VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

October 19, 2021

COPN Request No. VA-8574
Doctors' Hospital of Williamsburg
Williamsburg, Virginia
Transfer of 20 Medical/Surgical Beds from Riverside Regional Medical Center to Doctors' Hospital of Williamsburg

Applicant

Doctors' Hospital of Williamsburg d/b/a Riverside Doctors' Hospital of Williamsburg (RDHW) is a 501(c)(3) not-for-profit, Virginia domiciled non-stock corporation. RDHW is a wholly owned subsidiary of Riverside Healthcare Association, Inc. d/b/a Riverside Health System which is Virginia domiciled, non-stock, not-for-profit corporation. RDHW is located in the eastern part of the City of Williamsburg in Planning District (PD 21) and Health Planning Region (HPR) V.

Background

RDHW is a 40-bed hospital, consisting of 30 medical/surgical beds and 10 ICU beds, which provides a variety of services including inpatient medical-surgical services, emergency services, diagnostic imaging, and pathology services. RDHW is designated as a Primary Stroke Center by Det Norske Veritas Germanischer Lloyd (DVL GL) Healthcare through certification under a partnership with the American Heart Association and the American Stroke Association. On May 15, 2009, the Virginia State Health Commissioner (Commissioner) issued COPN No. VA-04209 authorizing the construction and establishment of RDHW. RDHW is one of six COPN authorized providers of inpatient medical/surgical services in PD 21. According to DCOPN records, there are currently 1,001 medical/surgical beds in PD 21 (**Table 1**). In 2019, the last year for which the Division of Certificate of Public Need (DCOPN) has data available from Virginia Health Information (VHI), RDHW's 40 medical/surgical beds operated at 39% of the State Medical Facilities Plan (SMFP) utilization threshold (**Table 8**).

Table 1. PD 21 Medical/Surgical Bed Inventory[1]: 2019

Facility	COPN Authorized Beds
Bon Secours Mary Immaculate Hospital	123
Hampton Roads Specialty Hospital	25
Riverside Doctors' Hospital Williamsburg	40
Riverside Regional Medical Center	450
Sentara Careplex Hospital	224
TOTAL/Average	**1,001**

Source: VHI and DCOPN Records

Proposed Project

RDHW proposes to transfer 20 medical/surgical beds from Riverside Regional Medical Center (RRMC) to RDHW. RRMC currently has 372 COPN authorized medical/surgical beds. In 2019, the last year for which DCOPN has data from VHI, RRMC staffed 184 of the 372 COPN authorized medical/surgical beds. The applicant asserts that there is an institutional need to expand inpatient medical/surgical services at RDHW. The total capital and financing cost of the proposed project is $21,860,868 (**Table 2**). The applicant states that the proposed project will be financed using the accumulated reserves of Riverside Health System.

Table 2. Capital and Financing Costs

Direct Construction Costs	$16,809,882
Equipment Not Included in Construction Contract	$2,009,955
Site Preparation Costs	$1,218,000
Architectural & Engineering Fees	$1,823,031
TOTAL Capital Costs	**$21,860,868**

Source: COPN Request No. VA-8574

Project Definitions

Section 32.1-102.1:3 of the Code of Virginia (the Code) defines a project, in part, as "[a]n increase in the total number of beds…in an existing medical care facility…" Section 32.1-102.1:3 of the Code defines a medical care facility, in part, as "[a]ny facility licensed as a hospital, as defined in § 32.1-123."

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 Adjudication Officer's case decision for COPN No. VA-04682 held that DCOPN was in error by including obstetric, intensive care, and pediatric patient days in its calculations for medical/surgical bed need, despite those beds being fungible and accordingly, able to convert to medical/surgical beds without COPN authorization. However, because obstetric, intensive care, and pediatric beds can be easily converted to medical/surgical beds, thereby changing the medical/surgical inventory without first obtaining COPN authorization, DCOPN maintains that obstetric, intensive care, and pediatric beds should be included in the medical/surgical inventory and the corresponding patient days used for medical/surgical bed need calculations.

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

The applicant proposes to transfer 20 medical/surgical beds from RRMC to RDHW. The applicant states RDHW has an institutional need to expand its medical/surgical inpatient services. As discussed below, DCOPN determined that there is not an institutional need to expand, both now and in the immediate future, medical/surgical inpatient services at RDHW. While the proposed project would relocate unstaffed beds from RRMC to RDHW, the relocation of underutilized beds at one location to another underutilized location would not benefit patients in either facility's service area. As such, DCOPN concludes that the applicant has not established how the proposed project would provide or increase access to health care services for people in the area to be served.

Geographically, RDHW is located at the intersection of US-60 and VA-199. The applicant asserts that the facility is located on two major routes of Williamsburg Area Transport. DCOPN confirmed that there is a Williamsburg Area Transit Authority bus stop located approximately 0.3 miles from the facility. The applicant did not address any benefits or drawbacks to the location with regards to public parking.

The most recent Weldon-Cooper data projects a total PD 21 population of 504,939 residents by 2030 (**Table 3**). This represents an approximate 5.9% increase in total population from 2010 to 2030. Comparatively, Weldon-Cooper projects the total population of Virginia to increase by approximately 16.6% for the same period. With regard to the City of Williamsburg specifically, Weldon-Cooper projects a total population increase of 2,940, or approximately 20.9%, from 2010 to 2030. With regard to the 65 and older age cohort, Weldon-Cooper projects a much more rapid increase among PD 21 as a whole than for the City of Williamsburg. Specifically, Weldon-Cooper projects an increase of approximately 74.2% in residents age 65 and over for PD 21 as a whole from 2010 to 2030, while an increase of only 59.9% is projected among the same age cohort for the City of Williamsburg (**Table 4**). While RDHW touts the significant growth of both the general population and the population over the age of 65 in their application, the percentage growth of both groups in the City of Williamsburg are substantially lower than the overall percentage growth in the Commonwealth for the same period.

DCOPN did not identify any additional geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

Table 3. PD 21 and Statewide Total Population Projections, 2010-2030

Locality	2010	2020	% Change	2030	% Change	2010-2030 % Change
Hampton City	137,436	135,530	-1.4%	127,842	-5.7%	-7.0%
James City	67,009	78,016	16.4%	92,210	18.2%	37.6%
Newport News City	180,719	181,581	0.5%	179,752	-1.0%	-0.5%
Poquoson City	12,150	12,382	1.9%	12,635	2.0%	4.0%
Williamsburg City	14,068	15,463	9.9%	17,008	10.0%	20.9%
York	65,464	69,582	6.3%	75,492	8.5%	15.3%
Total PD 21	**476,846**	**492,554**	**3.3%**	**504,939**	**2.5%**	**5.9%**
Virginia	8,001,024	8,655,021	8.2%	9,331,666	7.8%	16.6%

Source: U.S. Census, Weldon Cooper Center Projections (August 2019) and DCOPN (interpolations)

Table 4. PD 21 Population Projections for 65+ Age Cohort, 2010-2030

Locality	2010	2020	% Change	2030	% Change	2010-2030 % Change
Hampton City	16,856	20,430	21.2%	25,467	24.7%	51.1%
James City	13,870	23,287	67.9%	31,875	36.9%	129.8%
Newport News City	19,219	22,973	19.5%	28,428	23.7%	47.9%
Poquoson City	1,891	2,451	29.6%	2,919	19.1%	54.3%
Williamsburg City	1,879	2,616	39.2%	3,005	14.8%	59.9%
York	7,934	11,723	47.8%	15,707	34.0%	98.0%
Total PD 21	**61,649**	**83,480**	**35.4%**	**107,401**	**28.7%**	**74.2%**
Virginia	976,937	1,352,448	38.4%	1,723,382	27.4%	76.4%

Source: U.S. Census, Weldon Cooper Center Projections (August 2019) and DCOPN (interpolations)

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

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

DCOPN did not receive any letters of support regarding this project. DCOPN received one letter of opposition from Bon Secours Hampton Roads (BSHR). First, BSHR states that VHI hospital discharge data shows residents of RDHW's primary service area have access to, and are receiving care at several hospitals, including those that are part of the Bon Secours, Sentara, VCU, and HCA health systems. BSHR states that the data provided shows that there is no evidence of a lack of sufficient access to hospital care within RDHW's primary service area. BSHR additionally states that BSHR fails to establish an institutional need for additional beds. Finally, BSHR states that the proposed project will have a negative effect on existing providers and cites staffing issues, and nursing shortages specifically, as a primary concern. On October 12, 2021, RDHW submitted a response to BSHR's letter of opposition. In its response to BSHR's first two points, RDHW reiterated the arguments made in its application. Regarding the negative effect on existing providers, RDHW states that the relocated beds will be located 3 miles, or six minutes of driving time, further from Bon Secours Mary Immaculate Hospital.

Public Hearing

DCOPN provided notice to the public regarding this project on August 10, 2021. The public comment period closed on September 24, 2021. Section 32.1-102.6 of the Virginia Code mandates that "in the case of competing applications or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public, [DCOPN shall] hold one hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city." The proposed project is not competing, and no public hearing was requested by the applicant, the Commissioner, an interested party, or member of the public. As such, no public hearing was held.

(ii) the availability of reasonable alternatives to the proposed project that would meet the needs of the people in the area to be served in a less costly, more efficient, or more effective manner;

The status quo is a preferable alternative to the proposed project. As discussed below, the applicant fails to establish a need for the requested beds at RDHW. As such, relocation of the underutilized beds at RRMC would result in their underutilization at RDHW. This would be effectuated for the substantial cost of approximately $21.86 million dollars. The status quo would allow the applicant to continue to offer the same services without the significant cost to the health system. Moreover, the underutilization of the beds at RDHW would be exacerbated by the addition of the proposed beds, resulting in additional costs to RDHW to maintain the unutilized beds. As such, DCOPN concludes that the status quo is a preferable alternative to the proposed project.

(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 V designated by the Virginia Department of Health to serve as the Health Planning Agency for PD 21. Therefore, this consideration is not applicable to the review of either proposed project.

(iv) any costs and benefits of the proposed project;

The total capital and financing cost for the project is $21,860,868 (**Table 2**). The proposed project would cost significantly more, per bed, than other recently approved projects that sought to expand medical/surgical inpatient services. For example, the cost per medical/surgical bed in COPN No. VA-4724 was approximately $431,507, the cost per medical/surgical bed in COPN No. VA-04649 was approximately $470,000, and the cost per medical/surgical bed in COPN No. VA-04658 was approximately $529,590. Comparatively, the cost per medical/surgical bed for the proposed project would be approximately $1,093,043.40. As such, DCOPN concludes that the proposed project is significantly more expensive, per bed, than other recent projects that sought to expand medical/surgical inpatient services. Moreover, as discussed in detail below, the most current VHI data shows that the

current beds at RDHW are severely underutilized, and that no institutional need to expand exists at this location. As the proposed project would not provide any benefit nor address an unmet need for the residents of PD 21 and cost significantly more than other recent similar projects, DCOPN concludes that the costs of the project are not reasonable.

(v) the financial accessibility of the proposed project to the people in the area to be served, including indigent people; and

As **Table 6** below demonstrates, RDHW provided 5.82% of its gross patient revenue in the form of charity care in 2019. This percentage was the highest level of charity care provided by all reporting facilities in HPR V in 2019. In accordance with section 32.1-102.4.B of the Code of Virginia, should the proposed project receive approval, RDHW is expected to provide a level of charity care for total gross patient revenues that is no less than the equivalent average for charity care contributions in HPR V.

Table 5: HPR V 2019 Charity Care Contributions

Hospital	Gross Patient Revenues:	Adjusted Charity Care Contribution:	Percent of Gross Patient Revenue:
Riverside Doctors' Hospital Williamsburg	$154,484,401	$8,984,653	5.82%
Riverside Tappahannock Hospital	$178,917,096	$10,301,634	5.76%
Riverside Shore Memorial Hospital	$260,969,719	$14,708,470	5.64%
Sentara Careplex Hospital	$957,419,827	$49,854,327	5.21%
Bon Secours DePaul Medical Center	$646,905,565	$33,341,271	5.15%
Riverside Walter Reed Hospital	$256,987,962	$11,824,515	4.60%
Bon Secours Maryview Medical Center	$1,271,861,494	$53,695,556	4.22%
Sentara Obici Hospital	$921,265,904	$37,299,918	4.05%
Sentara Virginia Beach General Hospital	$1,263,503,075	$49,259,329	3.90%
Riverside Regional Medical Center	$2,076,281,863	$72,651,353	3.50%
Sentara Norfolk General Hospital	$3,715,953,612	$128,674,022	3.46%
Sentara Leigh Hospital	$1,318,114,262	$39,689,346	3.01%
Sentara Williamsburg Regional Medical Center	$705,249,390	$21,107,537	2.99%
Sentara Princess Anne Hospital	$1,092,371,655	$31,716,570	2.90%
Bon Secours Mary Immaculate Hospital	$656,379,835	$18,964,605	2.89%
Chesapeake Regional Medical Center	$963,632,536	$26,148,298	2.71%
Hampton Roads Specialty Hospital	$31,270,985	$613,073	1.96%
Bon Secours Southampton Memorial Hospital	$247,313,417	$3,200,565	1.29%
Bon Secours Rappahannock General Hospital	$82,964,493	$1,067,845	1.29%
Children's Hospital of the King's Daughters	$1,116,322,433	$7,869,958	0.70%
Lake Taylor Transitional Care Hospital	$43,115,803	$0	0.00%
Hospital For Extended Recovery	$26,389,988	$0	0.00%
Total $ & Mean %	**$17,987,675,315**	**$620,972,845**	**3.5%**

Source: VHI

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

DCOPN did not identify any other discretionary factors, not discussed elsewhere in this staff analysis report, to bring to the attention of the Commissioner as may be relevant to determining a public need for the proposed project.

3. The extent to which the proposed project is consistent with the State Health Services Plan;

Section 32.1-102.2:1 of the Code of Virginia calls for the State Health Services Plan Task Force to develop, by November 1, 2022, recommendations for a comprehensive State Health Services Plan (SHSP). In the interim, DCOPN will consider the consistency of the proposed project with the predecessor of the SHSP, the State Medical Facilities Plan (SMFP).

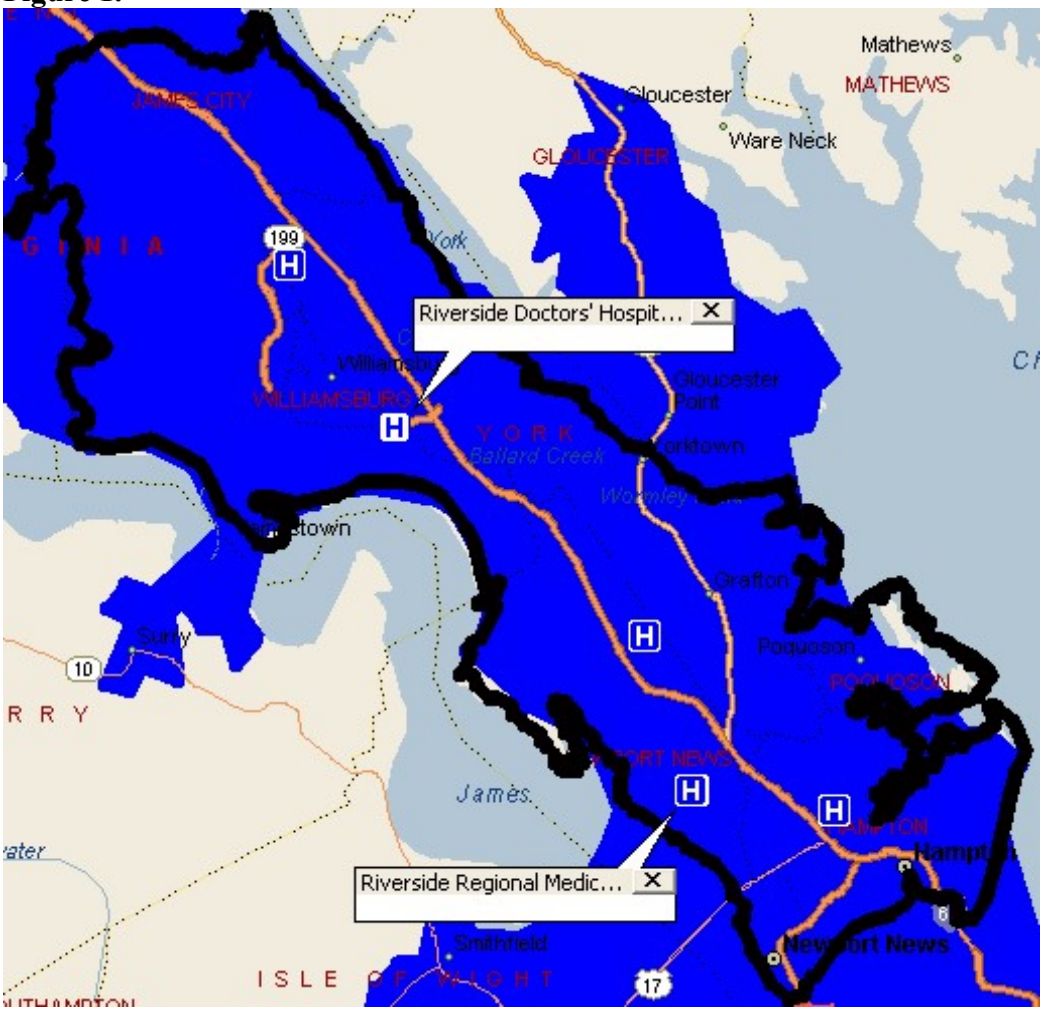
The State Medical Facilities Plan (SMFP) contains the criteria and standards for the addition of medical/surgical beds. They are as follows:

Part VI. Inpatient Bed Requirements

12VAC5-230-520. Travel Time.
Inpatient beds should be within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district using a mapping software as determined by the commissioner.

The heavy dark line in **Figure 1** identifies the boundary of PD 21. The blue shaded area includes all locations that are within a 30-minute drive one way under normal conditions of inpatient bed services in PD 21. **Figure 1** clearly illustrates that medical/surgical inpatient services are currently available within 30-miniutes normal driving time, one way, under normal conditions of 95% of the population of PD 21. As RDHW is an existing provider of medical/surgical inpatient services, approval of the proposed project will not increase access to medical/surgical inpatient services to any resident of PD 21 not within a 30-minute drive one way under normal conditions of inpatient bed services

Figure 1.



12VAC5-230-530. Need for New Service.

A. No new inpatient beds should be approved in any health planning district unless:

1. **The resulting number of beds for each bed category contained in this article does not exceed the number of beds projected to be needed for that health planning district for the fifth planning horizon year; and**
2. **The average annual occupancy based on the number of beds in the health planning district for the relevant reporting period is:**
    a. **80% at midnight census for medical/surgical or pediatric beds;**
    b. **65% at midnight census for intensive care beds.**

B. For proposals to convert under-utilized beds that require a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection C of this section, consideration may be given to such proposal if:

1. **There is a projected need in the applicable category of inpatient beds; and**
2. **The applicant can demonstrate that the average annual occupancy of the converted beds would meet the utilization standard for the applicable bed category by the first year of operation.**

For purposes of this part, "underutilized" means less than 80% average annual occupancy for medical/surgical or pediatric beds, when the relocation involves such beds and less than 65% average annual occupancy for intensive care beds when relocation involves such beds.

C. The capital expenditure threshold referenced in subsection B of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:

$$A \times (1 + B)$$

Where:
A = the capital expenditure threshold amount for the previous year; and
B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.

Not applicable. The applicant is an existing provider of inpatient bed services.

12VAC5-230-540. Need for Medical/surgical Beds.
The number of medical/surgical beds projected to be needed in a health planning district shall be computed as follows:

1. Determine the use rate for the medical/surgical beds for the health planning district using the formula:

$$BUR = (IPD / PoP)$$

Where:
BUR = the bed use rate for the health planning district.
IPD = the sum of total inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and
PoP = the sum of total population 18 years of age and older in the health planning district for the same five years used to determine IPD as reported by a demographic program as determined by the commissioner.

Step 1. PD 21 SMFP Medical/Surgical Bed Use Rate

IPD 2015-2019 Sum of Patient Days Last 5 Years	**Pop** 2015-2019 Sum Population Age 15+ Last 5 Years	**BUR** 2015-2019 Bed Use Rate
923,293	1,976,769	0.4671

Table 6. PD 21 Inpatient Utilization of General Medical/Surgical Services[2] (2015-2019)

	2015	2016	2017	2018	2019	TOTAL & Average
Authorized Beds	1,001	1,001	1,001	1,001	1,001	**5,005**
Available Patient Days	336,165	333,060	326,800	333,975	330,325	**1,660,325**
Patient Days	180,901	184,361	180,634	187,669	189,728	**923,293**
Occupancy	53.8%	55.4%	55.3%	56.2%	57.4%	**55.6%**

Source: VHI (2015-2019) and DCOPN interpolations

Table 7. PD 21 Historical and Projected Population (Ages 18+)

	2015	2016	2017	2018	2019	TOTAL 2015-2019	2026 (Projected)
Population	391,647	393,329	395,181	397,206	399,405	**1,976,769**	407,016

Source: Weldon Cooper
Note: While the SMFP requires population data for ages 18+, Weldon Cooper data is broken into age groups by 5-year increments. As such, the calculations above include data for persons aged 15-17 years of age.

The medical/surgical bed use rate for 2015-2019 in PD 21 was 0.4671 per capita for the population age 15 and over.

2. Determine the total number of medical/surgical beds needed for the health planning district in five years from the current year using the formula:

$$\textbf{ProBed} = \frac{\textbf{((BUR x ProPop) / 365)}}{\textbf{0.80}}$$

Where:

ProBed = The projected number of medical/surgical beds needed in the health planning district for five years from the current year.
BUR = the bed use rate for the health planning district determined in subdivision 1 of this section.
ProPop = the projected population 18 years of age and older of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

$$\text{ProBed} = \frac{((0.4671 \times 407{,}016) / 365)}{0.80}$$

ProBed = 651

[2] DCOPN again notes that the Adjudication Officer's case decision for COPN No. VA-04682 held that DCOPN was in error by including obstetric, intensive care and pediatric patient days in its calculations for medical/surge bed need, despite these beds being fungible and accordingly, able to convert to medical/surgical beds without COPN authorization. However, because obstetric, intensive care and pediatric beds can be easily converted to medical/surgical beds, thereby changing the medical/surgical inventory without first obtaining COPN authorization, DCOPN maintains that obstetric, intensive care and pediatric beds should be included in the medical/surgical inventory and the corresponding patient days used for medical/surgical bed need calculations.

At a medical/surgical average utilization of 80%, there is a need for 651 medical/surgical beds in PD 21 for five years from the current year.

3. Determine the number of medical/surgical beds that are needed in the health planning district for the five year planning horizon year as follows:

NewBed = ProBed – CurrentBed

Where:

NewBed = the number of new medical/surgical beds that can be established in a health planning district, if the number is positive. If NewBed is a negative number, no additional medical/surgical beds should be authorized for the health planning district.

ProBed = the projected number of medical/surgical beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.

CurrentBed = the current inventory of licensed and authorized medical/surgical beds in the health planning district.

New Bed = 651 – 1,001
New Bed = (350)

At a medical/surgical average utilization of 80%, there is a calculated **surplus of 350 medical/surgical beds** in PD 21 by 2026.[3] The applicant's calculations differ slightly, anticipating a surplus of 310 beds in PD 21 by 2026. This 40-bed disparity is likely the result of the applicant not including obstetric, pediatric, and intensive care beds. As discussed throughout this report, because obstetric, intensive care and pediatric beds can be easily converted to medical/surgical beds, thereby changing the medical/surgical inventory without first obtaining COPN authorization, DCOPN maintains that obstetric, intensive care and pediatric beds should be included in the medical/surgical inventory and the corresponding patient days used for medical/surgical bed need calculations. DCOPN notes that all parties concur that there is a calculated surplus of over 300 beds in PD 21 by 2026. As the applicant is seeking to relocate existing beds from another location within the planning district, this section is not applicable to the proposed project and serves to provide an overview of inpatient medical/surgical services in PD 21.

[3] The Adjudication Officer's case decision for COPN No. VA-04682 held that "When the PD 15 computational surplus of 380 medical/surgical beds identified by St. Francis is adjusted by the 355 unstaffed medical/surgical beds, the computational surplus is reduced to 25 medical/surgical beds." DCOPN notes that in order for a medical care facility to maintain COPN authorization for an unstaffed bed, the facility must be capable of staffing the bed and putting it back online within a 24-hour period. For this reason, DCOPN maintains that unstaffed beds should be included in the total inventory for medical/surgical beds as well as the total number of available patient days.

12VAC5-230-550. Need for Pediatric Beds.

The number of pediatric beds projected to be needed in a health planning district shall be computed as follows:

1. **Determine the use rate for pediatric beds for the health planning district using the formula:**

$$PBUR = (PIPD/PedPop)$$

Where:

PBUR = The pediatric bed use rate for the health planning district.
PIPD = The sum of total pediatric inpatient days in the health planning district for the most recent five years for which inpatient days data has been reported by VHI; and
PedPop = The sum of population under 18 years of age in the health planning district for the same five years used to determine PIPD as reported by a demographic program as determined by the commissioner.

2. **Determine the total number of pediatric beds needed to the health planning district in five years from the current year using the formula:**

$$ProPedBed = \frac{((PBUR \times ProPedPop)/365)}{0.80}$$

Where:

ProPedBed = The projected number of pediatric beds needed in the health planning district for five years from the current year.
PBUR = The pediatric bed use rate for the health planning district determined in subdivision 1 of this section.
ProPedPop = The projected population under 18 years of age of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. **Determine the number of pediatric beds needed within the health planning district for the fifth planning horizon year as follows:**

$$NewPedBed – ProPedBed – CurrentPedBed$$

Where:

NewPedBed = the number of new pediatric beds that can be established in a health planning district, if the number is positive. If NewPedBed is a negative number, no additional pediatric beds should be authorized for the health planning district.
ProPedBed = the projected number of pediatric beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.

CurrentPedBed = the current inventory of licensed and authorized pediatric beds in the health planning district.

Not applicable. The applicant is not seeking to expand the number of pediatric care beds.

12VAC5-230-560. Need for Intensive Care Beds.
The projected need for intensive care beds in a health planning district shall be computed as follows:

1. **Determine the use rate for ICU beds for the health planning district using the formula:**

ICUBUR = (ICUPD / Pop)

Where:
ICUBUR = the ICU bed use rate for the health planning district.
ICUPD = The sum of total ICU inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and
Pop = The sum of population 18 years of age or older for adults or under 18 for pediatric patients in the health planning district for the same five years used to determine ICUPD as reported by a demographic program as determined by the commissioner.

2. **Determine the total number of ICU beds needed for the health planning district, including bed availability for unscheduled admissions, five years from the current year using the formula:**

ProICUBed = ((ICUBUR x ProPop) / 365) / 0.65

Where:

ProICUBed = The projected number of ICU beds needed in the health planning district for five years from the current year;
ICUBUR = The ICU bed use rate for the health planning district as determined in subdivision 1 of this section;
ProPop = The projected population 18 years of age or older for adults or under 18 for pediatric patients of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. **Determine the number of ICU beds that may be established or relocated within the health planning district for the fifth planning horizon year as follows:**

NewICUBed = ProICUBed – CurrentICUBed

Where:

NewICUBed = The number of new ICU beds that can be established in a health planning district, if the number is positive. If NewICUBed is a negative

number, no additional ICU beds should be authorized for the health planning district.

ProICUBed = The projected number of ICU beds needed in the health planning district for five years from the current year as determined in subdivision 2 of this section.

CurrentICUBed = The current inventory of licensed and authorized ICU bed sin the health planning district.

Not applicable. The applicant is not seeking to expand the number of intensive care beds.

12VAC5-230-570. Expansion or Relocation of Services.

A. Proposals to relocate beds to a location not contiguous to the existing site should be approved only when:
   1. **Off-site replacement is necessary to correct life safety or building code deficiencies;**
   2. **The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;**
   3. **The number of beds to be moved off-site is taken out of service at the existing facility;**
   4. **The off-site replacement of beds results in:**
      a. **A decrease in the licensed bed capacity;**
      b. **A substantial cost savings, cost avoidance, or consolidation of underutilized facilities; or**
      c. **Generally improved operating efficiency in the applicant's facility or facilities; and**
   5. **The relocation results in improved distribution of existing resources to meet community needs.**

B. Proposals to relocate beds within a health planning district where underutilized beds are within 30 minutes driving time one way under normal conditions of the site of the proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.

DCOPN disagrees with the applicant's interpretation of this section of the SMFP. In their application, RDHW addresses each portion of 12VAC5-230-570 individually, including claiming that section A.1 is not applicable because it is not a relocation of a hospital. DCOPN notes that there is no distinction, in the current version of the SMFP, between the relocation of beds generally and the relocation of a hospital or acute care services. Moreover, DCOPN notes that 12VAC5-230-570 requires that the applicant must meet all criteria under sections A to receive approval to relocate beds under this section of the SMFP. The applicant has not identified any life safety or building code deficiencies that would require the proposed relocation. Moreover, the proposed relocation would be inventory neutral and would not therefore result in the decrease of licensed beds in the planning district. Finally, the applicant has not identified any substantial cost savings, cost avoidance, or consolidation of underutilized facilities that would result from the proposed project. As such, DCOPN concludes that the applicant has not met the necessary threshold mandated under 12VAC5-230-570(A).

BSHR alleges that approval of the project would materially harm existing providers. BSHR asserts that many providers, including Bon Secours Mary Immaculate hospital already serve patients in this area and have additional capacity to continue to provide care for them. While DCOPN acknowledges that some portion of the 1,407 discharged patients from Mary Immaculate could be lost to RDHW, it finds the addition of these beds would be highly unlikely to cause a material harm to Bon Secours Mary Immaculate. There is already ample capacity available at RDHW that could be used by any Bon Secours Mary Immaculate patient if they wished to receive treatment at RDHW. It is highly unlikely that the addition of more beds, when the current beds are underutilized, would materially shift patients away from Bon Secours Mary Immaculate. Moreover, as discussed below, DCOPN finds that, while a staffing shortage exists currently, the applicant has provided sufficient significant recruiting tools that the proposed project would not adversely affect the staffing at Bon Secours Mary Immaculate. As such, DCOPN rejects BSHR's assertion that the proposed project would represent a material harm to Bon Secours Mary Immaculate. However, this section of the SMFP clearly places the burden of proof on the applicant to demonstrate that the proposed relocation will not materially harm existing providers. The applicant does not address this issue beyond asserting that the project will cause no harm because it is meeting an institutional need. As addressed in detail below, the applicant does not have an institutional need to expand its medical/surgical beds. As such, DCOPN concludes that the applicant has not demonstrated that the proposed relocation will not materially harm existing providers.

While the applicant does not meet the threshold necessary to justify approval of the proposed project under this section of the SMFP, RDHW's primary argument is that this relocation is necessary to meet an institutional need at RDHW. Because there is a significant number of unstaffed beds within Riverside's health system, relocation of beds, rather than adding to the surplus within the planning district, is mandated under 12VAC5-230-80. These arguments and DCOPN's analysis are discussed below in the relevant section.

12VAC5-230-580. Long-Term Acute Care Hospitals (LTACHs).

A. LTACHs will not be considered as a separate category for planning or licensing purposes. All LTACH beds remain part of the inventory of inpatient hospital beds.

B. A LTACH shall only be approved if an existing hospital converts existing medical/surgical beds to LTACH beds or if there is an identified need for LTACH beds within a health planning district. New LTACH beds that would result in an increase in total licensed beds above 165% of the average daily census for the health planning district will not be approved. Excess inpatient beds within an applicant's existing acute care facilities must be converted to fill any unmet need for additional LTACH beds.

C. If an existing or host hospital converts existing beds for use as LTACH beds, those beds must be delicensed from the bed inventory of the existing hospital. If the LTACH ceases to exist, terminates its services, or does not offer services for a period of 12 months within its first year of operation, the beds delicensed by the host hospital to establish the LTACH shall revert back to that host hospital.

If the LTACH ceases operation in subsequent years of operation, the host hospital may reacquire the LTACH beds by obtaining a COPN, provided the beds are to be used

exclusively for their original intended purpose and the application meets all other applicable project delivery requirements. Such an application shall not be subject to the standard batch review cycle and shall be processed as allowed under Part VI (12VAC5-220-280 et seq.) of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.

D. The application shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients.

E. A LTACH shall be established for 10 or more beds.

F. A LTACH shall become certified by the Centers for Medicare and Medicaid Services (CMS) as a long-term acute care hospital and shall not convert to a hospital for patients needing a length of stay of less than 25 days without obtaining a certificate of public need.
   1. If the LTACH fails to meet the CMS requirements as a LTACH within 12 months after beginning operation, it may apply for a six-month extension of its COPN.
   2. If the LTACH fails to meet the CMS requirements as a LTACH within the extension period, then the COPN granted pursuant to this section shall expire automatically.

Not applicable. The applicant is not seeking to introduce LTACH beds.

12VAC5-230-590. Staffing.
Inpatient services should be under the direction or supervision of one or more qualified physicians.

The applicant is an established provider of inpatient services and have provided assurances that the beds will remain under the direction of one or more qualified physicians.

Part 1.
Definitions and General Information

12VAC5-230-80. When Institutional Expansion Needed.
A. Notwithstanding any other provisions of this chapter, the commissioner may grant approval for the expansion of services at an existing medical care facility in a health planning district with an excess supply of such services when the proposed expansion can be justified on the basis of a facility's need having exceeded its current service capacity to provide such service or on the geographic remoteness of the facility.

The applicant states that there is an institutional need to expand its medical/surgical beds. In support of this, the applicant first asserts that use of the applicant's medical/surgical beds increased by 17.5% between 2018 and 2019. As shown in **Table 9** below, this is not reflected in VHI's data for 2018 and 2019. The applicant operated at 33.8% of the SMFP threshold in 2018 and at 39% of the SMFP threshold in 2019. This amounts to an increase of 15.5% and was directly proceeded by a decrease in the prior year of 3.4%. The applicant next asserts that RDHW is now operating at between 70% and 80% occupancy. This would amount to an

increase in utilization of between 79.5% and 105.1% within one year. Moreover, the applicant provides little explanation for why this increase would occur, or why none of the available data, such as population growth in the area, can account for such a sudden and staggering increase in utilization. The sole explanation provided is aggressive recruitment of physicians to the hospital. However, the small amount of data provided regarding this recruitment is speculative, anticipating the increase by the end of 2021, and only amounts to an increase of 101 admissions. Even if one were to accept this extremely unlikely increase in utilization, the sole explanation would be the COVID-19 pandemic, which would not represent the average utilization of RDHW, and should not therefore be considered indicative of a need by RDHW to expand. As this alleged sudden and drastic increase in utilization directly contradicts all data trends, and no evidence was provided to support sufficiently the applicant's assertion, DCOPN cannot accept the applicant's assertions on this subject. As such, DCOPN concludes that the applicant has significant available capacity and does not, therefore, have an institutional need to expand.

The applicant additionally argues that they anticipate a continued and significant growth in medical/surgical inpatient bed utilization. First, they cite an increase in their primary service area and an aging population within the area. While the percentages of growth are significant in both accounts, the actual population numbers do not amount to a particularly large group of patients, particularly when spread out between all of the various health systems discussed in BSHR's letter of opposition. The applicant next addresses its aggressive recruitment of physicians over the past six months. As discussed above, the actual utilization increase discussed in this section is both minimal and speculative. Finally, the applicant states that they anticipate a 10% annual growth in medical/surgical inpatient utilization over the next five years. Even accepting this extremely high continued growth, RDHW will not reach the requisite 80% utilization threshold until 2027. For the reasons discussed above, DCOPN concludes that any additional expansion of medical/surgical capacity is premature.

Table 8. PD 21 Medical Surgical Utilization: 2019

Facility	Licensed Beds	Staffed Beds	Licensed Bed Available Days	Patient Days	Occupancy Rate
Bon Secours Mary Immaculate Hospital	123	123	44,895	20,477	45.6%
Hampton Roads Specialty Hospital	25	25	9,125	6,382	69.9%
Riverside Doctors' Hospital Williamsburg	40	17	14,600	5,697	39.0%
Riverside Regional Medical Center	450	240	159,870	88,644	55.4%
Sentara Careplex Hospital	224	140	51,100	39,015	76.4%
Sentara Williamsburg Regional Medical Center	139	139	50,735	29,513	58.2%
Total	**1,001**	**684**	**330,325**	**189,728**	**57.4%**

Source: VHI (2015-2019) and DCOPN interpolations

Table 9. RDHW Medical Surgical Utilization Occupancy Changes (2015-2019)

	Authorized Beds	Staffed Beds	Available Patient Days	Patient Days	Occupancy	Occupancy Change from Prior Year
2015	40	13	14,600	4,314	29.5%	N/A
2016	40	13	14,640	4,587	31.3%	6.3%
2017	40	14	14,600	5,107	35%	11.3%
2018	40	15	14,600	4,932	33.8%	-3.4%
2019	40	17	14,600	5,697	39%	15.5%

Source: VHI (2015-2019) and DCOPN interpolations

B. If a facility with an institutional need to expand is part of a health system, the underutilized services at other facilities within the health system should be reallocated, when appropriate, to the facility with the institutional need to expand before additional services are approved for the applicant. However, underutilized services located at a health system's geographically remote facility may be disregarded when determining institutional need for the proposed project.

The applicant is proposing to reallocate underutilized beds from another facility within the health system, Riverside Regional Medical Center.

C. This section is not applicable to nursing facilities pursuant to § 32.1-102.3:2 of the Code of Virginia.

The applicant is not seeking to use institutional need to add nursing beds.

D. Applicants shall not use this section to justify a need to establish new services.

The applicant is not seeking to use this section to justify a need to establish a new service.

Required Considerations Continued

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

As the latest data from VHI shows that significant capacity is currently available at RDHW, approval of the proposed project would not foster institutional competition.

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

The proposed project would not affect the overall utilization and efficiency of existing services in PD 21. The beds that would be relocated are currently not staffed at RRMC, so relocation of these beds would increase the overall percentage utilization of beds at RRMC by decreasing the number of beds. However, as the beds located at RDHW are also significantly underutilized, relocation of these beds would exacerbate the already low utilization of medical/surgical beds at this location. Using the 2019 data, the last year DCOPN has data available from VHI, approval of the proposed project would cause the occupancy rate of RDHW to drop to 26%. Because this project would effectively result in a change of the proposed beds being underutilized at RRMC to the proposed beds being underutilized at RDHW, the proposed project would not ultimately affect the overall utilization and efficiency of existing services in PD 21.

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

As already discussed, the total capital costs for the proposed project are $21,860,868 (**Table 2**). These costs would be paid for using the accumulated reserves of the applicant's parent company. Accordingly, there are no financing costs associated with this project. As such, DCOPN concludes that the proposed project is financially feasible. However, as discussed above, the cost of the project, per bed, is significantly higher than other recent projects that seek to expand inpatient medical/surgical services. Moreover, DCOPN concludes that, because of the high costs and the lack of benefit provided by the proposed project, the costs associated with the project are not reasonable.

With regard to staffing, RDHW anticipates the need to hire an additional four Registered Nurses and three Nursing Assistants. The applicant asserts that RRMC provides a wide variety of training programs in health professions. Its accredited School of Health and Medical Sciences trains radiologic technologists, surgical technologists, registered nurses, licensed practical nurses, certified nursing assistants, renal dialysis technicians, medical assistants, and unit secretaries. For the current 2021 year, 227 students are enrolled in the registered nursing program. The nursing assistant program has moved to Employee Student only because of COVID-19 constraints. The applicant asserts that many of these students are from the Williamsburg/James City area. The applicant additionally asserts that RRMC receives numerous employment applications daily, of which many are from Registered Nurses or Nursing Assistants. Based on the assertions made by the applicant above, as well as the modest number of necessary staff, DCOPN concludes that the applicant will successfully be able to staff the proposed project and that doing so will not have a significant negative impact on existing providers of this service in the area.

7. The extent to which the proposed project provides improvements or innovations in the financing and delivery of health care 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 health care 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; and

The proposed project would 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 in the delivery of health care services, nor does it provide for the provision of services on an outpatient basis. Additionally, the proposed project would not provide improvements or innovations in the financing and delivery of health care services as demonstrated by any cooperative efforts to meet regional health care needs. DCOPN did not identify any other relevant factors to bring to the Commissioner's attention.

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 and is not affiliated with a medical school.

DCOPN Staff Findings and Conclusions

DCOPN finds that the proposed project to transfer 20 Medical/Surgical Beds from RRMC to RDHW is inconsistent with the applicable criteria and standards of the SMFP and the Eight Required Considerations of the Code of Virginia. DCOPN concludes that the applicant has not met the applicable criteria under 12VAC5-230-570 and has not established an institutional need for the requested medical/surgical beds. Additionally, even the applicant's ambitious projections do not show an institutional need to expand the capacity of their medical/surgical inpatient service within the next five years.

Moreover, DCOPN finds that the status quo is a preferable alternative to the proposed project. The latest data available to DCOPN shows that the beds currently available are significantly underutilized. Moreover, as discussed throughout the report, RDHW does not have an institutional need to expand its medical/surgical inpatient services. As such, relocation of the underutilized beds at RRMC would result in their underutilization at RDHW. This would be effectuated for the substantial cost of approximately $21.86 million dollars. The status quo would allow for the applicant to continue to offer the same services without the significant cost to the health system. Moreover, the underutilization of the beds will be exacerbated, resulting in additional costs to RDHW to maintain the unutilized beds.

Finally, DCOPN finds that the total capital costs of $21,860,868 (**Table 2**) for the proposed project, which would be paid through the use of the accumulated reserves of the applicant's parent company, are financially feasible, but are significantly higher, per bed, than other recent projects of expand medical/surgical inpatient services.

DCOPN Staff Recommendations

The Division of Certificate of Public Need recommends the **denial** of Doctors' Hospital of Williamsburg's COPN Request No. VA-8574 to transfer 20 Medical/Surgical Beds from Riverside Regional Medical Center to Doctors' Hospital of Williamsburg. DCOPN's recommendation is based on the following findings:

1. The proposed project is not 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 applicant has not demonstrated an institutional need to expand its existing inventory of medical/surgical beds.

3. The cost of the project is significantly higher, per bed, than other recent projects to expand medical/surgical inpatient services.