VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

October 17, 2024

COPN Request No. VA-8546
Maryview Hospital, LLC, d/b/a Bon Secours Maryview Medical Center
and Harbour View Medical Center, LLC
Suffolk, Virginia
Expand Bon Secours Harbour View Medical Center

Applicant

Harbour View Medical Center, LLC ("HVMC") is wholly owned by Maryview Hospital, LLC d/b/a Bon Secours Maryview Medical Center ("MMC"). MMC is wholly owned by Bon Secours Hampton Roads Health System ("BSHR"), which is wholly owned by Bon Secours Mercy Health ("BSMH"). BSMH, BSHR, MMC and HVMC are all not-for-profit Virginia limited liability companies. MMC also owns other entities, including Harbour View MOB 2, LLC, Bon Secours Surgery Center at Harbour View, LLC and Bon Secours Surgery Center at Virginia Beach, LLC. HVMC is co-applicant because it is the owner and operator of the facility. HVMC has no subsidiaries. Bon Secours Harbour View Medical Center (previously Bon Secours Harbour View Hospital) is in Planning District (PD) 20, Health Planning Region (HPR) V.

Background

COPN No. VA-04631 was issued to MMC in 2018 authorizing the establishment of Bon Secours Harbour View Hospital (now HVMC), an inpatient acute care hospital with 18 acute care beds and 4 general purpose operating rooms, to relocate from MMC and 1 CT scanner relocated from Bon Secours Harbour View (outpatient services) already in service. According to COPN No. VA-04631, the authorized project was scheduled to be operational by February 1, 2021. The application for the project described Harbour View Hospital as an innovative, short-stay surgically focused, inpatient hospital and the project included the relinquishment of 36 beds by MMC in a two-to-one relinquishment of beds transferred. In March 2020 the Commissioner approved a significant change authorizing the relocation of the beds from DePaul Medical Center, LLC, rather than MMC. MMC and DePaul subsequently merged and DePaul closed effective April 1, 2021. In December 2021 a significant change was granted by the Commissioner to extend the completion date for the project to November 30, 2025.

On July 1, 2020, MMC and DePaul submitted an application for COPN Request No. VA-8520, to introduce obstetrical services at Harbor View Hospital with up to 12 beds, general and intermediate level neonatal services, intensive care services with up to 8 beds, and expand medical/surgical bed capacity by up to 16 medical/surgical beds. All beds were proposed to be relocated from DePaul Medical Center. On October 19, 2020, the DCOPN recommended denial of the proposed expansion project. On March 11, 2021, the State Health Commissioner denied COPN Request No. VA-8520, in part because it would unnecessarily duplicate health care resources in PD 20 and would dramatically extend and alter the scope, size and purpose of the approved but undeveloped Harbour View Hospital, before that hospital has even generated utilization data.[1]

On January 1, 2021, MMC submitted an application for COPN Request No. VA-8546, to add up to 36 acute care beds, including medical/surgical, intensive care and obstetric beds, as well as intermediate level neonatal special care services to the yet-to-be-constructed Bon Secours Harbour View Hospital – a significant expansion of the previously approved 18 bed short-stay acute care hospital pursuant to COPN No. VA-04631. On March 31, 2021, prior to receiving a recommendation from the DCOPN, MMC requested to delay indefinitely the review of COPN Request No. VA-8546.

This report resumes the review of COPN Request No. VA-8546 at the request of the applicants. The revised proposal now excludes the obstetrical beds and neonatal care services that were proposed at HVMC in the project's original application. Rather than constructing a new building on an undeveloped portion of the property, the current construction plan describes HVMC as an expansion of Health Center at Harbour View, which has operated as an ambulatory medical campus since 1999. Should the proposal be approved, existing services will be integrated within the expanded hospital in place, rather than moved into an all-new building as originally described. Subsequent to the submission of the revised application, MMC has proffered a two-to-one relinquishment of beds, such that, in addition to relocating 36 beds to HVMC, MMC will decrease its licensed bed capacity by another 36 beds (for a total of a 72-bed reduction) at MMC.

The Division of Certificate of Public Need (DCOPN) notes that nearly all acute care hospital beds in Virginia can be classified as "medical/surgical" beds, with the exception of psychiatric, substance abuse treatment, and rehabilitation beds. As long as the total licensed bed complement is not exceeded, hospitals may configure and use medical/surgical beds, as circumstances require. For this reason, DCOPN has included beds that VHI classifies as obstetric (OB), pediatric, and intensive care unit (ICU) beds in the total count of licensed medical/surgical beds (**Table 1**). Because the proposed project involves ICU beds and the State Medical Facilities Plan (SMFP) has a separate occupancy threshold for ICU beds, they are also shown separately in **Table 1**.

[1] COPN Request No. VA-8520 Adjudication Officer's Recommendation, p. 8.

Table 1. PD 20 Medical/Surgical Beds, 2022

Facility Name	Class	Licensed Beds	Staffed Beds	Licensed Bed Available Days	Patient Days	Occupancy Rate per Licensed Bed
ICU Beds						
Bon Secours Maryview Medical Center	Adult ICU	22	22	8,030	5,535	68.9%
Bon Secours Southampton Memorial Hospital	Adult ICU	8	8	2,920	1,417	48.5%
Chesapeake Regional Medical Center	Adult ICU	28	28	10,220	8,648	84.6%
Sentara Leigh Hospital	Adult ICU	20	20	7,300	5,972	81.8%
Sentara Norfolk General Hospital	Adult ICU	78	78	28,470	23,502	82.6%
Sentara Obici Hospital	Adult ICU	12	12	4,380	3,779	86.3%
Sentara Princess Anne Hospital	Adult ICU	16	16	5,840	4,543	77.8%
Sentara Virginia Beach General Hospital	Adult ICU	24	19	8,760	6,754	77.1%
Children's Hospital of The King's Daughters	Pediatric ICU	95	95	34,675	27,599	79.6%
PD 20 ICU Bed Totals/Averages		**303**	**298**	**110,595**	**87,749**	**79.3%**
Medical/Surgical Beds (Excluding ICU Beds)						
Bon Secours Maryview Medical Center	Med/Surg	245	110	89,425	31,865	35.6%
Bon Secours Southampton Memorial Hospital	Med/Surg	82	72	29,930	2,883	9.6%
Chesapeake Regional Medical Center	Med/Surg	282	250	102,930	73,592	71.5%
Children's Hospital of The King's Daughters	Med/Surg	103	85	37,595	19,684	62.7%
Hospital Authority of Norfolk	Med/Surg	104	104	37,960	23,021	60.6%
Hospital for Extended Recovery	Med/Surg	35	35	12,775	5,322	41.7%
Sentara Leigh Hospital	Med/Surg	254	254	92,710	78,138	84.3%
Sentara Norfolk General Hospital	Med/Surg	391	374	142,715	124,324	87.1%
Sentara Obici Hospital	Med/Surg	143	143	52,195	43,989	81.1%
Sentara Princess Anne Hospital	Med/Surg	158	158	57,670	49,721	85.1%
Sentara Virginia Beach General Hospital	Med/Surg	217	175	79,205	63,535	78.8%
PD 20 Medical/Surgical Bed Totals/Averages		**2,014**	**1,760**	**735,110**	**516,074**	**70.2%**
PD 20 Total Medical/Surgical Beds, including ICU Beds		**2,317**	**2,058**	**845,705**	**603,823**	**71.4%**

Source: 2022 VHI

In total, PD 20 licensed medical/surgical beds had an occupancy of 71.4% in 2022, the latest year for which such data are available. Licensed beds designated as ICU beds in PD 20 had an occupancy of 79.3% (**Table 1**). Of the 2,317 licensed medical/surgical beds in PD 20, 259 were not staffed in 2022 (11.2%). **Table 2** shows MMC had licensed medical/surgical bed occupancy of 38.4% in 2022, 68.9% for beds designated as ICU beds separately. Of its 267 licensed medical/surgical beds, MMC had 135 beds that were not staffed (50.6%).

Table 2. Bon Secours Maryview Medical Center Medical/Surgical Beds

Class	Licensed Beds	Staffed Beds	Licensed Bed Available Days	Patient Days	Occupancy Rate per Licensed Bed
Med/Surg	245	110	89,425	31,865	35.6%
Adult ICU	22	22	8,030	5,535	68.9%
	267	**132**	**97,455**	**37,400**	**38.4%**

Source: 2022 VHI

Proposed Project

The proposed project is the addition of 36 beds (24 designated as medical/surgical and 12 designated as intensive care beds) to HVMC, currently under construction, by relocating them from MMC. In conjunction, MMC has proffered the relinquishment of 36 additional acute care beds, for a total bed reduction of 72 acute care beds at MMC. HVMC is now being constructed as an addition to the Bon Secours Health Center at Harbour View facility. The current address is 5818 Harbour View Boulevard, but will change to 1020 Bon Secours Drive, Suffolk, Virginia prior to HVMC's opening. COPN No. VA-04631 authorized HVMC as a short-stay, 18-bed, surgically focused hospital. The proposal adds a fourth floor and the fit-out of shell space on the third floor, in 32,168 gross square feet, to house the additional 36 beds, observation rooms, staff support and ancillary services. Should the proposal be approved, HVMC would have a total of 54 medical/surgical beds, including 12 designated as intensive care beds; and MMC would relinquish 72 beds from its 267 medical/surgical beds, and have 195 licensed medical/surgical beds remaining. The applicants assert that the proposed project remains surgically focused but would not be exclusive to an inpatient surgical population; HVMC would also be able to treat medical conditions requiring hospitalization as appropriate.

Capital cost for the proposed project is $62,110,160, funded entirely with accumulated reserves of BSMH such that no financing costs are incurred (**Table 3**). The target date for completion is 32 months after COPN approval.

Table 3. Capital Costs Bon Secours Harbour View Medical Center

Direct Construction Cost	$	45,667,948
Equipment not included in construction contract	$	9,425,521
Site Acquisition Costs	$	-
Site Preparation Costs	$	200,000
Architectural and Engineering Fees	$	4,157,161
Other Consultant Fees	$	2,659,530
Total Capital Cost	**$**	**62,110,160**

Source: COPN Request No. VA-8546

Project Definition

Section 32.1-102.1:3 of the Code of Virginia defines a project, in part, as "(a)n increase in the total number of beds…in an existing medical care facility as described in subsection A." and "(r)elocation of beds from an existing medical care facility…to another existing medical care facility. A medical care facility includes "[a]ny facility licensed as a hospital…"

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

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

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

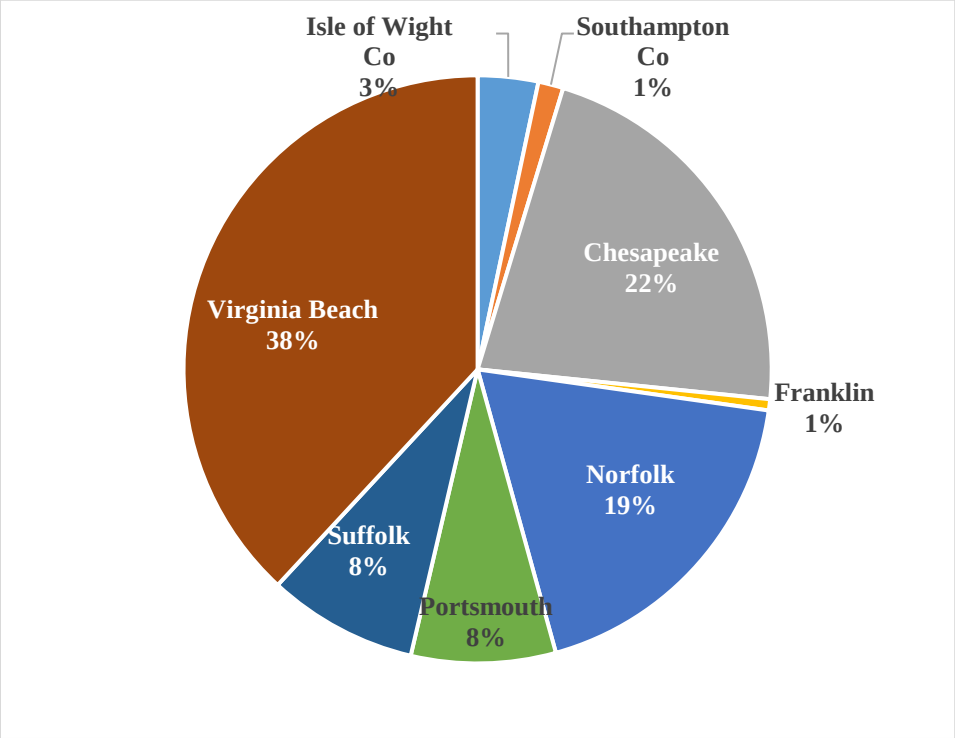
PD 20 had a population of about 1.2 million in 2020 and is projected to grow by just over 40,000 people, 3.3%, between 2020 and 2030. This is less than the population growth rate projected for Virginia during this decade, 5.8% (**Table 4**). Suffolk City, where the proposed project is located, is projected to have a population exceeding 100,000 by 2030. It is projected to grow by 8.7%, 8,247 people, between 2020 and 2030, a higher rate than that of PD 20 and that of Virginia (**Table 4**). The growth rates projected for 2020-2030 in the 65 and older age group are 33.8% in PD 20 and 32.4% in Suffolk, compared to 26.3% in Virginia (**Table 4**). **Figure 1** shows that Suffolk City makes up 8% of the population of PD 20.

Table 4. PD 20 Population Data

Geographic Name	2020 Census	2030 Projection	Projected Population Change 2020-2030	Projected % Change 2020-2030	2020 65 + Census	2030 65+ Projection	Projected Population Change 65+ 2020-2030	Projected Percent Change 65+ 2020-2030
Isle of Wight County	38,606	41,341	2,735	7.1%	7,751	10,388	2,637	34.0%
Southampton County	17,996	17,172	-824	-4.6%	3,719	4,756	1,037	27.9%
Chesapeake City	249,422	272,670	23,248	9.3%	36,045	50,838	14,793	41.0%
Franklin City	8,180	7,667	-513	-6.3%	1,787	1,982	195	10.9%
Norfolk City	238,005	229,864	-8,141	-3.4%	29,215	36,636	7,421	25.4%
Portsmouth City	97,915	98,857	942	1.0%	15,496	19,321	3,825	24.7%
Suffolk City	94,324	102,571	8,247	8.7%	14708	19473.7792	4,766	32.4%
Virginia Beach City	459,470	474,052	14,582	3.2%	69,375	94,903	25,528	36.8%
PD 20 Totals	**1,203,918**	**1,244,194**	**40,276**	**3.3%**	**178,096**	**238,297**	**60,201**	**33.8%**
Virginia	***8,631,393***	***9,129,002***	***497,609***	***5.8%***	***1,395,291***	***1,762,641***	***367,350***	***26.3%***

Source: Weldon-Cooper Data, updated August 2023

Figure 1. Percent of PD 20 Population by Locality



Source: Weldon-Cooper Data, updated August 2023

With respect to socioeconomic barriers, the poverty rate of PD 20 is comparable to that of Virginia (**Table 5**). Suffolk has a poverty rate slightly higher than that of PD 20 or Virginia. Portsmouth, from which beds are proposed to move, has a poverty rate nearly double that of the PD and Virginia.

Table 5. 2022 Poverty Rates, PD 20

Locality	**Percent in Poverty**
Isle of Wight County	8.5%
Southampton County	15.0%
Chesapeake City	8.7%
Franklin City	19.0%
Norfolk City	18.8%
Portsmouth City	19.8%
Suffolk City	11.6%
Virginia Beach City	9.9%
PD 20	**10.8%**
Virginia	*10.6%*

Source: https://www.census.gov/data-tools/demo/saipe/#

Given low utilization at MMC in 2022 and the large number of unstaffed beds (**Table 1**), it is unlikely the proposal to relocate beds and the relinquishment of 36 additional bed from MMC will diminish bed accessibility in Portsmouth. In their response to Sentara's letter of opposition, MMC and HVMC assured DCOPN of their continued commitment to the Portsmouth area, noting investments totaling $50 million at MMC since 2018, the openings of a Women's Imaging Center and a primary care clinic in 2025 and the Bon Secours Maryview Community Health Hub offering programs including nutrition education, diabetes education, Alcoholics Anonymous and Narcotics Anonymous.

HVMC is accessible from Harbour View Boulevard and Bon Secours Drive. It is located at the intersection of US Route 17 and Interstate 664, immediately accessible to both. US Route 17 has existing turn lane and traffic lights for access in either the east or west direction. Suffolk Transit has a stop located on the Harbour View campus.

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

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

DCOPN received a resolution from MMC's medical staff and eighteen letters of support dated at the time COPN Request No. VA-8546 was first submitted. Letters of support were forwarded from the newly instated mayors of Suffolk and Portsmouth in January of 2021. DCOPN also received a letter of opposition from Sentara Hospitals d/b/a Sentara Obici Hospital in March of 2021.

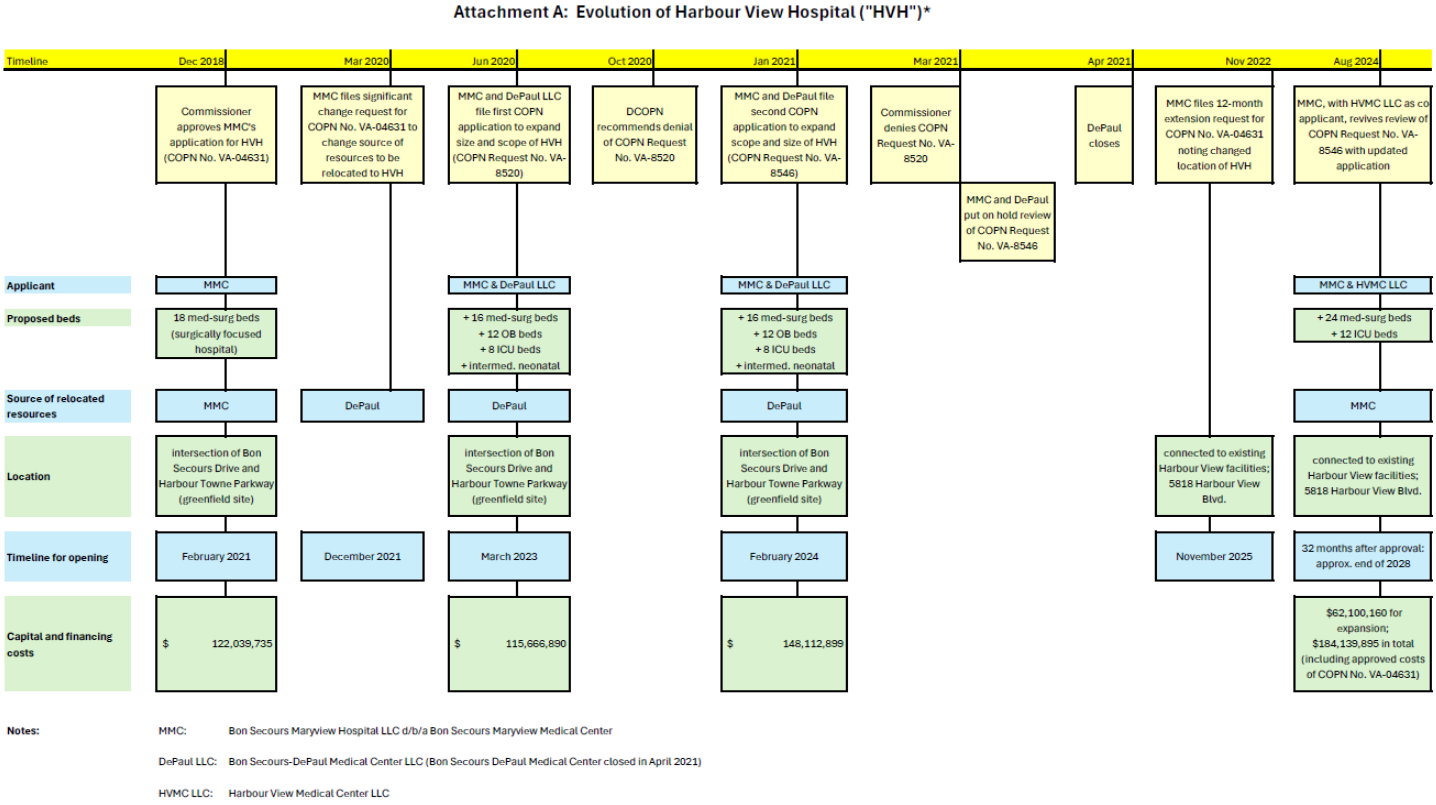
Upon resumption of the review of the proposed project, DCOPN has received a letter from the president of MMC's medical staff expressing the continued support of the medical staff for the proposed project and two additional letters of support as well as resubmission of letters referring to the original conceptualized project. Letters were from the mayor and city manager of Suffolk, 64th district delegate of the Virginia House of Delegates, several board members, a professor at Eastern Virginia Medical School, Bernadine Franciscan Sisters Foundation, the president of the Harbour View Commerce Association, several physicians and advanced care providers and area residents. These letters, in aggregate, expressed the following:

- Bon Secours has a long-standing reputation for providing compassionate care for all, regardless of their ability to pay.
- Suffolk has experienced high growth, especially among the senior population.
- The area needs adequate acute care services to support the growing anticipated demand for health care.
- Being responsive to the communities being served is how health care systems can improve the health, reduce healthcare disparities and increase the livability of communities.
- Additional analysis has revealed that the planned Bon Secours Harbour View Hospital already needs expansion.

- The additional beds at Bon Secours Harbour View Hospital will allow patients to stay in their community to receive the care they need.
- The Bon Secours Harbour View Campus has developed a comprehensive outpatient program over the past 25 years.
- The hospital construction has been extremely well received by the community and has been a catalyst for a growing medical corridor.
- The modest expansion, accomplished through relocation of unused beds, will provide people access close to where they already access a majority of their health care services.
- Harbour View is convenient, easy to get to, recommended by doctors and keeps all (my) care in one place with one system.
- The expansion is a wise investment.
- Several letters expressed support of obstetrical services, no longer included in the current version of the proposal.

Sentara renewed its opposition with a letter received by DCOPN September 30, 2024. The letter states that the approved Harbour View Medical Center remains unbuilt and that the current application "revives and amends" what was "a second attempt in less than a year to significantly expand the scope and size of HVMC, an 18-bed short-stay facility predicated on its being a surgically focused specialty facility." Sentara summarizes what it calls "Maryview's continued resubmission tactics" with the following graphic (**Figure 2**):

Figure 2. Timeline of HVMC COPN Applications and Changes



Sentara states that nothing has materially changed since the Commissioner denied MMC's first attempt to dramatically expand the scope of HVMC. Sentara asserts that Maryview represented in 2018 that the HVMC project would meet needs ten to twenty years into the future, and yet six years later it has not been executed. Sentara's letter describes the original concept of HVMC as being for lower acuity and short stay patients, with higher acuity patients receiving care at Maryview, bifurcating acute care between the two facilities; however, the addition of ICU beds would facilitate higher-acuity patients and the new projections of a 3.95-day average length of stay are somewhat higher than the 2.62 day average length of stay included in the original HVMC application approved by the Commissioner. The Adjudication officer stated in his denial recommendation of COPN Request No. VA-8520 that the expansion project before was "clearly premature, as the hospital has not yet been constructed and operationalized." [2]

Sentara argues that the proposed project makes it harder for the more economically challenged Portsmouth population to access care. Its opposition letter sites substantially higher health indicators, such as breast cancer and colorectal cancer incidence and mortality rates, diabetes incidence and hospitalization rates, in Portsmouth than Virginia and the Hampton Roads area.

[2] COPN Request No. VA-8520 Adjudication Officer's Recommendation, p. 5.

Riverside Health submitted a letter of opposition to the proposed project on October 14, 2024 stating that it should be denied for the same reason that COPN Request No. VA-8520 was denied, that MMC has not made substantial progress on the construction of HVMC and that nothing has materially changed since COPN Request No. VA-8520 was denied in 2021. Riverside notes that MMC's amended application for the proposed project changed the bed complement and the construction plan and updated data and most exhibits but new notification letters were not sent to alert existing providers of the resumption of the review of the current proposal. Riverside Smithfield Hospital ("RSH"), authorized since COPN Request No. VA-8546 was first submitted, did not receive notification of COPN Request No. VA-8546 at all.

Riverside asserts that approval of the proposed project will result in an unnecessary duplication of services in PD 20 and, to the extent that there is a need to enhance access to the Western Hampton Roads area, the opening of RSH will address it. Riverside states that the proposed HVMC expansion threatens the financial viability of RSH, a recently approved rural hospital. Due to the overlapping service areas of RSH and HVMC, Riverside concludes that it would be poor planning to authorize an expansion at HVMC before RSH is open and fully operational.

Chesapeake Regional Medical Center ("CRMC") submitted a letter of opposition as well, on October 15, 2024, stating that the HVMC proposal is premature and alters the scope of the project originally approved, and posits that approval of an application pending for three and a half years would "undercut the intent and purpose of the COPN process" and harm existing patients by diverting resources from other providers in PD 20. CRMC's letter argues the following: HVMC was not approved as a full-service hospital, but approved based on its limited nature and as a support for MMC; the Commissioner rejected Bon Secours' previous plan to create a full-service hospital; the current project does not respond to the Commissioner's prior concerns about Bon Secours' previous application to expand HVMC (COPN Request No. VA-8520); there is no unmet bed need in PD 20 nor an institutional need within Bon Secours; there is no improvement in geographic access to justify the proposed project's approval; the proposal's benefits do not justify the cost; the proposed project results in duplication of services; the proposed project is not an expansion because HVMC has not yet been built, there is no service to expand, and it changes the nature of the short stay surgical hospital approved.

The applicants, MMC and HVMC, responded to the three opposition letters. In response to the Sentara opposition, the applicants state that Sentara's "overwhelmingly dominant" position in PD 20 and the "utter absence of any material risk of harm" the proposal poses to Sentara means that Sentara's objections merit no weight. Its procedural objections are without merit, as the applicants worked with DCOPN and the Office of the Attorney General to secure a determination that resumption of the COPN review process was appropriate.

MMC and HVMC maintain that resumption of their application is not "gamesmanship," but circumstances have materially changed and HVMC needs to change with them. First, the Centers for Medicare and Medicaid Services ("CMS") published final rulings removing total hip arthroplasty from its inpatient only list and adding total knee arthroplasty and total hip arthroplasty to the ambulatory surgery-center covered surgical procedures list so that these procedures are not required to be performed in an inpatient setting; Second, the applicants state that Sentara's dominance has grown since 2018 when the establishment of HVMC was

authorized and that approving HVMC's expansion through relocation of beds will provide better use of existing licensed beds and should help address Sentara's "overwhelmingly dominant" market share of inpatient discharges; Third, the applicants say that Sentara's objections deny the reality of changed circumstances, including the higher than projected growth rate in Suffolk, the shifting of procedures from inpatient only and the lessons of the COVID-19 pandemic, the necessity of surge capacity and ability to accommodate medical admissions, for example. Lastly, MMC and HVMC assert that the requested expansion of HVMC is partially driven by actual experience with increased acuity in patients presenting at Habour View's emergency department, underscoring the need for additional bed capacity and provision of ICU beds. The applicants conclude that Sentara's argument against ICU beds is for the purpose of forcing HVMC to compete for inpatient market share without offering a basic service that every other PD 20 hospital offers. The letter assures the DCOPN that there is no "bait and switch," rather a reassessment of the public need and how best to configure HVCM and MMC to meet that need.

The applicants respond to Sentara's arguments about economic sustainability by describing MMC and HVMC as collectively competing with other established PD 20 providers, most notably Sentara and its dominant inpatient market share. They conclude that Sentara's goal is to constrain HVMC to 18 beds and a surgical focus in the face of market changes in order to handicap its competing with Sentara's offerings on its Belle Harbour campus. They state that it is unlikely that the economic position of Portsmouth residents will improve in the near future, and BSHR's footprint must expand to sustain economic balance to support its mission of service to the community.

In response to Riverside Health System, the applicants state that its opposition letter was not submitted within the public comment period and that Riverside did not copy any representative of its submission as is consistent with common, expected practice. MMC and HVMC state that Riverside's opposition mostly duplicates Sentara's opposition, so in the interest of brevity, they address Riverside's additional argument that the proposed expansion of HVMC will harm the financial viability of the under-developed RSH. The applicants state that COPN approval for RSH occurred after the authorization for HVMC and after COPN Request No. VA-8546 was submitted to expand bed capacity at HVMC. They also assert that, unlike RSH, the proposed HVMC project will not add to the inventory of licensed beds in PD 20 and construction of HVMC is well underway, providing photographic evidence of HVMC's construction progress.

The applicants submitted a statement in response to CRMC's letter of opposition saying it was submitted two days prior to the scheduled publication of the DCOPN staff report for the proposal and did not copy the applicants or their counsel. It further notes that CRMC's arguments were duplicative of Sentara's and Riverside's and have been addressed.

Public Hearing

§32.1-102.6B of the Code of Virginia directs DCOPN to hold one public hearing on each application 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-8546 is not competing with another project and DCOPN did not receive a request to conduct a public hearing for the proposed project. Thus, no public hearing was held.

DCOPN originally provided notice to the public regarding this project inviting public comment on February 10, 2021. The public comment period closed on March 29, 2021. When the project was resumed with a different description of services, another public notice was provided on August 15, 2024. The public comment period closed on September 30, 2024. Other than the letters of support and opposition referenced above, no members of the public commented.

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

The proposed project is more beneficial than the status quo, which is implementation of the 18-bed short-stay, surgically focused hospital originally envisioned. The proposal redistributes a portion of the 135 medical/surgical beds currently located at MMC that are not staffed (**Table 1**) and the applicants have also proffered relinquishment of an additional 36 beds, reducing the acute care bed surplus in the PD. Though there is no inpatient data available for HVMC because it has not yet opened, the beds to be relocated are not being utilized or staffed at MMC; furthermore, sufficient time has passed that MMC now has updated population projections and five additional years of inpatient data from MMC that support the enhancement of HVMC. The applicants present data showing MMC has experienced an increase of nearly 7,000 patient days (56%) from patients residing in HVMC's primary service area between 2019 (just after HVMC was authorized) and 2023, and in increase of 7.7% in admissions from the Harbour View Emergency Department to MMC. The proposed project is an opportunity to make beds more accessible in an area of PD 20 where MMC patients are already seeking care. Another material change in recent years is CMS' approval to treat higher acuity patients in ambulatory surgery settings. This change means that acuity in inpatient settings will predictably be higher than it was previously, and higher than MMC predicted when HVMC was initially designed. The expectation and reality of higher acuity patients at HVMC supports the addition of ICU beds, as proposed.

(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.b

Currently there is no organization in HPR V designated by the Virginia Department of Health to serve as the Health Planning Agency for PD 20. Therefore, this consideration is not applicable to the review of the proposed project.

(iv) Any costs and benefits of the project.

Total projected capital costs for the proposed project are $62,110,160, funded entirely with accumulated reserves, so no financing costs are involved in the proposed project. Costs for similar authorized projects vary greatly, but at $1.7 million per bed, the estimated costs of the proposal are reasonable when compared to recently approved, similar projects to construct beds, for example, COPN Nos. VA-04865 at $7.5 million per bed and VA-04888 at $1.1 million per bed.

The applicants have described several benefits to the proposed project. Improved availability of medical/surgical beds when HVMC opens will reduce travel for its patient base already seeking care at HVMC. The proposed expansion ensures access for MMC's patient base near HVMC despite population growth and increasing acuity and patient volumes. The inclusion of ICU beds will facilitate care for higher acuity patients now expected at HVMC. Approval of the proposal will not add beds to the PD 20 inventory, rather relocate them for a more beneficial geographic distribution for BSHR patients, and the relinquishment of 36 additional beds will decrease the surplus of acute care beds in PD 20. Expansion of MMC's footprint will promote beneficial competition by improving its financial balance and strength to sustain its mission to provide service to the community.

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

Bon Secours facilities treat all patients regardless of their ability to pay for services or of their payor source. MMC provided charity care in the amount of 0.8% in 2022, the latest year for which such data are available, and Bon Secours Surgery Center at Harbour View, LLC provided 0% charity care that year (**Table 6**). These are both well below the HPR V average of 1.9% in 2022. In the proforma provided in the application for COPN Request No. VA-8546, MMC and HVMC proffer 4% charity care (**Table 10)**, consistent with Bon Secours Hampton Roads Health System's systemwide condition.

Table 6. 2022 Charity Care Percent of Gross Revenue, HPR V

HPR V	Gross Pt Rev	Total Charity Care Provided Below 200%	%
Inpatient Hospitals			
Riverside Doctors' Hospital Williamsburg	$235,047,426	$7,344,864	3.1%
Sentara Norfolk General Hospital	$3,864,668,030	$109,016,224	2.8%
Riverside Shore Memorial Hospital	$322,109,369	$8,731,934	2.7%
Chesapeake Regional Medical Center	$1,155,918,449	$29,774,782	2.6%
Sentara Obici Hospital	$1,129,233,332	$28,033,924	2.5%
Sentara Careplex Hospital	$1,034,820,882	$23,699,497	2.3%
Riverside Walter Reed Hospital	$331,866,869	$7,551,194	2.3%
Riverside Regional Medical Center	$2,771,854,623	$59,626,052	2.2%
Sentara Virginia Beach General Hospital	$1,541,137,501	$32,477,460	2.1%
Sentara Leigh Hospital	$1,751,776,448	$36,872,093	2.1%
Virginia Beach Psychiatric Center	$53,717,475	$1,004,000	1.9%
Sentara Princess Anne Hospital	$1,248,353,068	$19,746,037	1.6%
VCU Health Tappahannock Hospital	$180,355,500	$2,408,281	1.3%
Sentara Williamsburg Regional Medical Center	$752,613,462	$8,404,028	1.1%
Bon Secours Mary Immaculate Hospital	$709,536,813	$7,318,928	1.0%
Bon Secours Maryview Medical Center	$1,351,611,536	$11,279,831	0.8%
Newport News Behavioral Health Center	$30,706,561	$244,159	0.8%
Bon Secours Southampton Medical Center	$241,085,104	$1,877,601	0.8%
Bon Secours Rappahannock General Hospital	$92,843,633	$716,430	0.8%
Riverside Rehabilitation Hospital	$62,764,853	$388,974	0.6%
Children's Hospital of the King's Daughters	$1,343,335,333	$3,354,180	0.2%
Hospital For Extended Recovery	$26,673,737	$14,488	0.1%
The Pavilion at Williamsburg Place	$48,867,340	$17,535	0.0%
Kempsville Center for Behavioral Health	$44,555,478	$0	0.0%
Lake Taylor Transitional Care Hospital	$42,830,830	$0	0.0%
Select Specialty Hospital-Hampton Roads	$73,328,103	$0	0.0%
Total Inpatient Facilities:			26
HPR V Inpatient Median			1.2%
HPR V Inpatient Total $ & Mean%	$ 20,441,611,755	$ 399,902,496	**2.0%**

Continued on next page

Table 6 continued

Outpatient Centers

Riverside Peninsula Surgery Center	$26,825,317	$646,330	2.4%
Careplex Orthopaedic Ambulatory Surgery Center	$54,808,248	$1,290,094	2.4%
Sentara BelleHarbour Ambulatory Surgery Center	$2,732,407	$50,587	1.9%
Riverside Hampton Surgery Center	$35,603,742	$247,351	0.7%
CHKD Health & Surgery Center (Newport News)	$18,626,720	$91,323	0.5%
Sentara Princess Anne Ambulatory Surgery Management, LLC	$45,406,534	$191,358	0.4%
Riverside Doctors Surgery Center	$38,658,425	$155,389	0.4%
Bon Secours Mary Immaculate Ambulatory Surgery Center	$28,531,734	$114,059	0.4%
Bon Secours Surgery Center at Virginia Beach	$41,672,833	$80,023	0.2%
CHKD Health & Surgery Center (Virginia Beach)	$33,722,353	$62,513	0.2%
Sentara Obici Ambulatory Surgery LLC	$18,535,929	$17,065	0.1%
Sentara Leigh Orthopedic Surgery Center, LLC	$107,157,116	$13,664	0.0%
Sentara Virginia Beach Ambulatory Surgery Center	$21,565,567	$2,700	0.0%
Bon Secours Surgery Center at Harbour View, L.L.C.	$50,778,791	$4,037	0.0%
Advanced Vision Surgery Center LLC	$1,969,222	$0	0.0%
Bayview Medical Center, Inc	$4,246,866	$0	0.0%
Center for Visual Surgical Excellence, LLC	$9,769,037	$0	0.0%
Chesapeake Regional Surgery Center at Virginia Beach, LLC	$47,742,818	$0	0.0%
CVP Surgery Center	$19,000,461	$0	0.0%
Sentara Port Warwick Surgery Center	$1,740,580	$0	0.0%
Surgery Center of Chesapeake	$14,774,000	$0	0.0%
Surgical Suites of Coastal Virginia	$38,314,052	$0	0.0%
Virginia Center for Eye Surgery	$6,172,666	$0	0.0%
Total Outpatient Facilities:			23
HPR V Outpatient Median			0.2%
HPR V Outpatient Total $ & Mean%	$ 668,355,418	$ 2,966,493	**0.4%**
Total Facilities:			**49**
HPR V Median			**0.5%**
HPR V Total $ & Mean%	$ 21,109,967,173	$ 402,868,989	**1.9%**

Source: VHI

In accordance with section 32.1-102.4.B of the Code of Virginia, should the proposed project receive approval, the project would be conditioned to provide 4% charity care based on gross patient revenue, which is Bon Secours Hampton Roads Health System's systemwide condition. Pursuant to Code of Virginia language any COPN issued for this project will also be conditioned on the applicant's agreement to accept patients who are the recipients of Medicare and Medicaid.

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

There are no other factors, not addressed elsewhere in the analysis, relevant to the determination of a public need for either project.

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

Section 32.1-102.2:1 of the Code of Virginia calls for the State Health Services Plan Task Force to develop 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).

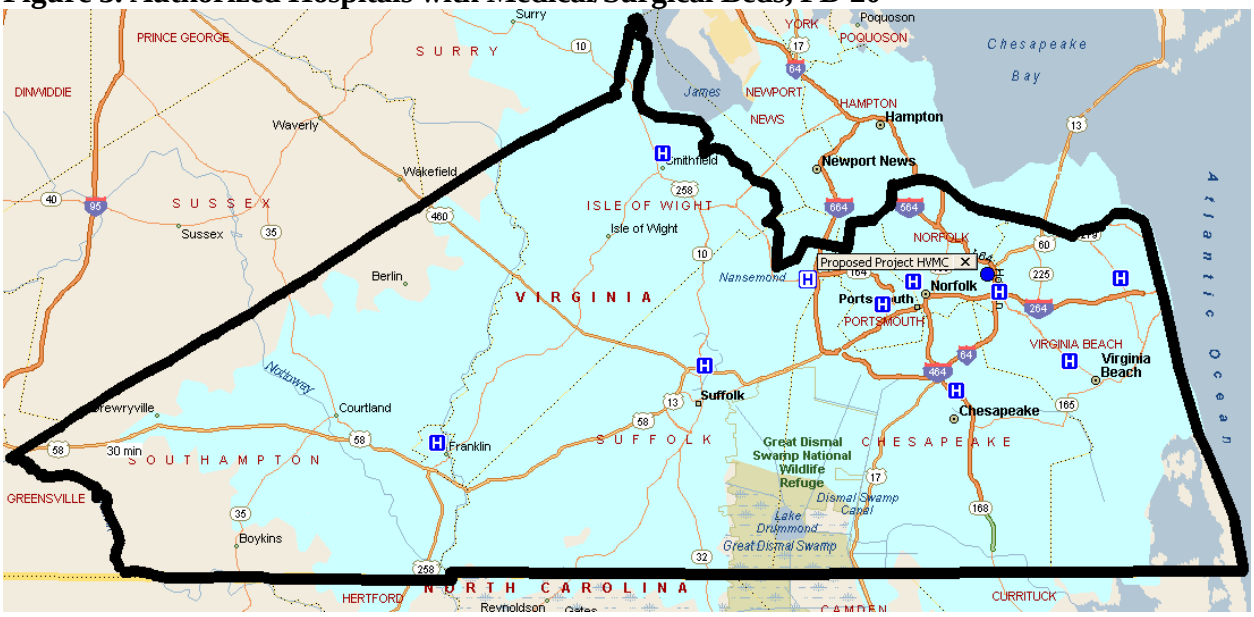
The State Medical Facilities Plan (SMFP) contains the criteria and standards for inpatient beds. They are as follows:

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 black line in **Figure 3** shows the boundary of PD 20. The blue shaded area illustrates the area within 30 minutes driving distance of a PD 20 acute care hospital. The dark blue H icons locate authorized acute care hospitals while the blue dot locates a transitional care facility with medical/surgical beds. The white icon with a blue H shows the location of HVMC and the proposed project.

The largest towns in the rural area outside the blue shading, not within 30 minutes from medical/surgical beds in PD 20 are Boykin (population 511 in 2022), Drewryville (population 2,203 in 2022), and Berlin (population 2,966 in 2022). These three towns represent less than half a percent of the PD 20 population so it is likely over 95% of the PD is within the appropriate driving time from an acute care hospital in accordance with the SMFP standard. The proposed project, at a facility previously authorized for inpatient beds, will not increase geographical access to acute care services in PD 20.

Figure 3. Authorized Hospitals with Medical/Surgical Beds, PD 20



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 the 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 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.

This provision is not applicable as the proposed project does not add new inpatient beds to the PD.

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.
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:
ProBed = ((BUR x 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 planning horizon years 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.

This provision is not applicable. For context, the medical/surgical bed need in PD 20 is as follows:

Table 7. Medical/Surgical[3] Bed Need Data, PD 20

	2018	2019	2020	2021	2022	5-Year Total
Days	581,986	588,737	590,921	636,896	603,823	3,002,363
Population>15	966,298	973,842	983,905	986,407	989,194	4,899,646

Source: VHI & Weldon-Cooper Data, updated August 2023

3,002,363/4,899,646 =0.61 (Bed Use Rate)

(BUR X 1,017,145)/365 =1,707.6
2029 population

1707.6/0.8= 2,134.5 (bed need in 5 years)

Current Beds =2,317

Surplus of 182.5 (**183**) medical/surgical beds

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 = ((PBUR x 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] Medical/Surgical includes VHI Classifications Medical/surgical, Obstetric, Pediatric and intensive care unit (ICU) beds.

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.

This section is not applicable.

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 determine 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 planning year as follows:
NewICUB = 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 beds in the health planning district.

The ICU bed need calculation is as follows:

Table 8. ICU Bed Need Data

	2018	2019	2020	2021	2022	5-Year Total
ICU Days	95,409	88,883	90,836	91,494	87,749	454,371
Population>15	966,298	973,842	983,905	986,407	989,194	4,899,646

Source: VHI & Weldon-Cooper Data, updated August 2023

454,371/4,899,646 =0.09 (Bed Use Rate)

(BUR X 1,017,145)/365 =258.4
2029 population

1707.6/0.65= 397.6 (bed need in 5 years)

Current Beds =316

Deficit of 81.6 (**82**) ICU 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.

The proposed relocation of beds from MMC to HVMC is not due to life safety or building code deficiencies. The proposed project is for the purpose of an improved distribution of acute care beds for MMC's patient base currently seeking care at HVMC or residing nearby. Patients seeking care at HVMC's emergency department and patients admitted to MMC from HVMC's primary service area will benefit from the proposed project, ensuring that adequate medical/surgical beds and ICU beds are accessible closer to their homes and where they already seek care. An occupancy calculation after decreasing 36 beds from MMC to relocate to HVMC (using MMC's 2022 patient days and 36 fewer beds) results in an occupancy rate of 44.4%. An occupancy calculation after decreasing the 72 beds from MMC results in an occupancy rate of 52.5% still maintaining ample bed capacity for patients closer to MMC. Construction of the proposed additional beds in conjunction with the beds already authorized will be less costly than two separate construction projects.

Figure 4. Hospitals within 30 Minutes' Drive of HVMC

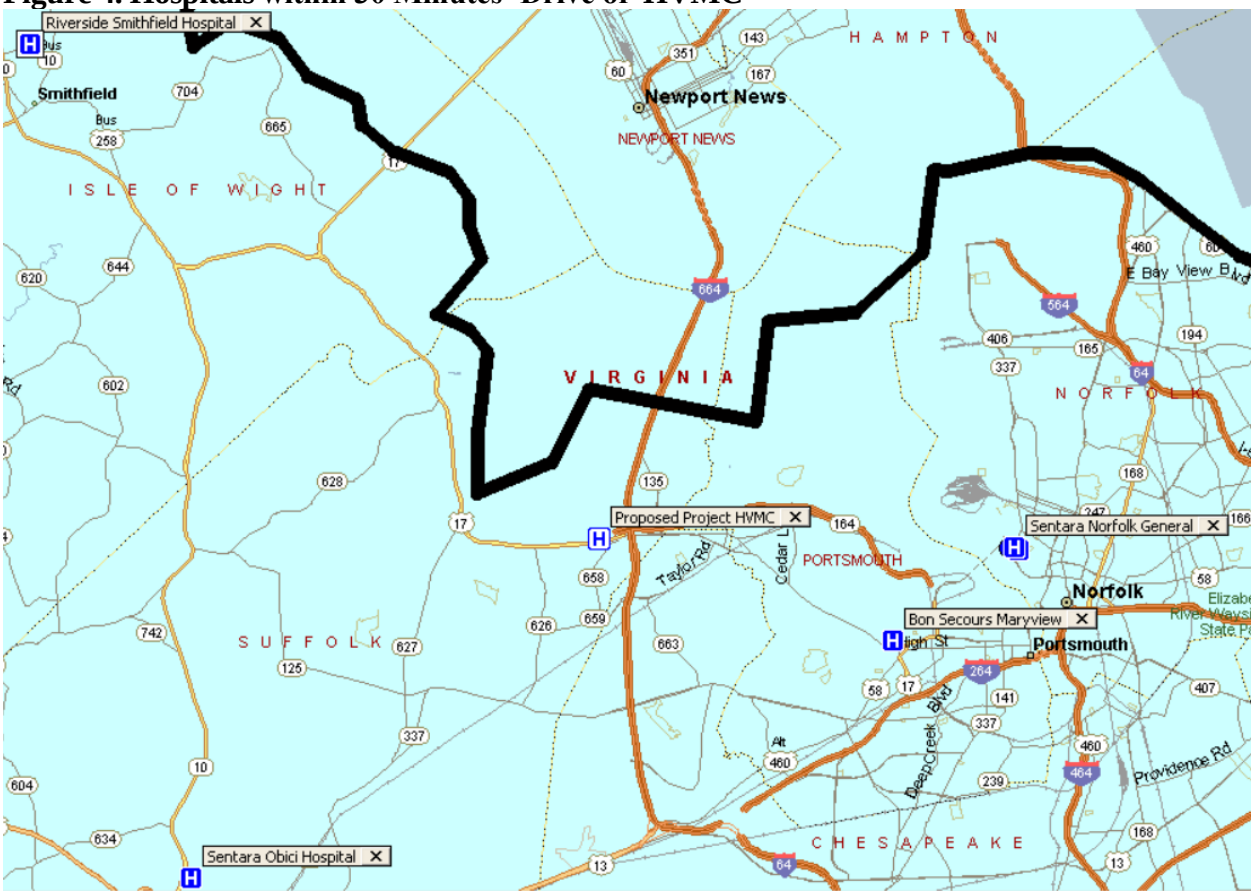


Table 9. Distance from HVMC

Hospital	Mile	Minutes	2022 Occupancy
MMC	6.7	16	38.4%
Sentara Obici	17.1	20	86.4%
Sentara Norfolk General	9.6	12-20+ depending on tunnel traffic	84.4%
Riverside Smithfield Hospital	15.7	26+ depending on traffic	Not yet Open

Source: Google Maps & COPN Request No. VA-8546

HVMC's projections underlying the need for 36 additional medical/surgical beds, including 12 beds designated as ICU beds, are based on MMC and HVMC demand, acuity and projected growth, from its existing patient base. The proposal is unlikely to significantly impact volumes of neighboring facilities. The two Sentara hospitals within 30 minutes of HVMC are not underutilized, each having occupancy rates greater than 80% (**Table 9**). RSH, authorized by COPN No. VA-04785 in March 2022 after HVMC was authorized stated in its application that HVMC is located more than a 26-minute drive from RSH in good driving conditions. RSH is not yet operational. Though the inventory-reducing MMC proposal shifts existing PD 20 medical/surgical beds to just within 30 minutes of RSH when driving conditions are optimal, it is outside of HVMC's primary service area presented in the proposed project. RSH and HVMC have overlapping expected service areas but data supporting HVMC's expansion rely only on patients already seeking care at HVMC and MMC.

In a PD with a surplus of beds, the project includes the relinquishment of twice as many beds as those to be relocated, shifting medical/surgical capacity from MMC to HVMC and decreasing the medical/surgical bed surplus. Medical/surgical beds can be designated and utilized as ICU beds without a COPN, so the ICU bed need calculation is somewhat academic; however, the proposal will address some of the calculated ICU bed need in PD 20.

12VAC5-230-580. Long-term acute care hospitals (LTACHs).

The beds to be relocated are not LTACH beds. This section is not applicable.

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

The applicant has provided assurances that the proposed additional beds will be supervised appropriately.

Required Considerations Continued

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

Sentara Health System has the dominant portion of medical/surgical beds and highest share of patient days in PD 20. In 2018, Sentara had 52% of the licensed medical/surgical beds in PD 20 and this percentage grew to 57% by 2022. Sentara had 64% of medical/surgical patient days in 2018, growing to 67% by 2022. During this same time period, Bon Secours Hampton Roads' percentage of medical/surgical beds and patient days decreased from 21% to 15% of PD 20 medical/surgical beds and 12% to 7% of medical/surgical patient days in PD 20.

Though the proposal is in response to a growing and increasingly higher-acuity existing patient base and not upon drawing patients from existing providers, it does foster beneficial competition. It strengthens BSHR's service offerings and financial position while reallocating unstaffed/unutilized beds from MMC to a growing area of PD 20.

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

Sentara Health System has the dominant share of PD 20. As mentioned above, Sentara had 67% of the medical/surgical patient days in PD 20 in 2022, the last year for which such data are available. Bon Secours had 7% and Chesapeake had 14%. While the Sentara and Chesapeake Hospitals are well-utilized (**Table 1**), Bon Secours Hampton Roads hospitals in PD 20 have lower utilization. Riverside Smithfield Hospital is authorized but not yet open in Smithfield, Virginia.

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

Capital Costs for the proposed project are reasonable with a comparable cost per bed to other similar, recently approved projects. The proforma (**Table 10**) shows the proposal is expected to ganerate over $10 million in income from operations the first and second years.

Table 10. Pro forma, Bon Secours Harbour View Medical Center

	Year 1	Year 2
Gross Patient Revenue	**$ 230,182,649**	**$ 240,920,606**
Contractual Adjustments	$ 145,152,865	$ 153,135,728
Bad Debt	$ 3,546,098	$ 3,711,523
Charity Care	$ 9,207,306	$ 9,636,824
Other	$ 8,672,667	$ 9,238,000
Total Operating Revenue	**$ 63,603,713**	**$ 65,198,531**
Total Operating Expenses	**$ 52,730,000**	**$ 53,964,000**
Income/(Loss) from Operations	**$ 10,873,713**	**$ 11,234,531**

Source: COPN Request No. VA-8546

Though some staff members are already hired and staffing ambulatory services at HVMC, another 83.9 full-time equivalent staff members will be needed for the proposed project. The applicants site successful recruitment methodologies of Bon Secours Mercy Health as well as affiliated entities that operate a school of nursing and health professionals. Though recruitment may prove difficult, the proposed project is wholly feasible.

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

The proposal does not provide innovations in the delivery of health services or additional 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. (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 associated with a public institution of higher education or a medical school in the area to be served.

DCOPN Staff Findings and Conclusions

The proposed project seeks to add 36 medical/surgical beds, including 12 designated as ICU beds, to HVMC, relocated from MMC. In addition, MMC has proffered as part of the proposed project to relinquish an additional 36 medical/surgical beds, thereby decreasing the surplus of medical/surgical beds in PD 20. HVMC, authorized by COPN No. VA-04631 as an inpatient

acute care hospital, expected to be complete by November 30, 2025. The current COPN request was originally submitted in January of 2021 and delayed prior to a DCOPN recommendation. This current analysis is the resumption of COPN Request No. VA-8546 after the applicants made revisions to account for market changes, care dynamics and feedback from the Commissioner in the denial of COPN Request No. VA-8520, a previous request to expand HVMC.

In contrast to COPN Request No. VA-8520, the current proposal does not include/duplicate obstetrical services or intermediate neonatal care. A material change has occurred in CMS reimbursement, driving lower acuity, short-stay procedures, including many orthopedic procedures, to the ambulatory setting and leaving only higher acuity procedures with longer post operative stays to be performed in inpatient facilities. A shift from the original short-stay hospital concept is reasonable under these circumstances, as is the addition of ICU beds to care for patients with higher acuity than originally anticipated. Though HVMC is not yet operational, significant data now exist from outpatient services and from MMC admission data to substantiate that BSHR patient volumes exist to support the HVMC expansion as described in the current proposal. Data presented show that the proposed relocation of beds to HVMC can be supported with patients seeking care at HVMC's emergency department and admitted to MMC, and projected growth. Though opposition for an HVMC expansion continues from existing providers in PD 20, evidence of an existing patient base for the facility decreases the likelihood that the proposal will have a significant impact on existing authorized inpatient providers. In addition, the proposal will decrease the acute care bed surplus in PD 20.

The location of the proposal, the City of Suffolk, has a projected growth rate higher than that of the PD and Virginia. The proposal is more beneficial than the status quo, providing a better distribution of beds and access to BSHR's patient base in the Suffolk area without detriment to the Chesapeake area. Its costs are reasonable and to be financed with accumulated reserves. BSHR has a systemwide charity condition of 4%, higher than the HPR average of 1.8% of gross patient revenues. The project is wholly feasible and is generally consistent with the applicable standards and criteria of the State Medical Facilities Plan and the 8 Required Considerations of the Code of Virginia.

DCOPN Staff Recommendations

The Division of Certificate of Public Need recommends **conditional approval** of Bon Secours Maryview Medical Center and Bon Secours Harbour View Medical Center's COPN Request number VA-8546 to expand the number of medical/surgical beds at Harbour View Medical Center in Suffolk, Virginia by 36 medical/surgical beds (including 12 ICU beds) by relocating them from Bon Secours Maryview Medical Center. As previously discussed, the applicants have agreed to relinquish 36 additional medical/surgical beds at Bon Secours Maryview Medical Center upon completion of the project. This recommendation of conditional approval is based on the following reasons:

1. The proposal to relocate 36 medical/surgical beds from Bon Secours Maryview Medical Center to Bon Secours Harbour View Medical Center (including 12 ICU beds) is generally consistent with the applicable standards and criteria of the State Medical Facilities Plan and the 8 Required Considerations of the Code of Virginia.

2. Bon Secours Maryview Medical Center has proffered the relinquishment of 36 additional medical/surgical beds from its licensed capacity as it relocates 36 beds to Bon Secours Harbour View Medical Center, reducing the surplus of medical surgical beds in PD 20.

3. The proposed project improves access to medical/surgical beds in a relatively high growth area of Virginia.

4. The capital costs of the proposed project are reasonable and it is wholly feasible in the immediate and long-term.

5. The proposed project is unlikely to have a significant negative impact upon the utilization, costs, or charges of other acute care hospitals in PD 20.

6. The proposed project appears to be financially viable in the immediate and long-term.

DCOPN's recommendation is contingent upon Bon Secours Maryview Medical Center and Bon Secours Harbour View Medical Center's agreement to the following charity care condition:

Bon Secours Harbour View Medical Center will provide acute care services to all persons in need of this service, regardless of their ability to pay, and will provide as charity care to all indigent persons free services or rate reductions in services and will facilitate the development and operation of primary medical care services to medically underserved persons in PD 20 in an aggregate amount equal to the 4.0% systemwide charity care condition applicable to Bon Secours Hampton Roads pursuant to COPN No. VA-04237 (issued January 1, 2015) . Compliance with this condition will be documented to the Division of Certificate of Public Need annually by providing audited or otherwise appropriately certified financial statements documenting compliance with the preceding requirement. Bon Secours Harbour View Medical Center will accept the revised charity condition based on data valued under the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. is available from Virginia Health Information. The value of charity care provided individuals pursuant to this condition shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

Bon Secours Harbour View Medical Center will provide acute care services 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. Additionally, Bon Secours Harbour View Medical Center will facilitate the development and operation of primary and specialty medical care services in designated medically underserved areas of the applicant's service area.