VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

November 19, 2025

RE: COPN Request No. VA-8827
Virginia Hospital Center Arlington Health System
Arlington County, Virginia
Add Eleven (11) Intensive Care Unit (ICU) Beds and One (1) Cardiac Catheterization Laboratory

Applicant

Virginia Hospital Center (VHC) is a 501(c)(3) Virginia non-stock corporation. VHC Health (previously Virginia Hospital Center Arlington Health System), a 501(c)(3) non-profit corporation, is the sole owner of VHC. VHC is located in Arlington, Virginia, Planning District (PD) 8, within Health Planning Region (HPR) II.

Background

VHC is an acute care hospital with 453 licensed beds: 274 medical/surgical, 32 ICU, 13 pediatric, 58 obstetric (OB), 20 medical rehabilitation, and 56 psychiatric beds[1]. VHC has the second highest number of acute care beds in PD 8, only behind Inova Fairfax Hospital (**Table 1**). It also operates as a Level II Trauma Center, a certified Comprehensive Stroke Center, and has Arlington County's only acute care hospital-based mental health unit.

ICU Beds

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. Hospitals may configure and use medical/surgical beds, as circumstances require, so long as they do not go over their number of licensed beds. For this reason, DCOPN has included beds that Virginia Health Information (VHI) classified as Obstetric (OB), pediatric, and 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 No. VA-04888 authorized the new VHC Health Wellness Hospital which will have 96 psychiatric beds. VHC will be transferring 42 psychiatric beds to VHC Health Wellness Hospital, including the 16 that were authorized but never implemented under COPN No. VA-04773.

Table 1. PD 8 Medical/Surgical Beds, 2024

Facility Name	Class	Licensed Beds	Staffed Beds	Licensed Bed Available Days	Patient Days	Occupancy Rate per Licensed Bed
ICU Beds						
Inova Alexandria Hospital	Adult ICU	50	50	18,300	8,697	45.35%
Inova Fair Oaks Hospital	Adult ICU	12	12	4,392	2,928	66.67%
Inova Fairfax Hospital	Adult ICU	102	102	37,332	31,658	84.80%
Inova Fairfax Hospital	Pediatric ICU	26	26	9,516	5,996	63.01%
Inova Loudoun Hospital	Adult ICU	23	23	8,418	5,901	70.10%
Inova Mount Vernon Hospital	Adult ICU	20	20	7,320	2,944	40.22%
Reston Hospital Center	Adult ICU	28	28	10,248	6,042	58.96%
Sentara Northern Virginia Medical Center	Adult ICU	16	16	5,856	4,581	78.23%
Stone Springs Hospital Center	Adult ICU	10	10	3,660	506	13.83%
UVA Health Haymarket Medical Center	Adult ICU	8	5	2,928	1,825	62.33%
UVA Health Prince William Medical Center	Adult ICU	11	7	4,026	2,555	63.46%
Virginia Hospital Center	Adult ICU	40[2]	39	14,640	6,639	45.35%
PD 8 ICU Bed Totals/Averages		**346**	**338**	**12,6636**	**80,272**	**63.39%**
Medical/Surgical Beds (Excluding ICU Beds)						
Inova Alexandria Hospital	Med/Surg	252	252	92,232	49,569	53.74%
Inova Fair Oaks Hospital	Med/Surg	162	162	59,292	35,117	59.23%
Inova Fairfax Hospital	Med/Surg	694	694	254,004	221,839	87.34%
Inova Loudoun Hospital	Med/Surg	166	166	60,756	48,724	80.20%
Inova Mount Vernon Hospital	Med/Surg	88	88	32,208	19,945	61.93%
Inova Specialty Hospital	Med/Surg	32	32	11,712	7,943	67.82%
Reston Hospital Center	Med/Surg	185	185	67,710	36,855	54.43%
Sentara Northern Virginia Medical Center	Med/Surg	167	167	61,122	39,477	64.59%
Stone Springs Hospital Center	Med/Surg	97	97	35,502	7,316	20.61%
UVA Health Haymarket Medical Center	Med/Surg	52	26	19,032	9,313	48.93%
UVA Health Prince William Medical Center	Med/Surg	89	78	32,574	28,470	87.40%
Virginia Hospital Center	Med/Surg	337	304	123,342	91,406	74.11%
PD 8 Medical/Surgical Bed Totals/Averages		2,321	2,251	849,486	595,974	70.16%
PD 8 Total Medical/Surgical Beds, including ICU Beds		**2,667**	**2,589**	**976,122**	**676,246**	**69.28%**

Source: 2024 VHI

[2] VHC operates 32 ICU beds. Since 2020 they have erroneously reported a total of 40 ICU beds to VHI due to a misclassification of 8 med/surg beds used as ICU step-down beds. VHC claims that while the 40 ICU beds reported were an error, the corresponding ICU patient days only reflect the 32 ICU beds.

In total, PD 8 licensed medical/surgical beds (including ICU) had an overall average occupancy rate of 69.28% in 2024, the latest year for which such data are available. Licensed beds designated as ICU beds in PD 8 had an occupancy of 63.39% (**Table 1**). Of the 2,667 licensed medical/surgical beds (including ICU beds) in PD 8, 78 were not staffed in 2024 (2.9%). **Table 2** shows that VHC had a total overall licensed medical/surgical bed (including ICU) occupancy of 71.06% in 2024, 45.35% for beds designated as ICU beds. Of its 377 licensed medical/surgical beds (including ICU), VHC had 34 beds that were not staffed (9.0%).

Table 2. Virginia Hospital Center Medical/Surgical Beds, 2024

Class	Licensed Beds	Staffed Beds	Licensed Bed Available Days	Patient Days	Occupancy Rate per Licensed Bed
Med/Surg*	337	304	123,342	91,406	74.11%
Adult ICU	40	39	14,640	6,639	45.35%
	377	**343**	**137,982**	**98,045**	**71.06%**

*Excluding ICU
Source: 2024 VHI and COPN Request No. VA 8827

DCOPN acknowledges that VHC Health has mistakenly reported eight step-down med/surg beds as ICU beds to VHI since 2020. Removing these beds would bring its ICU bed total to 32 instead of 40 and would lead to an ICU bed occupancy rate of 56.84% in 2024 (**Table 3**). In a conversation with the head of the Health System's Agency of Northern Virginia (HSANV), Dean Montgomery, on September 12th, 2025, DCOPN was informed that VHC Health has assured HSANV that even though the number of ICU beds was misreported, the associated patient days were correct. In other words, though they had mistakenly reported 40 ICU beds, patient days for ICU beds only reflected the 32 actual ICU beds. Calculations using the same patient day rate but 8 less ICU beds for 2024 are in **Table 3**.

Table 3. 2024 Virginia Hospital Center ICU and Med/Surg Bed Occupancy Corrected

Class	Licensed Beds	Licensed Bed Available Days	Patient Days	Occupancy Rate per Licensed Bed
Med/Surg*	345	125,925	91,406	72.58%
Adult ICU	32	11,680	6,639	56.84%
	377	**137,982**	**98,045**	**71.06%**

*Excluding ICU
Source: 2024 VHI and COPN Request No. VA 8827

Cardiac Catheterization

Cardiac Catheterization Laboratories (Cardiac Cath Labs) are laboratories that examine how well the heart is working by inserting a catheter, a thin, hollow tube, into a large blood vessel that leads to the heart.[3] Cardiac catheterization services are performed to find diseases of the heart muscle, valves, or coronary (heart) arteries by measuring the pressure and blood flow in the heart.[4]

[3] https://www.heart.org/en/health-topics/heart-attack/diagnosing-a-heart-attack/cardiac-catheterization
[4] Ibid.

In order to measure the pressure and blood flow of the heart and associated tissues, coronary angiography is utilized; a contrast dye, visible in X-rays, is injected through the catheter and the x-ray images show the dye as it flows through the heart arteries, indicating where arteries are blocked.[5]
Catheterization labs are essential in treating heart conditions in a minimally invasive manner as an alternative to surgery.[6] Some common catheterization lab procedures are:

- Cardiac coronary angiogram (procedure to evaluate the blood vessels supplying the heart using catheters and x-ray dye)
- Coronary stent placement (a procedure where small metal scaffolds are placed within a blocked artery to keep the artery open)
- Right heart catheterization (a procedure where physicians examine blood flow and pressure filling in the right side of the heart)
- Peripheral angiogram (a procedure that evaluates the flow of blood through arteries in the upper extremities, similar to a coronary angiogram)
- Valve replacement (a minimally invasive procedure that implants an artificial valve in the heart to replace a narrowed heart valve)[7]

According to VHI, there were 21 cardiac cath labs reported to VHI for PD 8 in 2024, the latest year for which such data are available (**Table 4**). Their utilization equaled diagnostic equivalent procedures (DEPs)[8] of 26,145, 103.75% of the SMFP standard for increasing the number of cardiac cath labs (**Table 4**). It is worth noting that two facilities in particular had reported DEPs that were much higher than the rest of the PD, Inova Fairfax Hospital (158.50%) and UVA Health Prince William Medical Center (131.00%).

In 2024, VHC reported a total of four cardiac catheterization labs that operated at 88.52% of the SMFP standard (**Table 4**). Inova Fairfax Hospital and Virginia Hospital Center are the only facilities in PD 8 that offer open heart surgery; therefore, they are the only sites that can provide complex cardiac catheterization per Section 12VAC5-230-420 of the State Medical Facilities Plan (SMFP).[9] Additionally, Inova Fairfax Hospital is the only facility in PD 8 that offers pediatric cardiac catheterization services, which is reflected in their DEP total in **Table 4**.

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[5] https://www.heart.org/en/health-topics/heart-attack/diagnosing-a-heart-attack/cardiac-catheterization
[6] Saira Samani, MD. "What Is a Cath Lab?: Ochsner Health." Ochsner Health System. Ochsner Health System, August 5, 2022. https://blog.ochsner.org/articles/cath-lab-101-behind-the-laboratory-door.
[7] Ibid.
[8] "DEP" means diagnostic equivalent procedure, a method for weighing the relative value of various cardiac catheterization procedures as follows: a diagnostic cardiac catheterization equals 1 DEP, a simple therapeutic cardiac catheterization equals 2 DEPs, a same session procedure (diagnostic and simple therapeutic) equals 3 DEPs, and a complex therapeutic cardiac catheterization equals 5 DEPs. A multiplier of 2 will be applied for a pediatric procedure (i.e., a pediatric diagnostic cardiac catheterization equals 2 DEPs, a pediatric simple therapeutic cardiac catheterization equals 4 DEPs, and a pediatric complex therapeutic cardiac catheterization equals 10 DEPs.)

[9] 12VAC5-230-420: Proposals to provide complex therapeutic cardiac catheterization should be approved only when open heart surgery services are available on-site in the same hospital in which the proposed complex therapeutic service will be located.

Table 4. VHI 2024 Utilization, PD 8

Facility Name	# of Labs	Adult Diagnostic	Adult Simple Tx	Adult Same Session Dx and Tx	Adult Complex Tx	Peds Dx	Peds Tx	Peds Same Session Dx and Tx	Peds Complex
Inova Alexandria Hospital	2	954	18	294	0	0	0	0	0
Inova Fairfax Hospital	7	4111	92	1233	912	45	0	0	67
Inova Loudoun Hospital	2	914	3	444	0	0	0	0	0
Reston Hospital Center	2	324	217	198	0	0	0	0	0
Sentara Northern Virginia Medical Center	2	926	12	187	0	0	0	0	0
Stone Springs Hospital Center	1	10	2	3	0	0	0	0	0
UVA Health Prince William Medical Center	1	33	705	43	0	0	0	0	0
Virginia Hospital Center	4	1305	215	503	201	0	0	0	0
PD 8 Total	**21**	**8,577**	**1,264**	**2,905**	**1,113**	**45**	**0**	**0**	**67**

		DEP Multiplier (weighted)										
Facility Name	**# of Labs**	**x 1**	**x 2**	**x 3**	**x 5**	**x 2**	**x4**	**x 6**	**x 10**	**Total DEPs**	**DEPs/ Cath Lab**	**% of SMFP Threshold**
Inova Alexandria Hospital	2	954	36	882	0	0	0	0	0	1,872	936	78.00%
Inova Fairfax Hospital	7	4111	184	3699	4560	90	0	0	670	13,314	1,902	158.50%
Inova Loudoun Hospital	2	914	6	1332	0	0	0	0	0	2,252	1,126	93.83%
Reston Hospital Center	2	324	434	594	0	0	0	0	0	1,352	676	56.33%
Sentara Northern Virginia Medical Center	2	926	24	561	0	0	0	0	0	1,511	756	62.96%
Stone Springs Hospital Center	1	10	4	9	0	0	0	0	0	23	23	1.92%
UVA Health Prince William Medical Center	1	33	1410	129	0	0	0	0	0	1,572	1,572	131.00%
Virginia Hospital Center	4	1305	430	1509	1005	0	0	0	0	4,249	1,062	88.52%
PD 8 Total	**21**	**8,577**	**2,528**	**8,715**	**5,565**	**90**	**0**	**0**	**670**	**26,145**	**1,007**	**103.75%**

Source: 2024 VHI and DCOPN Calculations

DCOPN records show that there are, as of November 2025, 23 cardiac catheterizations in PD 8 (**Table 5**), two more than the number reported to VHI in 2024. COPN No. VA-04891 authorized Inova Fairfax Hospital for an additional cardiac catheterization lab and COPN No. VA-04604 authorized UVA Health Prince William Medical Center[10] for an additional cardiac catheterization lab. Additionally, Sentara Northern Virginia Medical Center moved one of its cardiac catheterization labs to a new facility, Sentara Heart and Vascular Center under COPN No. VA-04847. Data from these changes are not yet available.

[10] UVA Health Prince William Medical Center was authorized under COPN No. VA-04604 to add an additional cardiac catheterization lab to bring their total number of labs to 2. The second lab was finished in May 2020. Starting in 2023, however, the facility reported only having 1 lab again.

Table 5. Cardiac Catheterization Laboratory Inventory: 2025

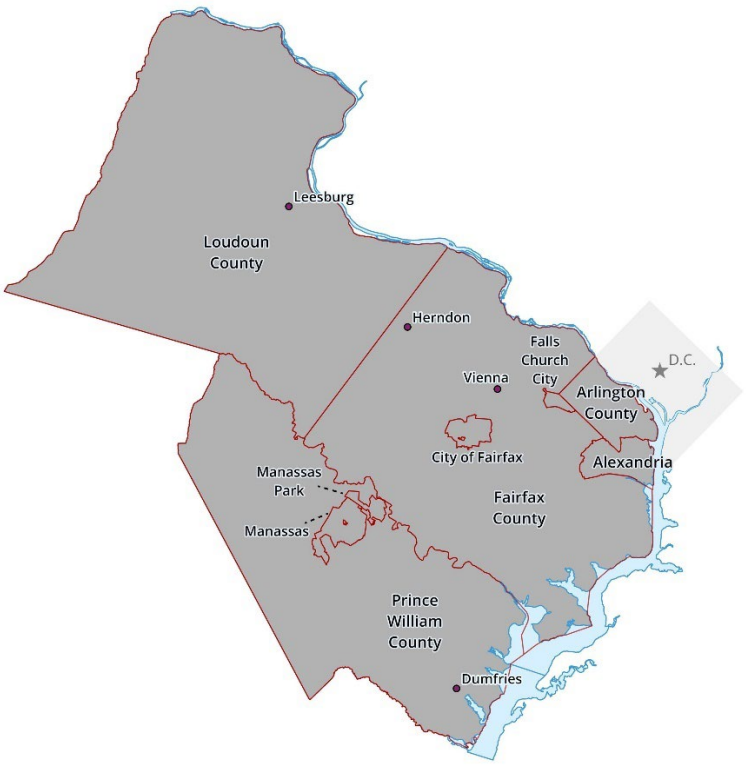
Facility	Cardiac Catheterization Labs
Inova Alexandria Hospital	2
Inova Fairfax Hospital	8
Inova Loudoun Hospital	2
Reston Hospital Center	2
Sentara Heart and Vascular Center	1
Sentara Northern Virginia Medical Center	1
Stone Springs Hospital Center	1
UVA Health Prince William Medical Center	2
Virginia Hospital Center	4
Total	**23**

Source: DCOPN Records

Proposed Projects

The applicant proposes to expand three key services at the existing Virginia Hospital Center facility located at 1701 N George Mason Dr, Arlington: intensive care, cardiac catheterization, and emergency department (ED) services[11]. Arlington County borders Fairfax County to its west and Washington D.C. to its east (**Figure 1**).

Figure 1. Counties in Northern Virginia



Source: novaregion.org/233/Northern-Virginia-Map

[11] Emergency Departments do not require COPN certification.

ICU expansion
The proposed project would add 11 ICU beds to VHC's current inventory of 32 for a total of 43 ICU beds should the project be approved. To accommodate these extra beds, 11 private ICU rooms will be constructed in the currently existing ICU wing. Five beds will be designated for cardiovascular ICU (CVICU) patients, and the remaining six will be used for general ICU patients. The project will additionally expand the size of all currently existing ICU rooms, which the applicant states are undersized.

Cardiac Catheterization
The applicant also proposes adding one cardiac catheterization lab to their existing inventory. If approved, VHC would have a total of five cardiac catheterization labs. The new lab would be added to the already existing cardiovascular floor.

The target date for completion is March 2028[12].

Project Definitions
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". A medical care facility is defined, in part, as "[a]ny facility licensed as a hospital, as defined in § 32.1-123."

Section 32.1.1-102.1 of the *Code of Virginia* defines a project, in part, as "The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization..."

[12] The cardiac catheterization lab is anticipated to be complete in May 2027 and the ICU beds in August 2027.

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.**

VHC is centrally located in Arlington County, a suburb of Washington, D.C., making it readily accessible to residents of PD 8. The surrounding area is a mix of single-family residential communities, large multi-family housing developments, and commercial development around the Orange Line and Silver Line of the Metrorail transit system. Major highway access is provided by Interstate 66 and Route 29 (east and west) and by N. George Mason Drive and Glebe Road, two four-lane cross-country connectors that travel primarily north/south. Emergency vehicles primarily use Glebe Road and Washington Boulevard to access the hospital.
Public transportation, including Metrorail and bus services, adds to VHC's accessibility. Metrorail patrons can use the Arlington Connector to access the hospital from the local metro transit stations. There are two bus stops adjacent to the hospital campus. One stop is at the hospital's main entrance at N. George Mason Drive, and the other stop is at the hospital entrance off 16th Street. Additionally, the Washington Metropolitan Area Transportation Authority provides handicapped paratransit.

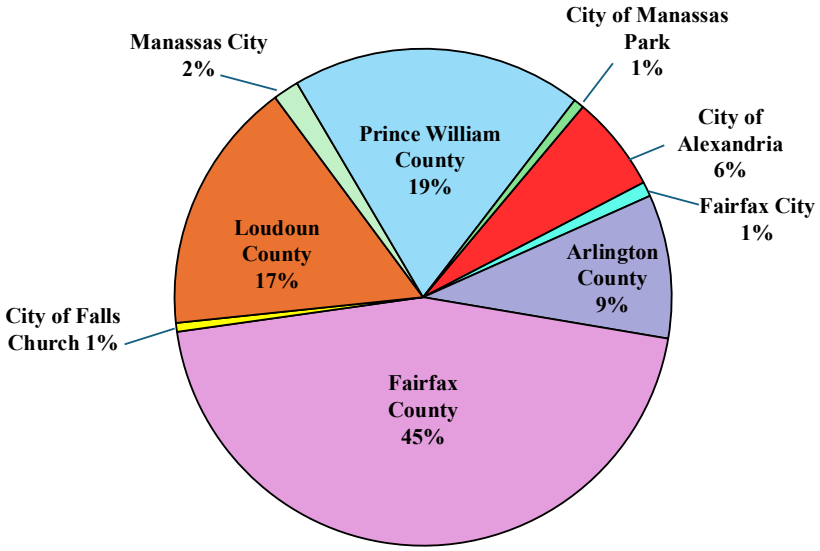
PD 8 had a population of about 2.5 million in 2020 and is projected to grow by just under 300,000 people, a 10.9% increase, by 2030. This is nearly double the population growth rate projected for the Commonwealth of Virginia during this decade, 5.8% (**Table 6**). Arlington County, where the proposed project is located, is projected to have a population exceeding 260,000 by 2030. In total, it is projected to grow by 27,151 people, a 11.4% increase, between 2020 and 2030, a higher rate than that of PD 8 and that of Virginia (**Table 6 & Figure 3**). The 65+ population in PD 8 is expected to grow by 97,855 people (a 31.9% increase) between 2020 and 2030. In Arlington County, the 65+ population is expected to grow by 3,168 people (a 12.5% increase) (**Table 6 & Figure 3**). Fairfax County, which borders Arlington County, is the largest in PD 8 and the Commonwealth with over 1.1 million residents in 2020 (45% of the population of PD 8, 13.3% of the total population of Virginia). **Figure 2** shows that Arlington County makes up 9% of the population of PD 8.

Table 6. PD 8 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
City of Alexandria	159,467	176,403	16,936	10.6%	18,758	22,941	4,183	22.3%
Arlington County	238,643	265,794	27,151	11.4%	25,333	28,501	3,168	12.5%
Fairfax County	1,150,309	1,201,420	51,111	4.4%	158,687	195,132	36,445	23.0%
Fairfax City	24,146	25,358	1,212	5.0%	3,871	4,726	855	22.1%
City of Falls Church	14,658	16,741	2,083	14.2%	2,185	2,545	360	16.5%
Loudoun County	420,959	522,015	101,056	24.0%	41,497	65,844	24,347	58.7%
Manassas City	42,772	47,039	4,267	10.0%	4,505	6,593	2,088	46.3%
City of Manassas Park	17,219	19,876	2,657	15.4%	1,343	2,162	819	61.0%
Prince William County	482,204	554,344	72,140	15.0%	50,522	76,112	25,590	50.7%
PD 8 Totals/Avg.	**2,550,377**	**2,828,990**	**278,613**	**10.9%**	**306,701**	**404,556**	**97,855**	**31.9%**
Virginia	***8,631,393***	***9,129,002***	***497,609***	***5.8%***	***1,395,291***	***1,762,641***	***367,350***	***26.3%***

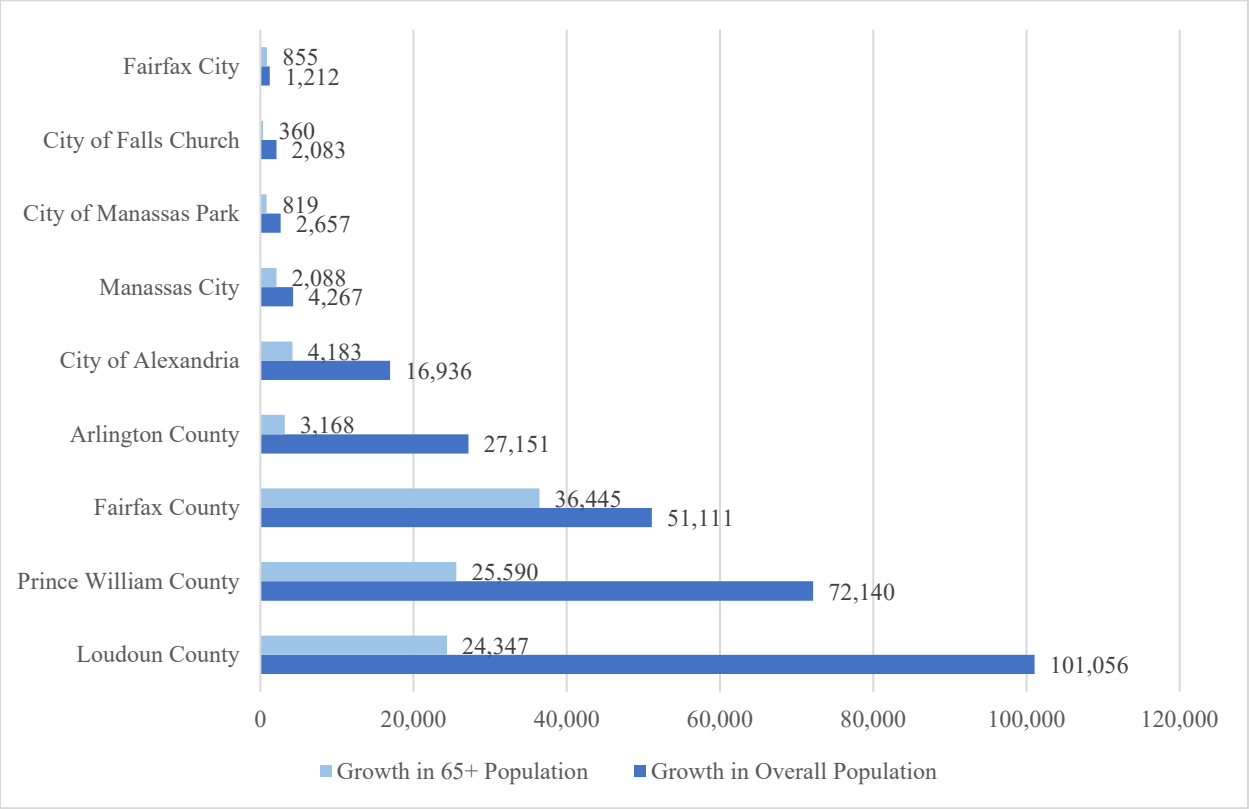
Source: Weldon-Cooper Data, updated June 2025

Figure 2. Percent of PD 8 Population by Locality



Source: Weldon-Cooper Data, updated June 2025

Figure 3. Projected Population Growth by Locality, PD 8, 2020-2030



Source: Weldon-Cooper Data, updated June 2025

With respect to socioeconomic barriers, the overall poverty rate of PD 8, 6.2% is lower than that of Virginia, 10.2% (**Table 7**). Arlington County has a poverty rate comparable to the rest of PD 8 at 7.1%.

Table 7. 2023 Poverty Rates, PD 8

Locality	**Percent in Poverty**
Alexandria City	8.5%
Arlington County	7.1%
Fairfax County	6.1%
Fairfax City	7.4%
Falls Church City	5.1%
Loudoun County	4.1%
Manassas City	10.7%
Manassas Park City	7.7%
Prince William County	6.7%
PD 8	**6.2%**
Virginia	*10.2%*

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

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 several letters in support of the proposed project from the Chief Medical Officer of VHC, the Executive Medical Director of the Mid-Atlantic Permanente Group (Kaiser), Senator of the 40th Virginia Senatorial District (Barbara Favola), the Chief of Cardiac Thoracic & Vascular Surgery at VHC Health, a member of the Virginia House of Delegates 1st District (Patrick Hope), the Chief Business Development Officer at Goodwin Living, the founder of Ethiopian Community Development Council Inc., a group of VHC Health cardiologists, and the President of US Acute Care Solutions. In summary, these letters stated:

- VHC has a strong partnership with Kaiser Permanente, which covers over 330,000 patients in Northern Virginia. Currently wait times due to strain on services are impairing VHC and Kaiser's ability to provide timely access to inpatient services.
- VHC is also the only remaining independent hospital in Northern Virginia and offers a Level 2 Trauma Center to the region.
- VHC is experiencing increasing demand for critical care and cardiac services. Fluctuations in patient activity leads to spikes in ICU occupancy and high utilization of cardiac catheterization labs. The facility recently bolstered its cardiac catheterization staffing by adding several new surgeons, nurses and other support staff.
- VHC has the 2nd busiest ER in Northern Virginia and patients often go directly from the ER to the ICU or catheterization lab. When these services are not available due to overcrowding, it delays patient care.
- VHC is one of the lowest cost providers in PD 8 and Medicaid patients make up 6.8% of their patient payer population. VHC is also subject to a 3.0% charity condition.

Public Hearing

DCOPN provided notice to the public regarding this project inviting public comment on September 10, 2025. The public comment period closed on October 25, 2025. §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.

On September 15, 2025, the Health Systems Agency of Northern Virginia (HSANV) held a public hearing for the proposed project. Adrian Stanton, Vice President of VHC Health, presented the project, along with other members of the VHC leadership. Other than the letters of support referenced above, no members of the public commented.
There is no known opposition to the project.

(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.

ICU Beds

A reasonable alternative to this portion of the project would be to convert some of the underutilized OB and/or pediatric beds to ICU beds, though ICU bed occupancy data does not seem to warrant this conversion. DCOPN notes in particular that only six of the 13 pediatric beds were reported to be staffed. These underutilized/unused beds could potentially be converted to ICU beds.

The applicant also mentioned that it currently does not use three of its OB beds since they are located in rooms that need to be renovated and are not up to code (not part of the renovation proposed in this project). If the decision to convert these underutilized beds is made, it is unlikely to lead to overutilization of OB and pediatric bed services unless there is a significant increase in demand. For example, using the 2024 VHI patient day data, if five OB beds (the three not in use plus an additional two) and six pediatric beds (all not staffed) were converted to ICU beds, the occupancy rate for OB beds would be 58.87% and the occupancy rate for pediatric beds would be 3.56% (**Table 8**). This is far below the 80% SMFP threshold for expansion for these bed types. Another reasonable alternative would be the status quo of leaving all the beds as is until there is a proven need for expansion.

Table 8. Projections for Redistribution of 11 Pediatric and OB Beds

Bed Type	Licensed Beds	Licensed Bed Available Days	Patient Days	Occupancy Rate Per Licensed Bed
OB	54	19,710	11,604	58.87%
Pediatric	6	2,190	78	3.56%
ICU	43[13]	15,695	6,639	42.30%

Source: 2024 VHI

Cardiac Catheterization

The status quo is a reasonable alternative to the proposed project. The utilization rate of VHC's 4 cardiac cath labs was only 88.52% of the SMFP threshold required for expansion (**Table 4**), showing that the request to add another lab is premature for the time being. In 2024, the overall average cardiac catheterization utilization for the PD was 103.75%.

[13] See n 2

(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.

HSANV considered the proposed projects at its September 15, 2025, meeting.

The Board voted nine in favor and none opposed to recommend that the application be approved. HSANV stated that its recommendation was based on its review of the application, on the HSANV staff report on the proposal, on the testimony and other evidence presented at the September 15, 2025, public hearing, and on several findings and conclusions, including:

1. The project is a timely expansion of three Virginia Hospital Center (VHC) critical care services.
2. The project is consistent with applicable provisions of the State Medical Facilities Plan (SMFP).
3. The project is well conceived and timely. Expanding multiple services in one project will minimize disruption of hospital functions.

DCOPN notes that the decision from HSANV came before the 2024 VHI data, which showed a small decrease in cardiac catheterization DEPs and ICU bed occupancy, was released. Therefore, conclusions were made based on the 2023 VHI data.

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

As demonstrated by **Table 9**, the projected capital costs of the proposed project are $67,949,353, which will be funded wholly by accumulated reserves, so there are no financing costs on this project. Direct construction costs are estimated to be $50,533,295 or 75% of total costs and comes to $1,350 per square foot. This is comparable to recently approved similar projects, COPN No. VA-04939, COPN No. VA-04940 and COPN No. VA-04956 which ranged from $879 to $1,362 per square foot.

Table 9. Capital Costs

Direct Construction Costs	$50,533,295
Equipment Not Included in Construction Contract	$12,862,138
Architectural and Engineering Fees	$4,533,920
Total Capital Costs	**$67,949,353**

Source: COPN Request No. VA-8827

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

- VHC is the only acute care hospital in Arlington County, the only remaining independent hospital in PD 8, and serves over 350,000 patients annually. These patients would benefit from expanded services.
- Completing all requested renovations and expansions at once will reduce costs and potential service interruptions to patients.
- There is a need for additional ICU beds in PD 8 that VHC can meet.

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

The applicant asserts that their mission is to provide high-quality care to all patients regardless of their ability to pay for services or the payment source. As **Table 10** below demonstrates, VHC provided 2.1% of its gross patient revenue in the form of charity care in 2023. The Pro Forma Income Statement provided by the applicant proffered a charity care contribution equal to 3.5% of gross patient services revenue[14]. This amount is higher than the 1.9% HPR II charity care average (**Table 10**) and is higher than VHC Health's system-wide charity care condition currently in place of 3.0%[15]. Accordingly, should the Commissioner approve the proposed project, DCOPN contends that the 3.0% system-wide charity care condition should apply.

Table 10. HPR II Charity Care Contributions: 2023

	2023 at 200%		
HPR II	**Gross Pt Rev**	**Total Charity Care Provided Below 200%**	**%**
Encompass Health Rehab Hosp of Northern Virginia	$ 47,006,703	$1,815,624	3.9%
Sentara Northern Virginia Medical Center	$ 1,045,324,552	$36,160,381	3.5%
Inova Alexandria Hospital	$ 1,429,207,087	$37,429,423	2.6%
Inova Mount Vernon Hospital	$ 763,866,669	$18,931,409	2.5%
Inova Fairfax Hospital	$ 6,178,801,539	$147,787,884	2.4%
Inova Loudoun Hospital	$ 1,401,069,976	$30,988,208	2.2%
Virginia Hospital Center	$ 2,186,532,064	$46,172,024	2.1%
Inova Fair Oaks Hospital	$ 1,066,144,047	$22,481,850	2.1%
Dominion Hospital	$ 186,176,170	$2,045,071	1.1%
Reston Hospital Center	$ 2,138,632,642	$17,987,554	0.8%
StoneSprings Hospital Center	$ 539,217,793	$3,146,642	0.6%
North Spring Behavioral Healthcare	$ 81,326,336	$341,453	0.4%
UVA Health Prince William Medical Center	$ 635,237,781	$0	0.0%
UVA Health Haymarket Medical Center	$ 367,868,585	$0	0.0%
HPR II Inpatient Hospital Median			2.1%
HPR II Total Inpatient $ & Mean %	$ 18,066,411,944	$365,287,523	**2.0%**

[14] Source: COPN Request VA-8827
[15] 3.0% System-wide condition established pursuant to COPN No. VA-04447/04447 in 2014.

-HPR II Charity Care Contributions cont.-

HealthQare Services ASC, LLC	$ 12,393,083	$933,007	7.5%
Stone Springs Ambulatory Surgery Center	$ 42,421,176	$774,214	1.8%
Northern Virginia Eye Surgery Center, LLC	$ 16,978,280	$45,760	0.3%
Lake Ridge Ambulatory Surgical Center	$ 12,789,859	$30,788	0.2%
Haymarket Surgery Center	$ 62,445,476	$88,885	0.1%
Reston Surgery Center	$ 165,980,869	$37,296	0.0%
Northern Virginia Surgery Center	$ 63,630,227	$13,450	0.0%
McLean Ambulatory Surgery Center	$ 46,154,897	$7,660	0.0%
Inova Loudoun Ambulatory Surgery Center	$ 98,462,265	$15,163	0.0%
Inova Surgery Center @ Franconia-Springfield	$ 99,121,487	$7,799	0.0%
Fairfax Surgical Center	$ 170,498,365	$2,356	0.0%
Prince William Ambulatory Surgery Center	$ 58,808,176	$0	0.0%
Kaiser Permanente Tysons Corner Surgery Center	$ 48,527,291	$0	0.0%
Kaiser Permanente Caton Hill Ambulatory Surgery Center	$ 21,993,825	$0	0.0%
Inova Ambulatory Surgery Center at Lorton	$ 8,494,696	$0	0.0%
Pediatric Specialists of Virginia Ambulatory Surgery Center	$ 7,412,957	$0	0.0%
HPR II Outpatient Hospital Median			0.0%
HPR II Total Outpatient Hospital $ & Mean %	$ 936,112,929	$ 1,956,378	**0.2%**
HPR II Hospital Median			1.2%
HPR II Total Hospital $ & Mean %	$ 19,002,524,873	367,243,901	**1.9%**

Source: 2023 VHI

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

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

3. The extent to which the 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 recommendations for a comprehensive State Health Services Plan (SHSP). In the interim, DCOPN will consider the consistency of the proposed project with the State Medical Facilities Plan (SMFP), predecessor of the SHSP.

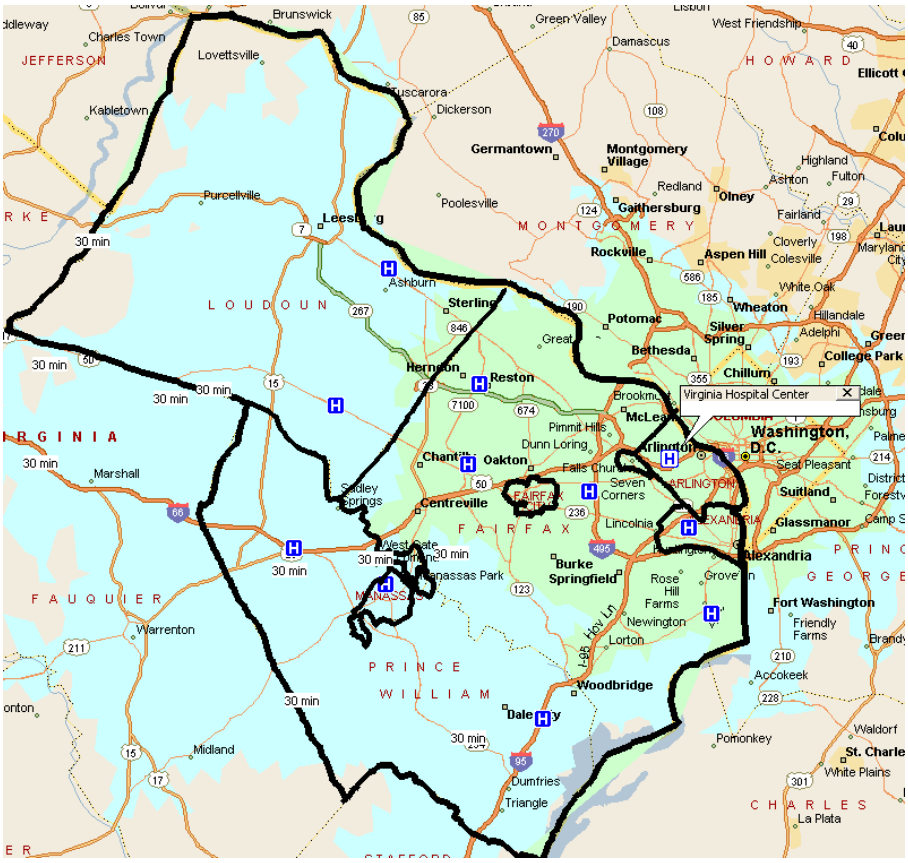
The SMFP contains criteria/standards for the addition of inpatient beds. They are as follows:

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 4** represents the boundary of PD 8. The "H" symbol with the white background represents the location of the proposed project. The "H" symbols with the blue backgrounds mark the locations of all other existing inpatient bed services in PD 8. The light-blue shaded area represents the area of PD 8 that is within 30 minutes' drive-time of existing inpatient bed services. The light-green shading is the area in and around PD 8 that is within 30 minutes driving distance of VHC. According to the map, it is clear that inpatient bed services currently exist within a 30-minute drive for at least 95% of the population of PD 8. The largest town that is not within 30 minutes of a PD 8 hospital is Lovettsville which has a population of just over 1,000 people. It is important to note that the applicant proposes adding medical-surgical beds at a location that already provides these services. Therefore, DCOPN concludes that approval of the proposed project would not improve geographic access to inpatient bed services for people in PD 8 in any meaningful way.

Figure 4. Authorized Hospitals with Medical/Surgical Beds, PD 8



Source: 2024 VHI

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 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.

Not applicable. The proposed project does not represent a new ICU service.

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.

Not applicable. VHC is not converting underutilized beds.

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

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

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

Not applicable. VHC is not converting underutilized 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:

$$\text{NewBed} = \text{ProBed} - \text{CurrentBed}$$

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.

This provision is not applicable since the applicant is asking for ICU beds specifically. For context, the medical/surgical bed need in PD 8 is as follows:

Table 11. Medical/Surgical[16] Bed Need Data, PD 8

	2020	2021	2022	2023	2024	5-Year Total
Days	586,493	636,226	629,232	648,434	676,246	3,100,561
Population 18+	1,939,750	1,967,611	1,995,43	2,023,334	2,051,195	9,838,057

Source: 2020 Census, 2024 VHI, and Weldon-Cooper

3,176,631/9,977,363= 0.3183838255 (Bed Use Rate)

(BUR X 2,190,090)/365 = 1,910
2030 population

1,910/0.8= 2,388 (bed need in 5 years)

Current Beds =2,667

2,388 – 2,667= -279

Surplus of **279** 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.

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

ProPedPop = The projected population under 18 years of age of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.
3. Determine the number of pediatric beds needed within the health planning district for the fifth planning horizon year as follows:
NewPedBed – ProPedBed – CurrentPedBed
Where:
NewPedBed = the number of new pediatric beds that can be established in a health planning district, if the number is positive. If NewPedBed is a negative number, no additional pediatric beds should be authorized for the health planning district.
ProPedBed = the projected number of pediatric beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.
CurrentPedBed = the current inventory of licensed and authorized pediatric beds in the health planning district.

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 12. ICU Bed Need Data

	2020	2021	2022	2023	2024	5-Year Total
ICU Days	77,276	81,203	78,667	80,060	80,272	397,478
Population 18+	1,939,750	1,967,611	1,995,43	2,023,334	2,051,195	9,838,057

Source: 2020 Census, 2024 VHI, and Weldon-Cooper

397,478/9,977,363 =0.0398379812 (Bed Use Rate)

(BUR X 2,190,090)/365 =239
2030 population

239/0.65= 368 (bed need in 5 years)
Current Beds =338

368-338 = 30
Deficit of **30** 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.

This section is not applicable. No beds are being relocated.

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

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 is an established provider of inpatient beds and services, and the applicant provided assurances that the existing and proposed inpatient beds will be under the direction of one or more qualified physicians.

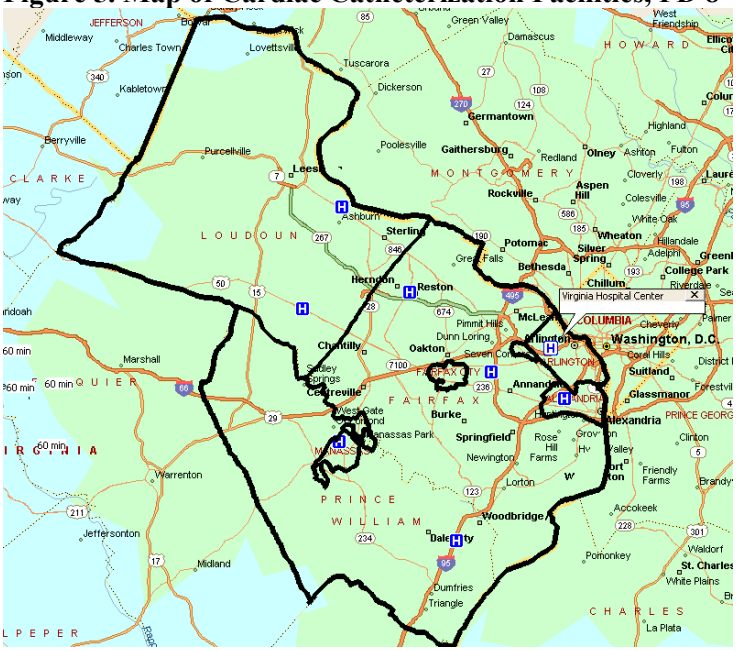
The SMFP contains additional criteria/standards for the addition of cardiac catheterization services. They are as follows:

Part IV
Cardiac Services

12VAC5-230-380. Travel time.
Article 1
Criteria and Standards for Cardiac Catheterization Services
Cardiac catheterization services should be within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

The black outline in **Figure 5** is the border of PD 8. The "H" symbol with the white background represents the proposed project and the "H" symbols with the blue background represents all providers in the PD that offer cardiac catheterization. The blue shading represents the area within 60 minutes' drive time of the proposed project, and the blue shading represents the area within 60 minutes of all of the cardiac catheterization providers in PD 8. It is evident by the map that the entire planning district is within a 60-minute drive of cardiac catheterization services.

Figure 5. Map of Cardiac Catheterization Facilities, PD 8



Source: 2023 VHI

12VAC5-230-390. Need for new service.
A. No new fixed site cardiac catheterization service should be approved for a health planning district unless:
1. Existing fixed site cardiac catheterization services located in the health planning district performed an average of 1,200 cardiac catheterization DEPs per existing and approved laboratory for the relevant reporting period;
2. The proposed new service will perform an average of 200 DEPs in the first year of operation and 500 DEPs in the second year of operation; and
3. The utilization of existing services in the health planning district will not be significantly reduced.

Not applicable. The proposed cardiac cath lab would expand an existing service.

B. Proposals for mobile cardiac catheterization laboratories should be approved only if such laboratories will be provided at a site located on the campus of an inpatient hospital. Additionally, applicants for proposed mobile cardiac catheterization laboratories shall be able to project that they will perform an average of 200 DEPs in the first year of operation and 350 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district below 1,200 procedures.

Not applicable. The proposed is not for a mobile cardiac catheterization laboratory.

C. Preference may be given to a project that locates new cardiac catheterization services at an inpatient hospital that is 60 minutes or more driving time one way under normal conditions from existing services if the applicant can demonstrate that the proposed new laboratory will perform an average of 200 DEPs in the first year of operation and 400 DEPs in the second

year of operation without significantly reducing the utilization of existing laboratories in the health planning district.

Not applicable. The proposed cardiac catheterization laboratory is not competing with another project.

12VAC5-230-400. Expansion of services.
Proposals to increase cardiac catheterization services should be approved only when:
1. All existing cardiac catheterization laboratories operated by the applicant's facilities where the proposed expansion is to occur have performed an average of 1,200 DEPs per existing and approved laboratory for the relevant reporting period; and

As reported to VHI in 2024, VHC had a utilization of 4,249 DEPs (1,062 DEPs per cardiac catheterization lab), 88.52% of the 1,200 DEP threshold (**Table 13**). This does not meet the SMFP threshold for expansion.

Table 13. VHC Cardiac Catheterization DEPs

Facility Name	# of Labs	Adult Diagnostic	Adult Simple Tx	Adult Same Session Dx and Tx	Adult Complex Tx	Peds Dx	Peds Tx	Peds Same Session Dx and Tx	Peds Complex			
Virginia Hospital Center	4	1305	215	503	201	0	0	0	0			
DEP Multiplier (weighted)												
		x 1	x 2	x 3	x 5	x 2	x4	x 6	x 10	Total DEPs	DEPs/ Cath Lab	% of SMFP Threshold
		1305	430	1509	1005	0	0	0	0	4,249	1,062	88.52%

Source: 2024 VHI and DCOPN Calculations

2. The applicant can demonstrate that the expanded service will achieve an average of 200 DEPs per laboratory in the first 12 months of operation and 400 DEPs in the second 12 months of operation without significantly reducing the utilization of existing cardiac catheterization laboratories in the health planning district.

With no changes to VHC's 2024 DEP volume, 4,249 DEPs spread over 5 cardiac catheterization labs (the 4 existing plus the proposed additional lab) is equal to 850 DEPs per lab which is 71% of the SMFP threshold. The facility should have no issue achieving 200 DEPs per lab in the first 12 months and 400 DEPs per lab in the second 12 months. The proposal is unlikely to impact existing cardiac catheterization labs in the PD.

12VAC5-230-410. Pediatric cardiac catheterization.
No new or expanded pediatric cardiac catheterization services should be approved unless:
1. The proposed service will be provided at an inpatient hospital with open heart surgery services, pediatric tertiary care services or specialty or subspecialty level neonatal special care;
2. The applicant can demonstrate that the proposed laboratory will perform at least 100 pediatric cardiac catheterization procedures in the first year of operation and 200 pediatric cardiac catheterization procedures in the second year of operation; and
3. The utilization of existing pediatric cardiac catheterization laboratories in the health planning district will not be reduced below 100 procedures per year.

Not applicable. VHC does not perform pediatric cardiac catheterization procedures.

12 VAC 5-230-420. Non-emergent Cardiac Catheterization.
A. Simple therapeutic cardiac catheterization. Proposals to provide simple therapeutic cardiac catheterization are not required to offer open heart surgery service available on-site in the same hospital in which the proposed simple therapeutic service will be located. However, these programs shall adhere to the requirements described in subdivisions 1 through 9 of this subsection.

The programs shall:

1. Participate in the Virginia Heart Attack Coalition, the Virginia Cardiac Services Quality Initiative, and the Action Registry-Get with the Guidelines or National Cardiovascular Data Registry to monitor quality and outcomes;

2. Adhere to strict patient-selection criteria;

3. Perform annual institutional volumes of 300 cardiac catheterization procedures, of which at least 75 should be percutaneous coronary intervention (PCI) or as dictated by American College of Cardiology (ACC)/American Heart Association (AHA) Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories effective 1991;

4. Use only AHA/ACC-qualified operators who meet the standards for training and competency;

5. Demonstrate appropriate planning for program development and complete both a primary PCI development program and an elective PCI development program that includes routine care process and case selection review;

6. Develop and maintain a quality and error management program;

7. Provide PCI 24 hours a day, seven days a week;

8. Develop and maintain necessary agreements with a tertiary facility that must agree to accept emergent and nonemergent transfers for additional medical care, cardiac surgery, or intervention; and

9. Develop and maintain agreements with an ambulance service capable of advanced life support and intra-aortic balloon pump transfer that guarantees a 30-minute or less response time.

VHC is an established provider of simple therapeutic cardiac catheterization procedures and affirms compliance with each of the requirements in this subsection.

12VAC5-230-430. Staffing.

A. Cardiac catheterization services should have a medical director who is board certified in cardiology and has clinical experience in performing physiologic and angiographic procedures.

The proposed cardiac catheterization lab will be under the direction of a board-certified cardiologist with the appropriate clinical experience, who already serves as medical director of VHC's cardiac catheterization services.

B. In the case of pediatric cardiac catheterization services, the medical director should be board-certified in pediatric cardiology and have clinical experience in performing physiologic and angiographic procedures.

Not applicable.

C. Cardiac catheterization services should be under the direct supervision or one or more qualified physicians. Such physicians should have clinical experience in performing physiologic and angiographic procedures.

The proposed cardiac catheterization lab will be under the direct supervision of one or more board certified cardiologists who are active members of the VHC medical staff and have the required clinical experience, as are the existing 4 cardiac catheterization labs at VHC.

D. Pediatric catheterization services should be under the direct supervision of one or more qualified physicians. Such physicians should have clinical experience in performing pediatric physiologic and angiographic procedures.

Not applicable.

Part I.
Definitions and General Information

12VAC5-230-80. When Institutional Expansion is Needed.

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

ICU Beds

According to the 2024 VHI report, VHC had an ICU bed occupancy rate of only 45.35% (**Table 1**). This is significantly lower than the SMFP threshold for expansion, 65%[17]. Again, DCOPN acknowledges that with the removal of 8 beds from their ICU inventory, VHC still would only have an ICU bed occupancy rate of 56.84% (**Table 3**), which is still below the SMFP threshold. A breakdown of ICU bed occupancy reports from 2021-2024 (**Table 14)** shows that occupancy in ICU beds decreased 7.05% during that time period. Furthermore, looking at historical bed occupancy in **Table 14**, it is evident that the facility's OB and pediatric beds are also consistently underutilized. The 13 pediatric beds in particular went from an occupancy rate of 60.55% in 2021, to 1.64% rate in 2024. Because of this, DCOPN has determined that any claims for institutional need are premature.

Table 14. VHC Bed Occupancy by bed type 2021-2024

2021	2022	2023	2024
Med/Surg			
94.53%	83.95%	82.75%	81.89%
OB			
52.40%	56.55%	57.22%	54.66%
Pediatric			
60.55%	3.61%	1.62%	1.64%
Adult ICU			
52.40%	49.75%	46.52%	45.35%

Source: 2021-2024 VHI

Cardiac Catheterization

VHC has asserted an institutional need to expand its cardiac catheterization services based on the overutilization of the existing four labs. The SMFP standard for expansion of an existing cardiac catheterization service requires the applicant to perform an average of 1,200 DEPs per lab annually. In 2024, VHC's cardiac catheterization labs performed an average of 1,131 DEPs per lab, and as such, operated at 88.52% of the 1,200 DEPs advocated by the SMFP as the minimum utilization level required for justifying an institution's specific need to expand a cardiac catheterization service. Looking at cardiac catheterization lab utilization data from 2020-2024, VHC reached 100% utilization in 2021, before dropping to 81.21% utilization the following year (**Table 15)**.

[17] https://law.lis.virginia.gov/admincodefull/title12/agency5/chapter230/

Because of this, DCOPN concludes that the request claim of institutional need is premature.

Table 15.VHC Utilization 2020-2024

Year	Cath Labs	Diagnostic	Therapeutic	Same Session	Complex	Total DEPs	Utilization
2020	4	1,207	273	856	0	4,321	90.02%
2021	4	1,633	634	633	0	4,800	100%
2022	4	1,162	375	662	0	3,898	81.21%
2023	4	1,198	262	607	196	4,523	94.23%
2024	4	1,305	215	503	201	4,249	88.52%

Source: VHI Data (2020-2024)

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

Not applicable. VHC is not part of a health system and there are no VHC-affiliated facilities from which underutilized beds could be reallocated.

C. This section is not applicable to nursing facilities pursuant to § 32.1-102.3:1 of the Code of Virginia.

Not applicable. The applicant is not a nursing facility seeking to utilize this section for the purpose of adding beds pursuant to §32.1-102.3:2 of the Code of Virginia.

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

Not applicable. The applicant is not seeking to utilize this section to justify a need to establish a new service.

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.

Table 16 below shows VHC's distance from the other hospitals in PD 8. Since traffic is variable in the area, the closest hospital, Inova Alexandria Hospital, can be anywhere from 18-40 minutes driving distance. It is important to note as well that Inova is working to close this facility, reallocating resources to Inova Alexandria Hospital II (Landmark) and Inova Franconia-Springfield Hospital.

Table 16. Distance from VHC

Hospital	Miles	Minutes	2024 ICU Bed Occupancy	2024 Cardiac Cath Utilization
Inova Alexandria Hospital*	5.9	18-40	45.35%	78.00%
Inova Fairfax Hospital	7.3	20-40	73.91%	158.50%
Inova Alexandria Hospital II (Landmark)**	7.8	22-45	N/A	N/A
Reston Hospital Center	16.7	35-60	58.96%	56.33%
Franconia-Springfield Surgery Center II**	16.7	28-45	N/A	N/A
Inova Fair Oaks Hospital	17.5	30-55	66.67%	N/A
Inova Mount Vernon Hospital	17.9	30-60	40.22%	N/A
Inova Loudoun Hospital	25.6	45-80	70.10%	93.83%
Sentara Northern Virginia Medical Center	26.2	40-70	78.23%	62.96%
StoneSprings Hospital Center	29.9	40-80	13.83%	1.92%
UVA Health System: Haymarket Medical Center	32.6	45-75	62.33%	N/A
UVA Health System: Prince William Medical Center	58.6	40-90	63.46%	131.00%

Source: Google Maps, 2024 VHI
*This facility is in the process of closing
**These facilities have been approved under COPN Va.-04793 and COPN Va.-04832 but are not yet open

ICU Beds

Inova has the dominant portion of medical/surgical beds and the highest share of patient days in PD 8. In 2024, Inova had 61% of all medical/surgical beds and 65% of medical/surgical bed patient days (**Table 17**). During this same time period, VHC made up 14% of PD 8 medical/surgical beds and 14% of medical/surgical patient days in PD 8 (**Table 17**).
This project would not offset Inova's large share of medical/surgical beds, nor would it help even the outpatient days in PD 8. According to VHC's year one projections, provided in COPN Request No. VA-8827, the addition of 11 ICU beds would only increase VHC's patient days share by about 1.5%.

Table 17. PD 8 Health Systems Share of Beds and Patient Days

Facility Name	Licensed Beds	Overall Share of Licensed Beds	Patient Days	Overall Share of Patient Days
Inova Health Systems (IHS)	1627	61%	441,261	65%
Healthcare Associates Inc (HCA)	320	12%	50,719	7%
Sentara Health	183	7%	44,058	6%
University of Virginia (UVA)	160	6%	46,247	7%
Virginia Hospital Center (VHC)	377	14%	98,045	14%
PD 8 Acute Bed Totals/Averages	**2,667**		**680,330**	

Source: VHI, 2024

Cardiac Catheterization

Once again, among its three facilities, Inova had the dominant share of cardiac catheterization labs in PD 8, with its 11 labs making up 52.38% of all labs in the PD in 2024. Additionally, Inova contributed 66.70% of all DEPs in PD 8 in 2024 (**Table 18**). VHC had 19.05% of the cardiac catheterization labs in the PD, which is the second highest share. It also contributed 16.25% of the DEPs in the PD. Should this project be approved, and accounting for the two additional cath labs that have been added to the inventory since the 2024 VHI report, VHC would operate 20.83% of the cath labs in PD 8 (**Table 18**).

Table 18. PD 8 Health Systems/Hospitals Share of Cardiac Catheterization labs

Facility Name	Licensed Cath Labs	Overall Share of Cath Labs	Overall Share of DEPs
Inova Health Systems (IHS)	11	52.38%	66.70%
Healthcare Associates Inc (HCA)	3	14.29%	5.26%
Sentara Health	2	9.52%	5.78%
University of Virginia (UVA)	1	4.76%	6.01%
Virginia Hospital Center (VHC)	4	19.05%	16.25%
PD 8 Cardiac Catheterization Totals	**21**		

Source: VHI, 2024

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.

VHC is the only remaining independent hospital in PD 8 and operates one acute care facility. As mentioned above, it operates 14% of the med/surg beds in the PD and 19.05% of the cardiac catheterization labs (**Table 17 and Table 18)**. VHC serves approximately 350,000 patients annually, operates a Level 2 Trauma Center, and has the second busiest ED in PD 8. VHC is a healthy competitor to Inova, which has the dominant share of facilities and equipment in PD 8. Overall, the PD has an overall med/surg bed occupancy rate of 68.95%, 63.39% for beds designated as ICU beds (**Table 1**). While this occupancy rate is below what would be considered for expansion on the individual facility level, there is a deficit of 30 ICU beds in the PD.

For cardiac cath labs, the overall utilization average for the PD was 103.75% (**Table 4**). As mentioned previously, this average is being greatly affected by two facilities that have utilization rates above 130%. Both locations have since been approved to open 1 additional cath lab each.

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

Capital Costs for the proposed project are $67,949,353 and are similar to recently approved projects and would be considered a reasonable amount (**Table 9**). The proforma (**Table 19**) shows that the proposal is expected to generate over $16 million in income from operations for the first and second years.

Table 19. Proforma, VHC Health

	Year 1	Year 2
Gross Patient Revenue	**$126,227,331**	**$130,014,151**
Contractual Adjustments	$1,893,410	$1,950,212
Bad Debt	$1,893,410	$1,950,212
Charity Care	$4,417,957	$4,550,495
Total Operating Revenue	**$34,081,379**	**$35,103,821**
Total Operating Expenses	**$17,601,248**	**$18,078,324**
Income/(Loss) from Operations	**$16,480,131**	**$17,025,497**

Source: COPN Request No. VA-8827

With regard to staffing, the applicant anticipates the need to hire 48 additional full-time employees (FTEs) in order to staff the additional ICU beds, the additional cardiac catheterization lab, and the expanded ER. This additional staffing need will compound with the existing 214 vacant positions, 130 of which are for registered nurses. The applicant states that there are nationwide health care staffing challenges, but they are working hard to strengthen staff retention and manage costs. VHC recently received CMS's Overall Hospital Quality Five Star Rating, which they hope will help attract new staff. VHC also assures that its close affiliation with numerous schools and training facilities in Virginia and Washington D.C. from which it can

recruit recent graduates. Additionally, VHC states that personnel will be recruited through the Internet and print advertising.

DCPON notes that VHC has historically reported high staffing vacancies, despite its recruitment efforts. **Table 20** shows VHC's reported vacancies in their last three COPN applications (2020, 2021 and 2025). Despite assurance from the applicant that they would not have any issues recruiting necessary staff, historical data shows that they have consistently had registered nurse positions, making up 61% of their total vacant positions. This does raise concern about the effectiveness of their recruitment efforts, and their ability to staff the requested ICU beds and cardiac catheterization lab.

With this, DCOPN also expresses concern about how these vacancies and subsequent recruitment efforts would impact other facilities in PD 8.

Table 20. VHC Health Vacancies

	Total Current Vacant Positions	Current Vacant Nursing Positions	Current Vacant Nursing Positions % of total
COPN Request VA-8519 (2020)	216	132	61%
COPN Request VA-8586 (2021)	214	130	61%
COPN Request VA-8827 (2025)	214	130	61%

Source: COPN Request No. VA-8519, COPN Request No. VA-8586, COPN Request No. VA-8827

7. The extent to which the project provides improvements 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 proposed project would not introduce any new technologies, or any services that could be offered on an outpatient basis, nor are there any cooperative efforts to meet healthcare needs. DCOPN did not identify any other discretionary factors to bring to the Commissioner's attention.

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

VHC partners with many training and educational facilities in Northern Virginia and the District of Columbia, including Marymount University, Northern Virginia Community College, George Mason University, Georgetown University, George Washington University, James Madison University, Catholic University, Shenandoah University, Stratford University, and Chamberlain University. In 2022, VHC Health became the first hospital in the D.C. Metro area to become a Practice Transition Accreditation Program which is a national certification awarded for meeting global standards that transitions new graduate registered nurses through their first twelve months of practice. The applicant does not address any criteria by which the proposed project would affect the unique research, training, and clinical mission of the teaching hospital or any contribution the teaching hospital may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations that is not addressed elsewhere in the report.

DCOPN Staff Findings and Conclusions

Virginia Hospital Center (VHC) proposes to add 11 Intensive Care Unit (ICU) beds and one Cardiac Catheterization Laboratory to its hospital campus on N George Mason Drive in Arlington. If approved, VHC would have 43 ICU beds, and five Cardiac Catheterization Labs. Projected capital costs for the project are reasonable and there is no known opposition, but the need to hire 48 additional FTEs when they are already in need of 214 FTEs facility-wide is of particular concern. The need to fill this many positions, particularly for registered nurses, is likely to impact staffing of surrounding facilities.

DCOPN finds the ICU bed portion of the project to be generally consistent with the SMFP and the Eight Required Considerations of the Code of Virginia. While VHC does not meet the 65% occupancy threshold for expansion on the grounds of institutional need, there is a deficit of 30 ICU beds in Planning District 8. On these grounds, VHC would be eligible for additional ICU beds. DCOPN identified that either maintaining the status quo or reclassifying other underutilized medical/surgical beds as ICU beds would be reasonable alternatives to this project.
DCOPN expresses concern about the applicant's ability to properly staff the additional beds, given historical vacancy rates.

DCOPN finds that the Cardiac Catheterization Laboratory portion of the proposed project is not consistent with the applicable criteria and standards of the SMFP and the Eight Required Considerations of the Code of Virginia. VHC's cardiac catheterization labs only operated at 88.52% of the SMFP threshold for expansion in 2024, and historical data have shown a pattern of stagnant utilization rates over the past 5 years. Because of this, the request for another catheterization lab is premature, and the status quo is a reasonable alternative to the project.

DCOPN Staff Recommendation

The Division of Certificate of Public Need recommends **conditional approval** of Virginia Hospital Center's request to add 11 Intensive Care Unit (ICU) beds for the following reasons:

1. The proposed 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. There is a deficit of 30 ICU beds in the planning district.

3. There is no known opposition to this project.

DCOPN's recommendation is contingent upon Virginia Hospital Center's agreement to the following charity care condition:

Virginia Hospital Center will provide inpatient intensive care services to all persons in need of this service, regardless of their ability to pay, and will facilitate the development and operation of primary medical care services to medically underserved persons in PD 8 in an aggregate amount equal to at least 3.0% of Virginia Hospital Center's gross patient revenue derived from medical-surgical services, consistent with the Virginia Hospital Center Arlington Health System system-wide charity care condition agreed to in 2014. 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. Virginia Hospital Center will accept a revised percentage based on the regional average after such time regional charity care data valued under the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. is available from Virginia Health Information. The value of charity care provided 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.
Virginia Hospital Center will provide inpatient intensive 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 Virginia Hospital 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.

The Division of Certificate of Public Need recommends **denial** of Virginia Hospital Center's request to add one Cardiac Catheterization Laboratory for the following reasons:

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

2. Existing Cardiac Catheterization Laboratories at VHC do not meet the 1200 DEP average per laboratory required for expansion under the SMFP.

3. There are reasonable alternatives to the proposed project, including maintaining the status quo.

4. Additional staff needed compounded with current staffing vacancies is likely to impact area providers.