VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

October 19, 2022

COPN Request No. VA-8653
Wellmont Health System d/b/a Norton Community Hospital
Norton, Virginia
Add 10 long-term care beds via relocation from Mountain View Regional Hospital

Applicant
Wellmont Health System, doing business as Norton Community Hospital (NCH) 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. Wellmont Health System is a wholly owned subsidiary of Ballad Health. NCH is located in the City of Norton, Virginia in Planning District (PD) 1, Health Planning Region (HPR) III. Wellmont Health System also operates Mountain View Regional Hospital (MVRH), which is located 2.2 miles from NCH, also in PD 1, HPR III.

Background
Division of Certificate of Public Need (DCOPN) records show that there are currently 641 licensed nursing home beds located PD 1 (**Table 1**). Virginia Health Information (VHI) data for 2020, the last year for which such data is available, showed that these facilities operated at a collective utilization of 83.9% (**Table 1**).

Table 1. PD 1 Long Term Care Beds and 2020 Utilization

Facility	Licensed Nursing Beds	Patient Days	Available Days	Occupancy Rate
Heritage Hall - Big Stone Gap	180	57,824	65,880	87.77%
Heritage Hall - Wise	97	31,936	35,502	89.96%
Lee Health and Rehab Center	110	35,220	40,260	87.48%
Mountain View Regional Hospital[1]	44	8,299	16,104	51.53%
Nova Health & Rehab Center	90	28,882	32,940	87.68%
Ridgecrest Manor Nursing and Rehabilitation	120	34,681	43,920	78.96%
Total and Average	**641**	**196,842**	**234,606**	**83.90%**

Source: VHI (2020) & DCOPN records

DCOPN notes that nearly all acute care hospital beds in Virginia are licensed as "medical-surgical" beds, with the exception of psychiatric, substance abuse treatment, and rehabilitation beds, which are licensed separately. As long as the total licensed bed complement is not exceeded, hospitals may

[1] Ballad Health has notified the Virginia Department of Health (VDH) that MVRH will close by April 2023.

configure and use medical-surgical beds, as circumstances require. For this reason, DCOPN has included obstetric, pediatric, and ICU beds in the total count of licensed medical-surgical beds (**Table 2**). According to DCOPN records, and as demonstrated by **Table 2** below, the medical-surgical bed inventory of PD 1 consists of 199 beds.

Table 2. Medical-Surgical Bed Inventory in PD 1[2]

Facility	**Licensed Beds**	**2020 Occupancy**
Lee County Community Hospital[3]	6	-
Lonesome Pine Hospital	60	11.93%
Mountain View Regional Hospital[4]	15	58.05%[5]
Norton Community Hospital	118	18.73%
Total/Average	**199**	**26.8%**

Source: VHI (2020) & DCOPN records

In 2020, the State Health Commissioner (Commissioner) issued COPN No. VA-04701 authorizing the establishment of a 15-bed inpatient medical rehabilitation service at MVRH through the conversion of MVRH's remaining 15 medical-surgical beds and the relocation of NCH's medical rehabilitation service to MVRH. Upon approval, Welmont Health System intended to establish a post-acute care center of excellence by co-locating hospital based long-term care beds with inpatient medical rehabilitation services. According to the applicant, due to the COVID-19 public health emergency and inflationary cost increases, it has become impractical and cost-prohibitive to implement COPN No. VA-04701.

Proposed Project

NCH proposes to establish a 10-bed long-term care unit at NCH through the relocation of 10 licensed hospital beds certified for long-term care from MVRH. According to the applicant, the goal of this project is identical to the goal sought in seeking approval for COPN No. VA-04701 – to establish a post-acute care center of excellence, but in a more cost-effective manner. The new unit will occupy space currently occupied by medical-surgical beds at NCH. If the proposed project is approved, NCH will convert 10 underutilized medical-surgical beds to 10 beds certified for long-term care. Additionally, upon relocating the 10 long-term care beds to NCH, the remaining 34 hospital beds certified for long-term care at MVRH will be delicensed. The total number of licensed hospital beds at NCH will remain 129, with designated medical-surgical beds decreasing from 99 to 89 beds through the conversion of 10 medical-surgical beds to being certified and used for long term care. Finally, if the proposed project is approved, MVRH will also delicense 15 underutilized medical-surgical beds at its facility. However, DCOPN notes that Ballad Health has notified the VDH that MVRH will close by April 2023.

The projected capital costs of the proposed project total $191,348.23, the entirety of which will be funded using the accumulated reserves of the applicant (**Table 3**). Accordingly, there are no financing costs associated with this project. If the Commissioner approves the proposed project,

---

[2] DCOPN notes that the number of available patient days reported by VHI for 2020 appear to be in error. DCOPN has calculated PD 1 occupancy using a corrected number of available patient days, derived by multiplying the number of licensed beds by 365, or in the event of a leap year, 366.
[3] Lee County Community Hospital did not open until 2021
[4] Ballad Health has notified the VDH that MVRH will close by April 2023.
[5] Combined utilization for acute care beds and beds certified for long-term care at MVRH.

construction is expected to begin March 1, 2023 and is projected to be complete by July 1, 2023. The target date of opening is July 1, 2023.

Table 3. NCH Projected Capital Costs

Direct Construction Costs	$123,237.26
Equipment Not Included in Construction Contract	$55,800
Architectural and Engineering Fees	$7,064.64
Other Consultant Fees	$5,246.33
Total Capital Costs	**$191,348.23**

Source: COPN Request No. VA-8653

Project Definitions

§32.1-102.1:3 of the Code of Virginia defines a project, in part, as "Addition of any new nursing home service at an existing medical care facility described in subsection A." §32.1-102.1:3 defines a medical care facility as "Any 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 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;**

Geographically, NCH is located at 100 15th Street Northwest, Norton, Virginia. NCH is near the intersection of U.S. Route 23 and U.S. Route 58, both four-lane highways. Primary access to NCH is by 15th Street Northwest.

The most recent Weldon-Cooper data projects a total PD 1 population of 84,849 persons by 2030 (**Table 4**). This represents an approximate 10% decrease in total population from 2010 to 2030. Comparatively, Weldon-Cooper projects the total population of Virginia to increase by 16.63% for the same period. With regard to the 65 and older age cohort in PD 1, Weldon-Cooper projects an increase. Weldon-Cooper projects a PD 1 increase of 24.40% among this age cohort from 2010-2030 (**Table 4**). While this is below the projected statewide growth of 76.41% for the 65+ cohort, PD 1's growth is still significant, and this age group typically uses health care services at a rate much higher than those under the age of 65.

Table 4. Statewide and PD 1 Total Population Projections, 2010-2030

Locality	2010	2020	% Change 2010-2020	Avg Ann % Change 2010-2020	2030	% Change 2020-2030	Avg Ann % Change 2020-2030	% Change 2010-2030
Lee	25,587	23,718	-7.30%	-0.74%	23,632	-0.36%	-0.04%	-7.64%
Scott	23,177	21,949	-5.30%	-0.53%	20,961	-4.50%	-0.46%	-9.56%
Wise	41,452	37,844	-8.70%	-0.88%	36,400	-3.82%	-0.39%	-12.19%
Norton	3,958	3,906	-1.32%	-0.13%	3,857	-1.24%	-0.13%	-2.55%
Total PD 1	**94,174**	**87,417**	**-7.18%**	**-0.72%**	**84,849**	**-2.94%**	**-0.30%**	**-9.90%**
PD 1 65+	**15,119**	**18,236**	**20.62%**	**1.85%**	**18,808**	**3.13%**	**0.31%**	**24.40%**
Virginia	8,001,024	8,655,021	8.17%	0.77%	9,331,666	7.82%	0.76%	16.63%
Virginia 65+	976,937	1,352,448	38.44%	3.22%	1,723,382	27.43%	2.45%	76.41%

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

Regarding socioeconomic barriers to access to the applicant's services, according to regional and statewide data regularly collected by VHI, for 2020, the most recent year for which such data is available, the average amount of charity care provided by HPR III facilities was 0.7% of all reported total gross patient revenues (**Table 5**).

Table 5: HPR III 2020 Charity Care Contributions

2020 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	$146,159,934	$3,708,842	2.54%
Bedford Memorial Hospital	$122,377,242	$2,357,210	1.93%
Dickenson Community Hospital	$25,321,849	$465,722	1.84%
Carilion Tazewell Community Hospital	$57,945,546	$956,508	1.65%
Carilion Giles Memorial Hospital	$107,478,905	$1,438,902	1.34%
Russell County Medical Center	$121,070,842	$1,529,332	1.26%
Wellmont Lonesome Pine Mt. View Hospital	$372,115,538	$4,558,248	1.22%
Carilion Medical Center	$3,983,507,417	$47,514,964	1.19%
Carilion New River Valley Medical Center	$711,175,865	$8,034,717	1.13%
Johnston Memorial Hospital	$855,313,389	$7,815,178	0.91%
Norton Community Hospital	$311,397,944	$2,789,910	0.90%
Smyth County Community Hospital	$198,825,769	$1,746,804	0.88%
Centra Health	$2,649,888,465	$20,969,883	0.79%
LewisGale Hospital -- Montgomery	$680,834,380	$5,052,836	0.74%
Lewis-Gale Medical Center	$2,312,565,268	$16,202,296	0.70%
LewisGale Hospital -- Pulaski	$346,826,376	$2,140,319	0.62%
LewisGale Hospital -- Alleghany	$189,090,272	$708,265	0.37%
Twin County Regional Hospital	$222,632,986	$649,064	0.29%
Clinch Valley Medical Center	$520,600,957	$946,557	0.18%
Buchanan General Hospital	$99,508,254	$105,669	0.11%
Memorial Hospital of Martinsville & Henry County	$668,028,626	$582,956	0.09%
Wythe County Community Hospital	$235,991,599	$93,569	0.04%
Danville Regional Medical Center	$910,930,415	-$19,407,300	-2.13%

2020 Charity Care Contributions at or below 200% of Federal Poverty Level			
Total Facilities Reporting			23
Median			0.9%
Total $ & Mean %	**$15,849,587,838**	**$110,960,451**	**0.7%**

Source: VHI Data (2020)

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 received seven letters in support of the proposed project from members of the Ballad medical community, and the PD 1 community. Collectively, these letters articulate numerous benefits of the project, including:

- NCH is an essential provider of healthcare services in southwest Virginia.
- If the project is approved, residents will have continued access to superior post-acute care and will benefit from an increase in the continuity of post-acute care provided at NCH.
- By providing long-term care services at NCH, Ballad Health will be able to establish a state of the art, post-acute care center that will reach a large portion of the community.
- Relocating beds from MVRH will reduce underutilized capacity within the PD.

Public Hearing

Section 32.1-102.6 B of the Code of Virginia directs DCOPN to hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city 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. COPN Request No. VA-8653 is not competing with another project in this batch cycle and DCOPN did not receive a request to conduct a public hearing for the proposed project. Thus, 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;

According to the applicant, approval of the proposed project will allow Ballad Health to consolidate the resources and staffing of post-acute care services at MVRH and NCH, which are located only 2.2 miles apart in Norton, Virginia. Additionally, the hospital based long-term care unit will complement NCH's existing medical rehabilitation unit.

As shown in **Table 1**, MVRH, the facility from which the proposed long-term care beds will be relocated, is the only hospital-based provider of long-term care services in PD 1. In 2020, the 44

long-term care beds at MVRH operated at a collective occupancy of only 51.53% (**Table 1**). The proposed project intends to establish a much smaller, 10-bed long-term care unit at NCH, which the applicant anticipates will operate at 80% utilization by 2023. Furthermore, as previously discussed, Ballad Health has notified the VDH that it intends to close MVRH. DCOPN concludes that approval of the proposed project is more advantageous than the status quo because it will preserve the only hospital based long-term care services in PD 1, while simultaneously allowing the service to operate at a much more appropriate utilization rate.

Furthermore, as previously discussed, approval of the proposed project would result in the conversion of 10 underutilized medical-surgical beds at NCH. The applicant reports that NCH's medical surgical beds, obstetric beds and ICU beds recorded 9,410[6] patient days in 2021, for an overall utilization of 22% (9,410 patient days/43,070 available days), indicating that the conversion of 10 medical-surgical beds is appropriate as those beds are underutilized. The hospital occupancy data reported to VHI (with corrected available days) for NCH in 2020 showed an occupancy of 18.73%. Using 2020 data as reported to VHI, if NCH had had 10 fewer beds available for acute care services, as proposed, the occupancy would still have only been 20.46%, demonstrating ample availability at NCH to convert underutilized medical-surgical beds. Finally, conversion of the underutilized beds will improve the overall utilization of the remaining medical-surgical beds in the planning district.

For these reasons, DCOPN concludes that the proposed project is more advantageous than the alternative of the status quo because approval of the proposed project will result in the delicensing of 59 underutilized hospital acute care beds (29% of the licensed hospital beds in the planning district) and will preserve access to hospital based long term care services for the residents of PD 1.

(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 the proposed project.

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

As demonstrated by **Table 3**, the projected capital costs of the proposed project are $191,348, the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with this project. DCOPN concludes that, when compared with similar projects, these costs are reasonable. For example, COPN No. VA-04765 issued to Autumn Care of Altavista to add eight nursing home beds through a transfer within PD 11, is projected to cost approximately $178,843.

The applicant identified numerous benefits of the proposed project, including:

[6] Application for COPN Request No. VA-8653 at pg. 20.

- The proposed project is a cost-effective approach to introducing long-term care beds at NCH.

- Renovation of existing space to accommodate the long-term care unit will provide for the efficient use of existing resources and will result in lower project costs when compared to new construction.

- Approval of the proposed project will not change the total licensed bed count at NCH.

- A post-acute care center of excellence will be established by co-locating inpatient medical rehabilitation services and hospital-based long-term care services at NCH.

- Once the long-term care beds are relocated from MVRH to NCH, the remaining 49 currently underutilized acute care beds at MVRH (15 medical-surgical beds and 34 long-term care beds) will be delicensed and taken out of service. This will allow Ballad Health to consolidate the resources and staffing of post-acute care services at these two hospitals, currently located just 2.2 miles apart, in a single location[7].

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

According to regional and statewide data regularly collected by VHI, for 2020, the most recent year for which such data is available, the average amount of charity care provided by HPR III facilities was 0.7% of all reported total gross patient revenues (**Table 5**).

Table 6. NCH Pro Forma Income Statement

	Year 1	Year 2
Total Gross Patient Revenue	**$1,669,528**	**$1,686,223**
Charity (1.6%)	($26,712)	($26,980)
Bad Debt	($56,764)	($57,332)
Net Patient Revenue	**$1,586,051**	**$1,601,912**
Total Operating Expenses	$1,121,213	$1,155,112
Net Operating Income	**$548,315**	**$531,111**

Source: COPN Request No. VA-8653

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

As previously discussed, Ballad Health has notified VDH that MVRH will close by April 2023 in compliance with the Virginia Order and Letter Authorizing a Cooperative Agreement.

[7] Ballad Health has notified the VDH that MVRH will close by April 2023.

3. The extent to which the application 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, these regulations provide the best available criteria and DCOPN will consider the consistency of the proposed project with the predecessor of the SHSP, the State Medical Facilities Plan (SMFP).

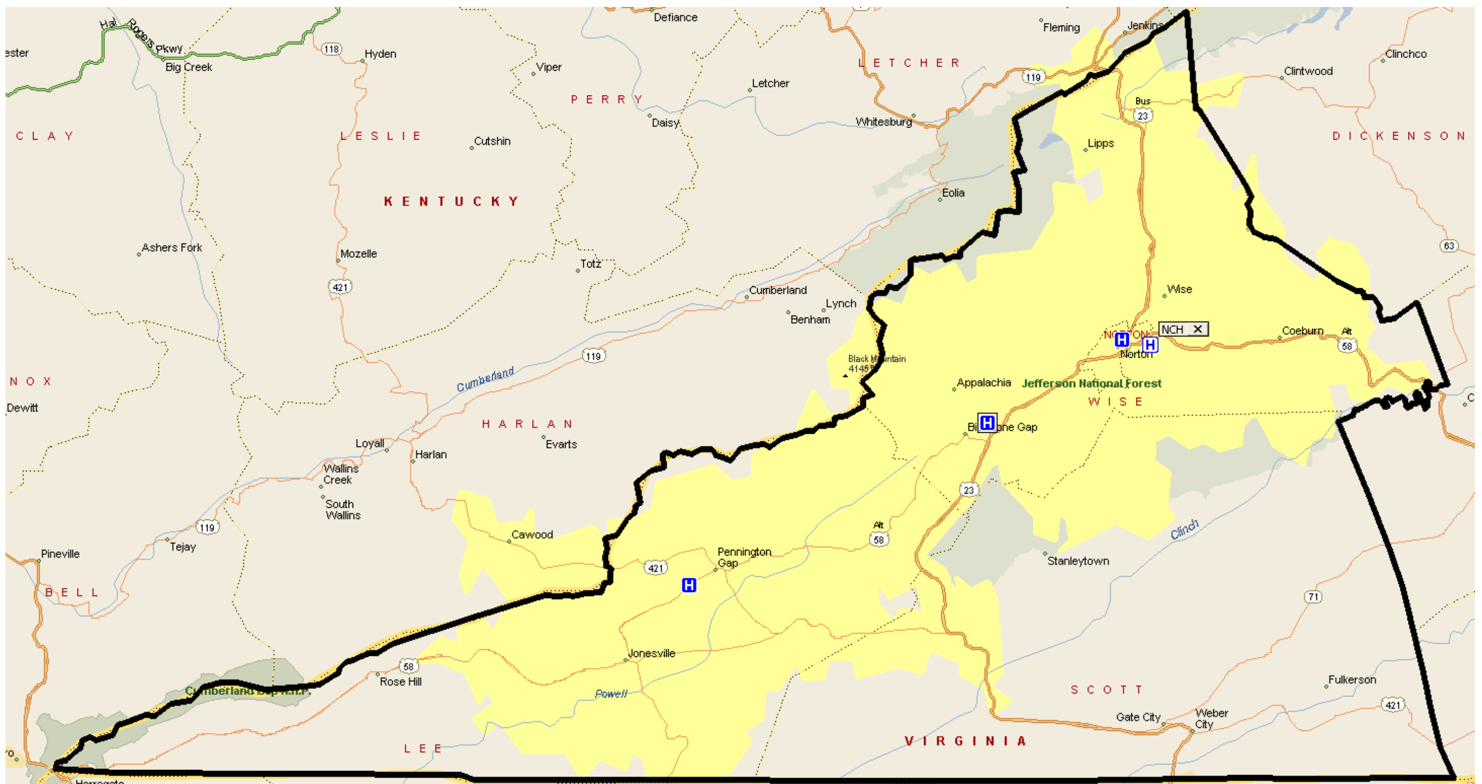
The SMFP contains criteria/standards for the addition of medical-surgical beds. They are as follows:

Part VI
Inpatient Bed Requirements

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

The heavy black line in **Figure 1** represents the boundary of PD 1. The white "H" symbol marks the locations of NCH. The blue "H" symbols mark the locations of all other existing inpatient bed services in PD 1. The yellow shaded area represents the area of PD 1 that is within 30 minutes' drive time of existing inpatient bed services. Given the amount of shaded area, it appears that inpatient bed services currently may not exist within a 30-minute drive for a least 95% of the population of PD 1. However, the applicant is already a provider of inpatient bed services in PD 1. Accordingly, DCOPN concludes that approval of the proposed project would not improve or diminish geographic access to inpatient bed services for persons in PD 1 in any meaningful way.

Figure 1: Acute Care Inpatient Beds in PD 1



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

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 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 and pediatric beds;**
   b. **65% at midnight census for intensive care beds.**

B. For proposals to convert under-utilized beds that require a capital expenditure of $15 million or more, consideration may be given to such proposals 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, "utilization" 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 the 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 x (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 not proposing to add new medical-surgical beds.

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 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 the total inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported to VHI; and

PoP= the sum of the 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.

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:

$$\text{ProBed} = \frac{((\text{BUR} \times \text{ProPop}) / 365}{0.80}$$

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.

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 negative,

No additional medical-surgical beds should be authorized in 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 as determined in Subdivision 2 of this section.
CurrentBed = the current inventory of licensed and authorized medical-surgical Beds in the health planning district.

Not applicable. The applicant is not proposing to add new medical-surgical beds to the PD 1 inventory.

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

In the interest of brevity, this calculation has been omitted from this DCOPN staff analysis report, as the applicant is not proposing to add pediatric beds.

12VAC5-230-560. Need for Intensive Care Beds.

In the interest of brevity, this calculation has been omitted from this DCOPN staff analysis report, as the applicant is not proposing to add new ICU beds to PD 1.

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 efficiency in the applicant's facility or facilities; and**
   5. **The relocation results in improved distribution of existing resources to meet community needs.**

As previously discussed, Ballad Health operates two hospitals 2.2 miles apart in Norton, Virginia. The applicant proposes to: (1) relocate 10 long-term care beds from MVRH to NCH; (2) discontinue long-term care services at MVRH[8]; and (3) convert 10 underutilized medical-surgical beds at NCH to long-term care beds.

The applicant has not identified any life safety or building code deficiencies that it will address through the relocation of the long-term care beds from MVRH to NCH. However, Ballad Health

[8] Ballad Health has notified the Virginia Department of Health (VDH) that MVRH will close by April 2023.

has notified the VDH that it intends to close MVRH. Regarding the population served by the beds to be moved, because of the proximity of the two hospitals, it is reasonable to conclude that the populations served are identical and that the population will continue to have access to long term care services if the beds are relocated to NCH, just 2.2 miles away.

As previously discussed, approval of the proposed project would result in the conversion of 10 underutilized medical-surgical beds at NCH, which, according to the applicant, operated at 22% utilization in 2021. The conversion of 10 medical-surgical beds is appropriate, as those beds are underutilized, and will improve the overall utilization of the remaining medical-surgical beds in the planning district.

Furthermore, as previously discussed, the applicant has indicated that locating the post-acute care center of excellence at NCH represents a cost-effective way for Ballad Health to eliminate unnecessary duplication of services in Norton, and consolidate staffing and resources, thus improving the overall operating efficiency of the system's hospitals in PD 1.

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 proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.

As shown in **Table 1**, NCH is one of four providers of medical-surgical services in PD 1, all of which are hospitals owned by Ballad Health. As such, it is reasonable to conclude that there will be no negative impact on existing providers that Ballad Health did not already take into consideration when submitting COPN Request No. VA-8653. DCOPN notes that it did not receive any letters in opposition to the proposed project.

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

In the interest of brevity, this standard has been omitted from this DCOPN staff analysis report, as the applicants are not proposing to add LTACH beds or to convert existing beds to LTACH beds.

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

The applicant has provided assurances that proposed project will be under the direction of Dr. Bernie Sergeant, the current Medical Director of MVRH's long-term care unit.

The SMFP also contains the criteria and standards for the addition of nursing beds. They are as follows:

Part VII. Nursing Facilities

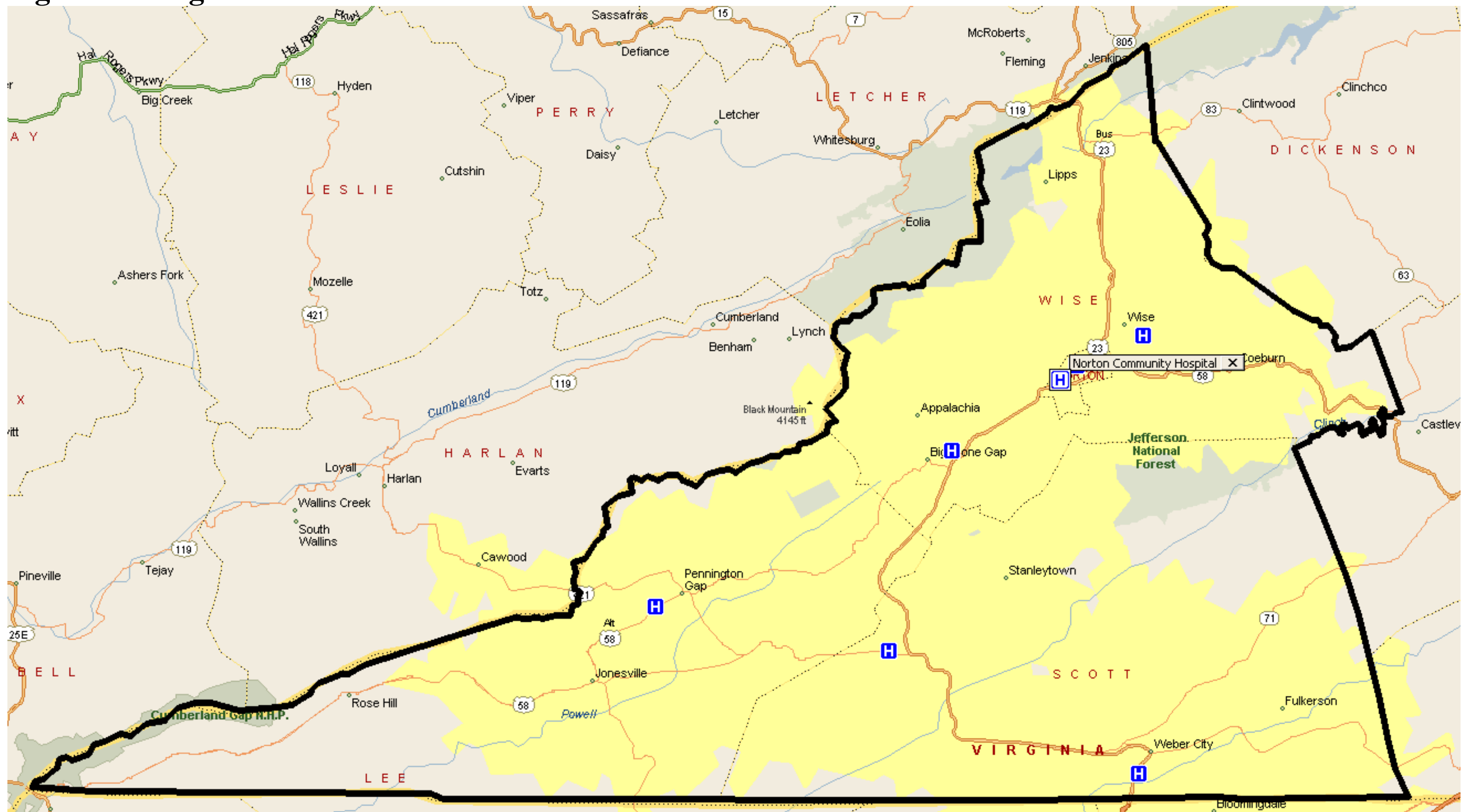
12VAC5-230-600. Travel Time.

A. Nursing facility beds should be accessible within 30 minutes driving time one way under normal conditions of 95% of the population in a health planning district using mapping software as determined by the commissioner

The heavy black line in **Figure 2** identifies the boundary of PD 1. The white "H" symbol marks the location of the proposed project. The blue "H" symbols mark the locations of all other providers of nursing home care in PD 1. DCOPN notes that MVRH, the facility from which the proposed long-term care beds will be relocated, is the only hospital-based provider of long-term care services in PD 1. The yellow shaded area illustrates the area of PD 1 and the surrounding area that is currently within the 30-minue drive time of long-term care services in PD 1. Given the amount of shaded area, and its location, it is reasonable to conclude that 95% of the PD 1 population may be within 30-minutes driving time, one-way, under normal driving conditions, of existing long-term care services. Furthermore, because the applicant currently provides this service at MVRH, which is only 2.2 miles from NCH, DCOPN concludes that the proposed project would not improve geographic access for residents of PD 1 in any meaningful way. The reduction in the number of available long term care beds in PD 1 through the closure of the 44 hospital beds used for long term care at MVRH and the new use of 10 hospital beds at NCH for long term care, (net loss of 34 long term care beds in PD 1) will only marginally improve overall long term care bed utilization in PD 1 to 85.2%, from 83.9%.[9]

[9] Using 2020 utilization data reported to VHI.

Figure 2: Long Term Care Beds in PD 1



B. Nursing facilities should be accessible by public transportation when such systems exist in an area.

Not applicable. The applicant is not a nursing facility.

C. Preference may be given to proposals that improve geographic access and reduce travel time to nursing facilities within a health planning district.

The proposed project is not competing with another project. Accordingly, this standard is not applicable.

12VAC5-230-610. Need for New Service.

A. A health planning district should be considered to have a need for additional nursing facility beds when:

1. **The bed need forecast exceeds the current inventory of beds for the health planning district; and**
2. **The average annual occupancy of all existing and authorized Medicaid-certified nursing facility beds in the health planning district was at least 93%, excluding the bed inventory and utilization of the Virginia Veterans Care Centers.**
   EXCEPTION: When there are facilities that have been in operation less than three years in the health planning district, their occupancy can be excluded from the

calculation of average occupancy if the facilities had an annual occupancy of at least 93% in one of its first three years of operation.

B. No health planning district should be considered in need of additional beds if there are unconstructed beds designated as Medicaid certified. This presumption of 'no need' for additional beds extends for three years from the issuance date of the certificate.

C. The bed need forecast will be computed as follows:

PDBN = (UR64 x PP64) + (UR69 x PP69) + (UR74 + PP74) + UR79 + PP79) + UR84 + PP84) + UR85 + PP85)

Where:

- **PDBN = Planning district bed need.**
- **UR64 = The nursing home bed use rate of the population aged 0 to 64 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.**
- **PP64 = The population aged 0 to 64 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.**
- **UR69 = The nursing home bed use rate of the population aged 65 to 69 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.**
- **PP69 = The population aged 65 to 69 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.**
- **UR74 = The nursing home bed use rate of the population aged 70 to 74 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.**
- **PP74 = The population aged 70 to 74 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.**
- **UR79 = The nursing home bed use rate of the population aged 75 to 79 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.**
- **PP79 = The population aged 75 to 79 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.**
- **UR84 = The nursing home bed use rate of the population aged 80 to 84 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.**
- **PP84 = The population aged 80 to 84 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.**
- **UR85+ = The nursing home bed use rate of the population aged 85 and older in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.**

- **PP85+ = The population aged 85 and older projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.**

Health planning district bed need forecasts will be rounded as follows:

Health Planning District Bed Need	Rounded Bed Need
1-29	0
30-44	30
45-84	60
85-104	90
105-134	120
135-164	150
165-194	180
195-224	210
225+	240

EXCEPTION: When a health planning district has:

1. **Two or more nursing facilities;**
2. **Had an average annual occupancy rate in excess of 93% for the most recent two years for which bed utilization has been reported to VHI; and**
3. **Has a forecasted bed need of 15 to 29 beds, then the bed need for this health planning district will be rounded to 30.**

D. No new freestanding nursing facilities of less than 90 beds should be authorized. However, consideration may be given to a new freestanding facility with fewer than 90 nursing facility beds when the applicant can demonstrate that such a facility is justified based on a locality's preference for such smaller facility and there is a documented poor distribution of nursing facility beds within the health planning district.

E. When evaluating the capital cost of a project, consideration may be given to projects that use the current methodology as determined by the Department of Medical Assistance Services.

F. Preference may be given to projects that replace outdated and functionally obsolete facilities with modern facilities that result in the more cost-efficient resident services in a more aesthetically pleasing and comfortable environment.

In its most recent Notice of No Need, DCOPN calculated a net surplus of 81 nursing beds in PD 1 and an average occupancy of 90.8% for the 2022 planning horizon, indicating no need for additional nursing home beds. However, as previously discussed, MVRH, the facility from which the proposed long-term care beds will be relocated, is the only hospital-based provider of long-term care services in PD 1. In 2020, the 44 long-term care beds at MVRH operated at a collective occupancy of only 51.53% (**Table 1**). The proposed project intends to establish a much smaller 10-bed long-term care unit at NCH, which the applicant anticipates will operate at 80% utilization by 2023. Furthermore, as previously discussed, Ballad Health has notified the VDH that it intends to close MVRH, thereby closing the remaining 34 long-term care beds MVRH is licensed to operate. Therefore, approval of the proposed project will preserve the only hospital based long term care services in PD 1, while simultaneously allowing the service to operate at a much more appropriate utilization rate and reducing the surplus of nursing home beds in PD 1.

12VAC5-230-620. Expansion of Services.
Proposals to increase an existing nursing facility's bed capacity should not be approved unless the facility has operated for at least two years and the average annual occupancy of the facility's existing beds was at least 90% in the relevant reporting period as reported to VHI.

Note: Exceptions will be considered for facilities that operated at less than 90% average annual occupancy in the most recent year for which bed utilization has been reported when the facility offers short stay services causing an average annual occupancy lower than 90% for the facility.

Not applicable. The applicant is not seeking to expand its existing complement of nursing home beds.

12VAC5-230-630. Continuing Care Retirement Communities.
Proposals for the development of new nursing facilities or the expansion of existing facilities by continuing care retirement communities (CCRC) will be considered when:

1. **The facility is registered with the State Corporation Commission as a continuing care provider pursuant to Chapter 49 (§38.2-4900 et seq.) of Title 38.2 of the Code of Virginia;**
2. **The number of nursing facility beds requested in the initial application does not exceed the lesser of 20% of the continuing care retirement community's total number of beds that are not nursing home beds or 60 beds;**
3. **The number of new nursing facility beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed 20% of its total number of beds that are not nursing facility beds; and**
4. **The continuing care retirement community has established a qualified resident assistance policy.**

This provision is not applicable to the proposed project, as the applicant is not a continuing care retirement community.

12VAC5-230-640. Staffing.
Nursing facilities shall be under the direction or supervision of a licensed nursing home administrator and staffed by licensed and certified nursing personnel qualified as required by law.

The applicant has provided assurances that proposed project will be under the direction of Dr. Bernie Sergeant, the current Medical Director of MVRH's long-term care unit.

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 previously discussed, MVRH, the facility from which the proposed long-term care beds will be relocated, is the only hospital-based provider of long-term care services in PD 1. Approval of the proposed project would result in this service transferring to NCH with diminished capacity. Accordingly, DCOPN contends that the proposed project is not intended to foster institutional competition. DCOPN 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 proposed project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

For 2020, the 641 existing long-term care beds operated at a collective occupancy of 83.9% and the existing long-term care beds at MVRH operated at 51.53% utilization (**Table 1**). As previously discussed, the proposed project intends to establish a much smaller 10 bed long term care unit at NCH, which the applicant anticipates will operate at 80% utilization by 2023. Therefore, the project will preserve the only hospital based long term care services in PD 1 while simultaneously allowing the service to operate at a much more appropriate utilization rate. Regarding the impact to existing facilities, it is unlikely that approval of the proposed project would have a negative impact on the utilization of existing long-term care providers, as MVRH is the only hospital-based provider of long-term care services in PD 1. DCOPN 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 conversion of underutilized medical-surgical beds in PD 1, thereby resulting in the improved utilization of the remaining medical-surgical inventory.

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 previously discussed, the projected capital costs of the proposed project are $191,348 (**Table 3**), the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with this project. DCOPN concludes that, when compared with similar projects, these costs are reasonable. For example, COPN No. VA-04765 issued to Autumn Care of Altavista to add eight nursing home beds through a transfer within PD 11, which is projected to cost approximately $178,843. Furthermore, the Pro Forma Income Statement provided by the applicant projects a net profit of $548,315 from in the first year of operation and of $531,111 in the second year of operation (**Table 6**), illustrating that the proposed project is financially feasible in the immediate and long-term.

With regard to staffing, the applicant asserts that no additional staff are required for transfer of the beds from MVRH. According to the applicant, "[u]pon opening the LTC unit at NCH, MVRH will delicense its 44 LTC beds. Given MVRH's existing LTC unit, which is located just 2.2 miles away from NCH, NCH already has the employee resources necessary for this project. The current personnel and staff at MVRH will be transferred to NCH."

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 project would not introduce new technology that would promote quality or cost effectiveness in the delivery of inpatient acute care. Nor does the project increase the potential for provision of services on an outpatient basis.

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, and (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 Findings and Conclusions

DCOPN finds that the proposed project to add 10 long-term care beds at NCH by relocation from MVRH is generally consistent with the applicable criteria and standards of the SMFP and the Eight Required Considerations of the Code of Virginia. DCOPN finds that the proposed project is more advantageous than the alternative of the status quo, or the entire loss of all hospital based long term care beds in the planning district. As discussed above, approval of the project will result in the delicensing of underutilized hospital beds and will preserve access to hospital based long term care services for residents of PD 1, while allowing the long term care beds to operate at a much more appropriate utilization rate.

Furthermore, DCOPN finds that the total capital and financing costs for the project of $191,348. (**Table 3**) are reasonable and consistent with previously approved projects similar in scope. For example, COPN No. VA-04765 issued to Autumn Care of Altavista to add eight nursing home beds through a transfer within PD 11, which is projected to cost approximately $178,843. The Pro Forma income statement provided by the applicant displays net operating income of $548,315 in Year 1 of operations and $531,111 in Year 2 of operations, indicating that the proposed project appears to be financially feasible in the immediate and the long-term.

Additionally, there is no known opposition to the proposed project. Finally, the proposed project is not likely to have a significant negative impact on the costs, utilization, or staffing of existing area providers.

DCOPN Staff Recommendation

The Division of Certificate of Public Need recommends **conditional approval** of Wellmont Health System d/b/a Norton Community Hospital's request add 10 long term care beds at NCH by relocation from MVRH 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 is more advantageous than the status quo.

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

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.

Recommended Condition

Wellmont Health System d/b/a Norton Community Hospital will provide inpatient long term care to individuals who are eligible for benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.), Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), and 10 U.S.C. § 1071 et seq. Wellmont Health System d/b/a Norton Community Hospital will facilitate the development and operation of primary and specialty medical care services in designated medically underserved areas of the applicant's service area.