COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

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State Health Commissioner

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February 18, 2020

Ms. Emily W.G. Towey
Hancock, Daniel & Johnson, P.C.
4701 Cox Road, Suite 400
Glen Allen, Virginia 23060

RE: **COPN Request No. VA-8477**
Wellmont Health System d/b/a Mountain View Regional Hospital, Norton, Virginia
Introduce medical rehabilitation services with 15 medical rehabilitation beds through the conversion of existing licensed bed capacity at Mountain View Regional Hospital.

Dear Ms. Towey:

For your consideration, I enclose the Division of Certificate of Public Need (DCOPN) report and recommendation on the above referenced project. DCOPN is recommending **conditional approval** of this application for the reasons listed in the attached staff report.

If Wellmont Health System d/b/a Mountain View Regional Hospital is willing to accept the recommendation for conditional approval of this project, please provide documentation of this acceptance no later than **February 24, 2020**. If not willing to accept, before the State Health Commissioner makes his decision on this project, the Department will convene an informal-fact-finding conference (IFFC) pursuant to Title 2.2 of the Code of Virginia to be conducted on a date, time and place to be determined. A copy of the procedures for conduct at IFFCs may be found at http://www.vdh.virginia.gov/OLC/copn/.

Persons wishing to participate in an IFFC have four days from the date of this letter to submit written notification to the State Health Commissioner, DCOPN and the applicant stating a factual basis for good cause standing. If no person has submitted written notification stating grounds and providing a factual basis for good cause standing and Mary Washington Hospital, Inc. accepts the conditional approval, DCOPN will then notify you of the cancellation of the scheduled IFFC. DCOPN would then anticipate action by the State Health Commissioner within a few weeks of transmission.

Should you have questions or need further clarification of this report and/or its recommendations, please feel free to call me at (804) 367-1889 or email me at Erik.Bodin@VDH.Virginia.Gov.

Sincerely,

Erik Bodin, Director
Division of Certificate of Public Need

Enclosures

cc: Douglas R. Harris, J.D., Office of Adjudication, Virginia Department of Health

VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

February 18, 2020

RE: COPN Request No. VA-8477
Wellmont Health System d/b/a Mountain View Regional Hospital, Norton, Virginia
Introduce medical rehabilitation services with 15 medical rehabilitation beds through the conversion of existing licensed bed capacity at Mountain View Regional Hospital.

Applicant

Wellmont Health System, doing business as Mountain View Regional Hospital (MVRH), is a Tennessee nonprofit corporation first organized in 1996. The applicant has numerous subsidiaries that include hospitals, imaging services, ambulatory surgery facilities, pharmacies, and physician services, among others. Wellmont Health System is a wholly owned subsidiary of Ballad Health, an integrated healthcare delivery system serving 29 counties of Northeast Tennessee, Southwest Virginia, Northwestern North Carolina, and Southeastern Kentucky. MVRH is located in the City of Norton, Virginia in Planning District (PD) 1, Health Planning Region (HPR) III.

Background: PD 1 Inpatient Medical Rehabilitation Beds

Norton Community Hospital (NCH) is a Mountain States Health Alliance hospital and also part of the Ballad Health system. With 11 inpatient rehabilitation beds, NCH is PD 1's sole provider of inpatient medical rehabilitation services. As of 2017, all eleven inpatient rehabilitation beds at NCH were staffed and collectively operated at 57.4% occupancy (**Table 1**).

Table 1. PD 1 Inpatient Rehabilitation Bed Utilization: 2017

Facility	Licensed Beds	Available Days	Patient Days	Occupancy
Norton Community Hospital	11	4,015	2,305	57.4%

Source: Virginia Health Information (VHI) 2017

Background: PD 1 Medical/Surgical Beds

In 2017, the 214 medical/surgical beds in PD 1 operated at a collective utilization of 15.0% (**Table 2**). Although MVRH and Lonesome Pine Hospital are separately licensed hospitals, the two hospitals are Medicare-certified as a single hospital. For this reason, VHI reports the data for these two hospitals together. Therefore, the utilization numbers reported by VHI are not necessarily an accurate depiction of the utilization rates for MVRH's medical/surgical beds. In its application, MVRH provided utilization rates for the 74 medical/surgical beds that were in operation at MVRH in 2018 and 2019 (**Table 3**), however DCOPN notes that it cannot quantifiably confirm this data. DCOPN also notes that effective September 30, 2019, MVRH delicensed 59 of its 74 medical/surgical beds, resulting in a current complement of 15 medical/surgical beds. By using the number of actual patient days reported by the applicant for MVRH in 2019 and adjusting the number

of available days to reflect a current complement of 15 medical/surgical beds, DCOPN calculated that the resulting occupancy of the remaining 15 beds at MVRH would be approximately 36.6%.

Table 2. PD 1 Medical/Surgical Bed Utilization: 2017

Facility	Licensed Beds	Staffed Beds	Available Days	Patient Days	Occupancy
Norton Community Hospital	98	47	35,770	7,061	19.7%
Wellmont Lonesome Pine / Mt. View Hospital*	116	40	42,340	4,626	10.9%
TOTAL and Average	**155[1]**	**87**	**78,110**	**11,687**	**15.0%**

Source: VHI (2017) and DCOPN records.
*Effective September 30, 2019, MVRH delicensed 59 medical/surgical beds resulting in a current inventory of 15 medical/surgical beds (and 42 medical/surgical beds at Wellmont Lonesome Pine Hospital)

Table 3. Mountain View Regional Hospital Medical/Surgical Utilization: 2018-2019

Year	Licensed Beds	Patient Days	Occupancy
2018	74	2,814	10.4%
2019	74	2,006	7.4%

Source: COPN Request No. VA-8477
*Note: Complement as of the date of this report is 15 medical/surgical beds.

DCOPN also notes that MVRH operates 44 well-utilized acute care beds that are certified for long-term care. In 2017, these beds operated at a collective occupancy of 73.2%.

Background: Inpatient Medical Rehabilitation versus Skilled Nursing Care

While area skilled nursing facilities (SNFs) provide Medicare-certified inpatient rehabilitation services, it is arguable that inpatient rehabilitation facilities (IRFs) would better serve some patients. An article published by the Center for Medicare Advocacy cites a study conducted by Dobson Da Vanzo & Associates, LLC and commissioned by the ARA Research Institute, an affiliate of the American Medical Rehabilitation Providers Association. The study assessed the outcomes of patients who received care in IRFs with clinically and demographically similar patients who received their post-acute rehabilitation in SNFs. The 2014 study found that IRFs provide better care to patients over a number of outcome measures.[2] Specifically, the study found that patients who receive care at IRFs oftentimes live longer, spend more days at home and fewer days in health care facilities, have fewer emergency room visits and, for patients with some diagnoses, have fewer rehospitalizations.[3] The study also found that in addition to better treatment outcomes, the average length of stay is considerably longer at SNFs than at IRFs—the average length of stay for patients receiving care at an IRF facility was 12.4 days, while the average length of stay for a patient receiving care at a SNF facility was 26.4 days.[4]

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[1] Though not used in the calculation for overall utilization, the total number of licensed inpatient medical/surgical beds reflects the 59 beds that were delicensed at MVRH effective September 30, 2019.
[2] Edelman, T. S. (2014, July 31). Inpatient Rehabilitation Facilities and Skilled Nursing facilities: Vive La Difference! || Center for Medicare Advocacy. Retrieved February 26, 2019, from https://www.medicareadvocacy.org/inpatient-rehabilitation-facilities-and-skilled-nursing-facilities-vive-la-difference/#_edn1.
[3] Ibid.
[4] Ibid.

The Dobson DaVanzo study also analyzed the cost of care, both during the initial inpatient stay and for two subsequent years after discharge. The researchers found that care in an IRF is more expensive than care in a SNF, and that patients treated in IRFs had slightly higher overall medical costs over the two-year period.[5] However, the analysis did not consider Medicare costs for physicians or durable medical equipment over the two-year period, nor did it consider the costs of nursing home care paid by Medicaid for patients treated in IRFs or SNFs.[6]

The Medicare Payment Advisory Commission (MedPAC) March 2018 Report to Congress contained similar findings. MedPAC noted that IRFs have higher rates of discharging patients to the community (IRFs: 76.9% vs SNFs: 39.5%) and lower hospital readmission rates (IRFs: 4.4% vs. SNFs: 10.8%).[7] The March 2018 MedPAC report also states that with IRFs, patients receive care at a lower cost per discharge.[8] When comparing IRF and SNF cost per stay, SNF Medicare costs per discharge range from $15,940 to $22,472, whereas IRF costs average $15,494.[9]

Proposed Project

The applicant proposes to relocate PD 1's existing inpatient medical rehabilitation service from NCH (also part of the Ballad Health System) to MVRH, located approximately 2.2 miles away within the city of Norton, Virginia. The applicant proposes to convert its 15 remaining medical/surgical beds to inpatient medical rehabilitation beds. Once the 15-bed inpatient medical rehabilitation service opens at MVRH, the 11 existing inpatient medical rehabilitation beds at NCH will be de-licensed and the NCH rehabilitation unit will close. Upon completion of the proposed project, MVRH will stop operating medical/surgical beds. Consequently, the existing PD 1 inventory of medical rehabilitation beds will increase by four beds and the existing PD 1 medical/surgical inventory will decrease by an additional 15 beds. The proposed project, taken together with the previous delicensing of 59 medical/surgical beds at MVRH, would ultimately result in a net reduction of 70 licensed beds in PD 1.

The new medical rehabilitation unit will be located in renovated space within what is currently medical/surgical space at MVRH. Selective demolition will create an open and more functional floor plan on the third floor, which the applicant states will result in greater operational efficiencies and lower project costs when compared to new construction. The renovation will not result in additional square footage at the facility. When complete, the planned "therapy wing" will house a therapy gym, living space, and work space. The "patient wing" will contain the patient rooms and all necessary accessory spaces.

The projected capital costs of the proposed project total $4,574,000 (**Table 4**). The applicant will fund the entire project using accumulated reserves. Accordingly, there are no financing costs associated with this project.

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[5] Ibid.

[6] Ibid.

[7] Medicare Payment Advisory Commission (MedPAC) Report to Congress. (2018, March). Retrieved February 26, 2019, from http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec_rev_0518.pdf?sfvrsn=0

[8] Ibid, at 224, 286, and 287.

[9] Ibid.

Table 4. MVRH Projected Capital Costs

Direct Construction Costs	$3,500,000
Equipment Not Included in Construction Contraction	$544,000
Site Preparation Costs	$250,000
Architectural and Engineering Fees	$280,000
TOTAL Capital Costs	**$4,574,000**

Source: COPN Request No. VA-8477

The applicant projects that construction on the proposed project will begin on December 15, 2020 and be complete by June 13, 2021. The applicant anticipates a July 1, 2021 date of opening.

Project Definition

Section 32.1-102.1 of the Code of Virginia (the Code) defines a project, in part, as the "introduction into an existing medical care facility of any new…medical rehabilitation…service…which the facility has never provided or has not provided in the previous 12 months." Medical care facilities are defined, in part, as "general hospitals."

Required Considerations -- § 32.1-102.3, of the Code of Virginia

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable.

1. **The extent to which the proposed service or facility will provide or increase access to needed services for residents of the area to be served, and the effects that the proposed service or facility will have on access to needed services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care;**

MVRH is located near the intersection of U.S. 23 (north/south) and U.S. Route 58 (east/west), both four-lane highways. As will be discussed in more detail later in this staff analysis report, DCOPN concludes that at least 95% of the population of PD 1 is likely within 60 minutes' drive time, one way, under normal driving conditions to existing medical rehabilitation services. Additionally, because the project would simply relocate PD 1's sole existing service to a new location approximately 2.2 miles away, DCOPN concludes that the proposed project would not improve geographic access to this service in any meaningful way.

Regarding socioeconomic barriers to access to services, the applicant has provided assurances that it will accept both Medicare and Medicaid patients. The payor mix section of the Pro Forma income statement submitted by the applicant projects that approximately 7% of MVRH's total patient population will be covered by commercial payors, with a combined total of approximately 93% being covered by Medicare or Medicaid (**Table 5**). With regard to this standard, the applicant provided the following:

> *"Most patients who access inpatient medical rehabilitation services are over the age of 65 and covered by Medicare. With the recent expansion of Medicaid, the majority of all non-Medicare beneficiaries who access inpatient medical rehabilitation are covered by Medicaid.*

A few are covered by commercial payors. Although MVRH will make the service available to patients who need the care regardless of the patient's ability to pay, MVRH anticipates there will be very limited, if any, opportunities to provide charity care on the inpatient medical rehabilitation unit. Therefore, MVRH does not estimate any provision of charity care."

Table 5. MVRH Estimated Payor Mix

Payor	%
Medicare	65%
Medicare—Managed	20%
Medicaid	8%
Commercial Payors	7%
Self Pay/Charity Care	0%

Source: COPN Request No. VA-8477

Although the applicant does not proffer any provision of charity care, DCOPN notes that for 2018, the HPR III average charity care contribution was 3.1% (**Table 6**). DCOPN also notes that the commissioner has conditioned inpatient rehabilitation services in the past, despite a large percentage of the patient population being covered by Medicare or Medicaid.[10] Furthermore, DCOPN notes that the city of Norton, as well as every county in PD 1, has a much higher poverty rate than the statewide poverty rate of 10.7% (**Table 7**). Similarly, each county in surrounding PD's 2 and 3 have poverty rates exponentially higher than the statewide average. For the preceding reasons, should the commissioner approve the proposed project, DCOPN recommends a charity care condition of 3.1% based on gross patient services revenue derived from MVRH's non-Medicare/non-Medicaid patient population.

[10] COPN No. VA-04650 conditioned UVA Encompass Health and Rehabilitation Hospital, LLC at 4.6% of gross patient services revenue derived from the non-Medicare/non-Medicaid patient population, despite 78.5% of the patient population being covered by Medicare or Medicaid.

Table 6. HPR III Charity Care Contribution: 2018

Health Planning Region III			
2018 Charity Care Contributions at or below 200% of Federal Poverty Level			
Hospital	**Gross Patient Revenues**	**Adjusted Charity Care Contribution**	**Percent of Gross Patient Revenue:**
Carilion Franklin Memorial Hospital	$140,570,971	$12,554,448	8.93%
Carilion Tazewell Community Hospital	$56,372,076	$4,461,261	7.91%
Carilion New River Valley Medical Center	$641,976,306	$35,497,216	5.53%
Bedford Memorial Hospital	$106,076,131	$5,296,511	4.99%
Carilion Medical Center	$3,558,873,340	$159,649,849	4.49%
Wellmont Lonesome Pine Mt. View Hospital	370345839	16158822	4.36%
Dickenson Community Hospital	$25,823,572	$1,031,068	3.99%
Russell County Medical Center	$110,087,349	$4,369,909	3.97%
Centra Health	$2,328,985,662	$89,202,278	3.83%
Carilion Giles Memorial Hospital	$93,368,852	$3,016,041	3.23%
Smyth County Community Hospital	$191,874,758	$5,908,813	3.08%
Johnston Memorial Hospital	$849,445,825	$23,815,840	2.80%
Norton Community Hospital	$290,440,432	$7,990,982	2.75%
Lewis-Gale Medical Center	$2,081,736,631	$45,082,951	2.17%
Pulaski Community Hospital	$306,530,249	$6,493,909	2.12%
LewisGale Hospital -- Montgomery	$578,517,580	$9,337,489	1.61%
LewisGale Hospital -- Alleghany	$196,433,577	$2,962,798	1.51%
Twin County Regional Hospital	$235,254,272	$2,331,223	0.99%
Clinch Valley Medical Center	$492,663,256	$4,385,186	0.89%
Buchanan General Hospital	$98,290,606	$540,974	0.55%
Memorial Hospital of Martinsville & Henry County	$680,100,049	$2,249,897	0.33%
Wythe County Community Hospital	$224,998,295	$633,916	0.28%
Danville Regional Medical Center	$866,889,606	$377,575	0.04%
Total Facilities Reporting			23
Median			2.8%
Total $ & Mean %	**$14,525,655,234**	**$443,348,956**	**3.1%**

Source: VHI 2018

Table 7. Statewide and City of Norton, PDs 1, 2 and 3 Poverty Rates

Locality	PD	Poverty Rate
Virginia	--	10.7%
Wise County	1	25.4%
Lee County	1	24.8%
City of Norton	1	20.8%
Scott County	1	18.5%
Buchanan County	2	27.6%
Dickenson County	2	25.2%
Russell County	2	21.5%
Tazewell County	2	18.2%
Smyth County	3	20.4%
Grayson County	3	18.4%
Carroll County	3	15.7%
Washington County	3	15.4%
Wythe County	3	15.4%
Bland County	3	14.1%

Source: U.S. Census Data (census.gov)

The most recent Weldon-Cooper data projects a total PD 1 population of 89,515 persons by 2030. This represents an approximate 5% decrease in total population from 2010 to 2030. Comparatively, Weldon-Cooper projects the population of Virginia as a whole to increase by approximately 9% for the same period. With regard to the PD 1 65 and older age cohort, the opposite is true. For that age group, Weldon-Cooper projects a total population of 1,862 persons by 2030, an approximate 11% increase from 2010 to 2030. This is significant, as this age group uses health care services, including medical rehabilitation services, at a much higher rate than those under the age of 65.

2. The extent to which the project will meet the needs of the residents of the area to be served, as demonstrated by each of the following:

(i) The level of community support for the project demonstrated by citizens, businesses, and governmental leaders representing the area to be served;

The applicant provided several letters of support for the proposed project from area physicians, healthcare professionals, and government officials. Collectively, these letters addressed the following:

1. Approval of the proposed project would allow MVRH to offer convenient and cost-effective care in an inpatient setting—a much needed service for the project community.
2. Norton Community Hospital's inpatient rehabilitation unit ranks in the top 10 percent of more than 800 inpatient rehabilitation facilities across the nation. Upon the transitioning of the unit to MVRH, Ballad Health will be able to establish a state of the art care center that will reach a large portion of the community and ensure the best possible care. The already outstanding quality of care provided by the program at NCH will be bolstered by MVRH's ability to provide improved continuity of care.

3. This project will allow MVRH to establish a "center of excellence" for post-acute care by locating the inpatient rehabilitation service at the same facility as its existing skilled nursing and long-term care services.

DCOPN did not receive any letters in opposition to the proposed project.

DCOPN conducted the required public hearing on January 10, 2020. A total of 16 individuals signed in, seven of which elected to speak on behalf of the applicant. No individual spoke in opposition to the project. Of the 16 attendees, 15 indicated support on the sign-in sheet and one indicated neither support nor opposition.

(ii) The availability of reasonable alternatives to the proposed service or facility that would meet the needs of the population in a less costly, more efficient, or more effective manner;

As previously discussed, NCH is PD 1's sole provider of inpatient rehabilitation services. In 2017, the eleven inpatient medical rehabilitation beds at NCH operated at a collective occupancy of only 57.4%, well beneath the SMFP threshold for expansion. However, DCOPN contends that maintaining the status quo is not necessarily a better, more cost effective alternative to the proposed project. First, as will be discussed in more detail later in this staff analysis report, using the SMFP standard for the establishment of a new service, DCOPN has calculated a projected need for 2.5 additional inpatient medical rehabilitation beds in PD 1 by 2025. The proposed project would address this need, but ultimately result in a nominal surplus of 1.5 beds. DCOPN concludes that, when the increasing elderly population of PD 1 is considered, this small surplus would not prove problematic.

Because area SNFs currently provide similar services, it is reasonable to expect that approval of the project would have some impact on the utilization of existing providers. However, as discussed in the Dobson DaVanzo study cited earlier in this staff analysis report, inpatient medical rehabilitation facilities typically treat a different type of patient than those commonly treated in SNFs. For this reason, DCOPN concludes that the impact on area SNFs is not likely to be significant. DCOPN further notes that no area SNF submitted opposition to the proposed project.

Finally, approval of the proposed project would ultimately result in the delicensing of 15 grossly underutilized medical/surgical beds in PD 1, and a net reduction of 11 beds in the licensed bed inventory, thereby improving utilization of the remaining medical/surgical beds in the planning district. Using the utilization data provided by MVRH for 2019, and accounting for the current complement of 15 medical/surgical beds, DCOPN has calculated that the medical/surgical complement at NCH would operate at approximately 25.3% (increased from 19.7% in 2017) once the medical/surgical unit at MVRH closes, assuming the patient volume shifts to NCH. DCOPN arrived at this number by adding the number of actual patient days reported by MVRH for 2019 to the number of actual days reported by VHI for NCH (2017), and then calculating occupancy based on the number of available days at NCH.

(iii) Any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6;

Currently there is no organization in HPR III designated by the Virginia Department of Health to serve as the Health Planning Agency for PD 1. Therefore, this consideration is not applicable to the review of this project.

(iv) Any costs and benefits of the project;

The total projected capital cost of the proposed project is $4,574,000, the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with the proposed project. The applicant identified the following benefits of the proposed project:

1. MVRH's project will result in continued access to high quality inpatient medical rehabilitation services in Wise County and PD 1.
2. MVRH's project will enhance the overall quality and continuity of post-acute care services available to PD 1 residents.
3. MVRH's project will result in the conversion of underutilized healthcare resources to a new and efficient use to meet the evolving community needs in PD 1.
4. MVRH's project will not result in the unnecessary proliferation of licensed inpatient medical rehabilitation beds in PD 1.

(v) The financial accessibility of the project to the residents of the area to be served, including indigent residents;

As previously discussed, DCOPN notes that the overwhelming majority of the applicant's projected patient pool will be persons covered by Medicare and Medicaid. The applicant has provided assurances that it will accept both Medicare and Medicaid patients and that it will provide inpatient medical rehabilitation services to all persons in need of such care without regard to ability to pay. However, the applicant did not proffer a provision for charity care in its Pro Forma income statement citing "very limited, if any, opportunity to provide charity care on the inpatient medical rehabilitation unit." DCOPN again notes that the commissioner has conditioned inpatient rehabilitation services in the past, despite a large percentage of the patient population being covered by Medicare or Medicaid. Furthermore, DCOPN again notes that the applicant's primary service area is one of the most impoverished areas in the Commonwealth. The city of Norton, as well as each county in PD 1, has a much higher poverty rate than the statewide poverty rate of 10.7%. Similarly, each county in surrounding PD's 2 and 3 have poverty rates exponentially higher than the statewide average. For the preceding reasons, should the commissioner approve the proposed project, DCOPN recommends a charity care condition of 3.1% based on gross patient services revenue derived from MVRH non-Medicare/non-Medicaid patient population.

(vi) At the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a project.

DCPON did not identify any other factors, not previously identified and discussed in this staff analysis report, to bring to the attention of the commissioner.

3. The extent to which the application is consistent with the State Medical Facilities Plan.

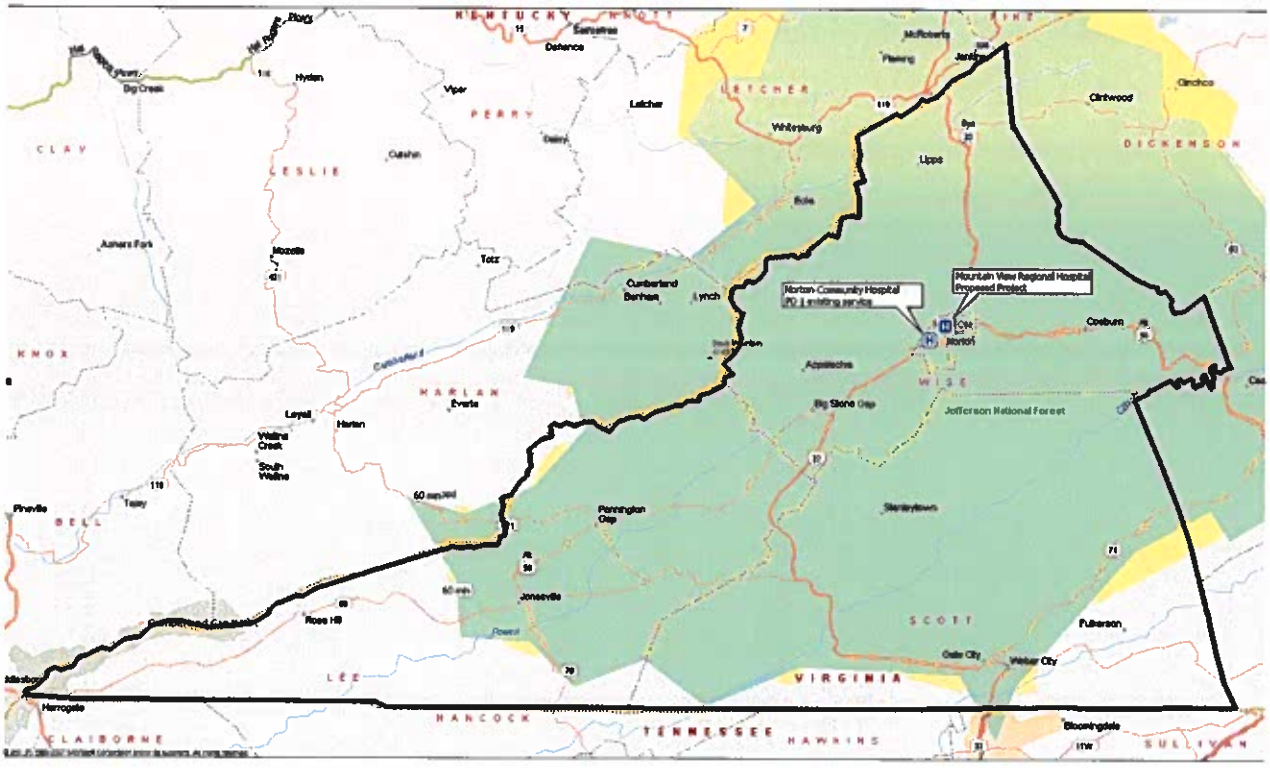
The State Medical Facilities Plan (SMFP) contains criteria and standards for the need for rehabilitation beds. They are as follows:

Part XI. Medical Rehabilitation

12VAC5-230-800. Travel Time.
Medical rehabilitation services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

The heavy black line in **Figure 1** identifies the boundary of PD 1. The solid blue "H" sign marks the location of the proposed project, while the solid white "H" sign marks the location of existing PD 1 medical rehabilitation services. The yellow shaded area represents the areas of PD 1 and the surrounding area that is within a 60-minute drive of the proposed project. The green shaded area represents the area of PD 1 and surrounding area that is within a 60-minute drive of existing medical rehabilitation services. As previously discussed, based on an analysis of the PD 1 population centers, DCOPN concludes that at least 95% of the PD 1 population is likely within 60 minutes' drive time, one way, under normal conditions of medical rehabilitation services. Additionally, the proposed project, if approved, would simply relocate the existing PD 1 medical rehabilitation service to a different facility approximately 2.2 miles away. Therefore, DCOPN concludes that approval of the proposed project would not improve geographic access to medical rehabilitation services for residents of PD 1 in any meaningful way.

Figure 1.



12VAC5-230-810. Need for New Service.

A. The number of comprehensive and specialized rehabilitation beds shall be determined as follows:

$$\frac{((UR \times PROPOP) / 365)}{0.80}$$

Where:

UR = the use rate expressed as rehabilitation patient days per population in the health planning district as reported by VHI; and

PROPOP = the most recent projected population of the health planning district five years from the current year as published by a demographic entity as determined by the commissioner.

The following calculation of the need for medical rehabilitation beds in PD 1 in 2025 is provided below. The calculation is based on utilization data reported to VHI for 2017 and the population of PD 1 based on a straight-line extrapolation of US Census data from 2010 and estimated for 2020 and 2030.

UR = 4,015 medical rehabilitation patient days in 2017 ÷ 90,974 population = 0.0441334887

PROPOP = 89,559 projected population in 2025

$$\frac{((0.0441334887 \text{ X } 89{,}559) / 365)}{0.80} = 13.5 \text{ beds}$$

There is an existing licensed inventory of 11 medical rehabilitation beds in PD 1. Based on the preceding calculation, there is a **projected need of 2.5 beds in PD 1 in 2025**. Approval of the proposed project would add four additional medical rehabilitation beds to the PD 1 inventory, thereby resulting in a surplus of 1.5 beds in PD 1.

B. Proposals for new medical rehabilitation beds should be considered when the applicant can demonstrate that:

1. **The rehabilitation specialty proposed is not currently offered in the health planning district; and**
2. **There is documented need for the service or beds in the health planning district.**

As discussed above, there is a calculated need for 2.5 medical rehabilitation beds in PD 1 in 2025. The proposed project would address this need, but result in a nominal surplus of 1.5 beds.

Additionally, DCOPN notes that the proposed project, if approved, would serve a much larger geographic area than PD 1 alone. Currently, NCH is the sole provider of medical rehabilitation services in PD 1. There is no inpatient medical rehabilitation service in neighboring PD 2. As **Table 8** below demonstrates, all other existing medical rehabilitation service providers in HPR III are more than 64 miles (more than an hour's drive time) away from the proposed project's location. Accordingly, DCOPN concludes that the addition of four medical rehabilitation beds at MVRH would increase access to this service for residents of PD 1 and HPR III alike.

Table 8. HPR III Medical Rehabilitation Beds and Distance to MVRH

Facility	PD	Number of Beds	Miles to MVRH	Time to MVRH
Norton Community Hospital*	1	11	2.3	6 mins
The Rehabilitation Hospital of Southwest Virginia	3	25	64.0	1 hour 17 mins
Smyth County Community Hospital	3	14	82.4	1 hour 35 mins
LewisGale Medical Center	5	35	176	3 hours 11 mins
Carilion Roanoke Community Hospital	5	34	185	3 hours 52 mins
Virginia Baptist Hospital	11	20	235	5 hours 1 min
Danville Regional Medical Center	12	10	227	4 hours 7 min

Source: VHI (2017) and MapQuest.com
*Note: Will close upon completion of the proposed project.

12VAC5-230-820. Expansion of Services.
No additional rehabilitation beds should be authorized for a health planning district in which existing rehabilitation beds were utilized with an average annual occupancy of less than 80% in the most recently reported year.

Preference may be given to a project to expand rehabilitation beds by converting underutilized medical/surgical beds.

The applicant is not proposing to expand an existing service, but rather to establish a new service. Accordingly, this standard is not applicable to the proposed project. However, in the interest of completeness, DCOPN notes that the proposed project would add four additional medical rehabilitation beds to the existing PD 1 inventory. The eleven medical rehabilitation beds currently operating at NCH operated at a collective utilization of only 57.4% for 2017, well beneath the SMFP threshold for expansion. However, DCOPN concludes that the proposed project warrants approval despite existing medical rehabilitation beds not operating at least 80% occupancy. First, DCOPN has calculated a projected need for 2.5 additional medical rehabilitation beds in PD 1 in 2025 based on the SMFP formula for the establishment of a new service. Approval of the proposed project would address this calculated need, but result in a surplus of 1.5 beds. DCOPN concludes that when the increasing elderly population of PD 1 is considered, this surplus is quite nominal. Additionally, DCOPN again notes that the proposed project would serve a much larger geographic area than PD 1 alone. To reiterate, if approved, MVRH would be PD 1's sole provider of medical rehabilitation services. Furthermore, there is currently no existing medical rehabilitation service in neighboring PD 2 and the closest HPR III provider of this service is more than 64 miles away from the proposed project.

Both NCH and MVRH's utilization of medical/surgical beds has been low historically (**Table 9**). VHI data indicates that in the three-year period between 2013 and 2015, the average annual occupancy of NCH's medical surgical beds has not exceeded 25.5%. Similarly, occupancy of MVRH's medical surgical beds has decreased from 13.8% to 6.6% for the same period. DCOPN again notes that in years 2016 and 2017, VHI reported MVRH's medical/surgical utilization together with Wellmont Lonesome Pine Hospital for Medicare purposes, and accordingly, DCOPN cannot quantifiably confirm MVRH's utilization data for those years. For that reason, 2016 and 2017 data was not included in the following table. DCOPN also again notes that as of September 30, 2019, MVRH delicensed 59 of its medical surgical beds, an action that, theoretically, would improve utilization among the remaining 15 beds.

It is reasonable to conclude that when the 15 medical/surgical beds currently in operation at MVRH are delicensed upon the opening of the new medical rehabilitation unit, those patients will receive care at NCH, located only 2.2 miles away. This transfer of patient volume will likely result in the improved utilization of medical/surgical beds at NCH. As discussed previously, DCOPN anticipates that the shift in patient volume would result in an occupancy of approximately 25.3% at NCH, an increase from 19.7% in 2017.

Table 9. NCH and MVRH Medical/Surgical Utilization: 2013-2015

Norton Community Hospital	Beds	Available Days	Actual Days	Occupancy
2013	98	35,770	8,241	23.1%
2014	98	35,770	7,472	20.9%
2015	98	35,770	9,106	25.5%
Average		**107,310**	**24,819**	**23.1%**
Mountain View Regional Hospital	**Beds**	**Available Days**	**Actual Days**	**Occupancy**
2013	66	24,090	3,313	13.8%
2014	68	24,820	2,788	11.2%
2015	68	24,820	1,628	6.6%
Average		**73,730**	**7,729**	**10.5%**

Source: VHI (2013-2015)

12VAC5-230-830. Staffing.
Medical rehabilitation facilities should be under the direction or supervision of one or more qualified physicians.

The applicant has provided assurances that the proposed service will be under the direction of Dr. Matthew Cusano. Dr. Cusano has served as the medical director of the NCH inpatient medical rehabilitation unit for more than 14 years and will transfer to MVRH upon approval of the proposed project.

4. The extent to which the proposed service or facility fosters institutional competition that benefits the area to be served while improving access to essential health care services for all persons in the area to be served;

As previously discussed, NCH is currently the sole provider of inpatient medical rehabilitation services in PD 1. Approval of the proposed project would result in this service transferring to MVRH. Accordingly, DCOPN contends that the proposed project is not intended to foster institutional competition. It is reasonable to expect that the addition of four inpatient medical rehabilitation beds in PD 1 would have some negative impact on the utilization of SNFs in the area that provide similar services, however DCOPN contends that the impact is not likely to be destabilizing. DCOPN again notes that it did not receive any letters in opposition to the proposed project from any existing PD 1 facility.

5. The relationship of the project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

As already noted, only one inpatient medical rehabilitation service exists in PD 1. If approved, that service would transfer from NCH to MRVH. For 2017, the eleven existing inpatient medical rehabilitation beds operated at a collective occupancy of 57.4%, well beneath the SMFP threshold for expansion. However, based on the SMFP formula for the establishment of a new service, DCOPN calculated a projected need for an additional 2.5 inpatient medical rehabilitation beds by 2025. The proposed project would address that need, but would ultimately result in a surplus of 1.5 beds. Again, DCOPN concludes that when PD 1's increasing elderly population is

considered, this surplus is nominal. Regarding the impact to existing facilities, it is reasonable to expect that approval of the proposed project would have some negative impact on the utilization of existing skilled nursing facilities that provide inpatient medical rehabilitation services. However, for reasons already discussed in this staff analysis report, DCOPN concludes that this impact is not likely to be significant. DCOPN again notes that it has not received any letters in opposition to the proposed project. Lastly, DCOPN again notes that approval of the proposed project would ultimately result in the delicensing of 15 grossly underutilized medical/surgical beds in PD 1, thereby resulting in the improved utilization of the remaining medical/surgical inventory.

Wellmont Lonsesome Pine Hospital and MVRH are Medicare-certified as part of the same hospital. Therefore, the two hospitals share personnel, services and equipment. In addition, MVRH, NCH, and Lonesome Pine Hospital have service agreements in place.

6. The feasibility of the project, including the financial benefits of the project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital;

The Pro Forma Income Statement (**Table 10**) provided by the applicant illustrates that the proposed project is financially feasible in the immediate and long-term. It projects a net income of $2,728,419 in the first year of operation and $2,977,060 by year two. The total projected capital cost of the proposed project is $4,574,000, with approximately 77% of that cost attributed to direct construction (**Table 4**). The applicant will fund the proposed project entirely with accumulated reserves. Accordingly, there are no financing costs associated with this project.

Table 10. MVRH Pro Forma Income Statement

	Year 1	Year 2
Total Gross Revenue	$15,373,228	$17,404,050
Deductions from Revenue	$10,515,288	$12,130,623
Total Net Revenue	**$4,857,940**	**$5,273,427**
Total Operating Expenses	$2,129,521	$2,296,367
Net Income	**$2,728,419**	**$2,977,060**
Projected Occupancy	**54%**	**58%**

Source: COPN Request No. VA-8477

With regard to staffing, DCOPN concludes that the proposed project would not have a significant negative impact upon other area healthcare providers. Upon the opening of the inpatient medical rehabilitation service at MVRH, the NCH inpatient medical rehabilitation beds will be delicensed and the unit will close. The current NCH personnel and staff will transfer to MVRH, approximately 2.2 miles away. Accordingly, MVRH already has the employee resources necessary for this project.

7. **The extent to which the project provides improvements or innovations in the financing and delivery of health services, as demonstrated by: (i) The introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services; (ii) The potential for provision of services on an outpatient basis; (iii) Any cooperative efforts to meet regional health care needs; and (iv) At the discretion of the Commissioner, any other factors as may be appropriate.**

With regard to this standard, the applicant provided the following:

> *"Currently, MVRH operates a 44-bed long-term care/skilled nursing unit which is dually certified by Medicare/Medicaid. The proposed inpatient medical rehabilitation service will compliment services currently provided on MVRH's long-term care unit. Co-locating the two services at MVRH will maximize the efficient and effective use of post-acute care resources and staff in a newly renovated facility."*

DCOPN concludes that the proposed project does not provide improvements or innovations in the financing and delivery of health services as demonstrated by the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services, nor does the proposed project provide for the provision of services on an outpatient basis. However, DCOPN again notes that the proposed project would ultimately result in the delicensing of 15 grossly underutilized medical/surgical beds, thereby improving the utilization of the remaining PD 1 medical/surgical bed inventory. DCOPN did not identify any other factors that have not been addressed elsewhere in this staff report to bring to the attention of the commissioner.

8. **In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served: (i) The unique research, training, and clinical mission of the teaching hospital or medical school; (ii) Any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations.**

Not applicable. The applicant is not a teaching hospital nor is it associated with a public institution of higher education or a medical school in the area to be served.

DCOPN Staff Findings and Conclusions

MVRH proposes to relocate PD 1's existing inpatient medical rehabilitation service from NCH to MVRH by converting its 15 remaining medical/surgical beds to inpatient medical rehabilitation beds. The applicant will renovate existing medical/surgical space in order to accommodate the new medical rehabilitation unit. Once the 15-bed inpatient medical rehabilitation service opens at MVRH, the 11 existing inpatient medical rehabilitation beds at NCH will be de-licensed and the NCH rehabilitation unit will close. Upon completion of the proposed project, MVRH will stop operating medical/surgical beds. Consequently, the existing PD 1 inventory of medical rehabilitation beds will increase by four beds and the existing PD 1 medical/surgical inventory will decrease by 15 beds. The proposed project would result in the net reduction of 11 licensed beds in the PD 1 inventory. The total projected capital costs of the proposed project total $4,574,000, the entirety of

which will be funded with accumulated reserves. Accordingly, there are no financing costs associated with this project. The applicant projects a July 2021 date of opening.

Based on the Pro Forma Income Statement provided by the applicant, the project would add to MVRH's overall profitability. The applicant projects a net profit of $2,977,060 by the end of the second full year of operation. DCOPN concludes that the proposed project appears financially feasible both in the immediate and the long-term.

Citing a patient population consisting mainly of patients covered by Medicare and Medicaid, the applicant did not proffer a provision for charity care. However, DCOPN notes that the commissioner has conditioned inpatient medical rehabilitation services in the past, despite the patient population of the applicant consisting primarily of Medicare/Medicaid recipients. Accordingly, should the commissioner approve the proposed project, DCOPN recommends a charity care condition of 3.1% based on gross patient services revenue derived from the applicant's non-Medicare/non-Medicaid patient population.

For 2017, VHI data demonstrates that the eleven existing inpatient medical rehabilitation beds in PD 1 operated at a collective occupancy of only 57.4%, well beneath the SMFP threshold for expansion. However, using the SMFP standard for the establishment of a new service, DCOPN calculated a projected need for an additional 2.5 beds by the 2025 planning year. The proposed project would address this need, however it would result in a nominal surplus of 1.5 inpatient medical rehabilitation beds. DCOPN concludes that when the steadily increasing elderly population of PD 1 is considered, this surplus is not likely to prove problematic. Furthermore, DCOPN again notes that the proposed project would serve a much larger geographical area than PD 1 alone. In addition, approval of the proposed project would ultimately result in the delicensing of 15 grossly underutilized medical/surgical beds in the planning district, thereby improving the utilization of the remaining medical/surgical inventory. For these reasons, DCOPN contends that maintaining the status quo is not a favorable alternative to the proposed project.

If approved, MVRH would be the sole provider of inpatient medical rehabilitation services in PD 1, however skilled nursing facilities within the planning district provide similar rehabilitation services. It is reasonable to expect that there would be some negative utilization and financial impact upon these service providers. However, DCOPN concludes that this impact is not likely to be significant and again notes that no existing facility has submitted opposition to the proposed project. Additionally, DCOPN notes that approval of the proposed project is not likely to have a negative impact on the staffing of existing providers as the staff from NCH will transfer to MVRH upon the opening of the MVRH rehabilitation unit.

DCOPN Staff Recommendation

The Division of Certificate of Public Need recommends **conditional approval** of Mountain View Regional Hospital's request to introduce inpatient rehabilitation services through the conversion of 15 medical/surgical beds, with a total projected capital cost of $4,574,000, for the following reasons:

1. The project is generally consistent with the applicable criteria and standards of the State Medical Facilities Plan and the eight Required Considerations of the Code of Virginia.

2. The proposed project appears to be financially feasible in the immediate and the long-term.

3. Approval of the proposed project will address the PD 1 calculated need of 2.5 inpatient medical rehabilitation beds, while resulting in only a marginal surplus within the health-planning district.

4. There is no known opposition to the proposed project.

5. The proposed project is not likely to have a significant negative impact on the costs, utilization, or staffing of existing area providers.

6. Approval of the proposed project will result in a net reduction of 11 licensed beds in PD 1.

DCOPN's recommendation is contingent upon Mountain View Regional Hospital's agreement to the following charity care condition:

> Wellmont Health System d/b/a Mountain View Regional Hospital will provide medical rehabilitation services to all persons in need of this service, regardless of their ability to pay, and will facilitate the development and operation of primary medical care services to medically underserved persons in PD 1 in an aggregate amount equal to at least 3.1% of Mountain View Regional Hospital's gross patient revenue derived from its non-Medicare/non-Medicaid patient population for inpatient rehabilitation services. Compliance with this condition will be documented to the Division of Certificate of Public Need annually by providing audited or otherwise appropriately certified financial statements documenting compliance with the preceding requirement. Mountain View Regional Hospital will accept a revised percentage based on the regional average after such time regional charity care data valued under the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. is available from Virginia Health Information. The value of charity care provided to individuals pursuant to this condition shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.