78 percent.

PROJECTED DISCHARGES

Atrium Health Cabarrus has maintained a fairly consistent average length of stay (ALOS) over the past two years, averaging 5.02 days, as shown in the table below.

Historical ALOS at Atrium Health Cabarrus

	CY23	***CY24****
Acute Care Days	139,559	149,482
Discharges	28,027	29,572
ALOS	4.98	5.05
Average ALOS	**5.02**	

*CY 2024 acute care days are based on actual January – November utilization and annualized using historical seasonal utilization patterns from CY 2023.

CMHA chose to calculate projected discharges for the license based on this average of 5.02 days. The projected ALOS for the Atrium Health Harrisburg campus is 3.71 days per Project ID # F-012505-24. The main campus's projected discharges are based on the total license discharges (calculated using the 5.02 ALOS), less the projected Harrisburg discharges (calculated using the 3.71 ALOS). As lower-acuity patients (with an ALOS of 3.71 days) shift to Harrisburg, the ALOS at the main campus will naturally increase as the remaining patient mix will include a greater proportion of higher-acuity cases, maintaining the projected ALOS of 5.02 days for the overall license. Please see forms C.1a and C.1b.

Form F.1a Capital Cost	Column B	Column C	Column D	Column E
	Applicant 1 The Charlotte-Mecklenburg Hospital Authority	Applicant 2 Insert Name Here *	Applicant 3 Insert Name Here *	Total (Sum of Columns B-D)
Building Purchase Price[a]	$ -			$0
Purchase Price of Land[a]	$ -			$0
Closing Costs[a]	$ -			$0
Site Preparation[a]	$ -			$0
Construction/Renovation Contract(s)[b]	$ 132,581,000			$132,581,000
Landscaping[a]	$ -			$0
Architect / Engineering Fees[c]	$ 8,411,000			$8,411,000
Medical Equipment[d]	$ 18,721,000			$18,721,000
Non Medical Equipment[e]	$ 537,000			$537,000
Furniture[f]	$ 2,776,000			$2,776,000
Consultant Fees (CON Fees and Legal Fees)[g]	$ 300,000			$300,000
Financing Costs[h]	$ 908,528			$908,528
Interest during Construction[i]	$ 10,053,762			$10,053,762
Other (IS, Security, Internal Allocation)[j]	$ 34,180,000			$34,180,000
Total Capital Cost	$208,468,290	$0	$0	$208,468,290

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

Form F.1a Assumptions

a Not applicable.

b Construction and renovation contract costs are based on the experience of the project architect with similar projects.

c Architect and engineering fees are based on the experience of the project architect with similar projects.

d Medical equipment costs are based on vendor estimates and the experience of CMHA with similar projects. Costs include associated freight and sales tax.

e Non-medical equipment costs are based on vendor estimates and the experience of CMHA with similar projects.

f Furniture costs are based on the vendor estimates and the experience of CMHA with similar projects.

g Consultant fees include CON fees and legal fees and are based on the experience of CMHA with similar projects.

h CMHA expects to fund the project with accumulated reserves, but has conservatively included financing costs in the event that the project is funded with bond financing. Financing costs are based on the experience of CMHA considering expected future interest rates.

i CMHA expects to fund the project with accumulated reserves, but has conservatively included interest during construction in the event that the project is funded with bond financing. Interest during construction costs are based on the experience of CMHA considering expected future interest rates.

j Other costs include IS, security, and internal allocation and are based on the experience of CMHA with similar projects.

Form F.2a Historical and Interim Revenues and Net Income Atrium Health Cabarrus (Total License)	Last Full FY F: 01/01/2023 T: 12/31/2023	Interim Full FY F: 01/01/2024 T: 12/31/2024	Interim Full FY F: 01/01/2025 T: 12/31/2025	Interim Full FY F: 01/01/2026 T: 12/31/2026	Interim Full FY F: 01/01/2027 T: 12/31/2027	Interim Full FY F: 01/01/2028 T: 12/31/2028	Interim Full FY F: 01/01/2029 T: 12/31/2029	Interim Full FY F: 01/01/2030 T: 12/31/2030
Patient Services Gross Revenue[a]								
Self Pay	$179,348,739	$188,333,062	$197,767,448	$207,674,440	$218,077,715	$229,002,133	$240,473,801	$252,520,132
Insurance *	$1,121,310,167	$1,177,481,249	$1,236,466,174	$1,298,405,899	$1,363,448,441	$1,431,749,235	$1,503,471,498	$1,578,786,628
Medicare *	$1,840,799,817	$1,933,013,123	$2,029,845,776	$2,131,529,179	$2,238,306,325	$2,350,432,383	$2,468,175,300	$2,591,816,449
Medicaid *	$515,833,943	$541,674,207	$568,808,917	$597,302,917	$627,224,300	$658,644,569	$691,638,811	$726,285,870
Other (Workers Comp/Other Govt.)	$141,798,205	$148,901,466	$156,360,558	$164,193,308	$172,418,433	$181,055,588	$190,125,414	$199,649,585
Total Patient Services Gross Revenue	$3,799,090,871	$3,989,403,107	$4,189,248,872	$4,399,105,742	$4,619,475,214	$4,850,883,908	$5,093,884,824	$5,349,058,665
Other Revenue (1)[b]	$16,637,237	$17,136,355	$17,650,445	$18,179,958	$18,725,357	$19,287,118	$19,865,732	$20,461,703
Total Gross Revenue (2)	$3,815,728,108	$4,006,539,461	$4,206,899,318	$4,417,285,701	$4,638,200,572	$4,870,171,026	$5,113,750,555	$5,369,520,368
Adjustments to Revenue								
Charity Care[c]	$115,500,323	$121,286,213	$127,361,943	$133,742,032	$140,441,726	$147,477,035	$154,864,772	$162,622,591
Bad Debt[d]	$101,360,624	$106,438,198	$111,770,130	$117,369,159	$123,248,668	$129,422,706	$135,906,026	$142,714,123
Contractual Adjustments[c]	$2,715,384,271	$2,851,409,143	$2,994,248,066	$3,144,242,384	$3,301,750,540	$3,467,148,934	$3,640,832,820	$3,823,217,252
Total Adjustments to Revenue	$2,932,245,217	$3,079,133,555	$3,233,380,139	$3,395,353,576	$3,565,440,934	$3,744,048,674	$3,931,603,618	$4,128,553,967
Total Net Revenue (3)	$883,482,891	$927,405,906	$973,519,178	$1,021,932,125	$1,072,759,638	$1,126,122,352	$1,182,146,938	$1,240,966,401
Total Operating Costs (from Form F.3.b)	$707,035,918	$741,490,797	$777,642,759	$815,575,951	$860,963,371	$908,184,357	$951,833,195	$997,638,682
Net Income (4)	$176,446,973	$185,915,109	$195,876,420	$206,356,175	$211,796,267	$217,937,994	$230,313,743	$243,327,719

*** Including any managed care plans**
F: = From
T: = To

(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

Applicants may delete Interim Full FY columns if not needed.

Form F.2b Projected Revenues and Net Income upon Project Completion Atrium Health Cabarrus (Total License)	Partial FY F: 01/01/2031 T: 12/31/2031	1st Full FY F: 01/01/2032 T: 12/31/2032	2nd Full FY F: 01/01/2033 T: 12/31/2033	3rd Full FY F: 01/01/2034 T: 12/31/2034
Patient Services Gross Revenue[a]				
Self Pay	$265,169,914	$278,453,376	$292,402,262	$307,049,905
Insurance *	$1,657,874,606	$1,740,924,428	$1,828,134,561	$1,919,713,412
Medicare *	$2,721,651,296	$2,857,990,110	$3,001,158,701	$3,151,499,201
Medicaid *	$762,668,545	$800,873,779	$840,992,872	$883,121,697
Other (Workers Comp/Other Govt.)	$209,650,862	$220,153,144	$231,181,529	$242,762,372
Total Patient Services Gross Revenue	$5,617,015,223	$5,898,394,837	$6,193,869,925	$6,504,146,587
Other Revenue (1)[b]	$21,075,555	$21,707,821	$22,359,056	$23,029,827
Total Gross Revenue (2)	$5,638,090,777	$5,920,102,658	$6,216,228,981	$6,527,176,414
Adjustments to Revenue				
Charity Care[c]	$170,769,032	$179,323,562	$188,306,624	$197,739,684
Bad Debt[d]	$149,863,266	$157,370,540	$165,253,883	$173,532,136
Contractual Adjustments[c]	$4,014,738,079	$4,215,852,978	$4,427,042,558	$4,648,811,501
Total Adjustments to Revenue	$4,335,370,377	$4,552,547,080	$4,780,603,065	$5,020,083,322
Total Net Revenue (3)	$1,302,720,400	$1,367,555,579	$1,435,625,915	$1,507,093,092
Total Operating Costs (from Form F.3.b)	$1,057,455,165	$1,113,540,537	$1,166,189,748	$1,221,445,433
Net Income (4)	$245,265,235	$254,015,042	$269,436,167	$285,647,659

*** Including any managed care plans**
F: = From
T: = To

(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.3a Historial and Interim Operating Costs Atrium Health Cabarrus (Total License)	Last Full FY F: 01/01/2023 T: 12/31/2023	Interim Full FY F: 01/01/2024 T: 12/31/2024	Interim Full FY F: 01/01/2025 T: 12/31/2025	Interim Full FY F: 01/01/2026 T: 12/31/2026	Interim Full FY F: 01/01/2027 T: 12/31/2027	Interim Full FY F: 01/01/2028 T: 12/31/2028	Interim Full FY F: 01/01/2029 T: 12/31/2029	Interim Full FY F: 01/01/2030 T: 12/31/2030
Salaries (from Form H Staffing)[a]	$314,072,317	$329,805,503	$346,326,830	$363,675,779	$381,893,809	$401,024,456	$421,113,436	$442,208,756
Taxes and Benefits[b]	$68,663,282	$72,102,911	$75,714,846	$79,507,717	$83,490,588	$87,672,978	$92,064,882	$96,676,794
Independent Contractors (Consultants) (1)[c]	$68,946,151	$72,399,950	$76,026,764	$79,835,260	$83,834,540	$88,034,160	$92,444,156	$97,075,068
Medical Supplies[c]	$123,732,111	$129,930,366	$136,439,117	$143,273,919	$150,451,105	$157,987,825	$165,902,091	$174,212,816
Other Supplies[c]	$19,494,007	$20,470,542	$21,495,997	$22,572,820	$23,703,587	$24,890,998	$26,137,891	$27,447,247
Dietary (2) (incl. in Other Supplies)	$0	$0	$0	$0	$0	$0	$0	$0
Housekeeping / Laundry (2) (incl. in Other Supplies)	$0	$0	$0	$0	$0	$0	$0	$0
Equipment Maintenance (2) (incl. in Independent Contractors (Consultants))	$0	$0	$0	$0	$0	$0	$0	$0
Building & Grounds Maintenance (2) (incl. in Central Office Overhead)	$0	$0	$0	$0	$0	$0	$0	
Central Office Overhead[d]	$21,893,799	$22,990,550	$24,142,242	$25,351,627	$26,621,595	$27,955,182	$29,355,573	$30,826,115
Professional Fees[e]	$0	$0	$0	$0	$0	$0	$0	$0
Utilities (incl. in Central Office Overhead)	$0	$0	$0	$0	$0	$0	$0	$0
Insurance[c]	$6,050,063	$6,353,136	$6,671,391	$7,005,589	$7,356,528	$7,725,047	$8,112,026	$8,518,391
Interest Expense[f]	$9,374,677	$9,655,917	$9,945,594	$10,243,962	$12,821,867	$15,280,257	$15,430,418	$15,585,156
Rental Expense[c]	$2,714,995	$2,851,000	$2,993,819	$3,143,792	$3,301,277	$3,466,652	$3,640,311	$3,822,669
Depreciation - Buildings[g]	$8,592,595	$8,850,373	$9,115,884	$9,389,361	$12,069,529	$14,758,146	$15,056,981	$15,364,781
Depreciation - Equipment[h]	$29,981,322	$30,880,761	$31,807,184	$32,761,400	$34,659,831	$36,587,748	$37,630,445	$38,704,423
Other Expenses[c]	$33,520,601	$35,199,787	$36,963,090	$38,814,725	$40,759,115	$42,800,909	$44,944,984	$47,196,465
Total Expenses	$707,035,918	$741,490,797	$777,642,759	$815,575,951	$860,963,371	$908,184,357	$951,833,195	$997,638,682

F: = From

T: = To

(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.

Applicants may add rows for costs that are not listed.

Applicants may delete rows for costs that are not applicable to the type of facility identified in Section A, Question 4.b.

Applicants may delete Interim Full FY columns if not needed.

Form F.3b Projected Operating Costs upon Project Completion Atrium Health Cabarrus (Total License)	Partial FY F: 01/01/2031 T: 12/31/2031	1st Full FY F: 01/01/2032 T: 12/31/2032	2nd Full FY F: 01/01/2033 T: 12/31/2033	3rd Full FY F: 01/01/2034 T: 12/31/2034
Salaries (from Form H Staffing)[a]	$464,360,829	$487,622,591	$512,049,631	$537,700,323
Taxes and Benefits[b]	$101,519,736	$106,605,281	$111,945,582	$117,553,401
Independent Contractors (Consultants) (1)[c]	$101,937,961	$107,044,457	$112,406,758	$118,037,679
Medical Supplies[c]	$182,939,859	$192,104,076	$201,727,367	$211,832,728
Other Supplies[c]	$28,822,193	$30,266,017	$31,782,167	$33,374,268
Dietary (2) (incl. in Other Supplies)	$0	$0	$0	$0
Housekeeping / Laundry (2) (incl. in Other Supplies)	$0	$0	$0	$0
Equipment Maintenance (2) (incl. in Independent Contractors (Consultants))	$0	$0	$0	$0
Building & Grounds Maintenance (2) (incl. in Central Office Overhead)	$0	$0	$0	$0
Central Office Overhead[d]	$32,370,323	$33,991,887	$35,694,682	$37,482,777
Professional Fees[e]	$0	$0	$0	$0
Utilities (incl. in Central Office Overhead)	$0	$0	$0	$0
Insurance[c]	$8,945,113	$9,393,211	$9,863,756	$10,357,872
Interest Expense[f]	$21,250,359	$23,933,778	$23,812,429	$23,684,396
Rental Expense[c]	$4,014,163	$4,215,249	$4,426,408	$4,648,145
Depreciation - Buildings[g]	$19,824,800	$22,222,837	$22,559,179	$22,905,611
Depreciation - Equipment[h]	$41,909,097	$44,097,718	$45,271,283	$46,480,054
Other Expenses[c]	$49,560,732	$52,043,435	$54,650,506	$57,388,177
Total Expenses	$1,057,455,165	$1,113,540,537	$1,166,189,748	$1,221,445,433

F: = From

T: = To

(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.

Applicants may add rows for costs that are not listed.

Applicants may delete rows for costs that are not applicable to the type of facility identified in Section A, Question 4.b.

CMHA's Financial Planning department provided the data used to develop Forms F.2 and F.3, which were obtained from internal reporting systems and include actual historical data and financial results for the total facility, Atrium Health Cabarrus (License) through the calendar year (CY) ending 12/31/2023, which is the last full calendar year for which financial data is available during the preparation of this application. Financial projections for Atrium Health Cabarrus (License) include all licensed beds at Atrium Health Cabarrus (including the Main Campus and Atrium Health Harrisburg Campus).

The projected financial statements assume 3.0 percent annual inflation based on expected annual inflation.

Form F.2 Atrium Health Cabarrus License Assumptions

a Patient Services Gross Revenue is based on the CY 2023 payor mix and charges, inflated 3.0 percent annually and applied to projected volume increases. Projected payor mix is based on the CY 2023 payor mix. Charges reflect a projected 2.0% increase in facility utilization, equal to that of the projected population growth of Cabarrus County. With the expansion of Medicaid coverage in North Carolina that began in December 2023, preliminary 2024 data indicates that the anticipated payor mix shift is occurring, with some patients previously classified as Self-Pay transitioning to Medicaid coverage. While this transition is ongoing, CMHA utilizes the historical 2023 payor mix data in this application as it represents the last complete fiscal year of data at the time of preparation of this application and provides a conservative baseline. This approach ensures that CMHA's projections account for the maximum potential volume of Self-Pay patients, who, along with Medicaid patients, are considered underserved population. As both Medicaid and Self-Pay are considered underserved, CMHA demonstrates that patients from both categories will continue to have access to the proposed services in conformity with Criterion (13)c, regardless of the yet-to-be-determined future shift between the two categories. Until there is greater clarity to guide the specific shift between Self-Pay and Medicaid, CMHA has assumed that the payor mix will be consistent with the historical payor mix assumptions above.

b Other Revenue is based on the CY 2023 Other Revenue, inflated 3.0 percent annually through the third project year.

c Contractual Adjustments are the difference between gross and net revenue for the facility. Charity care is the difference between gross and net revenue for self pay. Contractual adjustments by payor are based on CY 2023 experience for the license.

d Bad debt is based on the license's CY 2023 bad debt percentage of total patient services gross revenue, applied to total gross revenue.

Form F.3 Atrium Health Cabarrus License Assumptions

a Form H only includes those FTE's for the service component. Total Salaries for the entire facility are grown proportionally to facility utilization and inflated by 3.0 percent annually.

b Taxes and Benefits expense is based on the CY 2023 experience for the license as a percent of Salaries applied to projected Salaries (excluding contracted Temporary Help), assuming that this percentage will remain constant through the third project year.

c Independent Contractors (Consultants)(includes Equipment Maintenance), Medical Supplies, Other Supplies (includes Dietary, Housekeeping / Laundry), Insurance, Rental Expense, and Other Expenses, are based on the Atrium Health Cabarrus (license) CY 2023 expense and are grown proportionally to facility utilization and inflated by 3.0 percent annually.

d Central Office Overhead expense is based on the historical estimate of all allocated overhead expenses for the Atrium Health Cabarrus (License) as 2.5 percent of net revenue. Central Office Overhead expense includes all Atrium Health Cabarrus corporate overhead, building and grounds maintenance, utilities, registration, scheduling, billing, and all other costs necessary to provide the services. While the allocation methodology appears to produce different Central Office Overhead percentages for the license and service component, this is due to insurance and other expenses able to be reported separately at the license level. In contrast, these items are incorporated into the Central Office Overhead at the service component level.

e Atrium Health Cabarrus Hospital does not bill patients for professional fees for the proposed acute care bed service. Any professional fees associated with other services at Atrium Health Cabarrus are included in Independent Contractors (Consultants).

f Interest Expense is based on the CY 2023 Atrium Health Cabarrus experience, inflated 3.0 percent annually through the third project year. In addition, CMHA expects to fund the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23) with accumulated reserves, but has conservatively included interest expense in the event that the project is funded with bond financing. Interest expense for the previously approved projects are based on the respective applications. Interest expense for the proposed project is based on the project cost, assuming a 4.0 percent interest rate based on CMHA's current weighted average cost of capital.

g Depreciation-Building is based on the CY 2023 Atrium Health Cabarrus experience, inflated 3.0 percent annually through the third project year. Depreciation - Buildings also includes building depreciation expense for the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23). Depreciation - Buildings is calculated using the straight line method of depreciation over a useful life of 30 years.

h Depreciation-Equipment is based on the CY 2023 Atrium Health Cabarrus experience, inflated 3.0 percent annually through the third project year. Depreciation - Equipment also includes equipment depreciation expense for the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23). Depreciation - Equipment is calculated using the straight line method of depreciation over a useful life of seven years.

Form F.2a Historical and Interim Revenues and Net Income	Last Full FY	Interim Full FY	Interim Full FY	Interim Full FY	Interim Full FY	Interim Full FY	Interim Full FY	Interim Full FY
	F: 01/01/2023	F: 01/01/2024	F: 01/01/2025	F: 01/01/2026	F: 01/01/2027	F: 01/01/2028	F: 01/01/2029	F: 01/01/2030
Atrium Health Cabarrus (Main Campus) Acute Care Beds	T: 12/31/2023	T: 12/31/2024	T: 12/31/2025	T: 12/31/2026	T: 12/31/2027	T: 12/31/2028	T: 12/31/2029	T: 12/31/2030
Patient Services Gross Revenue[a]								
Self Pay	$20,124,616	$22,202,170	$23,632,318	$25,154,588	$26,774,916	$27,987,243	$29,043,860	$30,359,720
Insurance *	$126,753,149	$139,838,442	$148,846,105	$158,433,995	$168,639,486	$176,275,224	$182,930,232	$191,218,066
Medicare *	$325,332,952	$358,918,526	$382,038,185	$406,647,091	$432,841,175	$452,439,562	$469,520,743	$490,792,842
Medicaid *	$70,599,073	$77,887,331	$82,904,426	$88,244,697	$93,928,960	$98,181,919	$101,888,631	$106,504,796
Other (Workers Comp/Other Govt.)	$21,010,853	$23,179,897	$24,673,025	$26,262,333	$27,954,015	$29,219,730	$30,322,877	$31,696,685
Total Patient Services Gross Revenue	$563,820,642	$622,026,366	$662,094,059	$704,742,704	$750,138,552	$784,103,678	$813,706,343	$850,572,109
Other Revenue (1)[b]								
Total Gross Revenue (2)	$563,820,642	$622,026,366	$662,094,059	$704,742,704	$750,138,552	$784,103,678	$813,706,343	$850,572,109
Adjustments to Revenue								
Charity Care[c]	$20,021,073	$22,087,937	$23,510,727	$25,025,165	$26,637,156	$27,843,246	$28,894,426	$30,203,516
Bad Debt[d]	$15,042,865	$16,595,807	$17,664,823	$18,802,698	$20,013,870	$20,920,068	$21,709,874	$22,693,461
Contractual Adjustments[c]	$398,405,011	$439,534,140	$467,846,636	$497,982,875	$530,060,334	$554,060,655	$574,978,389	$601,028,350
Total Adjustments to Revenue	$433,468,949	$478,217,885	$509,022,186	$541,810,739	$576,711,360	$602,823,968	$625,582,688	$653,925,327
Total Net Revenue (3)	$130,351,694	$143,808,481	$153,071,873	$162,931,965	$173,427,192	$181,279,710	$188,123,655	$196,646,782
Total Operating Costs (from Form F.3.b)	$129,548,350	$139,576,952	$147,459,926	$156,896,230	$172,523,164	$185,508,472	$191,904,036	$199,893,939
Net Income (4)	$803,344	$4,231,530	$5,611,947	$6,035,735	$904,028	($4,228,762)	($3,780,381)	($3,247,157)

*** Including any managed care plans**
F: = From
T: = To

(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

Applicants may delete Interim Full FY columns if not needed.

Form F.2b Projected Revenues and Net Income upon Project Completion Atrium Health Cabarrus (Main Campus) Acute Care Beds	Partial FY F: 01/01/2031 T: 12/31/2031	1st Full FY F: 01/01/2032 T: 12/31/2032	2nd Full FY F: 01/01/2033 T: 12/31/2033	3rd Full FY F: 01/01/2034 T: 12/31/2034
Patient Services Gross Revenue[a]				
Self Pay	$32,206,566	$34,159,702	$36,224,006	$38,404,875
Insurance *	$202,850,264	$215,151,919	$228,153,762	$241,889,777
Medicare *	$520,648,804	$552,223,039	$585,594,423	$620,850,179
Medicaid *	$112,983,707	$119,835,493	$127,077,270	$134,727,967
Other (Workers Comp/Other Govt.)	$33,624,861	$35,664,008	$37,819,219	$40,096,128
Total Patient Services Gross Revenue	$902,314,203	$957,034,161	$1,014,868,680	$1,075,968,926
Other Revenue (1)[b]				
Total Gross Revenue (2)	$902,314,203	$957,034,161	$1,014,868,680	$1,075,968,926
Adjustments to Revenue				
Charity Care[c]	$32,040,860	$33,983,946	$36,037,630	$38,207,278
Bad Debt[d]	$24,073,952	$25,533,893	$27,076,931	$28,707,100
Contractual Adjustments[c]	$637,590,171	$676,256,200	$717,123,030	$760,297,476
Total Adjustments to Revenue	$693,704,983	$735,774,040	$780,237,591	$827,211,854
Total Net Revenue (3)	$208,609,220	$221,260,122	$234,631,089	$248,757,072
Total Operating Costs (from Form F.3.b)	$222,900,074	$240,450,289	$252,751,413	$265,755,255
Net Income (4)	($14,290,854)	($19,190,167)	($18,120,324)	($16,998,184)

*** Including any managed care plans**
F: = From
T: = To

(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.3a Historial and Interim Operating Costs Atrium Health Cabarrus (Main Campus) Acute Care Beds	Last Full FY F: 01/01/2023 T: 12/31/2023	Interim Full FY F: 01/01/2024 T: 12/31/2024	Interim Full FY F: 01/01/2025 T: 12/31/2025	Interim Full FY F: 01/01/2026 T: 12/31/2026	Interim Full FY F: 01/01/2027 T: 12/31/2027	Interim Full FY F: 01/01/2028 T: 12/31/2028	Interim Full FY F: 01/01/2029 T: 12/31/2029	Interim Full FY F: 01/01/2030 T: 12/31/2030
Salaries (from Form H Staffing)[a]	$94,453,648	$100,170,521	$105,310,975	$112,094,558	$119,315,105	$124,717,510	$129,426,034	$135,289,808
Taxes and Benefits[b]	$15,627,452	$18,054,443	$19,482,062	$20,736,995	$22,072,764	$23,072,185	$23,943,241	$25,028,013
Independent Contractors (Consultants) (1)[c]	$587,308	$647,939	$689,676	$734,101	$781,388	$816,768	$847,604	$886,005
Medical Supplies[c]	$8,631,124	$9,522,154	$10,135,521	$10,788,399	$11,483,331	$12,003,279	$12,456,445	$13,020,796
Other Supplies[c]	$1,878,114	$2,072,000	$2,205,468	$2,347,532	$2,498,748	$2,611,888	$2,710,495	$2,833,297
Dietary (2) (incl. in Other Supplies)	$0	$0	$0	$0	$0	$0	$0	$0
Housekeeping / Laundry (2) (incl. in Other Supplies)	$0	$0	$0	$0	$0	$0	$0	$0
Equipment Maintenance (2) (incl. in Independent Contractors (Consultants))	$0	$0	$0	$0	$0	$0	$0	$0
Building & Grounds Maintenance (2) (incl. in Central Office Overhead)	$0	$0	$0	$0	$0	$0	$0	
Central Office Overhead[d]	$6,517,585	$7,190,424	$7,653,594	$8,146,598	$8,671,360	$9,063,986	$9,406,183	$9,832,339
Professional Fees[e]	$0	$0	$0	$0	$0	$0	$0	$0
Utilities (incl. in Central Office Overhead)	$0	$0	$0	$0	$0	$0	$0	$0
Insurance (incl. in Central Office Overhead)	$0	$0	$0	$0	$0	$0	$0	$0
Interest Expense[f]	$0	$0	$0	$0	$2,270,586	$4,412,438	$4,236,564	$4,055,486
Rental Expense (incl. in Other Expenses)	$0	$0	$0	$0	$0	$0	$0	$0
Property and Other Taxes (except Income) (incl. in Central Office Overhead)	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation - Buildings[g]	$939,538	$967,725	$996,756	$1,026,659	$3,455,946	$5,886,156	$5,918,831	$5,952,487
Depreciation - Equipment[h]	$766,692	$789,693	$813,384	$837,785	$1,778,508	$2,719,985	$2,746,649	$2,774,113
Other Expenses[c]	$146,888	$162,052	$172,491	$183,602	$195,429	$204,277	$211,989	$221,594
Total Expenses	$129,548,350	$139,576,952	$147,459,926	$156,896,230	$172,523,164	$185,508,472	$191,904,036	$199,893,939

F: = From

T: = To

(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.

Applicants may add rows for costs that are not listed.

Applicants may delete rows for costs that are not applicable to the type of facility identified in Section A, Question 4.b.

Applicants may delete Interim Full FY columns if not needed.

Form F.3b Projected Operating Costs upon Project Completion Atrium Health Cabarrus (Main Campus) Acute Care Beds	Partial FY F: 01/01/2031 T: 12/31/2031	1st Full FY F: 01/01/2032 T: 12/31/2032	2nd Full FY F: 01/01/2033 T: 12/31/2033	3rd Full FY F: 01/01/2034 T: 12/31/2034
Salaries (from Form H Staffing)[a]	$143,519,772	$152,223,387	$161,422,397	$171,140,845
Taxes and Benefits[b]	$26,550,520	$28,160,650	$29,862,426	$31,660,296
Independent Contractors (Consultants) (1)[c]	$939,903	$996,902	$1,057,146	$1,120,792
Medical Supplies[c]	$13,812,879	$14,650,547	$15,535,894	$16,471,234
Other Supplies[c]	$3,005,653	$3,187,927	$3,380,577	$3,584,105
Dietary (2) (incl. in Other Supplies)	$0	$0	$0	$0
Housekeeping / Laundry (2) (incl. in Other Supplies)	$0	$0	$0	$0
Equipment Maintenance (2) (incl. in Independent Contractors (Consultants))	$0	$0	$0	$0
Building & Grounds Maintenance (2) (incl. in Central Office Overhead)	$0	$0	$0	$0
Central Office Overhead[d]	$10,430,461	$11,063,006	$11,731,554	$12,437,854
Professional Fees[e]	$0	$0	$0	$0
Utilities (incl. in Central Office Overhead)	$0	$0	$0	$0
Insurance (incl. in Central Office Overhead)	$0	$0	$0	$0
Interest Expense[f]	$9,374,799	$11,701,952	$11,213,647	$10,707,651
Rental Expense (incl. in Other Expenses)	$0	$0	$0	$0
Property and Other Taxes (except Income) (incl. in Central Office Overhead)	$0	$0	$0	$0
Depreciation - Buildings[g]	$10,130,136	$12,237,334	$12,274,110	$12,311,990
Depreciation - Equipment[h]	$4,900,878	$5,979,252	$6,009,263	$6,040,174
Other Expenses[c]	$235,074	$249,330	$264,397	$280,315
Total Expenses	$222,900,074	$240,450,289	$252,751,413	$265,755,255

F: = From

T: = To

(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.

Applicants may add rows for costs that are not listed.

Applicants may delete rows for costs that are not applicable to the type of facility identified in Section A, Question 4.b.

CMHA's Financial Planning department provided the data used to develop Forms F.2 and F.3, which were obtained from internal reporting systems that include cost center performance reports and encounter-level patient data for Atrium Health Cabarrus' acute care beds through the calendar year ending 12/31/2023, which is the last full calendar year for which financial data is available during the preparation of this application. Please note that Forms F.2 and F.3 include only charges and expenses assigned to performance reports relating to the acute care beds and do not include ancillary services such as lab, pharmacy, or radiology which generate additional revenue and expenses. The service component, Atrium Health Cabarrus (Main Campus) acute care beds, includes the 2021 Atrium Health Cabarrus project (Project F-012116-21) and the 2023 Atrium Health Cabarrus project (Project F-012367-23) which collectively add 87 acute care beds to Atrium Health Cabarrus (Main Campus) to begin operation in 2027.

The projected financial statements assume 3.0 percent annual inflation based on expected annual inflation.

Form F.2 Assumptions

a Patient Services Gross Revenue is based on the CY 2023 payor mix and charge per patient day for the service inflated 3.0 percent annually and applied to projected patient days. Percent of total utilization is based on the CY 2023 payor mix. With the expansion of Medicaid coverage in North Carolina that began in December 2023, preliminary 2024 data indicates that the anticipated payor mix shift is occurring, with some patients previously classified as Self-Pay transitioning to Medicaid coverage. While this transition is ongoing, CMHA utilizes the historical 2023 payor mix data in this application as it represents the last complete fiscal year of data at the time of preparation of this application and provides a conservative baseline. This approach ensures that CMHA's projections account for the maximum potential volume of Self-Pay patients, who, along with Medicaid patients, are considered underserved population. As both Medicaid and Self-Pay are considered underserved, CMHA demonstrates that patients from both categories will continue to have access to the proposed services in conformity with Criterion (13)c, regardless of the yet-to-be-determined future shift between the two categories. Until there is greater clarity to guide the specific shift between Self-Pay and Medicaid, CMHA has assumed that the payor mix will be consistent with the historical payor mix assumptions above.

b Not applicable.

c Contractual Adjustments are the difference between gross and net revenue for the service. Charity care is the difference between gross and net revenue for self pay. Contractual adjustments by payor are based on CY 2023 experience for the service.

d Bad debt is based on Atrium Health Cabarrus's CY 2023 percentage of total gross revenue as it is not available at a service component level. The application of facility-wide bad debt experience to a specific service may be conservative for some service components as it reflects the entire experience of the facility, but may not be specifically reflective of that service’s payor mix.

Form F.3 Assumptions

a Please see Form H for the proposed staffing chart. Total Salaries is based on projected FTE values and current salaries, inflated 3.0 percent annually.

b Taxes and Benefits expense is based on Atrium Health Cabarrus Campus acute care beds CY 2023 experience as a percent of Salaries applied to projected Salaries (excluding contracted Temporary Help), assuming that this percentage will remain constant through the third project year.

c Independent Contractors (Consultants) (includes Equipment Maintenance), Medical Supplies, Other Supplies (includes Dietary, Housekeeping / Laundry), and Other Expenses (includes Rental Expense), are based on CY 2023 experience, converted to a per patient day expense, inflated 3.0 percent annually, and applied to projected patient days.

d Central Office Overhead is projected based on five percent of net patient revenue and includes building and grounds maintenance, utilities, insurance, property and other taxes (except Income), corporate overhead, registration, scheduling, billing, and all other costs necessary to provide the proposed service.

e CMHA does not bill patients for professional fees for the service. Professional fees are billed separately by the physicians and practices.

f CMHA expects to fund the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23) with accumulated reserves, but has conservatively included interest expense in the event that the project is funded with bond financing. Interest expense for the previously approved projects are based on the respective applications. Interest expense for the proposed project is based on the project cost, assuming a 4.0 percent interest rate based on CMHA's current weighted average cost of capital.

g Depreciation - Buildings includes CY 2023 depreciation for the service, inflated 3.0 percent annually. Depreciation - Buildings also includes building depreciation expense for the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23). Depreciation - Buildings is calculated using the straight line method of depreciation over a useful life of 30 years.

h Depreciation - Equipment includes CY 2023 depreciation for the service, inflated 3.0 percent annually. Depreciation - Equipment also includes equipment depreciation expense for the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23). Depreciation - Equipment is calculated using the straight line method of depreciation over a useful life of seven years.

Form H Staffing Include employees, contract employees and temporary employees but not independent contractors [a]	Current Staff As of 12/31/2023			Projected Staff								
				1st Full FY			2nd Full FY			3rd Full FY		
	# of FTEs [b]	Average Annual Salary per 1 FTE [c]	Total Salary *	# of FTEs [b]	Average Annual Salary per 1 FTE [c]	Total Salary *	# of FTEs [b]	Average Annual Salary per 1 FTE [c]	Total Salary *	# of FTEs [b]	Average Annual Salary per 1 FTE [c]	Total Salary *
	B	C	D=B*C	E	F	G=E*F	H	I	J=H*I	K	L	M=K*L
Registered Nurse	538.7	$ 103,968	$ 56,002,460	761.0	$ 135,655	$ 103,231,039	783.5	$ 139,724	$ 109,469,393	806.4	$ 143,916	$ 116,060,006
Certified Nurse Aides / Nursing Assistants	13.8	$ 66,832	$ 921,918	17.9	$ 87,200	$ 1,564,872	18.5	$ 89,816	$ 1,659,438	19.0	$ 92,510	$ 1,759,345
Supervisory	37.7	$ 178,698	$ 6,740,034	49.1	$ 233,161	$ 11,440,594	50.5	$ 240,156	$ 12,131,961	52.0	$ 247,360	$ 12,862,366
Technician	226.0	$ 56,124	$ 12,684,513	294.0	$ 73,229	$ 21,530,804	302.7	$ 75,426	$ 22,831,932	311.6	$ 77,689	$ 24,206,530
Clerical	3.4	$ 48,035	$ 161,378	4.4	$ 62,675	$ 273,924	4.5	$ 64,555	$ 290,478	4.6	$ 66,492	$ 307,966
Business Office	2.3	$ 88,783	$ 204,845	3.0	$ 115,841	$ 347,706	3.1	$ 119,317	$ 368,718	3.2	$ 122,896	$ 390,917
License Practical Nurse	20.1	$ 70,431	$ 1,418,216	26.2	$ 91,896	$ 2,407,292	27.0	$ 94,653	$ 2,552,767	27.8	$ 97,493	$ 2,706,457
Temporary Help	78.8	$ 207,060	$ 16,320,285	42.3	$ 270,166	$ 11,427,156	43.5	$ 278,271	$ 12,117,710	44.8	$ 286,619	$ 12,847,258
Total	**920.8**		**$ 94,453,648**	**1,197.9**		**$ 152,223,387**	**1,233.3**		**$ 161,422,397**	**1,269.4**		**$ 171,140,845**

* Exclusive of taxes and benefits

State the percentage of total salary projected for taxes and benefits: 20.0%

Applicants may delete rows for position types not applicable to the type of facility identified in response to Section A, Question 4.

Applicants may add rows for position types not listed.

Form H Assumptions

a Types of positions are projected based on the existing positions for the service.

b Number of FTEs projected for each position type reflects historical staffing pattern and expected changes in utilization. CMHA expects a shift from temporary staffing to employed registered nurses in CY 2024 and CY 2025, resulting from a decrease in the use of traveler staff that has peaked due to the COVID-19 pandemic.

c Annual salary per FTE and position type are projected based on the current salary per FTE and position type, inflated 3.0 percent annually through the third project year. The inflation rate is based on expected annual inflation.

Form O Facilities/Health Services

	County (for mobile health service, use business location)	Name of Facility (or Health Service if mobile)	License Number	FID Number	Type of Health Service Facility (or Health Service, if mobile)	Owned by the Applicant(s)?	Provide the Name of the Related Entity if Not Owned by the Applicant (see 10A NCAC 14C .0202(10) for defn. of related entity)
1	Alleghany	Alleghany Memorial Hospital	H0108	942935	Hospital	No	Alleghany County Memorial Hospital, Inc.
2	Anson	Atrium Health Anson	H0082	120335	Hospital	Yes	
3	Cabarrus	Atrium Health Cabarrus	H0031	943049	Hospital	Yes	
4	Cabarrus	Atrium Health Harrisburg, a facility of Atrium Health Cabarrus[a]	H0031	061205	Hospital	Yes	
5	Cleveland	Atrium Health Cleveland	H0024	953106	Hospital	Yes	
6	Cleveland	Atrium Health Kings Mountain, a facility of Atrium Health Cleveland	H0024	943292	Hospital	Yes	
7	Columbus	Columbus Regional Healthcare System[b]	H0045	923111	Hospital	No	Columbus Regional Healthcare System
8	Davidson	Atrium Health Wake Forest Baptist - Lexington Medical Center	H0027	943307	Hospital	No	Lexington Medical Center
9	Davie	Atrium Health Wake Forest Baptist - Davie Medical Center	H0171	080175	Hospital	No	Davie Medical Center
10	Forsyth	Atrium Health Wake Forest Baptist - Wake Forest Baptist Medical Center	H0011	943495	Hospital	No	North Carolina Baptist Hospital
11	Guilford	Atrium Health Wake Forest Baptist - High Point Medical Center	H0052	943251	Hospital	No	High Point Regional Health
12	Guilford	Atrium Health Wake Forest Baptist - Greensboro Medical Center[a]	H0052	230130	Hospital	No	High Point Regional Health
13	Lincoln	Atrium Health Lincoln	H0225	070062	Hospital	Yes	
14	Mecklenburg	Atrium Health Pineville	H0042	110878	Hospital	Yes	
15	Mecklenburg	Atrium Health Steele Creek, a facility of Atrium Health Pineville[a]	H0042	070396	Hospital	Yes	
16	Mecklenburg	Atrium Health University City	H0255	923516	Hospital	Yes	
17	Mecklenburg	Atrium Health Lake Norman, a facility of Atrium Health University City[a,c]	H0255	190513	Hospital	Yes	
18	Mecklenburg	Carolinas Medical Center	H0071	943070	Hospital	Yes	
19	Mecklenburg	Atrium Health Mercy, a facility of Carolinas Medical Center	H0071	923352	Hospital	Yes	
20	Scotland	Scotland Memorial Hospital[b]	H0107	061346	Hospital	No	Scotland Memorial Hospital, Inc.
21	Stanly	Atrium Health Stanly	H0008	953472	Hospital	Yes	
22	Union	Atrium Health Union	H0050	923515	Hospital	Yes	
23	Union	Atrium Health Union West, a facility of Atrium Health Union	H0050	180514	Hospital	Yes	
24	Wilkes	Atrium Health Wake Forest Baptist - Wilkes Medical Center	H0153	943561	Hospital	No	WRMC Hospital Operating Corporation

a CON-approved, not yet operational.
b Facility is managed by Atrium Health.
c Pursuant to a material compliance request that was approved on September 22, 2023, Atrium Health Lake Norman will be licensed as a facility of Atrium Health University City