Atrium Health Pineville

Acute Care Beds

Certificate of Need

Application & Exhibits

October 15, 2019

A.1	Organizing Documents for CMHA
B.10-1	Quality Assessment and Performance Improvement Plan
B.10-2	Utilization Management Plan
B.10-3	Risk Management Plan
B.10-4	Non-Discrimination Policies
B.10-5	Language Assistance Plan
C.1-1	CON Exemption Notification and Response
C.1-2	Project ID # F-11622-18 Line Drawings
C.1-3	Line Drawings
C.4-1	Largest Bed Need as Percent of Total Analysis
C.4-2	Excerpt from 2013 Mecklenburg Bed Review Findings
C.4-3	Service to Service Area Provider Analysis
C.4-4	ESRI Southern Charlotte Population Data
C.10	Atrium Health Lake Norman Methodology and Assumptions
F.1	Capital Cost Estimate
F.2-1	Funding Letter
F.2-2	Audited Financials
G.1	*Proposed 2020 SMFP* Table 5A
I.1	Letter from Senior Vice President of Atrium Health Pineville
I.2	Support Letters
I.3	Chief Medical Officer Letter
L.4-1	Atrium Health Financial Policies
L.4-2	Atrium Health EMTALA Policy
O.3	CMS Documentation

2879

STATE OF NORTH CAROLINA

Department of State

CERTIFICATE OF INCORPORATION

OF

CHARLOTTE MEMORIAL HOSPITAL AUTHORITY OF

CHARLOTTE, NORTH CAROLINA

WHEREAS, Miss Emma Hall, Mrs. John B. London, Mrs. Hamilton W. McKay, Mrs. George C. Snyder, Ernest R. Cannon, J. A. Jones, A. L. Boyle, William H. Barnhardt, J. Herbert Bridges, M. E. Pierson, John C. Shepherd, John L. Wilkinson, F. J. Blythe, R. S. Dickson, E. C. Griffith, Mrs.E. C. Marshall, Harry L. Dalton and H. C. Jones, Commissioners, having been appointed as such by E. McA. Currie, Mayor of the City of Charlotte, North Carolina, to act as an Authority under the Hospital Authorities Law, being Chapter 780, 1943 Session Laws of North Carolina, and desiring to become a public body and a body corporate and politic under said law, and

WHEREAS, the said Commissioners having filed with the Secretary of State of the State of North Carolina an application for a certificate of incorporation, in accordance with the aforesaid act, under the name of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, which application was accompanied by exhibits showing full compliance with said law and has been filed and recorded as of this day.

NOW, THEREFORE, I , THAD EURE, Secretary of State of the State of North Carolina, do hereby certify that the above Commissioners and their successors in office, are duly incorporated as a public body and a body corporate and politic in accordance with the provisions of said law under the name of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, with perpetual succession, for the purposes set forth in the said Hospital Authorities Law with all of the powers and privileges conferred by said law.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal.

Done in office at Raleigh, this the 26th day of June, 1943.

Thad Eure

Secretary of State.

CITY OF CHARLOTTE
NORTH CAROLINA

CERTIFICATE OF APPOINTMENT OF COMMISSIONERS OF THE HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA, AND DESIGNATION OF THE FIRST CHAIRMAN.

****

WHEREAS, the City Council of the City of Charlotte, North Carolina, held a duly authorized regular meeting on Wednesday, March 17, 1943; and

WHEREAS, at said meeting the following resolution was unanimously passed and adopted, as will appear in Minute Book 10, at pages 233 and 234, in the Office of the City Clerk of the City of Charlotte:

"RESOLUTION REGARDING THE CREATION OF A HOSPITAL AUTHORITY

WHEREAS, the General Assembly of the State of North Carolina duly enacted Senate Bill No. 254 at its 1943 Session, which Bill is known as the Hospital Authorities Law; and

WHEREAS, the City of Charlotte has a population of more than seventy-five thousand according to the last Federal census; and

WHEREAS, the City Council of the City of Charlotte has duly made an investigation which it deemed necessary and sufficient to ascertain the facts herein contained;

NOW, THEREFORE, be it resolved that the City Council of the City of Charlotte finds that the public health and welfare, including the health and welfare of persons of low income in the City and said surrounding area, require the construction, maintenance or operation of public hospital facilities for the inhabitants thereof.

BE IT FURTHER RESOLVED that notice of this determination be given to the Mayor of the City of Charlotte for him to take such further steps and actions as are set out and contained in said Hospital Authorities Law."

NOW, THEREFORE, pursuant to the provisions of the "Hospital Authorities Law" of the State of North Carolina, as contained in Senate Bill No. 254 of the 1943 Session of the North Carolina General Assembly, and by virtue of my office as Mayor, and by virtue of the aforementioned resolution of the City Council of the City of Charlotte, I hereby appoint the eighteen (18) persons hereinafter named to serve as Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, and to serve for the number of years

~~CITY OF CHARLOTTE~~
~~NORTH CAROLINA~~

appearing after their names, respectively, from the 6th day of May, 1943.

Miss Emma Hall	4 years
Mrs. John B. London	4 years
Mrs. Hamilton W. McKay	4 years
Mrs. George C. Snyder	4 years
Ernest R. Cannon	4 years
J. A. Jones	4 years
A. L. Boyle	8 years
William H. Barnhardt	8 years
J. Herbert Bridges	8 years
M. E. Pierson	8 years
John C. Shepherd	8 years
John L. Wilkinson	8 years
F. J. Blythe	12 years
R. S. Dickson	12 years
E. G. Griffith	12 years
Mrs. E. C. Marshall	12 years
Harry L. Dalton	12 years
H. G. Jones	12 years

I hereby designate F. J. Blythe as the first Chairman of the Hospital Authority of the City of Charlotte, North Carolina.

IN WITNESS WHEREOF, I have hereunto signed my name as Mayor of the City of Charlotte, North Carolina, and caused the official corporate seal of said City of Charlotte, North Carolina to be attached hereto this 6th day of

APPLICATION FOR CERTIFICATE OF INCORPORATION FOR THE CHARLOTTE MEMORIAL HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA

TO THE SECRETARY OF STATE OF NORTH CAROLINA:

The undersigned, Emma J. Hall, Mrs. John B. London, Mrs. Hamilton W. McKay, Mrs. George C. Snyder, E. R. Cannon, J. A. Jones, A. L. Boyle, William H. Barnhardt, J. H. Bridges, M. E. Pierson, John C. Shepherd, John L. Wilkinson, F. J. Blythe, R. S. Dickson, E. C. Griffith, Mrs. E. C. Marshall, Harry L. Dalton and H. C. Jones, hereby apply for a certificate of incorporation for the Charlotte Memorial Hospital Authority of the City of Charlotte, North Carolina, pursuant to the "Hospital Authorities Law" of the State of North Carolina, as contained in Senate Bill No. 254 of the 1943 Session of the North Carolina General Assembly, and to that end do respectfully show:

1. That the City Council of the City of Charlotte, after proper investigation, did at a duly authorized regular meeting on Wednesday, March 17, 1943, determine that the public health and welfare, including the health and welfare of persons of low income in the City of Charlotte and surrounding area, require the construction, maintenance or operation of public hospital facilities for the inhabitants thereof, as set forth in a resolution duly adopted by the City Council of the City of Charlotte, copy of which is hereto attached, and that notice of this determination by the City Council of the City of Charlotte was duly given to the Mayor of the City of Charlotte, and that thereafter, on the 6th day of May, 1943, the Mayor of the City of Charlotte appointed the undersigned as Commissioners;

2 (a) That the name, official residence, and term of office of each of said undersigned Commissioners is as follows:

NAME	OFFICIAL RESIDENCE	TERM, IN YEARS FROM THE 7th DAY OF MAY, 1943	DATE OF TAKING PRESCRIBED OATH AND INDUCTION INTO OFFICE
Emma H. Hall, Commissioner	Charlotte, N. C.	4 years	May 7, 1943
Mrs. John B. London, Commissioner	Charlotte, N. C.	4 years	May 19, 194
Mrs. Hamilton W. McKay, Commissioner	Charlotte, N. C.	4 years	May 17, 194
Mrs. George C. Snyder, Commissioner	Charlotte, N. C.	4 years	May 8, 1943
Ernest R. Cannon, Commissioner	Charlotte, N. C.	4 years	May 7, 1943
J. A. Jones, Commissioner	Charlotte, N. C.	4 years	May 8, 1943
A. L. Boyle, Commissioner	Charlotte, N. C.	8 years	May 7, 1943
William H. Barnhardt, Commissioner	Charlotte, N. C.	8 years	May 7, 1943
J. Herbert Bridges, Commissioner	Charlotte, N. C.	8 years	May 7, 1943
M. E. Pierson, Commissioner	Charlotte, N. C.	8 years	May 7, 1943
John C. Shepherd, Commissioner	Charlotte, N. C.	8 years	May 7, 1943
John L. Wilkinson, Commissioner	Charlotte, N. C.	8 years	May 7, 1943
F. J. Blythe, Chairman	Charlotte, N. C.	12 years	May 17, 194
R. S. Dickson Commissioner	Charlotte, N. C.	12 years	May 7, 1943
E. C. Griffith, Commissioner	Charlotte, N. C.	12 years	May 7, 1943
Mrs. E. C. Marshall, Commissioner	Charlotte, N. C.	12 years	June 18, 19
Harry L. Dalton, Commissioner	Charlotte, N. C.	12 years	May 7, 1943
H. C. Jones, Commissioner	Charlotte, N. C.	12 years	May 7, 1943

(b) That a certified copy of the appointment evidencing the right of each of the undersigned to office is hereto attached.

(c) That each of the undersigned Commissioners was inducted into office and took the prescribed oath of office in the City of Charlotte, North Carolina, on the date shown in paragraph 2 (a) above.

(d) That the undersigned Commissioners desire said Hospital Authority to become a public body and a body corporate and politic under the said Hospital Authorities Law.

3. The name which is proposed for the corporation is the "CHARLOTTE MEMORIAL HOSPITAL AUTHORITY OF CHARLOTTE, NORTH CAROLINA".

4. The location of the principal office of the corporation is in the City of Charlotte, State of North Carolina.

IN WITNESS WHEREOF, we have hereunto subscribed our names on this the 25th day of June, 1943.

W. J. Blythe, Chairman

Miss Emma J. Hall, Commissioner

Mrs. John B. London, Commissioner

Mrs. Hamilton W. McKay, Commissioner

Mrs. George C. Snyder, Commissioner

Ernest R. Cannon, Commissioner

J. A. Jones, Commissioner

A. L. Boyle, Commissioner

William H. Barnhardt, Commissioner

J. Herbert Bridges, Commissioner

M. E. Pierson, Commissioner

John C. Shepherd, Commissioner

John L. Wilkinson, Commissioner

R. S. Dickson, Commissioner

E. C. Griffith, Commissioner

Mrs. E. C. Marshall, Commissioner

Harry L. Dalton, Commissioner

H. C. Jones, Commissioner

STATE OF NORTH CAROLINA
COUNTY OF MECKLENBURG

I, Zeeda McAnulty, a notary public in and for the said County, in said State, hereby certify that Emma J. Hall, Mrs. John B. London, Mrs. Hamilton W. McKay, Mrs. George C. Snyder, E. R. Cannon, J. A. Jones, A. L. Boyle, William H. Barnhardt, J. H. Bridges, M. E. Pierson, John C. Shepherd, John L. Wilkinson, F. J. Blythe, R. S. Dickson, E. C. Griffith, Mrs. E. C. Marshall, Harry L. Dalton and H. C. Jones came before me upon this day; that each of said persons is known to me to be the officer which the foregoing application asserts him to be; that each of said persons was duly sworn by me upon his or her aforesaid appearance before me upon this day; and that each of said persons subscribed and swore to the said application, and to the contents thereof, in my presence upon his or her appearance before me upon this day.

WITNESS my hand and official seal, thisthe 25th day of June, 1943.

Zeeda McAnulty
Notary Public.

(SEAL)

My commission expires: Jan. 15, 1945

FILED
JUN 26 1943
THAD EURE
SECRETARY OF STATE

STATE OF NORTH CAROLINA

COUNTY OF MECKLENBURG

R. S. Dickson and John B. London, being first duly sworn, depose and say:

That they are the Chairman and Secretary respectively of the Board of Commissioners of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, and, as such, are authorized to execute this verification; that the foregoing is a true and correct copy of a resolution adopted by the affirmative vote of more than a majority of the members of the Board of Commissioners of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, at a meeting of said Board of Commissioners which was duly and regularly called and held at the offices of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, located at 1400 Scott Avenue in the City of Charlotte, North Carolina, on the 19th day of September, 1961, at 7:30 o'clock, A. M., Eastern Standard Time, and that said resolution has not been altered, amended, rescinded or revoked since its adoption but that it is still in full force and effect.

R. S. Dickson

John B. London

Sworn to and subscribed before me,
this 27th day of September, 1961.

Thomas J. Parr
Notary Public

My commission expires: My Commission Expires July 12, 1963

WHEREAS, the General Assembly of the State of North Carolina did, on the 17th day of June, 1961, enact and ratify an act amending Chapter 131, Article 12 of the General Statutes of North Carolina, under the provisions of which amendment an authority created and existing pursuant to Article 12 of Chapter 131 of the General Statutes of North Carolina may, at any time, by resolution adopted by a majority of the commissioners of such authority, change its name; and

WHEREAS, Charlotte Memorial Hospital Authority of Charlotte, North Carolina, is a body corporate and politic created and existing pursuant to Article 12 of Chapter 131 of the General Statutes of North Carolina; and

WHEREAS, it has been made to appear to the Commissioners of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, and said Commissioners do find hereby, that it is to the best interests of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, that its name be changed to The Charlotte-Mecklenburg Hospital Authority:

NOW, THEREFORE, BE IT RESOLVED: That the name of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, be and it is changed hereby to The Charlotte-Mecklenburg Hospital Authority.

BE IT FURTHER RESOLVED: That a copy of this resolution, duly verified by the Chairman and Secretary of the Board of Commissioners of Charlotte Memorial Hospital Authority of Charlotte, North Carolina, before an officer authorized by the laws of this State to take and certify oaths, together with a conformed copy thereof, be delivered to the Secretary of State of the State of North Carolina.

FILED
OCT 10 10 32 AM 1962
THAD EURE
SECRETARY OF STATE
NORTH CAROLINA

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, H. C. Jones, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, [illegible] GOD.

(Signed) H. C. Jones

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, [illegible] hereby certify that H. C. Jones to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to H. C. Jones, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

~~CITY OF CHARLOTTE~~
~~NORTH CAROLINA~~

May, 1943.

(SIGNED) E. McA. Currie
Mayor

(OFFICIAL SEAL)

Attest:

Alice B. McConnell
City Clerk

CERTIFICATE OF MAYOR

I, E. McA. Currie, Mayor of the City of Charlotte, North Carolina, hereby certify that the foregoing certificate was duly filed in the office of the Clerk of the City of Charlotte, North Carolina, on the 6th day of May, 1943.

(SIGNED) E. McA. Currie
Mayor

I, Alice B. McConnell, Clerk of the City of Charlotte, North Carolina, hereby certify that the foregoing certificate of appointment of Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, etc., has been carefully copied from the original certificate on file and of record in the office of the City Clerk of the City of Charlotte, North Carolina.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 21st day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, Emma J. Hall, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, so help me GOD.

(Signed) Emma J. Hall

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that Miss Emma J. Hall to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to Miss Emma J. Hall, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

[redacted]
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, Mrs. John B. Londen, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; So help me, GOD.

(Signed) Mrs. John B. Londen

* * * * * * *

I, H. H. Baxter, Mayor of the City of Charlotte, State of North Carolina, [redacted] certify that Mrs. John B. Londen to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 19th day of June, 1943, and made the above oath.

(SEAL) (Signed) H. H. Baxter
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to Mrs. John B. Londen one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

~~CITY OF CHARLOTTE~~
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, Mrs. Hamilton W. McKay, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, So help me, GOD.

(Signed) Mrs. Hamilton W. McKay

* * * * * * *

I, H. H. Baxter, Mayor of the City of Charlotte, State of North Carolina, hereby certify that Mrs. Hamilton W. McKay to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 19th day of June, 1943, and made the above oath.

(SEAL) (Signed) H. H. Baxter
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to Mrs. Hamilton W. McKay, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, Mrs. George C. Snyder, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, so help me, God.

(Signed) Mrs. George C. Snyder

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that Mrs. George C. Snyder to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 5th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to Mrs. George C. Snyder, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, E. R. Cannon, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; so help me, GOD.

(Signed) E. R. Cannon

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that E. R. Cannon to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of June, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to E. R. Cannon, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 12th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, J. A. Jones, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; SO HELP ME GOD.

(Signed) J. A. Jones

* * * * * * *

I, H. McA. Garris, Mayor of the City of Charlotte, State of North Carolina, hereby certify that J. A. Jones to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 8th day of May, 1943, and made the above oath.

(SEAL) (Signed) H. McAlister Garris
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to J. A. Jones, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, A. L. Boyle, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, SO HELP ME, GOD.

(Signed) A. L. Boyle

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that A. L. Boyle to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL)

E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to A. L. Boyle, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONERS OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, William H. Barnhardt, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; SO HELP ME, GOD.

(Signed) William H. Barnhardt

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that William H. Barnhardt to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of June, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to William H. Barnhardt, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, M. E. Pierson, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; SO HELP ME, GOD.

(Signed) M. E. Pierson

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that M. E. Pierson to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to M. E. Pierson, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, J. H. Bridges, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law. So help me, GOD.

(Signed) J. H. Bridges

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I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that J. H. Bridges to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to J. H. Bridges, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, John C. Shepherd, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, [illegible] GOD.

(Signed) John C. Shepherd

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I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that John C. Shepherd to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to John C. Shepherd, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, John L. Wilkinson, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, so help me, GOD.

(Signed) John L. Wilkinson

* * * * * * *

I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that John L. Wilkinson to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of June, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to John L. Wilkinson, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

~~CITY OF CHARLESTON~~
~~NORTH CAROLINA~~

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, F. J. Blythe, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; SO HELP ME GOD.

(Signed) F. J. Blythe

* * * * * * *

I, H. H. Baxter, Mayor of the City of Charlotte, State of North Carolina, hereby certify that F. J. Blythe to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 17th day of June, 1943, and made the above oath.

(SEAL) (Signed) H. H. Baxter
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to F. J. Blythe, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, R. S. Dickson, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law. So help me, GOD.

(Signed) R. S. Dickson

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I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that R. S. Dickson to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to R. S. Dickson, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, E. C. Griffith, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; SO HELP ME, GOD.

(Signed) E. C. Griffith

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I, E. McA. Currie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that E. C. Griffith to me personally known, and to me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Currie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to E. C. Griffith, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

~~CITY OF CHARLOTTE~~
~~NORTH CAROLINA~~

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, Mrs. E. C. Marshall, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law, so help me, GOD.

(Signed) Mrs. E. C. Marshall

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I, H. H. Baxter, Mayor of the City of Charlotte, State of North Carolina, hereby certify that Mrs. E. C. Marshall to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 18th day of June, 1943, and made the above oath.

(SEAL)

(Signed) H. H. Baxter
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to Mrs. E. C. Marshall, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CITY OF CHARLOTTE
NORTH CAROLINA

OATH OF COMMISSIONER OF HOSPITAL AUTHORITY
OF THE CITY OF CHARLOTTE, NORTH CAROLINA.

* * * * * * *

I, Harry L. Dalton, do solemnly swear that I will support the Constitution of the United States; and I do solemnly and sincerely swear that I will be faithful and bear true allegiance to the State of North Carolina and to the constitutional powers and authorities which are or may be established for the government thereof; and that I will endeavor to support, maintain and defend the Constitution of the said State, not inconsistent with the Constitution of the United States, to the best of my knowledge and ability; and that I will well and truly execute and faithfully perform the duties of the office of Commissioner of the Hospital Authority of the City of Charlotte, North Carolina, according to the best of my skill and ability, according to law; so help me, GOD.

(Signed) Harry L. Dalton

* * * * * * *

I, E. McA. Gurrie, Mayor of the City of Charlotte, State of North Carolina, hereby certify that Harry L. Dalton to me personally known and by me known to be one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, appeared before me on the 7th day of May, 1943, and made the above oath.

(SEAL) (Signed) E. McA. Gurrie
Mayor

* * * * * * *

I, Alice B. McConnell, City Clerk of the City of Charlotte, North Carolina, hereby certify that the above is a true and exact copy of the oath administered to Harry L. Dalton, one of the Commissioners of the Hospital Authority of the City of Charlotte, North Carolina, as same appears filed and of record in my office.

WITNESS my hand and the official seal of said City of Charlotte, North Carolina, this 19th day of June, 1943.

Alice B. McConnell
City Clerk

CAROLINAS HEALTHCARE SYSTEM

RESOLUTIONS OF THE
BOARD OF COMMISSIONERS
AT ITS DECEMBER 12, 2017, MEETING

Authority of CHS management to submit applications for certificates of need

The Board of Commissioners believes it is in the best interests of the public and of The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("CHS") to describe with specificity its prior, existing and continuing policy related to certificate of need ("CON") applications filed by CHS.

The Board of Commissioners therefore resolves:

- that the policy of the Board is, and has been for many years, not to specifically and individually approve CON applications filed by CHS prior to filing;

- that the officers of CHS are, and have been, authorized to execute, deliver, certify and cause to be filed CON applications, and to make any associated representations, commitments or assertions therein, for the purpose of fulfilling the requirements of the CON law and any applicable CON application form; and

- that the Board ratifies, approves and adopts in all respects any and all actions taken by any officer of CHS on behalf of CHS related to the execution, delivery, certification and filing of CON applications.

This 12th day of December, 2017.

Atrium Health- Pineville

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN
2019

The Board of Commissioners (BOC) at Atrium Health, Medical Staff, Administration, and the staff of Atrium Health-Pineville are committed to upholding the Mission and Vision as described below:

Mission

To improve health, elevate hope and advance healing – for all.

The strategies used to accomplish this mission include:

1. Build upon world-class specialty service lines
2. Deliver the primary care and on-demand services consumers want
3. Create the next generation regional network
4. Improve the health of at-risk populations
5. Enhance community health and benefit in partnerships with others
6. Improve our value for teammates, their families and for employer partners
7. Deliver effectiveness and efficiency by practicing to the highest clinical standards
8. Streamline operations by identifying and minimizing the 8 wastes
9. Strengthen our integration as ONE system by reducing silos

Vision

To be the first and best choice for care.

Authority

The Board of Commissioners BOC at Atrium Health (AH) has the ultimate responsibility for performance improvement activities. The Quality Care and Comfort Committee (QCC) has direct responsibility for this function. The BOC delegates administrative and clinical leadership of the day to day performance improvement operations with administrative oversight to the System Chief Medical Officer (CMO) and holds the Medical and Dental staff accountable for the quality of patient care. The Atrium Health-Pineville Quality and Patient Experience Steering Council supports the medical staff through planning, developing, prioritizing, and supporting performance improvement initiatives, with an emphasis on Performance Improvement Teams. Atrium Health-Pineville incorporates, implements, and supplements system initiatives and goals as part of its overall Quality Assessment and Performance Improvement Plan.

Leadership

The leaders of Atrium Health and Atrium Health-Pineville play a central role in fostering performance improvement by providing motivation, mission, and resources. Atrium Health-Pineville leaders include the President, Chief Nursing Officer, Chief Medical Officer, Vice Presidents, Assistant Vice Presidents, Directors, Departmental Directors, Managers, and elected and appointed Physician Leaders.

Atrium Health Structure / Roles & Responsibilities

The Quality Care and Comfort Committee (QCC) is a sub-committee of the Board of Commissioners (BOC) which consists of the organizations leaders, representatives of the Medical Staff, and members of the BOC. The responsibilities of the Quality Care and Comfort Committee include overall guidance for the performance improvement program, assessing and prioritizing performance improvement activities, reporting performance improvement activities to the BOC, overseeing and reviewing of the annual plan for the improvement of quality care at AH facilities.

The QCC receives reports from the Medical Staff through the Medical Executive Committee (MEC) and its representatives. Reports on the analysis and actions taken regarding the various quality and utilization functions shall be received and acted upon according to the routine reporting schedule included in this plan. (Variations in the timing of reports described in this and other reporting schedules are allowed as long as appropriate oversight of all of these functions is maintained). The QCC remains responsible for establishing clear expectations for safety; allocating adequate resources for measuring, assessing, improving, and sustaining the hospital's performance and the reduction of risk to patients; and enhancing the efficiency and quality of care through an appropriate number of performance improvement projects. The QCC approves the QA/PI program, including the indicators used to measure performance.

The Quality Care and Comfort Committee shall have primary responsibility for the following functions:

1. **Health Outcomes**: The QCC shall assure that there is measurable improvement in indicators with a demonstrated link to improve health outcomes. Such indicators include, but are not limited to, measures reported to the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and information submitted to or received from the hospital's Quality Improvement Organization (QIO).
2. **Medical Error Reduction**: The QCC shall: a) assure there is a process for measurable improvement in the reduction of medical errors through implementation of best practices; b) assure that the system for the identification of medical errors within the institution is effective; c) oversee the analysis of near misses within the institution to assure that the root cause(s) is identified, and appropriate preventive actions and mechanisms (including feedback and learning throughout the hospital) are implemented.
3. **Quality Indicators:** The QCC shall oversee measurement, and shall analyze and track quality indicators, including adverse patient events, and other aspects of performance.
4. **Patient Safety:** The QCC shall provide a systematic and coordinated approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; on-going proactive reduction in medical/health care

errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

5. **Prioritization:** The QCC shall prioritize performance improvement activities to assure that they are focused on high-risk, high volume, or problem prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care, and patient safety.
6. **Improvement:** The QCC shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QCC must also oversee implementation of actions aimed at improving performance and enhancing safety.
7. **Performance Improvement Projects:** The QCC shall oversee performance improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospitals' services and operations. The QCC will also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measurable progress achieved on the projects.

Quality and Safety Operations Councils (QSOC™): QSOCs are AH Enterprise multidisciplinary teams that ensure evidence based clinical practice and facilitate excellent patient outcomes through efficient clinical care processes. QSOC members are charged with communicating information from the QSOC with administrations and the Quality and Patient Safety Steering Committee in their home facilities.

The Pharmacy and Therapeutics Committee is a system level multi-disciplinary committee responsible for the evaluation of processes and outcomes related to the selection, prescribing, ordering, dispensing, administering, and monitoring effects of medications and other therapeutic agents on patients. Additionally, the committee is responsible for reviewing and advising on therapeutic nutrition matters. Reports are made to the Medical Executive Committee.

Atrium Health-Pineville Structure/Roles & Responsibilities

The Medical Executive Committee (MEC) acts on behalf of the Atrium Health-Pineville Medical Staff in all matters, and is responsible for implementing the hospital's quality assessment plan as it affects the Medical Staff. Atrium Health-Pineville MEC reports to the AH Charlotte MEC whose reports are forwarded to the QCC.

The Quality Assessment Improvement Committee (QAIC) is responsible for the oversight of physician-related issues impacting the quality of medical care. The committee provides leadership and clinical expertise to maintain standards of professional and ethical practice and to ensure an effective physician peer review process. The QAIC's charge is to design and implement systems and initiatives to provide patient care with the highest possible value, to define and measure the quality of medical care delivered at Atrium Health-Pineville, and to seek ways to improve that quality. QAIC may also identify the need for Continuing Medical Education opportunities based on quality concerns. Members work collaboratively with the Nursing Quality and Peer Review Council to pursue opportunities for system-wide performance improvement. This committee also reviews various data available to identify and minimize variance and recommend opportunities for improvement for clinical/medical outcomes.

Performance Improvement & Patient Safety (PIPS) Committee provides a stabilizing influence so organizational concepts and directions are established and maintained in alignment with the mission and vision of Atrium Health. The PIPS meeting provides insight on long-term strategies in support of the AH Quality Care and Comfort Committee and facility goals. The primary charge to the PIPS meeting is to participate in the planning and oversight of Atrium Health-Pineville Quality and Patient Safety.

Members of the PIPS ensure that teams/projects/initiatives remain aligned to ensure objectives are adequately addressed. In practice these responsibilities are carried out by performing the following functions:

- Monitor and provide oversight of teams/projects/initiatives
- Hold teams/initiatives/projects leaders accountable for outcomes
- Provide assistance to the teams/initiatives/projects to drive progress or remove barriers on an as needed/requested basis
- Review the scope of teams/projects/initiatives as emerging issues force changes to be considered, ensuring that the overall scope aligns with the Atrium Health-Pineville PI Plan and Atrium Health-Pineville Patient Safety Plan
- Prioritization of future teams/projects/initiatives

The Performance Improvement Committee is a multidisciplinary committee responsible for clinical and non-clinical, performance improvement activities, which includes contracted services. The activity of the committee will include, but is not limited to: the collaboration of departments by objectively measuring processes and clinical outcomes, process improvement teams, proactive assessment of processes and efficient utilization of resources (i.e. clinical care management). Reports are made to Performance Improvement and Patient Safety (PIPS) meeting as needed.

The Patient Safety Champions Committee is a multi-departmental committee responsible for disseminating and educating patient safety information to co-workers and peers, promoting a culture of safe patient care, and communicating patient safety issues and concerns to the Atrium Health-Pineville Performance Improvement and Patient Safety (PIPS) meeting.

The Sentinel Event Task Force (SETF) is responsible to evaluate patient care cases regarding quality of or necessity for healthcare services to ascertain if the case meets the criteria for deeming the event as a "sentinel event, or safety event". Members of this committee, or its subcommittee, the Sentinel Event Review Team (SERT), which may deem cases as sentinel events between regularly scheduled SETF meetings, identify individuals to participate on Quality Review Teams to perform cause analysis and develop an implementation/action plan. The action plans are approved and/or modified by the SETF. The SETF also provides follow-up to ensure sustainability. Reports are made to the Atrium Health-Pineville MEC and to administration.

The Utilization Review Committee ensures high quality medical and other health care services are provided in a cost effective and efficient manner for all individuals. The committee analyzes and reviews data to determine medical necessity appropriateness, resource utilization and clinical outcomes.

The Infection Prevention Committee recommends appropriate surveillance, prevention, and control measures. Reports are made through the Performance Improvement and Patient Safety (PIPS) meeting and the Atrium Health-Pineville MEC.

The Critical Care Committee is a multidisciplinary committee responsible for monitoring and evaluating the appropriateness and quality of patient care provided in the Critical Care Unit and other special care areas and reviewing utilization and patterns of use. The committee is responsible for developing, reviewing, and recommending policies and procedures as appropriate concerning the functioning of the Critical Care Unit and other special care areas. Reports are made to the Atrium Health-Pineville MEC.

Nursing Services Quality Improvement Council (NSQIC) designs, implements, and monitors the Nursing Quality Improvement program with the goal of achieving optimal patient outcomes. Reports are made to Nursing Management, QAIC and Atrium Health-Pineville MEC.

All departments and employees of Atrium Health-Pineville have the responsibility of ensuring patient safety, quality services, and appropriate resource management within their departments and/or throughout the organization. All staff is responsible for seeking education and clarification of Atrium Health-Pineville quality initiatives and how they impact outcomes. Department managers support and encourage their staff's participation and involvement in performance improvement and patient safety activities within the organization.

Atrium Health-Pineville Performance Improvement

I. PERFORMANCE IMPROVEMENT GOALS

- To align with system goals and initiatives
- To measure and improve the satisfaction and quality of services we provide to all our customers
- To identify and improve systems and processes related to patient care, safety, and clinical processes
- To create effective systems to measure, assess, and improve the processes and outcomes associated with patient care
- To improve the overall understanding of continuous quality improvement tools and techniques within the organization

2019 AH PI Priorities

1. **Patient Safety**: focusing on designing and maintaining a safe environment
2. **Clinical Outcomes**: focusing on performance improvement in the clinical arena
3. **Patient Experience**: focusing on satisfaction of all of our customers
4. **Clinical Efficiency**: focusing on effective use of resources

II. PERFORMANCE IMPROVEMENT METHODOLOGY

Atrium Health-Pineville utilizes the Model for Improvement combined with the Plan, Do, Study, Act (PDSA) cycle to systematically plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization. A variety of other methods including Lean, DMAIC (Define, Measure, Analyze, Improve, Control), Failure Mode Effects Analysis (FMEA), and Root Cause Analysis (RCA) are also used by performance improvement teams.

The Model for Improvement

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

PDSA Cycle

Plan the improvement
- Plan the implementation of selected improvements
- Plan continued data collection

Do the improvement
- Make the change or improvement
- Communicate and educate staff about changes

Study the results
- Measure the impact of the improvement
- Examine outcomes data to determine whether change led to improvement

Act to hold the gains and continue to monitor the process
- Monitor improvements and/or make changes based on data
- Develop a strategy for maintaining the improvements

III. PERFORMANCE IMPROVEMENT INITIATIVES

The effectiveness of the hospital's performance is reflected in the continuous efforts of improving patient care outcomes and reducing risk. Atrium Health-Pineville maintains a culture of safety and quality and all staff members focus on maintaining EXCELLENCE in performance by assuming a demeanor of personal accountability for the safety and quality of care for the patients served. The Joint Commission has identified five (5) key systems that influence the effective performance of a hospital:

- Using data
- Planning

- Communicating
- Changing performance
- Staffing

The effective performance of these key systems results in a culture in which safety and quality are priorities. This culture will be evaluated on a regular basis through the Atrium Health-Pineville Performance Improvement and Patient Safety (PIPS) meeting. Through this process, data and information will be used to guide decisions and enhance those processes to support quality and safety. The information gained will be communicated to the appropriate teammates, including staff, licensed independent practitioners, patients, and families. Atrium Health-Pineville integrates change into all relevant processes so that its effectiveness can be assessed, measured and sustained. Quality and safety is the focus for all employees of Atrium Health-Pineville.

AH senior leadership annually reviews the facility priorities for the upcoming year. Results from the prior year are reviewed and discussed. That information is then discussed in collaboration with the BOC with top priorities established via consensus of senior leadership and the BOC. Atrium Health-Pineville measures other priorities based on the individual facility risk assessments. The Performance Improvement schedule shows responsibility for monitoring each important aspect of care or important hospital function.

Evaluation

The effectiveness of the Performance Improvement Program is measured and assessed annually by the leadership and presented to the Quality Care and Comfort Committee of the Board of Commissioners. During the annual review process, leaders evaluate performance improvement activities, volume data, risk management data, safety information, regulatory compliance, and community needs. Performance improvement is aligned with the mission and strategies for the year and compiled into the Performance Improvement Plan. Annual review and revisions demonstrate that the performance improvement is an ongoing, dynamic, and effective program. The plan is approved annually by the Quality Care and Comfort Committee of the Board of Commissioners. Changes to the plan will be submitted to the Quality Care and Comfort Committee and shall be effective upon approval.

CONFIDENTIALITY

All materials are handled in a confidential manner and are protected and maintained under the peer review statues of North Carolina.

SIGNATURES: (If applicable)

Christopher Hummer	1-24-19	
President, Carolinas HealthCare System Pineville	**Date**	
Saju Joy, MD	1-24-19	
Chief Medical Officer	**Date**	
Sridhar Pal, MD	1.24.19	
President, Medical Staff	**Date**	
Vicki Sutton	2-19-19	
Chair, Quality Care and Comfort Committee	**Date**	

Carolinas HealthCare System

Category:
Policy:
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UTILIZATION MANAGEMENT PLAN

A. PURPOSE (42 CFR 456.105)

The Utilization Management Plan describes the comprehensive and ongoing methodology conducted to ensure high quality medical and other health care services are provided in a cost effective and efficient manner for all individuals served by Carolinas Healthcare System (CHS). The Utilization Management Plan is a statement of procedures carried out by the Medical Staff, interdisciplinary personnel, and the Clinical Care Management department. These Utilization Management procedures are guided by this written plan, and include review of the hospital care services provided to those we serve regardless of the payment source. The procedures, authority, and accountability outlined in the plan are designed to meet the standards and requirements of the Joint Commission, Center for Medicare and Medicaid Services, Medical Review of North Carolina, the North Carolina Quality Improvement Organization, the Division of Medical Assistance (DMA), and other third party payers. The Utilization Management Plan is reviewed annually and revised as appropriate.

B. SCOPE (42 CFR 456.105,106, 112, 113; 42 CFR 482.30)

Individuals receiving services from CHS will be provided high quality health care throughout their hospitalization. The philosophy of the Utilization Management Plan is realized through the use of processes and procedures that assesses, analyze, and evaluate medical necessity and the appropriateness of services provided. Recognized clinically applicable review criteria, trended patient population clinical care data, patterns of hospital resource utilization, and clinical outcomes are reviewed to ensure corroboration of these processes and procedures. The current focus areas of the Plan's scope include but are not limited to:

1. Review of the professional services provided to determine medical necessity of those services and promotion of the most efficient use of available facility resources.
2. Continuous evaluation of the availability of necessary diagnostic and therapeutic services to ensure timeliness of service delivery with appropriate frequency and intensity.
3. Evaluation of over and underutilization of these services to ensure usage is effective and efficient.
4. Provision of care and services that are medically necessary and prudent, with an emphasis on maintenance of the patient's rights and dignity.
5. Optimizing efficient resource utilization through integration and coordination within the interdisciplinary health care teams while maintaining optimal patient outcomes.
6. Ongoing assessment and analysis to determine efficiency in resource management.
7. Foster effective collaboration and communication between all members of the health care team in an effort to enhance quality care in a cost efficient and safe environment.
8. Enforce and ensure consistent compliance with all regulatory agencies and contractual agreements.
9. Implement and monitor the effectiveness of educational programs provided to inform physicians and other members of the interdisciplinary team concerning optimal utilization management strategies, including alternative approaches to patient care, treatments, and current health care management guidelines.

10. Perform specific medical record review audits to include, but not necessarily limited to, determination and verification of the physician (s) intent regarding the patient type status, level of care provided, and review of patient care outcomes including response (s) to treatment.

C. OBJECTIVES

1. Review hospital inpatient admissions and observation stays, regardless of payer source, by examination of the patient's complete medical records in an effort to ensure efficient use of the health care services are provided.
2. Conduct initial and concurrent medical record reviews to determine the medical necessity of the hospital stay and ensure the appropriate level of care is provided.
3. Initiate and monitor any revisions in policies and procedures based on the Utilization Management Plan's scope and objectives and recommendations of the Utilization Review Committee.
4. Professional and therapeutic services reviews are carried out to ensure availability, timeliness of delivery, and medical necessity.

D. AUTHORITY, LEADERSHIP AND ACCOUNTABILITY (42 CFR 456.105, 106, 112,113; 42 CFR 482.30)

The Utilization Review Committee
The Utilization Review Committee is composed of active members of the Medical Staff of CHS, including a Physician Advisor, as well as other departmental representatives of the Hospital. Members of the Clinical Care Management department function as designees of the Utilization Review Committee. An individual with financial interest in any of the CHS facilities may not serve on the Committee. CHS is a non-profit public hospital; members of the Committee do not hold any ownership of the Carolinas Health Care System organization. Physicians who are members of the Utilization Review Committee are not involved in the adverse decision review process when they are professionally responsible for the care of the patient (s) under review. The committee meets at least quarterly and provides updates to the Medical Executive Committee.

The objective of the Utilization Review Committee members is to evaluate the appropriateness of admissions to the hospital and the utilization of ancillary diagnostic services, goal length of stay practices, and other factors in relation to the appropriate utilization of hospital and physician services; in this function, the Committee acknowledges its obligation to evidence its concern with cost of care, and provision of effective patient care services. Members of Clinical Care Management meet on an as needed basis with designated Committee members to discuss patients with complex medical care needs and determine if further discussion with other designated member (s) of the Utilization Review Committee is required. Designated members of the Utilization Review Committee are responsible for reviewing and approving changes in patient status when medical necessity for inpatient admission is not met. A subgroup of the UM Committee are physicians who are designated to serve as physician advisors, contracted by the organization to conduct second level reviews in accord with the UM plan.

E. CRITERIA UTILIZATION

Criteria used for review of inpatient and observation admissions:

1. InterQual Level of Care ® Acute Criteria (Adult and Pediatric), Xsolis, and/or MCG® are utilized by the Care Manager (CM) to perform admission, concurrent and extension stay reviews. In addition to utilizing criterion based screening tools, certification approvals are based on the CM's professional knowledge of patient care including diagnoses and treatment outcome expectations. Discharge Screens (DS) are used to assist in the determination of clinical stability for safe transfer to the next appropriate level of care.

F. REVIEW PROCEDURES AND FREQUENCY (42 CFR 456.101.456.121.456.60)

1. **Pre-Admission Review (42 CRF 456.127)**
   a. The Pre-admission review will be performed as deemed necessary and outlined in the Utilization Management Plan. Designated criteria will be utilized as a guide in determining the appropriate level of care and health care setting is appropriate. The Pre-admission review is performed for observation level of care cases approaching 24 hours of care. During the pre-admission screening review process, the CM will also assess patients who meet high risk criteria. Examples of high risk/high cost cases include but are not limited to patients who are elderly, may have multiple co-morbid conditions, have no family support, limited and/or no financial resources. The discharge planning team is consulted to evaluate and the patient's needs and meet with family members if available.
   b. Criterion is used to conduct the pre-admission screen. The attending physician is contacted by the CM for additional medical information if needed. If the CM is unable to approve inpatient admission by using the screening tool, the physician advisor is contacted to review the clinical information and/or discuss the case with the attending physician.

2. **Admission Reviews (42 CFR 456.80, 123)**
   a. For each inpatient admission, a physician must certify through the history and physical assessment and proposed treatment plan warranted for acute hospitalization. The physician certification must include the proposed treatment plan: diagnoses, symptoms, complaints, complications, and documented medical necessity for acute hospitalization. The physician certification must also include: patient functional level, orders for medications, treatment interventions, rehabilitative interventions, psychosocial needs and diet needs. The physician must also recertify the admission at a minimum of daily and up to every 60 days. The CM will perform an admission review utilizing the certification criteria identified in Section E. The review data will include identification of the patient, physician, admission date, plan of care, determination of any discharge needs, assessment of high risk indicators requiring additional consult (s) of members of the interdisciplinary team, the date of the operating room reservation if applicable, justification of emergency admission if applicable, the reasons and plan for continued stay, and other supporting data. For the admission to be approved, the medical record must provide evidence of the need for acute inpatient care. The history and physical, initial orders, laboratory and radiology results will be reviewed to determine the acute medical necessity needs of the patient. If acute medical necessity needs are determined, the CM will approve the admission and assign the next continued stay review date for re-assessment of the patient's need for continued acute care hospitalization. This review includes, but is not limited to, a review of the physical condition of the patient, response (s) to the current treatment plan, and any diagnostic results. Additional review dates may be assigned and further discussion with the attending physician and/or physician advisor for admission that are high cost and require additional hospital resources, services and longer lengths of stay.
   b. If the clinical information available does not meet complete and/or partial acute criteria, the attending physician will be notified by the CM. The attending physician will be provided the opportunity to present additional clinical information to substantiate the need for admission. Within twenty four hours of notification, the physician is required to document additional clinical information in the medical record outlining patient care issues that need to be addressed, including goals and expected outcomes to justify the inpatient continued stay. If the CM can approve the admission, s/he will assign the next continued stay review date. If the attending physician does not present additional information or clarify the need for admission, the physician advisor will be notified to intervene in securing the information. If the physician advisor or designee as a member of the Utilization Review Committee member determines the admission is appropriate, the next review date is established. Otherwise, the adverse decision procedures will be instituted, refer to Section F.10.
   c. Modifications to the initial continued stay review dates may be made when there are; co-morbidities impacting the patient's ability to respond to treatment, additional new diagnoses, complications, failure to respond to treatment and/or failure to meet discharge screens. Additional or more extensive criteria protocols, approved by the UM committee with full or expedited review, may be established for cases

associated with severity or illness or intensity supporting acute medical necessity as an exception to established criteria, have been associated with high cost, frequent use of excessive services or are attended by a physician whose patterns of care are questionable

3. **Exception: per Medicare regulation for Condition Code 44 – Inpatient admission changed to outpatient: (42CFR 456.124)**
   a. The change in patient status from inpatient to outpatient is and prior to discharge or release, while the beneficiary is still a patient of the hospital;
   b. The hospital has not submitted a claim to Medicare for inpatient admission;
   c. A physician concurs with the Utilization Review Committee decision;
   d. The physician's concurrence with the Utilization Review Committee's decision is documented in the patient's medical record (physician's order and/or progress notes).
   e. An order written "outpatient/observation" with the date and time the order was obtained, and documentation of whether it was a telephone order, as appropriate.
   f. Billing is notified to reflect the condition code 44
   g. Written notification of the determination will be provided to patient and /or next of kin/sponsor.

4. **Continued Stay Reviews (42 CFR 456.128-129 456.133-135)**
   If acute care criteria have been met after completion of the initial review and stay is extended; the CM will approve the admission and assign the next continued stay review date. This review date will be based on the need to assess the patient's appropriateness for continued acute care hospitalization, clinical condition and response to the plan of care, discharge planning needs, and the proposed discharge date. The continued stay review schedule and approval will be based on:
   a. Planned and performed surgical procedure/s;
   b. Projected recovery period for disease state and treatment;
   c. Intensity of medical treatment and patient response;
   d. Unplanned medical treatment alterations;
   e. Projected stabilization of the patient's medical condition;
   f. Utilization of screening tools, InterQual, Xsolis, and/or MCG criteria
   h. Patients with longer lengths of stay require closer screening and monitoring to ensure meeting the guidelines for inpatient acute care. The patient's care needs are assessed frequently to ensure appropriate discharge planning efforts are in place. The CM discusses the care needs of the patient with higher costs and/or longer lengths of stay with the attending physician to determine if care can be rendered safely in a lower level of care. The case may also be referred to the physician advisor to further discuss the case with the attending physician if needed.

If criterion is not met, the attending physician will be notified by the CM. The attending physician will be provided the opportunity to present additional information to substantiate the need for continued acute care hospitalization. Within twenty four hours of notification, the physician will provide documentation in the medical record outlining issues that need to be addressed, including goals and expected outcomes to justify the inpatient continued stay. If the CM can approve the hospital day; s/he will assign the next continued stay review date. If the attending physician does not present additional information or clarify the need for continued stay, a designated member (s) of the Utilization Review Committee will be notified to intervene in securing the information. If approved by this committee, the next review date is established. However, if the member of the Utilization Review Committee determines that the hospital stay does not meet acute care criteria, the adverse decision procedures will be Instituted, refer to Section F. 10.

5. **Observation Review/Surveillance**

Patients may be admitted to the hospital as an Observation status. Observation services are defined as the use of a bed and periodic monitoring by hospital's nursing and/or other ancillary staff, which are reasonable and necessary to medically evaluate a patient's physical condition and presenting symptoms to determine a

definitive diagnosis and/or the need for possible inpatient admission. Such services are covered only when provided by the order of a physician or another individual authorized by the State licensure law and hospital staff bylaws to admit patients to the hospital and conduct medical assessments.

Observation status is designed to provide the physician with an opportunity to evaluate patients in the acute care setting and make a decision regarding the need for inpatient care. A review is conducted by CMs from Clinical Care Management to assess the need for observation services and/or progression to inpatient status. Most observation services do not exceed one day. Some patients, however; may require a second day of outpatient observation services.

Following a thorough assessment and review, the CM can approve the observation status. The CM continues to monitor the clinical course to make certain that a disposition is established for the patient (progression to inpatient status or discharge). In cases where it is questionable regarding the need for continued observation or the patient warrants admission status, the CM will contact the attending physician for additional clinical information and/or clarification of status. If the CM can approve the observation status, s/he will continue to monitor for progress. Patient type status decisions are not based on the number of treatment hours alone. The observation status is approved by the CM after reviewing the level of care the patient requires, medical history, presenting clinical signs and symptoms, response (s) to treatment, and verification of physician intent for observation status.

If the clinical condition warrants admission (inpatient) status, this will be communicated to the attending physician. In addition, acute care criterion guidelines are utilized as a screening mechanism to assist the CM in determining if the patient meets inpatient status criteria. If the attending physician does not present additional information or clarify the need for observation status, nor does not view the patient as warranting admission status, the physician advisor as a member of Utilization Committee will be notified to intervene in securing the information required. If the physician advisor determines that the admission and/or observation status does not meet approved criteria, refer to Section F.10 (Adverse Decisions).

7. **Denial Notification**
The Clinical Care Management staff notifies the attending physician of an unresolved denial decision issued by the payer. Peer to peer option is given if available.

8. **Request for Appeal/Reconsideration**
A patient and/or appointed representative/provider may submit a written request for initial reconsideration and/or member grievance to the payer as appropriate. When a written request for initiation of a member grievance is received; the request will be forwarded to the appropriate agency for review and possible filing of a written appeal. A concurrent review denial issued while the patient is still hospitalized is reviewed and forwarded to the payer/and or regulatory agency for an expedited review and decision.

9. **Adverse Decisions (42 CFR 456. 136-137, 124, 126)**
If the CM, as designees of CMC's Utilization Review Committee, believes the admission, observation, or continued stay does not meet acute care criteria, s/he will arrange a conference with the attending physician within twenty-four hours, or one business day, to allow an opportunity for discussion of the patient's current treatment plan. If additional clinical information is not submitted or provided, the case will be discussed with physician advisor.
If it is determined at this point that the admission is not indicated, the physician advisor will contact the patient's attending physician and give him/her the opportunity to discuss the decision to admit the patient. If the attending physician does not provide additional information or clarification, the physician advisor decision is final. If the attending does provide additional information or clarification, two physicians may review the chart. If they determine that continued stay is not medically necessary, their decision is final. Final decision and notice

of adverse decision on recipient's need for continued stay must occur within 2 working days after assigned continued stay review date (or within 2 working days of final decision).

Written notification of the determination will be forwarded to the following for Medicare beneficiaries and Medicaid recipients:

a. The attending physician;
b. DMA and/or North Carolina Quality Improvement Organization;
c. The Patient Financial Services Office;
d. The recipient, and/or next of kin or sponsor;
e. Copy of letter maintained EMR.

In the event a denial is received from a commercial payer member; the CM will be notified if additional clinical information made available supports acute care criteria. The CM will conduct a nurse to nurse peer review with the commercial payer as appropriate to certify the days in question. If the continued stay is approved by the payer, the CM will conduct reviews as requested and submit clinical information as requested.

If the commercial payer determines admission or continued stay is not warranted after the nurse peer review, the attending physician is notified. The physician will be directed to contact the payer if appropriate and conduct a physician peer to peer review if the option is available. The physician advisor may also be contacted to assist in obtaining authorization as needed.

11. **Reinstatement of Benefits**

Once a patient's stay has been decertified and subsequently their medical condition deteriorates and requires continued acute hospitalization, the Clinical Care Management staff as designees of the Utilization Review Committee may request a review by member (s) of the Utilization Review Committee to authorize a reinstatement of benefits if payer appropriate. Written notification will be sent to the same parties as identified in Section F.10. The CM will continue to monitor the patient's stay following the established review process. Clinical information will be submitted to the payer as appropriate to obtain certification and approval for acute hospital days.

G. UTILIZATION REVIEW (42 CRF 456.112)

Activities of the Utilization Review Committee will be documented in the meeting minutes. Approved minutes are kept on file for a permanent record of the Committee's activities.

H. OTHER RESPOSIBILITIES AND FUNCTIONS OF UTILIZATION REVIEW COMMITTEE INCLUDE:

The Utilization Review Committee will report on a quarterly basis and as needed. Reports/report Summaries are presented to Medical Executive Committee by chair/member of Utilization Review Committee quarterly. Reports may include the following:

Review and the recommendation of quality indicators for ongoing monitoring and mechanisms in data collection for evaluation, regarding admission process, appropriateness of admissions and continued stay reviews, resource utilization and continuity of care:

a. Avoidable days trending and analysis;
b. One day stay reviews and medical necessity;
c. Review and discuss documentation expectations as directed by CMS;
d. Provide medical staff education as needed regarding efficient use of hospital resources;
e. Promote effective and efficient use of hospital resources that are consistent with the care needs of the patient and meet recognized community standards of care.

I. MEDICAL CARE EVALUATION STUDIES (MCES) (42 CFR 456.141-145)

The purpose of Medical Care Evaluation Studies is to identify opportunities to improve utilization of services. These opportunities shall be identified through ongoing monitoring and evaluation of admissions to the hospital, concurrent and retrospective medical record review, reports from the Utilization Review Committee, patient complaints, and customer satisfaction surveys.

The Utilization Review Committee selects the methods being used to conduct medical care evaluation review and other studies. The purpose of the medical care evaluation studies is to promote the most effective and efficient use of available health care facility resources and services. The services provided are consistent with patient care needs and based on professionally recognized standards of care. These studies are conducted to ensure consistent high quality patient care is delivered in an effective and efficient manner. Medical care studies are selected and prioritized based upon, but not limited to, the following criteria and/or other identified factors:

a. Diagnoses;
b. DRG (Diagnostic Related Group);
c. High cost, complex cases;
d. Identified outlier trends.

UM Committee members/Service Line Teams/Corporate Compliance and/or designated staff will:

1. Conduct medical care evaluation studies through medical record review, concurrent and/or retrospective, utilizing quality indicators, best practice indicators, and evidence based research findings.
2. Document the results and how these results have been or will be used to make changes to improve
3. Quality of care and promote additional and/or improvement in current effective and efficient use of facility resources and services.
4. Analyze and report findings.
5. Take action as needed to a) correct or investigate further deficiencies or problems in the review process or pre-admission, initial and continued stay reviews; b) recommend additional and/or revise current hospital care procedures; c) determine certain providers and/or categories of cases requiring additional review prior to admission to the hospital.

Each medical care evaluation study must a) identify and analyze medical and/or administrative factors related to patient care delivery; b) include analysis of at least the following: admissions, durations of stay, ancillary services provided, including drugs and biologicals, professional services performed, and if indicated, contain recommendations for changes that are beneficial to patients, staff, hospital, and the community.

Data the Committee uses to perform the studies will be obtained from one or more of the following sources; a) medical records or other appropriate hospital data; b) external organizations that compile statistics, design profiles, and produce other comparative data.

The hospital should have one study in progress at any time to ensure completion of a study each calendar year.

J. CONFIDENTIALITY (42CFR 456.113)

All activities of Utilization Review including findings and recommendations are confidential. Utilization Review records will be maintained securely and will be accessible only to those responsible for surveying the hospital to determine the existence of an ongoing, effective Utilization Management Plan. The confidentiality and reporting requirements of The Carolinas Center for Medical Excellence are observed. The identities of individual recipients in all Utilization Review records and reports are kept confidential. Findings of the Utilization Management Plan are considered to be peer review, and as such are protected under the provisions of State peer review statutes (NC GS, 131E-95).

References: Code of Federal Regulations Title 42, Part 456.50-456.146 – Utilization Control Subpart C Utilization Control; Hospitals. Intermediary Manual Part 3, Title 42, Part 482.30 Conditions of Participation.
https://www.ecfr.gov/cgi-bin/text-idx?SID=87916de3b86533cde4c930dcd4c5328b&mc=true&tpl=/ecfrbrowse/Title42/42cfr456_main_02.tpl

https://www.ecfr.gov/cgi-bin/text-idx?SID=87916de3b86533cde4c930dcd4c5328b&mc=true&tpl=/ecfrbrowse/Title42/42cfr456_main_02.tpl

Xsolis 2017, MCG 20th Edition ® and InterQual Acute Care Guidelines 2017.

DMA Acute Inpatient Hospital Services Clinical Coverage Policies revised 10/1/2015

CMS – Hospital Issued Notices of Non-Coverage – http://www.cms.hhs.gov/BNI/05HINNs.asp

Signature Page:

Barb Desilva
Vice President, System Care Coordination
Carolinas HealthCare System

8/4/2017
Date

CAROLINAS HEALTHCARE SYSTEM

CORPORATE RISK MANAGEMENT

MISSION STATEMENT

CATEGORY	**ADMINISTRATION**
NUMBER	**CRM 1.01**
DATE OF ISSUE	3/4/2005
REVIEWED / REVISED	3/2005, 11/2007, 2/2009, 9/2009, 2/2010, 2/2012, 7/2016, 9/2017

Mission:
Protect the assets of Carolinas HealthCare System against the financial effects of anticipated and accidental losses; facilitate the Carolinas HealthCare System core mission of providing healthcare, education and research; and reduce the overall cost of risk through an innovative and professional risk management program.

Vision:
To be a cost-effective, efficient and impactful operation within the Office of General Counsel. We will serve CHS and its affiliated entities as a highly valued strategic partner and resource providing innovation, quality service and cost efficient options for balancing risk and opportunity.

Objectives:

- Provide a safe environment for our patients, visitors, employees, and medical staff.
- Ensure the financial stability of the organization and minimize the frequency and severity of events.
- Educate staff on risk prevention and mitigation.
- Assist Compliance with accrediting and regulatory agency requirements.
- Integrate Corporate Risk Management activities and techniques into Performance Improvement and Patient Safety activities.

CAROLINAS HEALTHCARE SYSTEM

CORPORATE RISK MANAGEMENT

RISK MANAGEMENT PLAN

CATEGORY	**ADMINISTRATION**
NUMBER	**CRM 1.02**
DATE OF ISSUE	
REVIEWED / REVISED	3/2005, 12/2006, 11/2007, 2/2008, 2/2009, 9/2009, 2/2010, 2/2012, 7/2016, 9/2017

PURPOSE The purpose of the Corporate Risk Management program is to prevent and reduce the risk of injury to patients, visitors, team members and medical staff members and to protect the organization's financial resources.

It is the responsibility of each team member of the system to practice and promote safe work processes, to maintain equipment in proper operating condition and to report all unsafe conditions and unusual occurrences that are not consistent with routine patient care or the normal operation of the organization.

OBJECTIVES

A. To provide a safe environment by:
   - preventing incidents involving patients, visitors, team members, and medical staff
   - conducting risk assessments

B. To ensure the financial stability of the organization and minimize the frequency and severity of incidents by:
   - maintaining a systematic Corporate Risk Management reporting system to track the number of incidents and claims
   - identifying and correcting in a timely manner any situation which could cause professional and general liability claims and/or lawsuits
   - promptly investigating, reporting, and ensuring implementation of a plan of corrective action by the appropriate department
   - reducing the insurance costs to the hospital
   - maintaining confidentiality of all information

C. To educate staff about Corporate Risk Management and risk prevention by:
   - providing information to new team members about their responsibility in reporting unusual occurrences or incidents and in prevention of incidents
   - providing Corporate Risk Management education during orientation and annual training
   - offering departmental specific programs regarding relevant Risk Management issues

D. To assist Compliance with accrediting and regulatory agency requirements by:
   - providing assistance in coordinating activities with the Safety Officer, Patient Safety Officer, Corporate Compliance and Regulatory Compliance on compliance with local, state and federal safety regulations pertinent to the organization

E. To integrate Corporate Risk Management activities with performance improvement (PI) activities by:
   - communicating information to and participating in the Environment of Care, PI and Patient Safety Committees
   - referring issues to administrative and medical staff departments for quality review
   - communicating information as needed to the Pharmacy & Therapeutics Committee
   - communicating information by reporting to the appropriate oversight committee to the Quality Department

COMPONENTS The Corporate Risk Management program of CMHA is composed of three basic components: risk identification, risk control and risk financing.

Risk Identification Risk Identification is a way of determining where actual or potential risk exists within the organization.
The following are potential sources of risk identification:
- Event
- Communication Memos
- Reports of Patient Dissatisfaction
- Team Member Comments
- Information from the Credentialing Process
- Equipment Problem Logs
- Infection Control Reports
- Safety Inspections
- Emergency Preparedness and Fire Drills
- Compliance Helpline Reports
- Contract Reviews
- Cyber Technology and Analysis

Risk Control Risk Control is an effort to reduce or eliminate identified risks.
The following are examples of risk control measures:
- Preventative maintenance
- Equipment control
- Safety and security measures
- Hazard surveillance
- Policies & procedures/rules & regulations
- Claims management
- Team member training and education
- Service recovery programs
- Contract reviews

Risk Financing

Risk Financing refers to the method for providing funds to cover losses if and when they occur. CMHA uses the following risk financing techniques to cover the financial aspects of loss:

Self-Insurance – CMHA utilizes a Self-Insured Trust Fund for professional liability and general liability. The Charlotte-Mecklenburg Hospital Authority also Self-Insures for Workers' Compensation & Directors & Officers insurance.

Commercial Insurance – CMHA carries the following types of commercial insurance as protection against financial loss:
- Excess Professional Liability/General Liability
- Directors and Officers Liability
- Fiduciary Liability
- Crime
- Automobile
- Property
- Workers' Compensation
- Aviation Liability
- Kidnap and Ransom

Captive – A wholly-owned single parent captive, domiciled in Charleston, SC. Currently insures CMHA physicians for Medical Malpractice. Claims Management is provided by CHS Corporate Risk Management (CRM), and Loss Control provided by CRM and excess carrier.

The following are potential sources of information used in loss control activities:

Primary
- Claim Reports
- Event (Event report/occurrence screen)
- Communication memos
- Sentinel Event Action Plans
- Risk Management Reports
- Safety and Risk Assessment Surveys
- Medical Records
- Patient, Family, Physician and Team Member Complaints
- Clinical Technology Service Reports
- Performance Improvement Activities
- JCAHO Reports
- Insurance Carrier Inspection Reports
- Request for medical records by attorneys

Secondary
- Emergency Preparedness Drill Reports
- Fire Drill Reports
- Committee Meeting Minutes
- Infection Control Surveillance
- JCAHO Required Monitors
- Press Ganey Reports (Patient Satisfaction Survey)
- Compliance Helpline Reports
- Patient Safety Survey

Data Reporting The following reports are examples of Corporate Risk Management reporting – (this list is not all inclusive):
- Monthly Corporate Risk Management reports to the EOC
- Monthly/Quarterly Corporate Risk Management reports to administrative leaders upon request

Record Retention Events are entered online by the staff and retained in the Corporate Risk Management database.

Confidentiality All Corporate Risk Management reports are considered confidential Information. Corporate Risk Management events are investigated in an attempt to improve quality patient care. Investigation of each event is completed in an effort to provide a sound defense in anticipation of litigation.

PATIENT RESPONSIBILITIES

1. Patients, and their families when appropriate, are responsible for providing correct and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
2. Patients and their families are responsible for reporting unexpected changes in their condition or concerns about their care to the doctor or nurse taking care of them.
3. Patients and their families are responsible for asking questions when they do not understand their care, treatment, and service or what they are expected to do.
4. Patients and their families are responsible for following the care, treatment, and service plans that have been developed by the healthcare team and agreed to by the patient.
5. Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.
6. Patients and their families are responsible for following the hospital's rules and regulations.
7. Patients and their families are responsible for being considerate of the hospital's staff and property, as well as other patients and their property.
8. Patients and their families are responsible to promptly meet any financial obligation agreed to with the hospital.

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PATIENT RIGHTS

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PATIENT RIGHTS

1. A patient has the right to respectful care given by competent personnel.
2. A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.
3. A patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly.
4. A patient has the right to have all records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.
5. A patient has the right to know what facility rules and regulations apply to his conduct as a patient.
6. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
7. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
8. The patient has the right to full information in laymen's terms, concerning his diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's designee.
9. Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.
10. A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent must be obtained prior to actual participation in such program and the patient or legally responsible party, may, at any time, refuse to continue in any such program to which he has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in accord with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations under 21 CFR Parts 50 and 56. For any research study proposed for conduct under an FDA "Exception from Informed Consent Requirements for Emergency Research" or an HHS "Emergency Research Consent Waiver" in which informed consent is waived but community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study also must verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB reviewing the research study has authorized the start of the community consultation process required by the federal regulations for emergency research, but before the beginning of that process, notice of the proposed research study by the facility shall be provided to the North Carolina Medical Care Commission. The notice shall include:
    - the title of the research study;
    - a description of the research study, including a description of the population to be enrolled;
    - a description of the planned community consultation process, including currently proposed meeting dates and times;
    - an explanation of the way that people choosing not to participate in the research study may opt out; and
    - contact information including mailing address and phone number for the IRB and the principal investigator.
11. The Medical Care Commission may publish all or part of the above information in the North Carolina Register, and may require the institution proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.

12. A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to the extent permitted by law, and a physician shall inform the patient of his right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.
13. A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense. A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual preference, national origin or source of payment.
14. A patient who does not speak English or is hearing impaired shall have access, when possible, to a qualified medical interpreter (for foreign language or hearing impairment) at no cost, when necessary and possible.
15. The facility shall provide a patient, or patient designee, upon request, access to all information contained in the patient's medical records. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason. A patient's designee may have access to the information in the patient's medical records even if the attending physician restricts the patient's access to those records.
16. A patient has the right not to be awakened by hospital staff unless it is medically necessary.
17. The patient has the right to be free from needless duplication of medical and nursing procedures.
18. The patient has the right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.
19. When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility to which the patient is to be transferred must first have accepted the patient for transfer.
20. The patient has the right to examine and receive a detailed explanation of his bill.
21. The patient has a right to full information and counseling on the availability of known financial resources for his health care.
22. A patient has the right to expect that the facility will provide a mechanism whereby he is informed upon discharge of his continuing health care requirements following discharge and the means for meeting them.
23. A patient shall not be denied the right of access to an individual or agency who is authorized to act on his behalf to assert or protect the rights set out in this Section.
24. A patient, or when appropriate, the patient's representative has the right to be informed of his rights at the earliest possible time in the course of his hospitalization.
25. A patient, and when appropriate, the patient's representative has the right to have any concerns, complaints and grievances addressed. Sharing concerns, complaints and grievances will not compromise a patient's care, treatment or services.
    - If a patient has a concern, complaint, or grievance, he may contact his nurse, the nursing supervisor, or call the Customer Care Line at 704-355-8363.
    - If the patient issues are not satisfactorily addressed while the patient remains hospitalized, the investigation will continue. The intent is to provide the patient a letter outlining the findings within seven days.
    - If a patient chooses to identify a concern, complaint, or grievance after discharge, he may call the Customer Care Line at 704-355-8363 or write a letter to the Service Excellence Department at PO Box 32861, Charlotte, NC 28232.
    - The patient has the right to directly contact the North Carolina Department of Health and Human Services (State Survey Agency) or the Joint Commission.

NC Division of Health Services Regulation
Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711
www.ncdhhs.gov/dhsr/ciu/complaintintake.html
1-800-624-3004

The Joint Commission
Email: complaint@jointcommission.org
1-800-994-6610

26. The patient has the right to participate in the development and implementation of his plan of care, including his inpatient treatment/care plan, outpatient treatment/care plan, discharge care plan, and pain management plan.
27. The patient, or when appropriate, the patient's representative has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. Making informed decisions includes the development of their plan of care, medical and surgical interventions (e.g. deciding whether to sign a surgical consent), pain management, patient care issues and discharge planning.
28. The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.
29. The patient has the right to have a family member or representative of his or her choice and his own physician notified promptly of his admission to the hospital.
30. The patient has the right to personal privacy. Privacy includes a right to respect, dignity, and comfort as well as privacy during personal hygiene activities (e.g. toileting, bathing, dressing), during medical/nursing treatments, and when requested as appropriate. It also includes limiting release or disclosure of patient information such as patient's presence in facility, location in hospital, or personal information.
31. The patient has the right to receive care in a safe setting. A safe setting includes environmental safety, infection control, security, protection of emotional health and safety, including respect, dignity, and comfort, as well as physical safety.
32. The patient has the right to be free from all forms of abuse or harassment. This includes abuse, neglect, or harassment from staff, other patients, and visitors.
33. The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
34. The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.
35. A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient by blood or by marriage.

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Non-Discrimination
Number: PR 150.00
Date of Issue: 07/94 Reviewed / Revised: 05/17

NON-DISCRIMINATION POLICY STATEMENT

No individual shall be subject to discrimination or denied the benefits of the services, programs, or activities of the Carolinas HealthCare System on the basis of race, color, religion, national origin, age, sex, sexual orientation, gender identity, gender expression, disability or source of payment.

APPROVALS

Policy Coordinator	Kinneil Coltman, Vice President, Diversity & Inclusion
Policy Approver	Roger Ray, Executive Vice President & Chief of Physician Executive

-End-

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Non-Discrimination
Number: PR 150.01
Date of Issue: 08/91 Reviewed / Revised: 02/18

INDIVIDUALS WITH DISABILITIES

SUMMARY STATEMENT

This policy sets forth the procedure to protect the rights of individuals with disabilities as described in the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 and to ensure that no individual with a disability shall be subject to discrimination at any Carolinas HealthCare System facility.

PROCEDURE

A. All Carolinas HealthCare System facilities will comply with regulations as described in the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA) to reasonably accommodate individuals with disabilities.

B. Any complaint against a Carolinas HealthCare System facility alleging non-compliance with the Rehabilitation Act of 1973 or the ADA shall be communicated to the Carolinas HealthCare System Corporate Risk Management department and Office of General Counsel or Human Resources Department if it involves an employment issue.

C. These calls shall be assigned to the administrator or designate of the Carolinas HealthCare System facility involved in the complaint, who shall contact the complainant as soon as practical, investigate the complaint, and make every effort to equitably resolve the matter.

REFERENCES

Carolinas HealthCare System Office of General Counsel
Carolinas HealthCare System Human Resources

APPROVALS

Policy Coordinator	Danilo Formolo, Director, Patient Experience
Policy Approver	Maureen Swick, Senior Vice President/System Nurse Executive

- End -

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Non-Discrimination
Number: PR 150.03
Date of Issue: 08/91 Reviewed / Revised: 02/18

INDIVIDUALS WITH SPECIAL HEARING NEEDS

SUMMARY STATEMENT

This policy sets forth the procedure to provide a communications system for patients with special hearing needs.

PROCEDURE

A. Patients or their companions who are identified as having special hearing needs shall be referred to the facility department responsible for securing interpreters and auxiliary aids. Clinical staff shall conduct an assessment with the patient or companion to determine how to best meet the needs of the individual.

B. The facility department responsible for securing interpreters is responsible for accessing a qualified medical interpreter in a timely manner. The Carolinas HealthCare System Communications department shall be contacted for auxiliary aids.

C. It must be communicated to the patient and/or companion that a qualified medical interpreter and auxiliary aids will be provided at no cost to the patient or companion.

D. Family members and friends will not provide interpretation/translation for any direct patient care/medical interaction. Family members and friends may assist staff with basic instructions, for example: directions to the lab.

E. The following are examples of circumstances when it may be necessary to provide qualified medical interpreters:

- Determination of a patient's medical history or description of ailment or injury
- Provision of Patient's Rights, informed consent or permission for treatment
- Religious services and spiritual counseling
- Explanation of living wills or powers of attorney (or their availability)
- Diagnosis or prognosis of ailments or injuries
- Explanation of procedures, tests, treatment, treatment options, or surgery
- Explanation of medications prescribed (such a dosage, instructions for how and when the medication is to be taken, and side effects or food or drug interactions)
- Explanation regarding follow-up treatments, therapies, test results or recovery
- Blood donations or aphaeresis
- Discharge instructions
- Provision of mental health evaluations, group and individual therapy, counseling and other therapeutic activities, including grief counseling and crisis intervention

- Explanation of complex billing or insurance issues that may arise
- Educational presentations, such as classes concerning birthing, nutrition, CPR, and weight management

REFERENCES

Carolinas HealthCare System Facility Manuals - Department of Language Services

APPROVALS

Policy Coordinator	Danilo Formolo, Director, Patient Experience
Policy Approvers	Maureen Swick, Senior Vice President/System Nurse Executive

- End -

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Non-Discrimination
Number: PR 150.02
Date of Issue: 08/91 Reviewed / Revised: 02/18

LANGUAGE ASSISTANCE PLAN (LAP)

SCOPE

Carolinas HealthCare System (CHS) shall provide access to appropriate communication for patients, authorized representatives, and other individuals who are Limited English Proficient (LEP) or Deaf/Hard of Hearing. This communication shall be provided in the preferred language of our customer.

SUMMARY STATEMENT

CHS is committed to facilitating the delivery of healthcare in ways that are culturally sensitive, effective, and easy to understand. The Language Services Department strives to bridge communication gaps between patients and providers, reduce barriers to quality healthcare, and advocate for LEP patients and family members. Our mission is that the One Experience of the LEP patient will reflect as closely as possible to that of the non-LEP patient.

POLICY

LEP customers of CHS shall be offered language assistance at no cost to the patient. These services shall be made available 24 hours a day, 7 days a week. CHS receives federal funding and shall demonstrate compliance with the following federal regulations that mandate the provision of a qualified medical interpreter:

Title VI of the Civil Rights Act of 1964

"No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

A person's preferred language falls under "national origin" for the purpose of this law. Therefore, providing language assistance in a person's preferred language avoids discrimination.

Department of Health and Human Services (HHS), Office for Civil Rights (OCR)

The OCR enforces the Civil Rights Act of 1964. Organizations such as CHS that receive federal funding are subject to OCR oversight and enforcement. The OCR has the right to investigate any complaint related to such services and withhold federal funds due to non-compliance.

Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency

This executive order, signed by President Clinton in 2000, further emphasizes the need for federally funded agencies to examine the services they provide and develop a system for LEP individuals to have meaningful access.

PROCEDURES

1. **Rights and Purpose.** All LEP customers of CHS have the right to care or assistance in their preferred language. Medical Interpreters are provided to enhance the Patient Experience and bridge the linguistic and cultural barrier between customers and the healthcare system. Services promote patient safety, reduce anxiety, and enhance comprehension and retention of medical information. It is the responsibility of CHS caregivers to always evaluate a patient or family member's need for language access and provide when requested. A patient's preferred language shall always be documented by the caregiver or appropriate team mate in the electronic health record and revenue cycle software. A qualified medical interpreter must be used with every LEP encounter, every time. When charting medically related information following a patient encounter, caregivers must always document the use of an interpreter in the health record. The unit, practice, department, or facility encountering the LEP individual is responsible for securing a qualified Medical Interpreter and should do so as soon as the need is identified.
    a. **Meaningful Access.** CHS shall take reasonable steps and exhaust current CHS resources to provide a qualified Medical Interpreter as quickly as possible. It is understandable that there may be infrequent occurrences of Languages of Lesser Diffusion (LLDs) or rare dialects where an interpreter may not be readily available. Additionally, caregivers must be good stewards of financial resources and utilize interpreter resources within appropriate parameters. For example, it is unreasonable to request an interpreter to be immediately available and idle at the bedside for hours at a time. Caregivers should be mindful of appropriately utilizing and maximizing an interpreter's time.
    b. **Interpreter Refusal (Attached).** Though highly discouraged, a patient might choose to reject the provision of a qualified Medical Interpreter for personal or cultural reasons. We must always be sensitive to such desires. CHS shall never force an Interpreter Refusal scenario upon a patient due to interpreter costs or non-immediate availability. An Interpreter Refusal Form (found after the end of this policy document) must be completed indicating that language assistance was offered at no charge but declined. Doing so allows the patient to accept the risks of miscommunication. It is within the rights of CHS to still have an interpreter present following an interpreter refusal, especially if caregivers have doubts regarding the qualifications of an untrained, ad-hoc interpreter.

2. **Language Assistance Qualifications.**
    a. **Medical Interpreter Qualifications.** Medical Interpreting is not a skillset. It is a practice profession which requires rigorous testing, training, skill, knowledge, and cultural sensitivity. Team mates who function in the role of Medical Interpreter, assisting in the communication of medically related information, are required to

successfully pass the Interpreter Readiness Assessment as approved by Corporate Language Services. This test assesses an individual's language skills and determines the potential for success as a Medical Interpreter, given appropriate training. These team mates must also complete an approved 40-hour classroom training program as soon as possible. Language Services teammates whose primary function is to interpret must also complete the appropriate on-the-job training in the facility they serve.

b. **Bilingual Teammate Qualifications.** Bilingual CHS teammates may utilize bilingual skills only after passing a Language Assessment as approved by Corporate Language Services. Those passing the Non-Clinical Assessment may utilize language skills with customers only for non-medical interactions. Examples include Patient Access, Patient Transport, etc. Those passing the Clinical Language Assessment may provide care using foreign language skills. Examples include care provided by providers, nurses, techs, pharmacists, etc. Please note that teammates who pass the Clinical or Non-Clinical Language Assessment have not been tested, trained, or approved to function as interpreters and should avoid performing in such capacity.

c. **Language Assessment Requests.** CHS leaders, Human Resources, or other appropriate teammates may request Language Assessments for bilingual individuals by filling out a Language Assessment Request form. Candidates for job postings, including external candidates, may take a Language Assessment if bilingual skills are required or preferred by the hiring manager. Language screening should be part of the hiring process to avoid the risk of hiring an unqualified bilingual teammate.

3. **Document Translation.** Corporate Language Services is responsible for coordinating translation of all customer-facing written communications including CHS collateral, consents, patient education materials, instructions, signage, etc. Translation is a highly-specialized skill set which should not be performed by team mates who are simply bilingual. Foreign language materials may only be utilized if approved by the Corporate Language Services translation team. All materials should be appropriately evaluated for health literacy/plain language prior to submitting for translation as materials are translated to maintain the register and spirit of the source document. CHS teammates may request translation by filling out a Translation Project Request form and attaching the document(s) to be translated.

4. **Vital Documents.** Federal regulations established and monitored by the Office of Civil Rights (part of DHHS) require that "Critical Documents" be translated for every "LEP language group that constitutes 5% or 1000 persons – whichever is less – of the population served." It is the responsibility of CHS to identify universal, frequently used documents that are considered vital. The list of documents is subject to change at any time. CHS is currently committed (at the time of this policy document revision) to a year-long process of updating and translating all vital documents into our top 10 languages. This language mix is also subject to change based on shifting demographics. A multi-disciplinary committee, in partnership with the QSPX committee, evaluated existing patient-facing documents and determined the following to be vital:

a. Consent for Treatment
b. Consent for Procedure
c. Patient History Form
d. HIPAA form
e. Release of Records
f. AMA
g. CHS Interpreter Refusal Form
h. Patient Rights
i. Do Not Resuscitate (DNR)

5. **Interpreter Modalities.** CHS may offer a Medical Interpreter from a variety of options as appropriate: In-person Interpreting, Video Remote Interpreting (VRI), or Over-the-Phone Interpreting (OPI). CHS teammates should use best judgment to provide services that are accessible, cost-effective, and appropriate for the encounter with the LEP individual. It is crucial to be compliant and provide the best healthcare possible to LEP patients given the resources available. Caregivers should always assess whether the method used (such as OPI or VRI) is considered effective communication from the patient's perspective. A patient has the option of choosing an in-person Medical Interpreter if desired, subject to availability within a reasonable timeframe. Generally speaking, less acute or less invasive encounters that are relatively short in length may be appropriate for OPI or VRI, while more complex scenarios may require an In-Person interpreter. The following is an explanation of interpreting modalities and guidelines:

    a. **In-Person Medical Interpreting.** This resource can be a qualified CHS Language Services teammate, a bilingual CHS teammate who has been properly trained and assessed, or a third party on-site contractor. In-person interpreting is most ideal for sessions that require a higher need of personal attention. When requesting an in-person interpreter outside of a facility that does not have onsite staff interpreters, one should be mindful of associated costs and travel time. Third party on-site interpreting contractors carry additional costs of a minimum session time and mileage fees. The following are guidelines and examples of when an in-person interpreter may be appropriate:
        i. Patient is not fully cognitive or aware of surroundings, such as the experiencing of psychosis
        ii. Patients cannot leverage remote interpreting resources due to impaired vision, reduced motor skills, or disability
        iii. Sensitive topics such as an end-of-life scenario or new diagnosis for a terminal illness
        iv. Discussing a lengthy plan of care
        v. High-risk, acute OB/Gyn or pediatric scenarios
        vi. Interpreting for multiple parties at once, such as a group therapy session
        vii. Certain trauma situations
        viii. Continuous, lengthy sessions and multidisciplinary encounters such as Oncology, Transplant, complex OB/Gyn or pediatric scenarios, etc.
        ix. Sessions that involve a considerable amount of paperwork or education
        x. Select rehabilitation encounters that are lengthy and require a considerable amount of movement.

b. **Video Remote Interpreting (VRI)** is a cost-effective technology that allows ease of use and personal attention. VRI is a system where interpreting services are provided remotely via software on a portable device. VRI devices are attached to a rolling stand, allowing portability to where the patient encounter takes place. VRI devices are available (or available for implementation) at CHS facilities and departments that serve patients with Limited English Proficiency. VRI is an on-demand system with relatively short wait times and a wide variety of languages available. Because of the on-demand nature of the product, there are no minimum fees or pre-scheduling requirements. Video Remote Interpreting is most ideal for the following:
    i. Urgent and emergency situations where onsite interpreting is not available and a short wait time is critical
    ii. Same-day appointments and unscheduled patients
    iii. Routine primary and specialty care
    iv. Routing patient work-up, follow-up, brief teachings, routine discharge
    v. Subsequent or frequent patient visits such as Physical Therapy, Radiation Therapy, Chemotherapy, etc.
    vi. Less acute inpatient nursing or provider care and assessments
    vii. Non-acute Behavioral Health scenarios, including emergencies
    viii. Bridging the need while waiting for an in-person interpreter to arrive
    ix. Remote geographical areas that do not have easy interpreter access
    x. Care locations that do not have onsite staff medical interpreters

    Additional VRI tips. It's best practice to conduct a VRI session in an area with low ambient noise. Position the device to that the subject is not in front of a brightly lit background. Due to the nature of technology, troubleshooting may be required at times. Successful connectivity to VRI is based on a wireless internet signal. Any connectivity or equipment issues should be reported to Information and Analytics Services (IAS).
    Although VRI allows for sessions with a more personal attention to patients, an option for audio interpreting has been incorporated into the VRI system and is available on the VRI interface. This allows access to qualified interpreters in over 200 audio languages. Additionally, audio interpreting may be a good backup during times when high demand for VRI creates extended hold times.

c. **Over-the-Phone Interpreting (OPI)** is a systemwide on demand service, available 24/7, where caregivers obtain a qualified medical interpreter via telephone. CHS OPI can be accessed by dialing **(704) 446-1665** from any phone. Callers will be asked to provide cost center information comprised of a four-digit Business Unit number and six-digit department number. CHS OPI provides an unsurpassed scope of languages, with over 200 languages available. It's important to keep in mind that phone interpreters do not have access to visual cues or other non-verbal actions. This service is best suited for:
    i. Urgent or emergent situations where an in-person interpreter or VRI device is not available and immediate communication is needed

ii. Making phone calls to patients that are at a remote location outside of the walls of CHS. Examples include scheduling appointments, follow-ups, lab results, returning patient phone calls, updates, etc.
iii. Languages of lesser diffusion that are not available on VRI
iv. Shorter encounters where a significant cost savings is desired. This can include routine care, nursing assessments, etc.
v. Patient registration encounters that require privacy
vi. Remote areas that have no access to in-person interpreters or VRI

6. **Four-Factor Analysis.** Recipients of federal funds, such as CHS, are required to take reasonable steps and measures to provide meaningful access in a language that all LEP individuals can understand. Prior to developing and executing this LAP, a process and methodology known as the Four-Factor Analysis was conducted to determine the need for such a plan. The findings are listed on separate pages after the end of this policy document.

REFERENCE

U.S. Department of Health and Human Services

APPROVALS

Policy Coordinator	Danilo Formolo, Director, Patient Experience/Language Services
Policy Approver	Maureen Swick, Senior Vice President/System Nurse Executive

-End-

Interpreter Refusal

What are the benefits of using an interpreter and what should I know?

- I would have a trained Medical Interpreter that will maintain confidentiality.
- Using an interpreter will assist my healthcare team in understanding my needs and concerns.
- Using an interpreter will help me understand what my healthcare team tells me.
- I have a right to this service, which is offered free of charge.

What happens if I sign this form?

- I am accepting all the risks of miscommunication that come with not using a trained Medical Interpreter.
- I cannot blame any member of my healthcare team if there are bad results because I chose not to use a trained Medical Interpreter.

I also agree that my care team may still use a qualified Medical Interpreter if it is determined that there are communication barriers.

I have read, understand and accept all the information explained on this form.

_____

Patient Signature (or Authorized Representative) Date/Time

Interpreter statement:

I have interpreted the information and advice explained to the patient by the caregiver obtaining the consent as well as any patient questions and concerns.

This was done by using:

- In-house Interpreter
- VRI
- OPI

In the preferred language of _____.

_____

Interpreter signature or number Date/Time

_____

Caregiver signature and Title Date/Time

FOUR FACTOR ANALYSIS

Summary Statement:

In compliance with Title VI of the 1964 Civil Rights Act, Executive Order 13166, and Section 1557 of the Affordable Care Act (ACA), Carolinas HealthCare System has developed a Language Assistance Plan for individuals that identify as Limited English Proficient (LEP).

Background/History:

Title VI of the Civil Rights Act of 1964 is a federal law protecting individuals that participate in agencies or programs receiving federal financial assistance from discrimination based on grounds of race, color, or national origin. Executive Order 13166 further clarifies the requirements for individuals identifying as Limited English Proficient under Title VI of the 1964 Civil Rights Act; it mandates that federally funded agencies have a plan in place to provide meaningful language assistance to all persons who have a limited ability to speak, read, write or understand English. Section 1557 of the ACA further emphasizes the prohibition of discrimination as outlined in Title VI of the Civil rights act of 1964, specifying that no individual participating in a health program or activity receiving federal financial assistance shall be discriminated against based on race, color, national origin, sex, age, or disability.

As such, Carolinas HealthCare System is expected to make reasonable efforts to provide meaningful language assistance to all LEP persons. Failure to comply with this plan is in violation of federal law.

Methodology:

Four Factor Analysis

A. *Number or proportion of LEP individuals served or encountered in eligible service area*

The eligible areas for this four-factor analysis include the following counties in North Carolina serviced by Carolinas HealthCare System: Anson County, Cabarrus County, Cleveland County, Gaston County, Iredell County, Lincoln County, Mecklenburg County, Montgomery County, Rowan County, Rutherford County, Stanly County, Union County. These counties comprise the primary enterprise and receive federal funding under Title VI. The most recent data collected pertaining to language frequency in these areas is from the year 2015 as noted by the American Community Survey conducted through the US Census Bureau. Listed below is pertinent demographic information for these service areas:

Total Population	2,357,405
Total English Only Speakers	1,835,204
Total Speakers of Other Languages	522,201
Total LEP Speakers	120,420

B. *Frequency with which LEP individuals come into contact with the program*

Data from 2015 from CHS Language Services was aggregated to identify which LEP populations are served with greatest frequency across all programs and services offered in the eligible service area. The data shows how much time is spent (in hours) annually assisting LEP individuals by language needed. The top languages are shown.

Top 10 Languages Served	**Annual Hours of Service**
Spanish	22,785.50
American Sign Language	4,656.25
Vietnamese	3,948
Burmese	4,151.50
French	2,149
Russian	1,998.75
Nepali	1,829.50
Mandarin	1,651.25
Arabic	1,070.25
Korean	876.25

C. *The nature and importance of the program, activity, or service provided by the program*

The services and programs offered by Carolinas HealthCare System demonstrate a comprehensive and integrative approach to healthcare that is designed to improve the health of individuals and the community at large. The footprint of this system includes more than 7,600 licensed beds, employs nearly 60,000 people and accounts for almost 12 million patient interactions per year. The services and programs offered range from preventative health screenings to life-saving emergency services. These programs and services are in keeping with Carolinas HealthCare System's commitment in helping to improve Health, elevate Hope, and advance Healing – for all. Carolinas HealthCare System Language Services further advances this mission by facilitating the delivery of these services and programs through clear and effective communication while promoting a culturally sensitive environment. The nature of the services and programs offered by Carolinas HealthCare System are of significant importance to the service area(s) as outlined in section B, and as such cannot be limited to solely English-speaking individuals.

D. *The resources available and the cost to the recipient*

Carolinas HealthCare System Language Services is committed to bridging communication and cultural gaps between patients and providers, and reducing barriers in access to quality healthcare. In addition to providing recipients with qualified and culturally competent on-site medical interpreters, Carolinas HealthCare System also offers interpretation over the phone and through video-remote-interpreting in over 200 languages. There is also meaningful language assistance provided for the deaf community through on-site and video-remote-interpreting

services. Carolinas HealthCare System makes every effort to provide items of critical importance to all LEP patients in their language. All language services are free of charge to the recipient.

Conclusion

Based on this 4 factor analysis Carolinas HealthCare System must develop a Language Assistance Plan.

NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 23, 2018

Elizabeth Kirkman
2709 Water Ridge Parkway, Suite 200
Charlotte, NC 28217

Exempt from Review

Record #:	**2681**
Facility Name:	Carolinas HealthCare System Pineville
FID #:	110878
Business Name:	Mercy Hospital, Inc.
Business #:	1220
Project Description:	Construct a patient tower connected to the main hospital building and renovate other spaces within the existing hospital building
County:	Mecklenburg

Dear Ms. Kirkman:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency), determined that based on your letter of August 15, 2018, the above referenced proposal is exempt from certificate of need review in accordance with N.C. Gen. Stat. §131E-184(g). Therefore, you may proceed to offer, develop or establish the above referenced project without a certificate of need.

However, you need to contact the Agency's Construction and Acute and Home Care Licensure and Certification Sections to determine if they have any requirements for development of the proposed project.

It should be noted that this determination is binding only for the facts represented by you. Consequently, if changes are made in the project or in the facts provided in your correspondence referenced above, a new determination as to whether a certificate of need is required would need to be made by the Agency. Changes in a project include, but are not limited to: (1) increases in the capital cost; (2) acquisition of medical equipment not included in the original cost estimate; (3) modifications in the design of the project; (4) change in location; and (5) any increase in the number of square feet to be constructed.

If you have any questions concerning this matter, please feel free to contact this office.

Sincerely,

Julie M. Faenza

Julie M. Faenza
Project Analyst

Martha J. Frisone

Martha J. Frisone
Chief, Healthcare Planning and
Certificate of Need Section

cc: Construction Section, DHSR
Acute and Home Care Licensure and Certification Section, DHSR
Melinda Boyette, Administrative Assistant, Healthcare Planning, DHSR

Atrium Health

August 15, 2018

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

RE: Notice of Exemption for Mercy Hospital, Inc. d/b/a Carolinas HealthCare System Pineville Patient Tower

Dear Ms. Frisone:

This letter serves as notification of Mercy Hospital, Inc. d/b/a Carolinas HealthCare System Pineville's ("CHS Pineville") intent to construct a patient tower on its main campus. CHS Pineville intends to construct an eight-story, approximately 269,000 square foot tower. The patient tower will be located on CHS Pineville's main campus, adjacent and connected to the existing hospital building. A diagram showing the site is as attached as Exhibit 1. The total capital cost of the patient tower is estimated to be $153.8 million. Four of the floors will be built out and four floors will be shell space. The services proposed on each floor are as follows:

- Ground Floor – Loading Dock, Materials Management, Food Services, and Other Support Space
- Level 01 – Entry to Tower and Shell Space
- Level 02 – 36 Replacement Acute Care Beds
- Level 03 – 22 Replacement Acute Care Beds and 14 Observation Beds
- Level 04 – Shell
- Level 05 – Mechanical
- Level 06 – Shell
- Level 07 – Shell

The 58 licensed acute care beds planned for levels two and three of the patient tower will be relocated from their existing location on 2 East and 2 West. The vacated spaces will be decommissioned, with future use of the locations to be determined. As part of the project, CHS Pineville will renovate existing space within its hospital building including the reconfiguration of space in maternity services to extend corridors for patient circulation and provide connection with the proposed patient tower. CHS Pineville will also develop a temporary loading dock during the construction and relocate its mobile pad. The project will not increase the number of licensed beds, operating rooms, or other regulated assets, and CHS Pineville will file a certificate of need application for any additional new institutional health services that would be developed in any newly constructed space.

Pursuant to N.C. Gen. Stat. 131 E-184(g), "[t]*he Department shall exempt from certificate of need review any capital expenditure that exceeds the two million dollar ($2,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:*

(1) The sole purpose of the capital expenditure is to renovate, replace on the same site, or expand the entirety or a portion of an existing health service facility that is located on the main campus.

(2) The capital expenditure does not result in (i) a change in bed capacity as defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(3) The licensed health service facility proposing to incur the capital expenditure shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

N.C.G.S. 131E-176(14n) states, "*'Main campus' means all of the following for the purposes of G.S. 131E-184(f) and (g) only:*

a. The site of the main building from which a licensed health service facility provides clinical patient services and exercises financial and administrative control over the entire facility, including the buildings and grounds adjacent to that main building.

b. Other areas and structures that are not strictly contiguous to the main building but are located within 250 yards of the main building."

The CHS Pineville patient tower project meets each of the applicable conditions set forth above. The estimated capital cost of the project exceeds $2,000,000. The proposed project involves the expansion of an existing health service facility located at 10628 Park Road, Charlotte, NC 28210 which is the site from which CHS Pineville provides clinical patient services and exercises financial and administrative control over the entire facility (Hospital License # H0042, FID # 110878, see Exhibit 2 for the hospital license). CHS Pineville's President's office is located on the ground floor of the main hospital building.

The project will not result in a change in bed capacity as defined in G.S. 131E-176(5) or the addition of a health service facility or a new institutional health service other than that allowed in G.S. 131E-176(16)b. The project will not increase the number of operating rooms or gastrointestinal rooms. The project will not result in the acquisition of major medical equipment or the offering of health services not currently provided. This letter constitutes the required prior written notice.

Based on the above facts, the project is exempt from certificate of need review. We are requesting that you confirm in writing that CHS Pineville's patient tower project is exempt from certificate of need review and that we may proceed as planned with this project.

Sincerely,

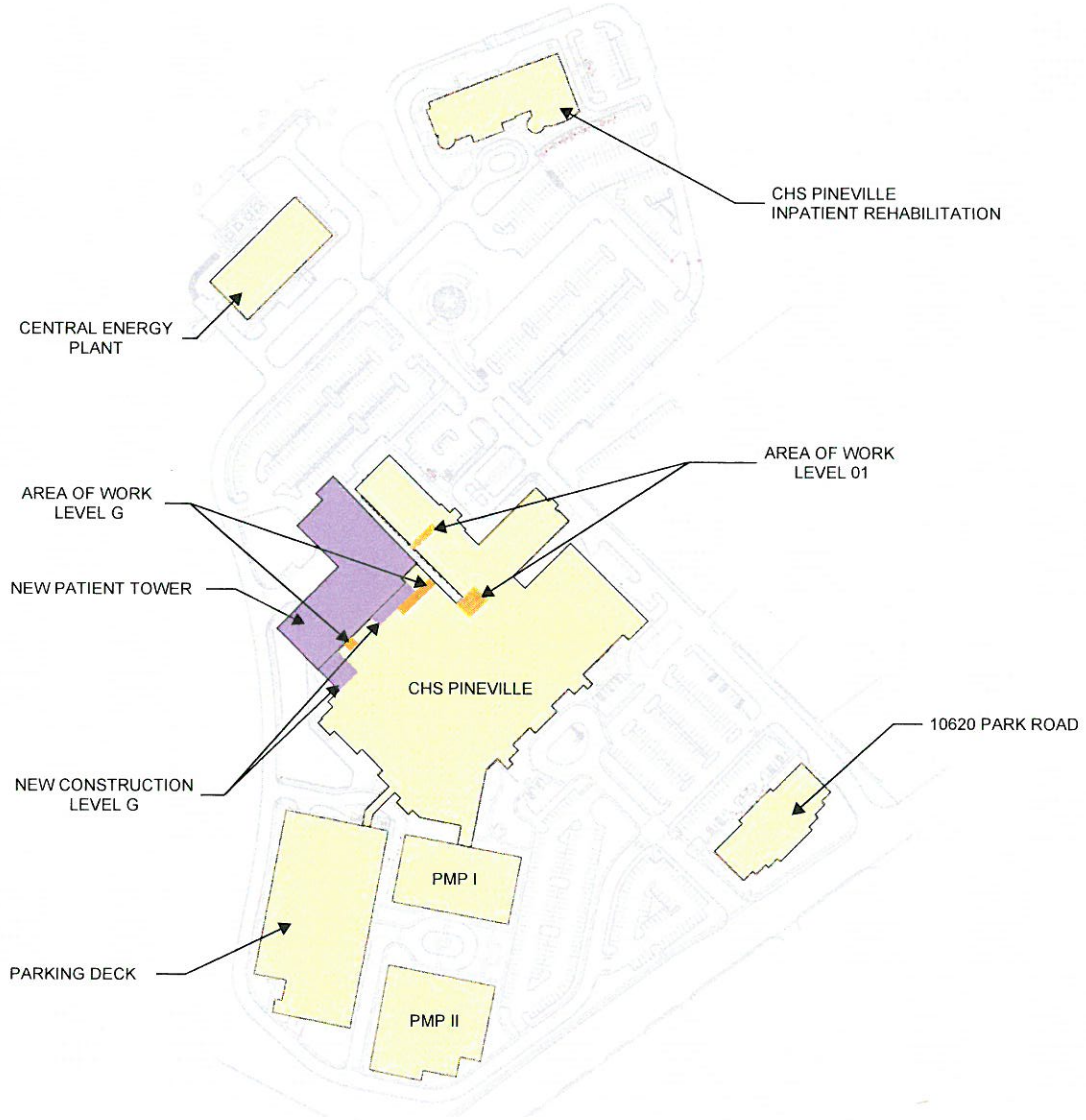
Elizabeth Kirkman

Elizabeth Kirkman
Assistant Vice President
CHS Strategic Services Group

Exhibit 1

COLOR KEY

- EXISTING BUILDING
- RENOVATION
- NEW CONSTRUCTION



SITE PLAN - NEW

PINEVILLE PATIENT TOWER ADDITION

Atrium Health

07/27/2018

CHS Pineville

Exhibit 2

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 01, 2018, this license is issued to

Mercy Hospital, Inc.

to operate a hospital known as

Carolinas HealthCare System Pineville

located in Charlotte, North Carolina, Mecklenburg County.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall remain in effect until amended by the issuing agency.

Facility ID: 110878

License Number: H0042

Bed Capacity: *235*

General Acute 206, Rehabilitation 29 ,

Dedicated Inpatient Surgical Operating Rooms: 3
Dedicated Ambulatory Surgical Operating Rooms: 0
Shared Surgical Operating Rooms: 9
Dedicated Endoscopy Rooms: 2

Authorized by:

Secretary, N.C. Department of Health and Human Services

Director, Division of Health Service Regulation

COLOR KEY

EXISTING BUILDING

RENOVATION

SITE PLAN

50 ACUTE CARE BEDS

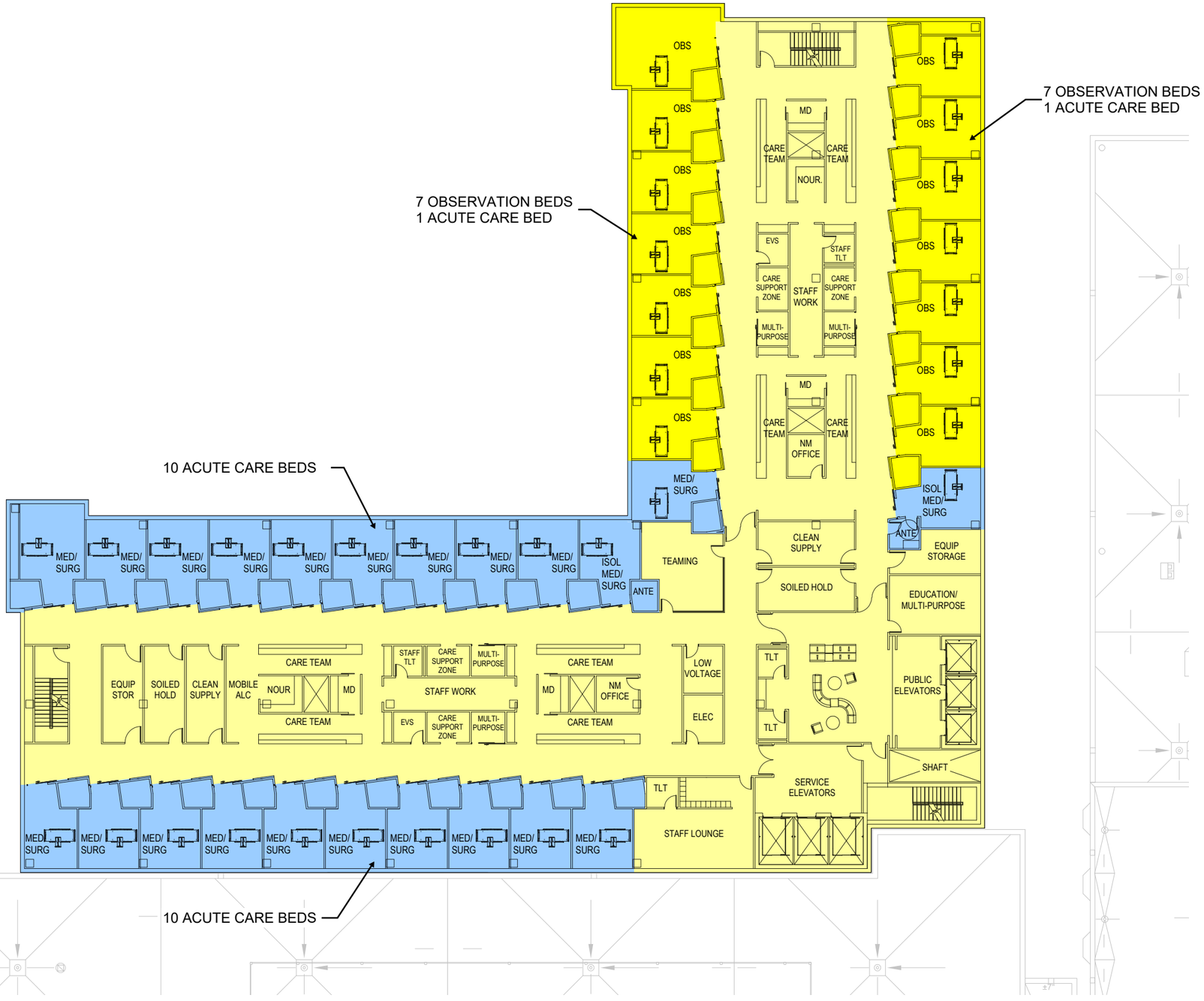
Atrium Health

10/15/2018

CHS Pineville

COLOR KEY

- EXISTING BUILDING
- LICENSED BEDS
- OBSERVATION



PATIENT TOWER EXISTING LEVEL 03 PLAN

50 ACUTE CARE BEDS

Atrium Health

10/15/2018

CHS Pineville

COLOR KEY

EXISTING BUILDING

LICENSED BEDS

PATIENT TOWER PROPOSED LEVEL 03 PLAN

50 ACUTE CARE BEDS

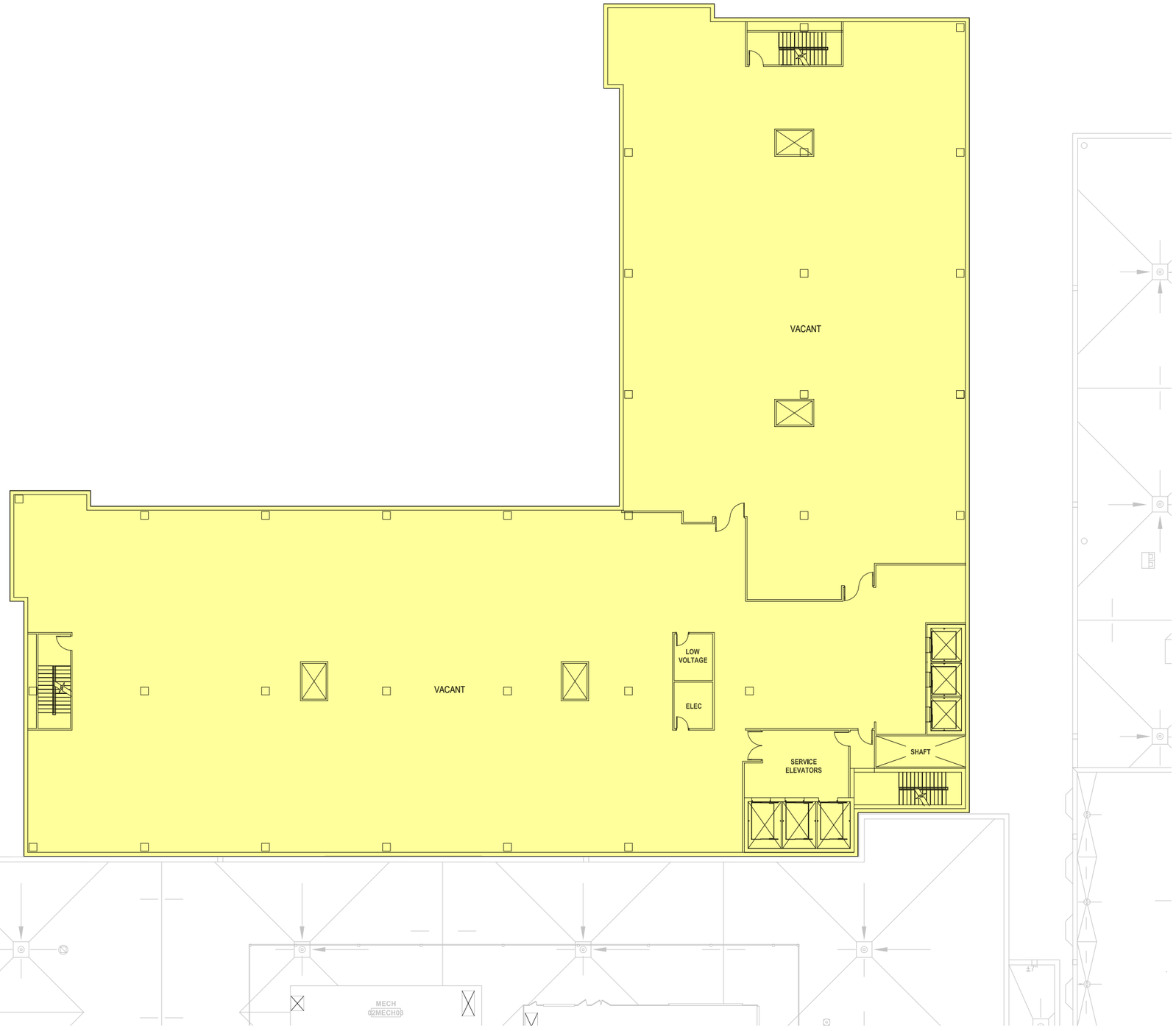
Atrium Health

10/15/2018

CHS Pineville

COLOR KEY

EXISTING BUILDING



PATIENT TOWER EXISTING LEVEL 04 PLAN

50 ACUTE CARE BEDS

Atrium Health

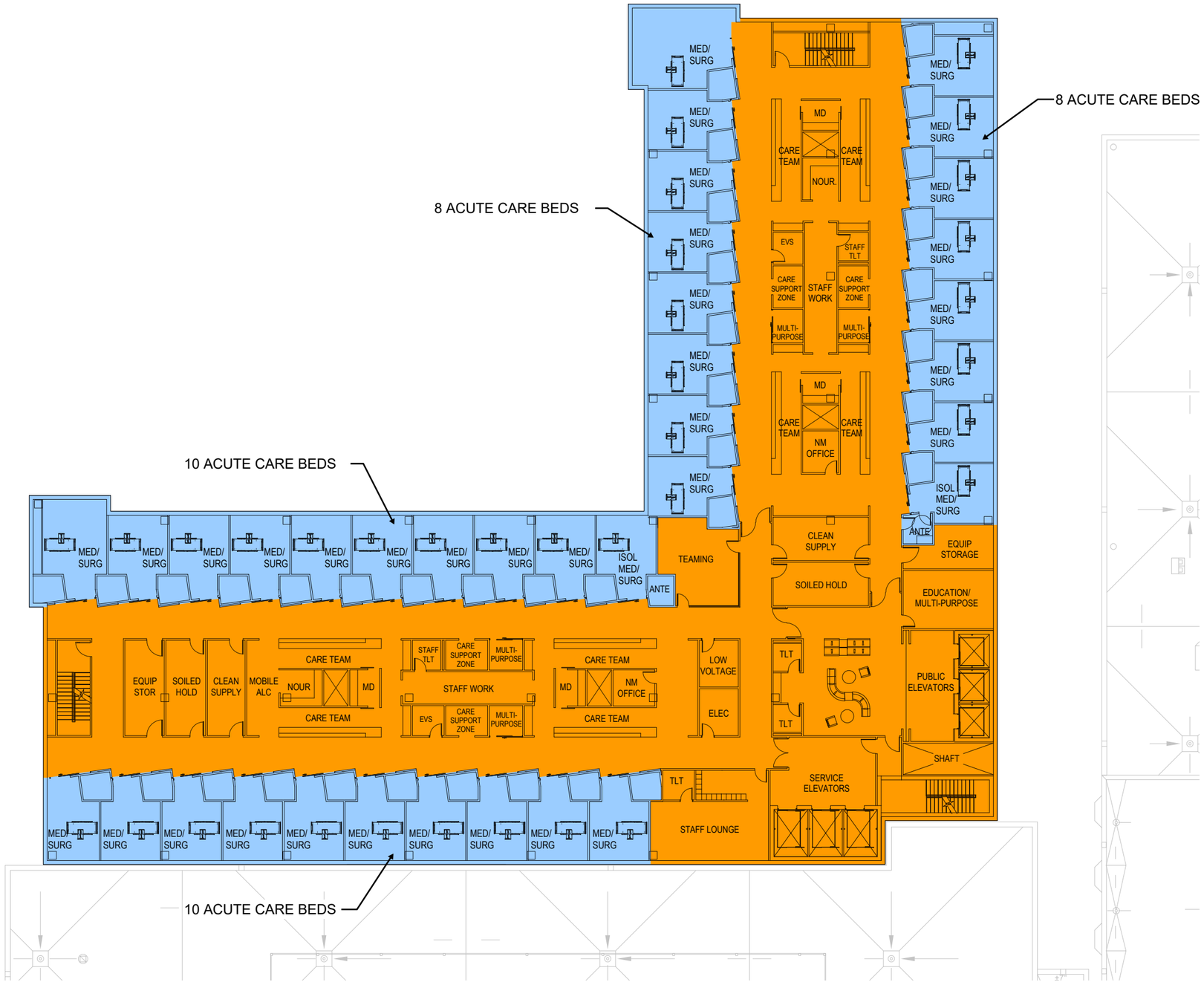
10/15/2018

CHS Pineville

COLOR KEY

RENOVATION

LICENSED BED



PATIENT TOWER PROPOSED LEVEL 04 PLAN

50 ACUTE CARE BEDS

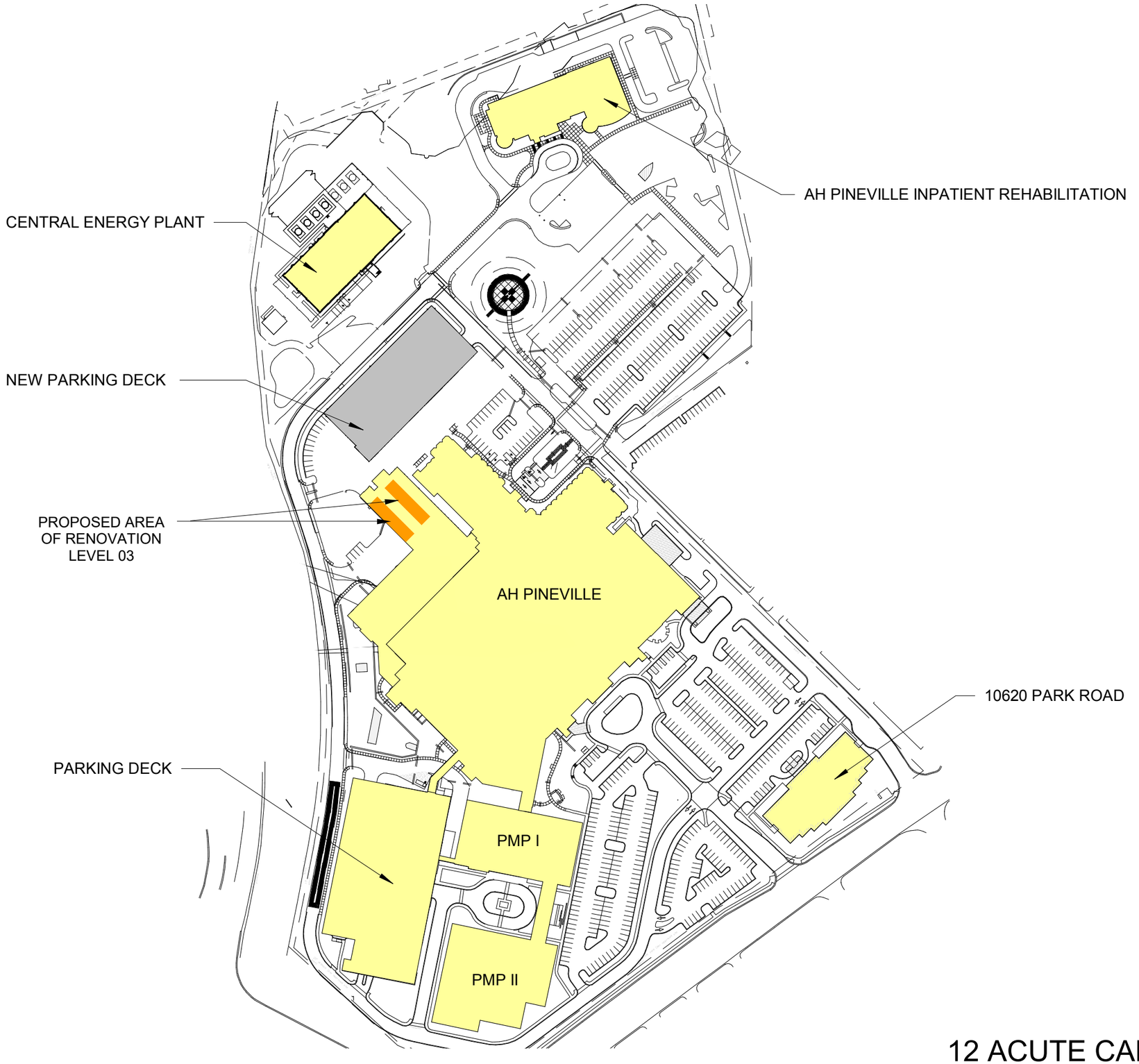
Atrium Health

10/15/2018

CHS Pineville

COLOR KEY

- EXISTING
- RENOVATION
- PROJECT UNDER CONSTRUCTION



SITE PLAN

Atrium Health

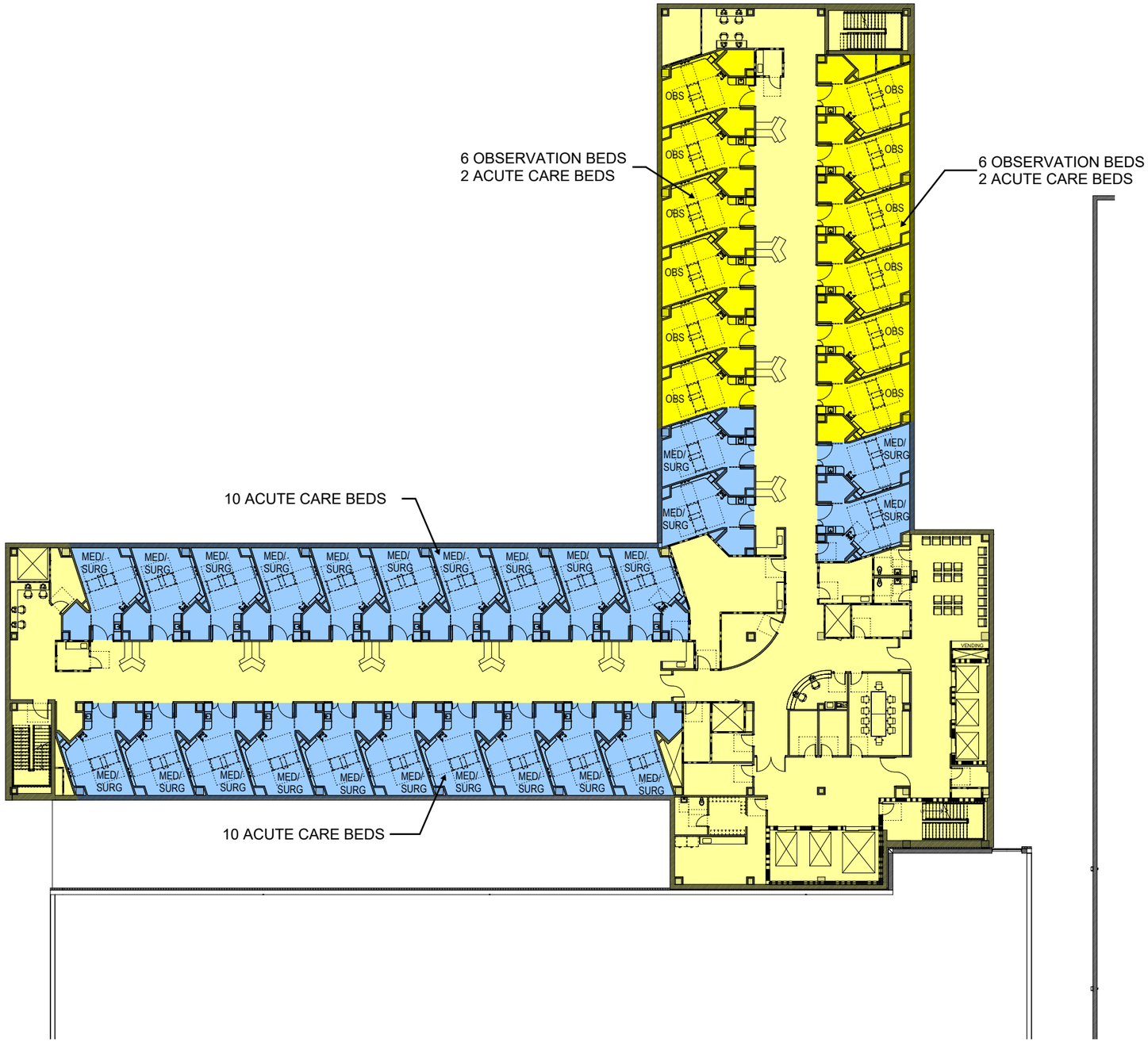
10/15/2019

12 ACUTE CARE BEDS

Atrium Health Pineville

COLOR KEY

- EXISTING BUILDING
- LICENSED BEDS
- OBSERVATION



PATIENT TOWER EXISTING LEVEL 03 PLAN

12 ACUTE CARE BEDS

Atrium Health

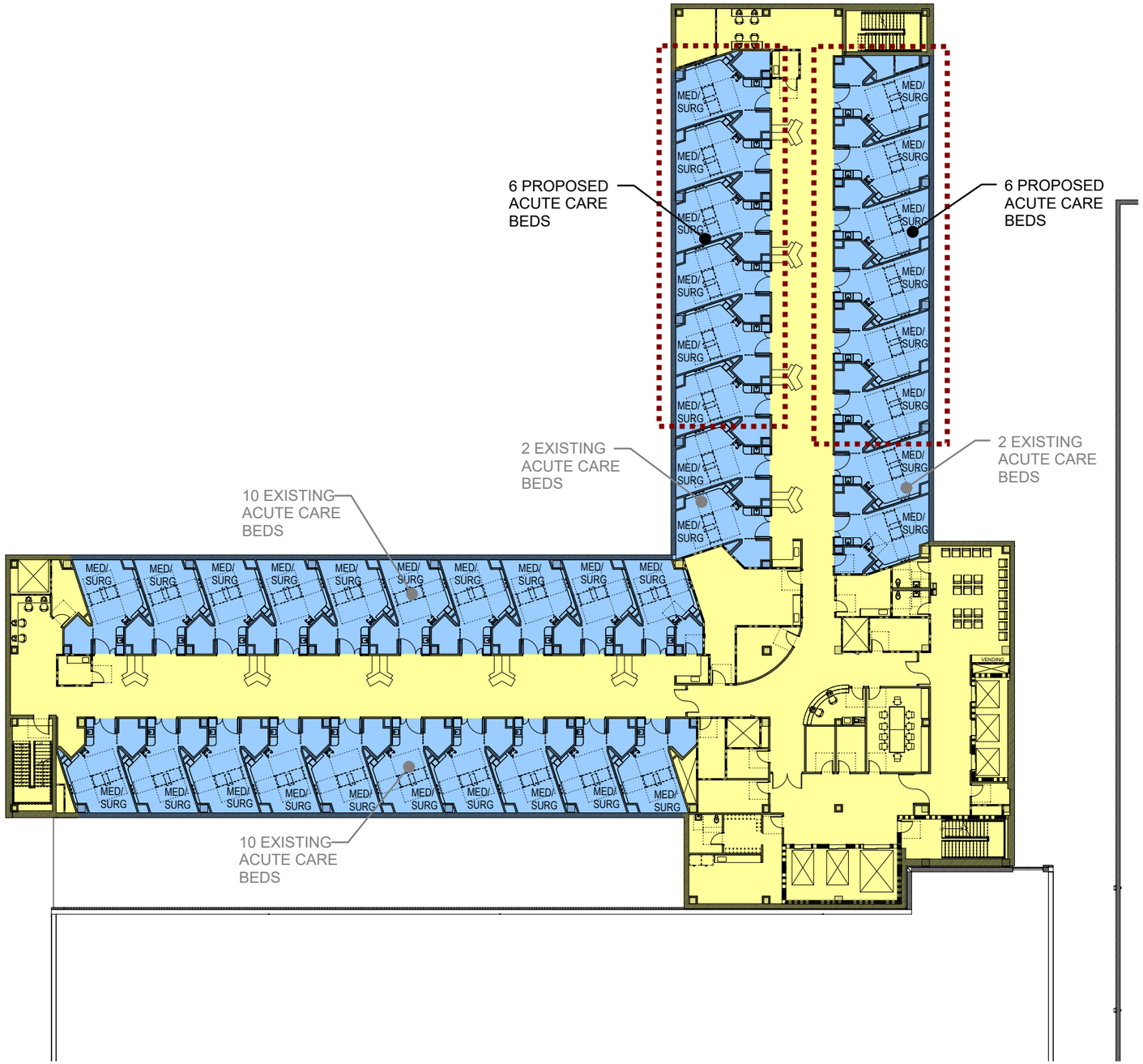
10/15/2019

Atrium Health Pineville

COLOR KEY

EXISTING BUILDING

LICENSED BEDS



PATIENT TOWER PROPOSED LEVEL 03 PLAN

12 ACUTE CARE BEDS

Atrium Health

10/15/2019

Atrium Health Pineville

Largest Percent of Acute Care Bed Need to Adjusted Total Licensed Beds Among All NC Hospitals That Are Currently Operational, *2010 - Proposed 2020 SMFP*

	Total Licensed Acute Care Beds	Projected Bed Need	CON Adjustments	Adjusted Total Acute Care Bed Inventory*	Facility Need	Percent of Bed Need to Adjusted Total Acute Care Bed Inventory
Proposed 2020 SMFP						
Atrium Health University City	100	124	0	100	24	24.0%
2019 SMFP						
Atrium Health Pineville	206	261	15	221	40	18.1%
2018 SMFP						
Duke University Hospital	924	1,059	0	924	135	14.6%
2017 SMFP						
Duke University Hospital	924	1,069	0	924	145	15.7%
2016 SMFP						
Novant Health Brunswick	74	84	0	74	10	13.5%
2015 SMFP						
FirstHealth Moore Regional Hospital	312	358	0	312	46	14.7%
2014 SMFP						
Cape Fear Valley Medical Center	490	682	65	555	127	22.9%
2013 SMFP						
Carolinas Medical Center	795	956	19	814	142	17.4%
2012 SMFP						
Carolinas Medical Center	795	929	0	795	134	16.9%
2011 SMFP^						
Carolinas Medical Center	795	929	0	795	134	16.9%
2010 SMFP						
Carolinas Medical Center	795	853	0	795	58	7.3%

Source: *2010 - Proposed 2020 SMFP* .

*Includes Total Licensed Acute Care Beds and Acute Care Beds Awarded.

^*2011 SMFP* Table 5A: Acute Care Bed Need Projections Revised Methodology.

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: March 28, 2014
FINDINGS DATE April 4, 2014

PROJECT ANALYST: Bernetta Thorne-Williams
INTERIM CHIEF: Martha J. Frisone

PROJECT I.D. NUMBER: F-10214-13/ Novant Health Huntersville Medical Center/ Add 17 acute care beds/ Mecklenburg County

F-10215-13/ The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center-Mercy/ Add 34 acute care beds/ Mecklenburg County

F-10221-13/ The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center-University/ Add 6 acute care beds/ Mecklenburg County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

C
All Applicants

The 2013 State Medical Facilities Plan (SMFP) identified a need for 40 additional acute care beds in Mecklenburg County. The 2013 SMFP states:

"Any qualified applicant may apply for a certificate of need to acquire the needed acute care beds. A person is a qualified applicant if he or she proposes to operate the additional acute care beds in a hospital that will provide:

(1) a 24-hour emergency services department,

Applicant	Medicare	Medicaid
NHHMC	50.04%	9.01%
CMC-Mercy	43.30%	8.90%
CMC-University	26.00%	16.70%

Source: Section VI.14(a) of the respective applications

NHHMC projects the highest Medicare percentage and CMC-University projects the highest Medicaid percentage. With regard to Medicare access, the NNHMC application is the most effective alternative. With regard to Medicaid access, the CMC-University application is the most effective alternative.

Meeting the Need for Additional Acute Care Beds

The 2013 SMFP includes tiered target occupancy rates for acute care beds based on average daily census. Specifically, for hospitals with an average daily census of less than 100 inpatients, the target occupancy rate is 66.7 %; for hospitals with an average daily census of 100 to 200 inpatients, the target occupancy rate is 71.4 %; for hospitals with an average daily census of more than 200 but less than 400 inpatients, the target occupancy rate is 75.2 %; and for hospitals with an average daily census of more than 400 inpatients, the target occupancy rate is 78.0 %. In FFY2011, CMC-Mercy-Pineville had an average daily census of more than 100 but less than 200. Thus, its target occupancy rate is 71.4%. CHS shifted CMC-Mercy to CMC's license effective October 1, 2013. Prior to that the CMC-Pineville campus was on the CMC-Mercy license. The average daily census for the CMC-Mercy campus was more than 100 but less than 200. Thus, its target occupancy rate is also 71.4 %. CMC-University and NHHMC had an average daily census of less than 100 inpatients, therefore their target occupancy rate is 66.7%.

As shown below, Table 5A of the 2013 SMFP (page 59) indicates that Mecklenburg County is projected to have a deficit of 40 acute care beds in 2015. CMC-Mercy-Pineville is projected to have a surplus of 97 beds, CMC-University is projected to have a surplus of 5 beds and NHHMC is projected to have a deficit of 10 beds.

2013 SMFP, Table 5A Acute Care Bed Need Projections

Facility	Licensed Acute Care Beds	2011 Acute Care Days	Projected 2015 Acute Care Days	2015 Average Daily Census	2015 Beds Adjusted for Target Occupancy	Projected 2015 Deficit (Surplus)
Carolinas Medical Center	795	256,117	272,584	747	956	44
CMC-Mercy-Pineville	294	69,975	74,474	204	271	(97)
CMC-University	130	20,318	21,624	59	89	(5)
All CHS Hospitals	**1,219**	**346,410**	**368,682**	**1,010**	**1,316**	**40**
NH Presbyterian Hospital	539	146,577	156,001	427	547	8
NHHMC	75	19,540	20,796	57	85	10
NH Matthews	117	31,535	33,563	92	138	4
Presbyterian Mint Hill	0	50	0	0	0	(50)
Presbyterian Orthopaedic Hospital	64	10,906	11,607	32	48	(16)
All NH Hospitals	**795**	**208,558**	**221,967**	**608**	**818**	**(44)**
Total for Mecklenburg Co	**2,014**					**40**

As shown in the table above, of the three hospitals that propose to add beds, NHHMC is the only one projected to have a deficit (10 beds) in 2015. However, when all CHS hospitals and all Novant Health hospitals are compared, Novant Health is projected to have a surplus of 44 beds by 2015 while CHS is projected to have a deficit of 40 beds in 2015. In fact it is CMC that is projected to have a deficit of 40 beds in 2015. CHS proposes to address the deficit at CMC by adding beds at CMC-Mercy (34) and CMC-University (6) and shifting lower acuity med/surg patients from CMC to those hospitals.

NHHMC projects that is project will be completed such that CY 2017 will be the first operating year. CMC-Mercy and CMC-University both project that their projects will be complete such that CY 2015 will be the first operating year. All three applicants propose to renovate existing space. CMC-Mercy and CMC-University, project to add the 40 beds in CY 2015, the year the SMFP projects they will be needed, a full tow years before NHHMC.

With regard to meeting a need for additional beds, the applications submitted by CMC-Mercy and CMC-University are the most effective alternatives.

Revenues

The following tables show the average gross and net patient revenue per adjusted patient day during CY 2017 for each applicant. The hospitals differ in several characteristics that could effect the average gross and net patient revenue per adjusted patient day, including differences in patient acuities and the types of medical and surgical subspecialty services provided. Moreover, many prayers necessitate discounts (also referred to as contractual adjustments) and government payers determine maximum allowable reimbursement rates. The majority of hospital reimbursements are paid by government payers. As a result, net revenue (gross revenue less discounts or contractual adjustments is the preferred comparative factor. Thus, generally the applicant projecting the lowest average net patient revenue per adjusted day is the most effective alternative.

2018 Mecklenburg County Acute Care Bed Admission Patient Origin by NC County and Other States, by Provider

NC County/State of Origin	Atrium Health	Novant Health	Total	Percent of Total
Mecklenburg	42,697	29,532	72,229	57.6%
South Carolina	13,884	2,545	16,429	13.1%
Union	4,152	5,847	9,999	8.0%
Gaston	3,808	1,772	5,580	4.4%
Other States	889	403	1,292	1.0%
Cabarrus	2,305	1,279	3,584	2.9%
Cleveland	2,055	195	2,250	1.8%
Iredell	1,038	1,357	2,395	1.9%
Lincoln	1,373	1,091	2,464	2.0%
Rowan	528	612	1,140	0.9%
All Others*	6,199	1,878	8,077	6.4%
Total	**78,928**	**46,511**	**125,439**	**100.0%**

Source: 2019 License Renewal Applications.

*All Others includes all other North Carolina counties.

Green indicates top provider to patients in each NC County/State of Origin

Site	2024 Total Population
28012 (Belmont)	26,311
28032 (Cramerton)	3,453
28079 (Indian Trail)	44,662
28103 (Marshville)	12,027
28104 (Matthews)	35,803
28105 (Matthews)	48,337
28110 (Monroe)	59,737
28112 (Monroe)	30,183
28120 (Mount Holly)	26,140
28134 (Pineville)	12,717
28173 (Waxhaw)	73,322
28174 (Wingate)	9,867
28210 (Charlotte)	46,906
28226 (Charlotte)	42,228
28270 (Charlotte)	36,901
28273 (Charlotte)	45,761
28277 (Charlotte)	79,750
28278 (Charlotte)	38,009
29704 (Catawba)	3,896
29708 (Fort Mill)	42,321
29710 (Clover)	41,609
29715 (Fort Mill)	44,090
29717 (Hickory Grove)	1,263
29720 (Lancaster)	56,808
29726 (Mc Connells)	1,832
29730 (Rock Hill)	66,346
29732 (Rock Hill)	65,454
29742 (Sharon)	2,726
29743 (Smyrna)	1,168
29745 (York)	35,644
Total	**1,035,271**

Source: ESRI

Form C Utilization – Methodology and Assumptions

The Charlotte Mecklenburg Hospital Authority d/b/a Atrium Health University City proposes to develop a new hospital campus, Atrium Health Lake Norman (as a remote location of Atrium Health University City), in order to bring high quality, convenient access to care for the residents of the Lake Norman area. Atrium Health Lake Norman will offer emergency, inpatient, and outpatient care, specifically:

- 30 licensed acute care beds (developed pursuant to the need determination in the *2019 SMFP* for 76 acute care beds) comprised of 20 medical/surgical, six obstetrics (LDRPs), and four ICU beds;
- Eight observation beds;
- Two operating rooms developed pursuant to the need determination in the *2019 SMFP* for six operating rooms;
- One C-Section operating room;
- One procedure room;
- 10 Emergency Department bays comprised of eight general treatment and two trauma rooms in addition to three triage spaces; and,
- Imaging and ancillary services including one fixed CT scanner, general radiography, fluoroscopy, ultrasound, and nuclear medicine, in addition to a mobile X-ray unit and mobile C-arm, neither of which will be housed in dedicated space in the imaging department. Mobile MRI will be provided through a contracted mobile MRI vendor. Other diagnostics, lab, and physical and other therapy will also be available.

The utilization projections are organized as follows:

- Acute Care Bed Utilization
- Obstetrics Bed Utilization
- ICU Bed Utilization
- Observation Bed Utilization
- Operating Room Utilization
- C-Section Room Utilization
- Procedure Room Utilization
- Emergency Department Utilization
- Imaging and Ancillary Utilization
    - CT Utilization

Please note that the utilization methodology, approach, and assumptions included below are consistent with those included in Atrium Health's approved application to develop Atrium Health Union West, a 40-bed community hospital in western Union County (Project ID # F-11618-18).

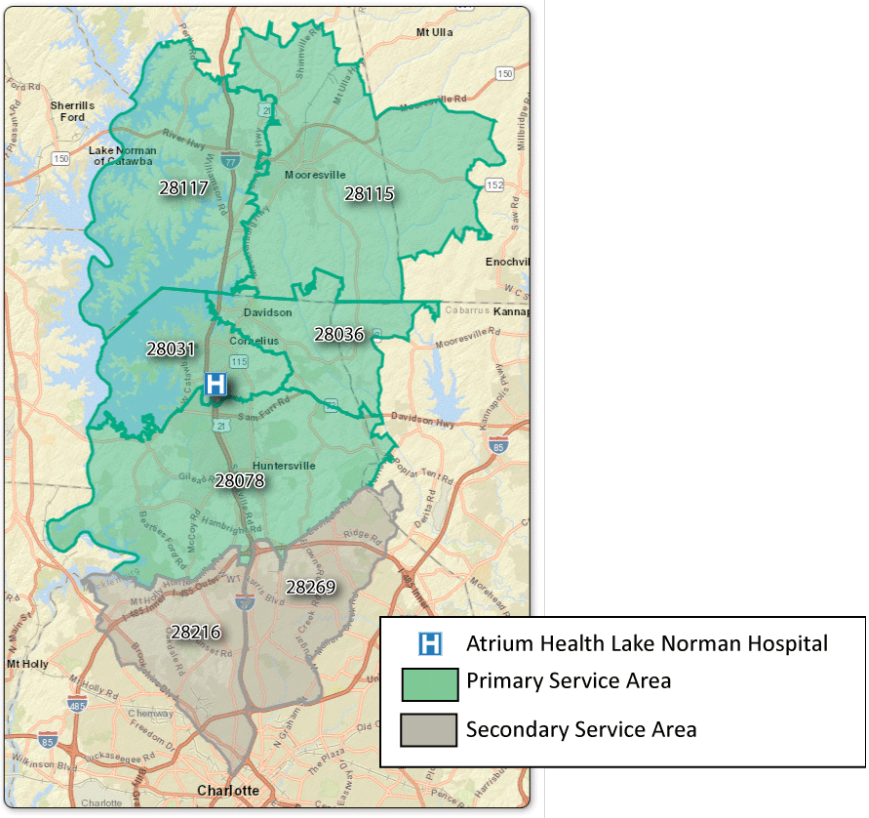
Acute Care Bed Utilization

Based on the geography of the Lake Norman area and expected patient travel patterns, Atrium Health considered its historical utilization originating from only certain geographies as identified in the table below.

Assumed Geographies for Atrium Health Lake Norman Patients

Primary Service Area (PSA)
28031-Cornelius
28035-Davidson (PO Box)
28036-Davidson
28070-Huntersville (PO Box)
28078-Huntersville
28115-Mooresville
28117-Mooresville
28123-Mooresville (PO Box)
Secondary Service Area (SSA)
28216-Charlotte
28269-Charlotte

These ZIP codes are identified in the map below alongside the proposed location of Atrium Health Lake Norman.



The impetus for the proposed project is to locate Atrium Health inpatient services closer to patients in the Lake Norman area that have historically accessed existing Atrium Health hospitals in Mecklenburg County; which, in turn, will help to decompress the highly utilized Atrium Health hospitals in the county. The table below provides the number of acute care days that were provided at an Atrium Health hospital to patients from the PSA and SSA from 2016 to 2018.

Historical Number of Acute Care Days Provided at an Atrium Health Hospital to Patients from PSA and SSA

All Patients	*2016*	*2017*	*2018*	*CAGR^*
PSA Days	14,224	14,725	15,398	4.0%
SSA Days	27,185	28,782	28,949	3.2%
PSA ADC*	39	40	42	4.0%
SSA ADC	74	79	79	3.2%
PSA + SSA ADC	**113**	**119**	**121**	**3.5%**

Source: Atrium Health internal data.
*Average Daily Census.
^Compound annual growth rate.

The table above shows that patients from the PSA and SSA accounted for an ADC of 121 patients in 2018, which means that 121 acute care beds at an Atrium Health hospital were occupied every day by patients from the Atrium Health Lake Norman PSA/SSA. Further, as shown above, the ADC of residents from the Atrium Health Lake Norman PSA/SSA in Atrium Health hospitals in Mecklenburg County increased by 3.5 percent annually from 2016 to 2018. The proposed hospital will have 30 beds, which is only 25 percent of the beds needed to support the PSA/SSA residents that occupied 121 Atrium Health acute care beds in 2018.

To determine the projected number of days to be served at Atrium Health Lake Norman, Atrium Health conducted an analysis of the potential patients to be served at the proposed facility. First, Atrium Health assumed that any patient days related to services that are not proposed to be provided at Atrium Health Lake Norman such as invasive/surgical cardiology, neurosurgery, pediatrics, and minor or advanced neonatal services would continue to be provided at existing Atrium Health facilities and not at Atrium Health Lake Norman. Second, Atrium Health assumed that Atrium Health Lake Norman would serve only patients with a Primary or Secondary Acuity Level MS-DRG, as defined by Atrium Health. The acute care days associated with services proposed to be provided at Atrium Health Lake Norman and with either a Primary or Secondary Acuity Level are hereafter referred to as "Atrium Health Lake Norman-appropriate" acute care utilization. These assumptions are consistent with the service and acuity assumptions used to project acute care utilization for the previously approved Atrium Health Union West.

For those patients in the identified PSA and SSA, the proposed Atrium Health Lake Norman facility will provide a convenient local option for care. Atrium Health Lake Norman patients from these ZIP codes will be comprised of patients historically served by Atrium Health Mecklenburg County hospitals, but only for the services proposed to be provided at Atrium Health Lake Norman and only for Primary and Secondary Acuity Levels (i.e. Atrium Health Lake Norman-appropriate patients).

Based on the previously stated assumptions, Atrium Health identified the following Atrium Health Lake Norman-appropriate patient days in CY 2018 within each assumed geography that could potentially be served by Atrium Health Lake Norman. Note this analysis includes CY 2018 days of care historically served

by Atrium Health Mecklenburg County hospitals for only Atrium Health Lake Norman-appropriate patients that reside in the PSA or SSA.

Potential Days of Care Appropriate at Atrium Health Lake Norman by Geography

	CY 2018 Atrium Health Lake Norman-Appropriate Days
PSA	4,671
SSA	15,948
Total Days	20,619
Total ADC	**56**

Based on the location of the proposed facility in relation to the selected geographies, Atrium Health assumes the following percentages of potential days will be served by Atrium Health Lake Norman in each geography. Please note that those patients assumed not to be served at Atrium Health Lake Norman will be served at existing Atrium Health Mecklenburg County hospitals (e.g. 80 percent of the identified PSA Atrium Health Lake Norman-appropriate patient days will be served at Atrium Health Lake Norman and 20 percent will be served at existing Atrium Health Mecklenburg County hospitals).

Percentage of Appropriate Days of Care to be Served at Atrium Health Lake Norman

	Percentage Served
PSA	80%
SSA	20%

Atrium Health believes these assumed percentages of patients to be served at Atrium Health Lake Norman are reasonable. All of the potential patients are clinically appropriate for Atrium Health Lake Norman. Patients in the PSA would be closer to Atrium Health Lake Norman than to any other Atrium Health Mecklenburg County hospital; thus, 80 percent of those patients are assumed to be served at Atrium Health Lake Norman. Some patients in the SSA are closer to Atrium Health Lake Norman and some are closer to existing Atrium Health Mecklenburg County hospitals; thus, 20 percent of those patients are assumed to be served at Atrium Health Lake Norman.

Based on these assumed percentages, Atrium Health determined the following number of patient days in CY 2018 that would be served by Atrium Health Lake Norman in future years.

Days of Care to be Served at Atrium Health Lake Norman

	CY 2018 Potential Days	*Percentage Served*	*Potential Days to be Served at Atrium Health Lake Norman*
PSA	4,671	80%	3,737
SSA	15,948	20%	3,190
Total	**20,619**		**6,926**

As shown, Atrium Health has identified 6,926 patient days to be served at Atrium Health Lake Norman, or approximately 34 percent of the 20,619 potential days originating from the selected geographies in CY 2018 that are clinically appropriate for the facility. Atrium Health conservatively assumes that the identified patient days will grow consistent with the projected annual population growth rate for the PSA and SSA as shown below based on Esri data.

Projected Population Growth

	2018	*2024*	*CAGR*
PSA Population	204,826	228,464	**2.21%**
SSA Population	140,208	152,127	**1.65%**

Source: Esri.

Atrium Health believes these projected growth rates are reasonable given that the historical growth in Atrium Health Lake Norman appropriate days of care served by Atrium Health Mecklenburg County hospitals has been 3.5 percent. The following table demonstrates the potential days of care that will shift to Atrium Health Lake Norman through CY 2025 based on the assumed growth rates. Please note that Atrium Health's analyses below consider the PSA and SSA separately given the differences in the patient population (e.g. the ALOS for SSA patients is higher than the PSA) and the size of the populations (e.g. Atrium Health Mecklenburg County hospitals have historically served a greater number of patients from the SSA given its population density and size, but Atrium Health Lake Norman projects to serve a proportionally higher number of patients from the PSA).

Potential Days of Care to be Served at Atrium Health Lake Norman

	CY19	*CY20*	*CY21*	*CY22*	*CY23*	*CY24*	*CY25*	*CAGR*
PSA	3,819	3,904	3,990	4,078	4,168	4,260	4,354	2.21%
SSA	3,242	3,295	3,350	3,405	3,461	3,518	3,576	1.65%
Total	**7,061**	**7,199**	**7,340**	**7,483**	**7,629**	**7,778**	**7,930**	

The proposed facility is expected to be operational on January 1, 2023. Upon opening, Atrium Health expects that the facility's utilization will ramp up over three years with 50 percent, 75 percent, and 100 percent of the potential days of care served in CY 2023 through 2025, respectively. The following table demonstrates the projected utilization of Atrium Health Lake Norman.

Projected Atrium Health Lake Norman Total Inpatient Bed Occupancy

	CY23	*CY24*	*CY25*
PSA Potential Days of Care	4,168	4,260	4,354
Ramp Up	50%	75%	100%
PSA Days of Care	**2,084**	**3,195**	**4,354**
SSA Potential Days of Care	3,461	3,518	3,576
Ramp Up	50%	75%	100%
SSA Days of Care	**1,730**	**2,638**	**3,576**
Total Days of Care	**3,814**	**5,833**	**7,930**
ADC	10	16	22
# of Beds	30	30	30
Occupancy	**34.8%**	**53.3%**	**72.4%**

As shown in the table above, Atrium Health Lake Norman projects to provide 7,930 patient days in its third year of operation at 72.4 percent occupancy of the 30 proposed acute care beds. While there are no applicable performance standards for Atrium Health Lake Norman, standing alone, the facility will exceed the target occupancy rate of 66.7 percent for hospitals with an ADC of 100 or less as identified by the *2019 SMFP*. Thus, Atrium Health Lake Norman demonstrates the need for its proposed beds.

In order to calculate projected total discharges, Atrium Health Lake Norman assumed that its average length of stay (ALOS) would be consistent with the CY 2018 ALOS for Atrium Health Lake Norman-appropriate inpatients in the PSA and SSA, 3.56 and 3.88 days, respectively. The table below provides projected acute care utilization at Atrium Health Lake Norman based on this assumption.

Projected Atrium Health Lake Norman Total Inpatient Utilization

	CY23	*CY24*	*CY25*
PSA Days of Care	2,084	3,195	4,354
PSA ALOS	3.56	3.56	3.56
PSA Discharges	**585**	**897**	**1,222**
SSA Days of Care	1,730	2,638	3,576
SSA ALOS	3.88	3.88	3.88
SSA Discharges	**446**	**680**	**922**
Total Discharges	**1,031**	**1,577**	**2,144**

In order to quantify the impact of this projected shift of acute care bed utilization to Atrium Health Lake Norman on other Atrium Health Mecklenburg County hospitals, Atrium Health analyzed the location of care for Atrium Health Lake Norman-appropriate patients that reside in the PSA or SSA in CY 2018, from page 4, as shown below.

CY 2018 Appropriate Days of Care to be Served at Atrium Health Lake Norman by Location of Care

	Total Days	*% of PSA/SSA*
PSA		
Atrium Health Pineville	121	2.6%
Atrium Health University City	1,297	27.8%
CMC	2,656	56.9%
Atrium Health Mercy	597	12.8%
PSA Total	**4,671**	**100.0%**
SSA		
Atrium Health Pineville	300	1.9%
Atrium Health University City	4,704	29.5%
CMC	7,501	47.0%
Atrium Health Mercy	3,443	21.6%
SSA Total	**15,948**	**100.0%**

Atrium Health assumes that days of care served by Atrium Health Lake Norman originating from the PSA and SSA will shift from existing Atrium Health Mecklenburg County hospitals proportional to their CY 2018 percentage of those days, as shown in table above. Based on this assumption, the table below reflects the expected shift of inpatient days from Atrium Health Mecklenburg County hospitals to Atrium Health Lake Norman.

Projected Shift of Acute Care Days by Hospital of Origin

	% of PSA/SSA	*CY23*	*CY24*	*CY25*
PSA				
Atrium Health Pineville	2.6%	54	83	113
Atrium Health University City	27.8%	579	887	1,209
CMC	56.9%	1,185	1,817	2,476
Atrium Health Mercy	12.8%	266	408	557
PSA Total	**100.0%**	**2,084**	**3,195**	**4,354**
SSA				
Atrium Health Pineville	1.9%	33	50	67
Atrium Health University City	29.5%	510	778	1,055
CMC	47.0%	814	1,241	1,682
Atrium Health Mercy	21.6%	374	570	772
SSA Total	**100.0%**	**1,730**	**2,638**	**3,576**
PSA/SSA Combined				
Atrium Health Pineville		**87**	**132**	**180**
Atrium Health University City		**1,089**	**1,665**	**2,264**
CMC		**1,999**	**3,058**	**4,158**
Atrium Health Mercy		**640**	**978**	**1,328**
Total		**3,814**	**5,833**	**7,930**

Obstetrics Beds at Atrium Health Lake Norman

To determine the projected utilization of its obstetrics beds, Atrium Health Lake Norman determined obstetrics days as a percentage of Atrium Health Lake Norman-appropriate acute care days in the PSA and SSA, respectively. In CY 2018, obstetrics days comprised 24.7 percent and 16.7 percent of Atrium Health Lake Norman-appropriate acute care utilization in the PSA and SSA, respectively. Based on this data, Atrium Health Lake Norman assumes that obstetrics days of care will comprise 24.7 percent of its projected PSA acute care utilization and 16.7 percent of its projected SSA acute care utilization as identified in the prior section. The following table demonstrates projected obstetrics utilization based on these assumptions.

Projected Atrium Health Lake Norman Obstetrics Bed Utilization

	CY23	***CY24***	***CY25***
PSA Days	2,084	3,195	4,354
PSA % Obstetrics Days	24.7%	24.7%	24.7%
PSA Obstetrics Days	**515**	**790**	**1,076**
SSA Days	1,730	2,638	3,576
SSA % Obstetrics Days	16.7%	16.7%	16.7%
SSA Obstetrics Days	**290**	**442**	**598**
Total Obstetrics Days	**805**	**1,231**	**1,674**

Given the seasonal nature of these services and the specialization of obstetrics units, Atrium Health Lake Norman believes the projected utilization is reasonable and provides flexibility to accommodate variation in patient demand.

ICU Beds at Atrium Health Lake Norman

To determine the utilization of its ICU beds, Atrium Health Lake Norman first calculated its non-obstetrics utilization (its combined medical/surgical and ICU utilization) by subtracting the obstetrics days of care projected in the section immediately above from its total projected days of care. As shown in the table below, Atrium Health Lake Norman projects 6,255 combined medical/surgical and ICU days in the third project year.

Projected Atrium Health Lake Norman Med/Surg and ICU Patient Day Utilization

	CY23	***CY24***	***CY25***
Total Days of Care	3,814	5,833	7,930
Obstetrics Days	805	1,231	1,674
Combined Med/Surg and ICU Days	**3,010**	**4,602**	**6,255**

In CY 2018, Atrium Health University City ICU days comprised 11.1 percent of its combined medical/surgical and ICU days. Atrium Health Lake Norman assumes that its ICU days as a percentage of combined medical/surgical and ICU days will be consistent with Atrium Health University City. The table below provides Atrium Health Lake Norman's projected ICU bed utilization through CY 2025 based on this assumption.

Projected Atrium Health Lake Norman ICU Bed Utilization

	CY23	*CY24*	*CY25*
Combined Med/Surg and ICU Days	3,010	4,602	6,255
ICU Days as % of Combined Med/Surg and ICU Days	11.1%	11.1%	11.1%
ICU Days	**333**	**509**	**692**

Given the specialization of ICU beds and the small size of the unit (four beds), Atrium Health Lake Norman believes the projected utilization is reasonable and provides flexibility to accommodate variation in patient demand.

Observation Beds at Atrium Health Lake Norman

To determine the utilization of its observation beds, Atrium Health Lake Norman analyzed Atrium Health University City's historical observation bed utilization. In CY 2018, Atrium Health University City provided nearly 3,902 observation days and 27,360 acute care days, or a ratio of 0.14 observation days to acute care days. Atrium Health Lake Norman assumes that its observation days will have a ratio of 0.14 to its acute care days based on Atrium Health University City's historical experience. The table below provides Atrium Health Lake Norman's projected observation bed utilization through CY 2025 based on this assumption.

Projected Atrium Health Lake Norman Observation Bed Utilization

	CY23	*CY24*	*CY25*
Total Patient Days	3,814	5,833	7,930
Ratio of Observation Days to Total Acute Care Days	0.14	0.14	0.14
Observation Days	**544**	**832**	**1,131**

In CY 2018, Atrium Health University City observation patients had an ALOS of 1.39 days. Atrium Health Lake Norman assumes that its observation patient ALOS will be consistent with Atrium Health University City's historical experience. The table below provides Atrium Health Lake Norman's projected observation ALOS and patients.

Projected Atrium Health Lake Norman Observation Patients

	CY23	*CY24*	*CY25*
Observation Days	544	832	1,131
Observation ALOS	1.39	1.39	1.39
Observation Patients	**393**	**601**	**816**

Operating Room Utilization

To determine the projected number of surgical cases to be performed at Atrium Health Lake Norman, Atrium Health conducted further analysis of the potential patients to be served at the proposed hospital. In CY 2018, surgical discharges comprised 17.2 percent and 9.9 percent of total Atrium Health Lake Norman-appropriate acute care discharges in the PSA and SSA, respectively. Please note these surgical discharges do not include C-Sections, which are discussed in a separate section below. Based on this data,

Atrium Health Lake Norman assumes that 17.2 and 9.9 percent of its projected discharges from the PSA and SSA, respectively, will be surgical cases, as shown in the table below. Atrium Health assumes that an inpatient surgical case in an operating room will be performed for each inpatient surgical discharge; as such the following analyses refer to inpatient surgical cases.

Projected Atrium Health Lake Norman Inpatient Surgical Cases

	CY23	*CY24*	*CY25*
PSA Discharges	585	897	1,222
PSA % Surgical	17.2%	17.2%	17.2%
PSA IP Cases	**101**	**155**	**211**
SSA Discharges	446	680	922
SSA % Surgical	9.9%	9.9%	9.9%
SSA IP Cases	**44**	**67**	**91**
Total IP Cases	**145**	**222**	**302**

In CY 2018, Atrium Health University City (excluding the operating rooms at Atrium Health Huntersville licensed under Atrium Health University City) performed 5,178 outpatient and 1,129 inpatient operating rooms cases, a ratio of 4.59 outpatient cases to inpatient cases. Atrium Health Lake Norman assumes that its outpatient to inpatient operating room case ratio will be consistent with Atrium Health University City's historical experience. The table below provides Atrium Health Lake Norman's projected inpatient and outpatient operating room cases.

Projected Atrium Health Lake Norman Inpatient and Outpatient Surgical Cases

	CY23	*CY24*	*CY25*
PSA IP Cases	101	155	211
SSA IP Cases	44	67	91
Ratio of IP to OP Cases	4.59	4.59	4.59
PSA OP Cases	462	709	966
SSA OP Cases	203	309	419
Total IP Cases	**145**	**222**	**302**
Total OP Cases	**665**	**1,018**	**1,385**

As noted throughout this application, the proposed Atrium Health Lake Norman will be licensed as part of Atrium Health University City. As such, the Operating Room Methodology in the *SMFP* will not distinguish between the two campuses but will evaluate their utilization in total. However, for purposes of demonstrating the need for the proposed operating rooms, Atrium Health has applied the Operating Room Methodology in the *SMFP* to Atrium Health Lake Norman separately from Atrium Health University City. According to Table 6B of the *2019 SMFP*, Atrium Health University City's final inpatient case time is 112.6 minutes and its final outpatient case time is 74.1 minutes. Using those case times to project estimated surgical hours, Atrium Health projects the following surgical hours through the project years for Atrium Health Lake Norman.

Projected Total Surgical Hours at Atrium Health Lake Norman

	CY24	*CY25*	*CY26*
Inpatient Surgical Cases	145	222	302
Outpatient Surgical Cases	665	1,018	1,385
Final Inpatient Case Time	112.6	112.6	112.6
Final Outpatient Case Time	74.1	74.1	74.1
Total Surgical Hours	**1,093**	**1,673**	**2,277**

According to the instructions in Section C.9, applicants are required to identify the facility's Group Assignment as reported in Table 6A in the *SMFP* in effect at the time the review begins. According to Table 6A in the *2019 SMFP*, Atrium Health University City is a Group 4 facility, Hospitals reporting less than 15,000 surgical hours. Group 4 hospitals have 1,500 standard hours per operating room per year.

Based on the projected surgical hours demonstrated above and its Group 4 standard hours per operating room per year, Atrium Health Lake Norman projects a need for 1.52 operating rooms, which demonstrates the need for the proposed two operating rooms.

Projected Operating Room Utilization at Atrium Health Lake Norman

	CY24	*CY25*	*CY26*
Total Surgical Hours	1,093	1,673	2,277
Standard Hours per OR per Year	1,500	1,500	1,500
Total Surgical Hours / Standard Hours per OR per Year	**0.73**	**1.12**	**1.52**
OR Capacity	2	2	2

Atrium Health assumes that the inpatient and outpatient surgical cases performed at Atrium Health Lake Norman will shift from other Atrium Health Mecklenburg County hospitals. Atrium Health assumes that inpatient and outpatient surgical cases performed by Atrium Health Lake Norman originating from the PSA and SSA will shift from existing Atrium Health Mecklenburg County hospitals proportional to its CY 2018 experience, as shown in the Acute Care Bed Utilization section above. Based on this assumption, the tables below demonstrate the expected shift of inpatient and outpatient operating room cases from Atrium Health Mecklenburg County hospitals to Atrium Health Lake Norman.

Projected Shift of Inpatient Cases by Hospital of Origin

	% of PSA/SSA	*CY23*	*CY24*	*CY25*
PSA				
Atrium Health Pineville	2.6%	3	4	5
Atrium Health University City	27.8%	28	43	58
CMC	56.9%	57	88	120
Atrium Health Mercy	12.8%	13	20	27
PSA Total	**100.0%**	**101**	**155**	**211**
SSA				
Atrium Health Pineville	1.9%	1	1	2
Atrium Health University City	29.5%	13	20	27
CMC	47.0%	21	32	43
Atrium Health Mercy	21.6%	10	15	20
SSA Total	**100.0%**	**44**	**67**	**91**
PSA/SSA Combined				
Atrium Health Pineville		**3**	**5**	**7**
Atrium Health University City		**41**	**63**	**85**
CMC		**78**	**120**	**163**
Atrium Health Mercy		**22**	**34**	**47**
Total		**145**	**222**	**302**

Projected Shift of Outpatient Cases by Hospital of Origin

	% of PSA/SSA	*CY23*	*CY24*	*CY25*
PSA				
Atrium Health Pineville	2.6%	12	18	25
Atrium Health University City	27.8%	128	197	268
CMC	56.9%	263	403	549
Atrium Health Mercy	12.8%	59	91	123
PSA Total	**100.0%**	**462**	**709**	**966**
SSA				
Atrium Health Pineville	1.9%	4	6	8
Atrium Health University City	29.5%	60	91	123
CMC	47.0%	95	145	197
Atrium Health Mercy	21.6%	44	67	90
SSA Total	**100.0%**	**203**	**309**	**419**
PSA/SSA Combined				
Atrium Health Pineville		**16**	**24**	**33**
Atrium Health University City		**188**	**288**	**392**
CMC		**358**	**548**	**746**
Atrium Health Mercy		**103**	**157**	**214**
Total		**665**	**1,018**	**1,385**

C-Section Room Utilization

To determine the projected utilization of its dedicated C-Section room, Atrium Health Lake Norman calculated its projected obstetrics discharges based on its projected obstetrics days shown in the Obstetrics Beds section above, and an assumed ALOS of 2.73 consistent with the CY 2018 ALOS for Atrium Health Lake Norman-appropriate obstetrics patients in the PSA and SSA. In order to calculate projected C-Sections, Atrium Health applied Atrium Health University City's historical ratio of C-Sections to obstetrics discharges (32.0 percent) to its projected obstetrics discharges. The following table demonstrates projected C-Section cases based on these assumptions.

Projected Atrium Health Lake Norman C-Section Room Utilization

	CY23	***CY24***	***CY25***
Obstetrics Days	805	1,231	1,674
ALOS	2.73	2.73	2.73
Obstetrics Discharges	294	450	613
C-Sections as % of Obstetrics Discharges	32.0%	32.0%	32.0%
C-Section Cases	**94**	**144**	**196**

Given the patient safety driven need to have a room available at a moment's notice for emergency C-Sections and the utilization of the two surgical operating rooms proposed for the hospital, Atrium Health Lake Norman needs one dedicated C-Section room.

Procedure Room Utilization

In order to project utilization for its procedure room, Atrium Health Lake Norman analyzed Atrium Health University City's historical procedure room utilization. Historically, Atrium Health University City's ratio of procedure room procedures to operating room cases is 0.78. Atrium Health applied this historical ratio to total operating room cases projected to be performed by Atrium Health Lake Norman in order to determine projected procedure room utilization, as shown below.

Projected Procedure Room Utilization at Atrium Health Lake Norman

	CY23	***CY24***	***CY25***
Operating Room Cases	810	1,240	1,687
Ratio of Procedure Room Procedures to Operating Room Cases	0.78	0.78	0.78
Procedure Room Procedures	**630**	**965**	**1,312**

Given the daily volume of procedures, 5.2 procedures per day (assuming 250 days per year) in the third year of operation, and the high utilization of the two surgical operating rooms proposed for the hospital, Atrium Health Lake Norman needs one procedure room to accommodate these cases.

Emergency Department Utilization

To determine its projected emergency department utilization, Atrium Health Lake Norman analyzed Atrium Health Mecklenburg County facility emergency visits in the PSA and SSA and assumed a consistent shift of utilization as shown below.

Potential Emergency Department Utilization at Atrium Health Lake Norman

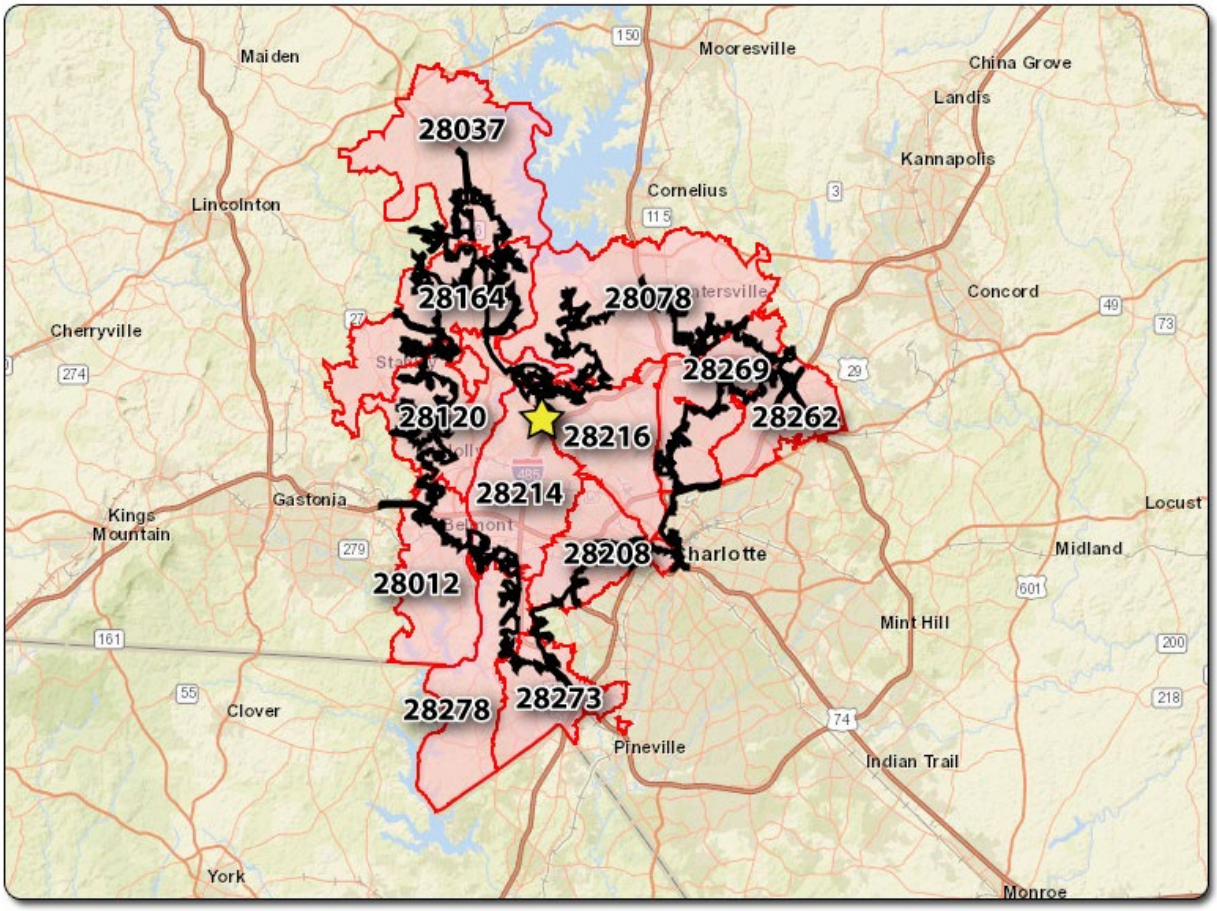
	CY 2018 Atrium Health Mecklenburg County ED Visits	*Percentage Served*	*Potential ED Visits to be Served at Atrium Health Lake Norman*
PSA	10,610	80%	8,488
SSA	35,026	20%	7,005
Total	**45,636**		**15,493**

As shown, Atrium Health has identified emergency department visits historically served by Atrium Health Mecklenburg County facilities that could be served at Atrium Health Lake Norman in future years. Atrium Health assumes that these identified emergency room visits will grow consistent with projected population growth in the PSA and SSA, respectively.

Potential Emergency Department Utilization at Atrium Health Lake Norman

	CY19	*CY20*	*CY21*	*CY22*	*CY23*	*CY24*	*CY25*	*CAGR*
PSA	8,675	8,867	9,063	9,263	9,468	9,677	9,890	2.21%
SSA	7,120	7,238	7,357	7,478	7,601	7,726	7,853	1.65%
Total ED Visits	**15,796**	**16,105**	**16,420**	**16,741**	**17,068**	**17,402**	**17,743**	

Atrium Health has been approved to develop Atrium Health Mountain Island, a freestanding emergency department in the Mountain Island area (Project ID # F-11658-19). As shown in that application and excerpted below, Atrium Health Mountain Island's proposed service area as defined by a 15-minute drive time from its location overlaps with several ZIP codes in the service area for Atrium Health Lake Norman.



According to its application, Atrium Health Mountain Island is expected to become operational in 2021. In its application, Atrium Health Mountain Island projected its impact on existing emergency departments, including Atrium Health facilities, based on existing hospitals' proportional market share of Atrium Health Mountain Island's proposed service area. As shown on page 19 of the Form C Assumptions and Methodology of its application, Atrium Health Mountain Island was projected to have the following impact on Atrium Health and other facilities.

Atrium Health Mountain Island Impact on Other Facilities

	2021	*2022*	*2023*
Carolinas Medical Center (incl. Levine's Children's and Behavioral Health)	-1,720	-1,970	-2,230
Atrium Health University City	-1,486	-1,702	-1,926
Novant Presbyterian	-1,399	-1,603	-1,814
CaroMont Regional Medical Ctr*	-1,273	-1,459	-1,651
Novant Huntersville	-1,113	-1,275	-1,443
Atrium Health Mercy	-671	-769	-870
Atrium Health Steele Creek	-616	-705	-798
Atrium Health Huntersville	-480	-550	-623
Atrium Health Pineville	-339	-389	-440
Atrium Health Lincoln	-189	-217	-245
Atrium Health Harrisburg	-118	-135	-153
Atrium Health SouthPark	-95	-109	-123
Atrium Health Cabarrus	-71	-82	-93
Novant Matthews	-63	-73	-82
Lake Norman Regional Medical Ctr	-43	-49	-56
Other	-298	-341	-386
Total	**-9,975**	**-11,428**	**-12,932**
Impact on Atrium Health Facilities	**-5,785**	**-6,628**	**-7,501**

Atrium Health assumed that the proposed impact would increase 1.8 percent annually through 2025 based on the population growth for Atrium Health Mountain Island's service area as stated in its application.

Projected Atrium Health Mountain Island Impact on Atrium Health Facilities

	2021	*2022*	*2023*	*2024*	*2025*	*CAGR*
Atrium Health Mountain Island Impact on Atrium Health Facilities	-5,785	-6,628	-7,501	-7,639	-7,780	1.8%

Out of an abundance of caution, given the proposed locations, Atrium Health assumes that all of this impact will occur in Atrium Health Lake Norman's service area and that all of those patients will be served at Atrium Health Mountain Island and not at Atrium Health Lake Norman. As such, Atrium Health assumes that Atrium Health Lake Norman's potential emergency room visits will be reduced in future years attributable to Atrium Health Mountain Island, as demonstrated in the table below.

Potential Emergency Department Utilization at Atrium Health Lake Norman

	CY23	*CY24*	*CY25*
Potential ED Visits	17,068	17,402	17,743
Impact of Atrium Health Mountain Island	-7,501	-7,639	-7,780
Adjusted ED Visits	**9,567**	**9,763**	**9,963**

Consistent with the facility ramp up assumptions, Atrium Health expects that the emergency department's utilization will ramp up over three years with 50 percent, 75 percent, and 100 percent of the potential visits served in CY 2023 through 2025, respectively. The following table demonstrates the projected emergency department utilization of Atrium Health Lake Norman.

Projected Atrium Health Lake Norman ED Utilization

	CY23	*CY24*	*CY25*
Adjusted ED Visits	9,567	9,763	9,963
Ramp Up	50%	75%	100%
Projected ED visits	4,784	7,322	9,963
# of ED rooms	10	10	10
# of ED visits per room	**478**	**732**	**996**

Based on ACEP guidelines (see Exhibit C.10), a facility with 10,000 projected annual visits should have between eight and 11 beds for a range of 909 to 1,250 visits per bed. As the utilization projections above demonstrate, Atrium Health Lake Norman's 10 emergency department rooms are projected to serve 9,963 visits by the third project year or 996 visits per room, which falls within the ACEP guidelines. Thus, Atrium Health Lake Norman will effectively utilize its proposed emergency department capacity.

Imaging and Ancillary Utilization

As discussed in Section C, a hospital is required to have sufficient imaging and ancillary services to support the inpatients, emergency patients, and outpatients utilizing the facility. Atrium Health Lake Norman is proposing to develop the necessary capacity to provide these services and to be reasonably utilized. It is important to note, however, that most of these services are needed and required to be provided at a hospital with the inpatient services proposed by Atrium Health, regardless of their utilization.

In order to project utilization for CT, ultrasound, X-ray, nuclear medicine, and mobile MRI services, Atrium Health Lake Norman analyzed Atrium Health University City's historical utilization of these services. Atrium Health Lake Norman compared Atrium Health University City's total inpatient discharges to its inpatient and outpatient volumes for each service. For inpatients, Atrium Health Lake Norman assumes that its ratio of inpatient procedures to inpatient discharges would equal that of Atrium Health University City.

Projected Inpatient Imaging and Ancillary Services at Atrium Health Lake Norman

Service	*Atrium Health University City CY18*	*Ratio to Discharges*	*Atrium Health Lake Norman*		
			CY23	*CY24*	*CY25*
Discharges	**6,968**		**1,031**	**1,577**	**2,144**
IP Lab	29,636	4.25	4,385	6,707	9,118
IP PT/OT/ST/Other	949	0.14	140	215	292
IP CT	3,864	0.55	572	874	1,189
IP MRI	1,338	0.19	198	303	412
IP X-Ray	6,750	0.97	999	1,527	2,077
IP Ultrasound	1,692	0.24	250	383	521
IP Nuclear Medicine	218	0.03	32	49	67

Source: Atrium Health internal data.
Note: Data does not include utilization attributable to Atrium Health Huntersville Health Pavilion.

For outpatient imaging and ancillary services, Atrium Health Lake Norman assumed that the Atrium Health University City ratio of outpatient procedures to inpatient procedures would equal that of Atrium Health Lake Norman with the exception of outpatient MRI, which is adjusted to reflect Atrium Health Lake Norman's more limited availability of a contracted mobile MRI service in comparison to Atrium Health University City's fixed scanner. The following table provides the resulting volumes.

Projected Outpatient Imaging and Ancillary Services at Atrium Health Lake Norman

Service	*Atrium Health University City CY18*	*Ratio to IP Procedures*	*Atrium Health Lake Norman*		
			CY23	*CY24*	*CY25*
OP Lab	320,491	10.81	47,419	72,526	98,602
OP PT/OT/ST/Other	2,163	2.28	320	489	665
OP CT	19,812	5.13	2,931	4,483	6,095
OP MRI	4,393	0.47*	93	142	193
OP X-Ray	36,878	5.46	5,456	8,345	11,346
OP Ultrasound	14,617	8.64	2,163	3,308	4,497
OP Nuclear Medicine	1,364	6.26	202	309	420

Source: Atrium Health internal data.
Note: Data does not include utilization attributable to Atrium Health Huntersville Health Pavilion.
*Adjusted to reflect Atrium Health Lake Norman's expected more limited availability of a contracted mobile MRI service in comparison to Atrium Health University City's fixed scanner

CT HECT Units

In order to determine HECT units as requested in Form C, Atrium Health Lake Norman applied Atrium Health University City's ratio of HECT units to CT scans per its 2019 Hospital License Renewal Application (1.614 HECT units per CT scan) to its projected number of CT scans, as shown in the table below.

Atrium Health Lake Norman CT Utilization

	CY23	*CY24*	*CY25*
Total CT Scans	3,503	5,358	7,284
HECT Units per Scan	1.614	1.614	1.614
HECT Units	**5,655**	**8,650**	**11,760**

The performance standard for a proposed CT scanner is 5,100 HECT units according to the Criteria and Standards for Computed Tomography Equipment at 10A NCAC 14C .2303. As shown above, the CT scanner to be operated by Atrium Health Lake Norman will operate above the 5,100 HECT unit utilization threshold.

Weighted MRI Procedures

In order to determine weighted MRI procedures as requested in Form C, Atrium Health Lake Norman applied Atrium Health University City's ratio of contrast/sedation procedures to total procedures by inpatient/outpatient type per its 2019 Hospital License Renewal Application to its projected number of inpatient and outpatient MRI scans.

Atrium Health Lake Norman MRI Utilization

	CY23	*CY24*	*CY25*
IP MRI procedures	198	303	412
IP % Contrast/Sedation	25.5%	25.5%	25.5%
IP With Contrast	**50**	**77**	**105**
IP No Contrast	**148**	**226**	**307**
OP MRI procedures	93	142	193
OP % Contrast/Sedation	32.1%	32.1%	32.1%
OP With Contrast	**30**	**46**	**62**
OP No Contrast	**63**	**96**	**131**
Total Weighted MRI Procedures*	**402**	**615**	**836**

*Weighted MRI procedures calculated based on the following weights: one outpatient MRI procedure without contrast or sedation is valued at 1.0 weighted MRI procedure, one outpatient MRI procedure with contrast or sedation is valued at 1.4 weighted MRI procedures, one inpatient MRI procedure without contrast or sedation is valued at 1.4 weighted MRI procedures, and one inpatient MRI procedure with contrast or sedation is valued at 1.8 weighted MRI procedures.

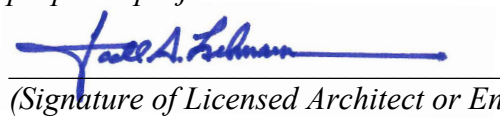
PROPOSED TOTAL CAPITAL COST OF PROJECT

Project name: 12 New Inpatient Beds

Provider/Company: Atrium Health

(1)	Purchase price of land	N/A
(2)	Closing costs	N/A
(3)	Site Preparation	$232,415
(4)	Construction/Renovation Contract	$5,355,473
(5)	Landscaping	$6,111
(6)	Architect/Engineering Fees	$475,490
(7)	Medical Equipment	$222,504
(8)	Non Medical Equipment	$56,296
(9)	Furniture	$30,643
(10)	Consultant Fees (CON Filing Fees and Legal Fees)	$150,000
(11)	Financing Costs	$33,270
(12)	Interest During Construction	$318,165
(13)	Other (IS, Security, Internal Allocation)	$350,735
(14)	**Total Capital Cost**	$7,231,102

I certify that, to the best of my knowledge, the above construction related costs of the proposed project named above are complete and correct.



September 3, 2019

(Signature of Licensed Architect or Engineer) *DATE*

Sales taxes have been included in these equipment costs. However, because Atrium Health is entitled to a sales tax refund under N.C. Gen. Stat. § 105-164.14(b) and 105-467, the sales tax that Atrium Health initially incurs for this medical equipment purchase will be refunded to Atrium Health, and thus will reduce the capital costs that Atrium Health actually incurs for the equipment by $11,681.

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

RE: Documentation of the Availability of Funds for Atrium Health Pineville Acute Care Beds CON

Dear Ms. Frisone:

As a requirement of the Certificate of Need process, I have been asked to document the availability of funds for the proposed project to develop 12 additional acute care beds at The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health Pineville.

As the Chief Financial Officer of The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health, formerly known as Carolinas HealthCare System, I am responsible for financial operations, and I am very familiar with the organization's financial position. The capital expenditure associated with this project is estimated to be $7,231,102. There are no working capital expenses required for the proposed project.

Atrium Health will fund the capital cost from existing accumulated cash reserves. This expenditure will not impact any other capital projects currently underway or planned at this time. For verification of the availability of funds and our ability to finance these projects internally, please refer to the Line Items "Cash and cash equivalents" and "Other assets: limited as to use," in the audited financial statements included with this CON application.

If any further information relating to financial operations is necessary for this CON application, please feel free to contact me.

Sincerely,

Anthony C. DeFurio
Executive Vice President and Chief Financial Officer
Atrium Health

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY

(d/b/a Atrium Health)

Basic Financial Statements and
Other Financial Information

December 31, 2018 and 2017

Report Thereon)

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Table of Contents

KPMG LLP
Duke Energy Center
Suite 3200
550 South Tryon Street
Charlotte, NC 28202-4214

Independent Auditors' Report

The Board of Commissioners
The Charlotte-Mecklenburg Hospital Authority:

We have audited the accompanying financial statements of The Charlotte-Mecklenburg Hospital Authority (d/b/a Atrium Health) and its discretely presented component unit, as of and for the years ended December 31, 2018 and 2017, and the related notes to the financial statements, which collectively comprise Atrium Health's basic financial statements for the years then ended as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the basic financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions

In our opinion, the basic financial statements referred to above present fairly, in all material respects, the respective financial position of The Charlotte-Mecklenburg Hospital Authority (d/b/a Atrium Health) and its discretely presented component unit as of December 31, 2018 and 2017, and the respective changes in financial position and cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that management's discussion and analysis on pages 3 through 17, the schedule of changes in the net pension liability and related ratios on page 75, the schedule of

pension contributions on page 76, and the schedule of pension plan investment returns on page 77 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of the financial reporting for placing the basic financial statements in an operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise Atrium Health's basic financial statements. The combining schedule of assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position – combined group, the combining schedule of revenues, expenses and changes in net position – combined group and the combining schedule of cash flows – combined group, for the years ended December 31, 2018 and 2017 (collectively the Combining Information) are presented for purposes of additional analysis and are not a required part of the basic financial statements. The Combining Information is the responsibility of management and derives from and related directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the Combining Information is fairly stated in all material respects in relation to the basic financial statements as a whole.

KPMG LLP

Charlotte, North Carolina
April 26, 2019

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)
Management's Discussion and Analysis - Unaudited
December 31, 2018 and 2017
(Dollars in thousands)

This Management's Discussion and Analysis provides an overview of the financial position and results of activities of Atrium Health, previously Carolinas HealthCare System (CHS), for the years ended December 31, 2018, 2017, and 2016. It has been prepared by management and is required supplemental information to the basic financial statements and the notes that follow this section. Except as otherwise noted, the financial highlights in this analysis refer exclusively to the Primary Enterprise as described in note 1 of the notes to basic financial statements.

Certain information set forth in the following discussion contains "forward-looking statements" regarding the future oriented financial information, business plans and the future performance of Atrium Health and the health care industry that are based on the beliefs and assumptions of the management of Atrium Health and the information available to management at the time that these disclosures were prepared. Words such as "expects," "plans," "believes," "will" and other similar expressions are intended to identify these forward-looking statements. Such statements are subject to factors that could cause actual results to differ materially from anticipated results. Readers are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date of this report. Actual results may differ materially from those expressed in or implied by any forward-looking statements. Atrium Health undertakes no obligation to revise or update publicly any forward-looking statements for any reason.

Atrium Health Overview

- In February 2018, Carolinas HealthCare System became Atrium Health, representing our commitment to improve health, elevate hope and advance healing – for all, beyond geographical borders. For more information on the organization, see note 1 of the notes to basic financial statements.
- In December 2018, Atrium Health and Navicent Health, Inc. (Navicent) signed a member substitution agreement, entering into a strategic combination, effective January 1, 2019 to enhance access, affordability, and equity of care for individuals and families in central and South Georgia. For more information on the arrangement, see note 1 of the notes to basic financial statements.

Atrium Health Financial Highlights

- For the year ended December 31, 2018, inpatient volumes, measured in discharges and observation stays (bedded discharges), were 183,368 or 2.1% over 2017 at the acute and tertiary care hospitals. Additionally, outpatient procedures, including surgeries, radiology, and endoscopies experienced growth from 2017.
- For the year ended December 31, 2017, bedded discharges, were 179,638 or 0.2% over 2016 at the acute and tertiary care hospitals. Additionally, outpatient procedures, including surgeries, radiology, and endoscopies experienced growth from 2016.
- For the year ended December 31, 2018, Medical Group patient visits were 5,278,014 or 1.0% less than 2017.
- For the year ended December 31, 2017, Medical Group patient visits were 5,331,134 or 4.1% greater than 2016 due in large part to an increase in providers.
- For the year ended December 31, 2018, net patient service revenue of $5,600,035 increased from 2017 by $197,294 or 3.7%. Total operating revenue in 2018 was $6,228,211. Total operating revenue consists of net patient revenue, grant revenue, pharmacy sales revenue, reimbursed services to affiliates and other revenue.

- For the year ended December 31, 2017, net patient service revenue of $5,402,741 increased from 2016 by $265,911 or 5.2%. Total operating revenue in 2017 was $5,965,573.
- For the year ended December 31, 2018, operating income was $247,846, a 4.1% increase over 2017 operating income of $238,018.
- For the year ended December 31, 2017, operating income was $238,018, a 10.4% increase over 2016 operating income of $215,520.
- For the year ended December 31, 2018, nonoperating loss, net was $325,479, a $874,219 decrease over 2017. This decrease was primarily due to unfavorable changes in the market value of investments in 2018.
- For the year ended December 31, 2017, nonoperating income, net was $548,740, a $300,685 increase over 2016. This increase was primarily due to favorable changes in the market value of investments in 2017.
- In September 2018, Atrium Health approved the project to prepare the Carolinas Medical Center (CMC) campus with necessary infrastructure and enabling upgrades to construct a new 12-story inpatient, surgical services and emergency services facility and to develop both a new Children's ambulatory destination center and pediatric ED/OR components of the bed tower. This project has a total budgeted cost of $756,900 and is expected to be complete in the years 2021 and 2025. $800 was incurred on this project during the year ended December 31, 2018.
- In September 2018, Atrium Health approved the project to construct a new Carolinas Rehabilitation-Charlotte facility, which includes a 78-bed inpatient hospital and outpatient rehabilitation clinics, to align rehabilitation with our world class service line approach as well as accommodate greater expected demand as acute care inpatient severity of illness rises with an aging population. This project has a total budgeted cost of $81,600 and is expected to be complete in year 2021. $477 was incurred on this project during the year ended December 31, 2018.
- In September 2018 and September 2017, Atrium Health approved components of a project to lease two new Medical Office Buildings located at the intersection of Kenilworth Avenue and Harding Place just north of Morehead St. in Charlotte, NC. The office buildings consolidate 13 medical groups, will create a flagship location for Sanger Heart and Vascular Institute's cardiovascular programs and will decompress CMC's campus. The project also supports the provider growth in central Charlotte. The project has a total budgeted cost of $75,000 and is expected to be completed in year 2020. $5,640 was incurred on this project during the year ended December 31, 2018.
- In September 2018, Atrium Health approved the project to construct a new 8-story inpatient and surgical facility on Atrium Health Pineville's campus. The new acute care tower will include 108 inpatient beds and expand surgical services to accommodate current and future need for inpatient services. The project has a total budgeted cost of $160,100 and is expected to be complete in year 2022. $1,099 was incurred on this project during the year ended December 31, 2018.
- In September 2018, Atrium Health approved the project to acquire multiple land tracts in several sub-markets that are of significant strategic value. This project has a total budgeted cost of $40,000 and is expected to be complete by year 2020. $4,085 was incurred on this project during the year ended December 31, 2018.
- In June 2017, Atrium Health approved the project to construct a new Medical Office Building on the campus of Atrium Health Pineville. This project was approved to support market growth for key service lines. The

project has a total budgeted cost of $100,000 and is expected to be completed in year 2020. $33,673 was incurred on this project during the year ended December 31, 2018.

- In June 2017, Atrium Health approved the project to either construct or lease a new Medical Office Building in Fort Mill located at the intersection of Highway 160 and Fort Mill Parkway in Fort Mill, South Carolina. This project was approved to support routine provider growth, decompress volume at other Atrium Health sites and add new specialty care services for the area. The project has a total budgeted cost of $55,000 if self-constructed or $22,000 if a Third Party develops and Atrium Health leases, but the total cost may be less, depending on the final size of the project, which is expected to be determined in the first half of 2019. The project is expected to be completed in year 2020. $80 was incurred on this project during the year ended December 31, 2018.
- In June 2017, Atrium Health approved the project to expand Foot and Ankle Operating Rooms (ORs) at Carolinas Medical Center (CMC) – Mercy, add a fourth OR and renovations to improve throughput in the OR. This project was approved to alleviate occupancy and OR utilization at CMC, improve utilization of the ORs and beds at CMC-Mercy, and expand OR capacity in the Central Division. The project has a total budgeted cost of $18,800 and is expected to be complete in year 2019. $1,890 was incurred on this project during the year ended December 31, 2018.
- In March 2016, Atrium Health approved the project to construct a second outpatient center for oncology services on the CMC campus. This project was approved to enhance Levine Cancer Institute's existing outpatient operations and develop a new 32 bed inpatient hematologic unit at CMC. The project has a total budgeted cost of $150,000 and is expected to be complete in year 2019. $68,754 was incurred on this project during the year ended December 31, 2018.
- In September 2014, Atrium Health approved the project to provide upgrades, renovations to existing areas within CHS NorthEast and new construction surrounding the cardiovascular service line. This project was divided into two phases. Phase I included renovation of Women's Service and was completed in year 2016. Phase II includes new construction of the tower for cardiology and the modernization of G, H and J wings. This project has a total budgeted cost of $141,400 and is expected to be complete in year 2021. $35,036 was incurred on this project during the year ended December 31, 2018.
- In December 2013, Atrium Health approved the project to replace Revenue Cycle technology to consolidate to one common system for both the Acute and Ambulatory environments. The project has a total budgeted cost of $92,600 and is expected to be complete in year 2019. $3,008 was incurred on this project during the year ended December 31, 2018.
- Atrium Health utilizes interest rate swaps to manage interest rate risk exposure on certain series of bonds. Interest rate swaps necessarily involve counterparty credit risk and Atrium Health seeks to control this risk by entering into transactions with high quality counterparties and through the monitoring of exposure to each counterparty. Atrium Health is a party to 14 floating-to-fixed rate payer swap agreements tied to the Series 2005 B, C and D Refunding Revenue Bonds, Series 2007 B and C Refunding Revenue Bonds and Series 2007 D, E, F, G and H Revenue Bonds. These agreements are used to create synthetic fixed rate bonds by converting the variable rates on those series to fixed rates. Therefore, cash flows on these agreements are recorded as interest expense. In January 2019, Atrium Health entered into a forward starting interest rate swap in connection with the planned synthetic fixed rate refunding of its Series 2011A Refunding Revenue

Bonds that are callable on January 15, 2021. These agreements are discussed in greater detail in note 5 of the notes to basic financial statements.

- In September and October 2018, Atrium Health completed updates with Moody's Investors Service (Moody's) and S&P Global Ratings (S&P), respectively. Moody's assigned a rating of Aa3 Stable on newly issued Series 2018 Revenue and Refunding Bonds and also affirmed its Aa3 Stable rating on previously issued Atrium Health bonds. S&P assigned a rating of AA- on newly issued Series 2018 Revenue and Refunding Revenue Bonds and also affirmed its AA- Stable rating on previously issued Atrium Health bonds.

Overview of the Basic Financial Statements

- This discussion and analysis is intended to serve as an introduction to Atrium Health's basic financial statements and the notes to the basic financial statements. This report also contains other required supplementary information in addition to the basic financial statements.
- The Governmental Accounting Standards Board (GASB) requires three financial statements: the statement of net position (balance sheet); the statement of revenues, expenses and changes in net position; and the statement of cash flows.
- The balance sheets; statements of revenue, expenses and changes in net position; and statements of cash flows are presented on an accrual basis, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP). This information provides an indication of Atrium Health's financial health. The balance sheets include all of Atrium Health's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, as well as an indication about which assets can be utilized for general purposes and which are restricted as a result of bond covenants or other agreements. The statements of revenue, expenses, and changes in net position report all of the revenue and expenses during the periods indicated. The statements of cash flows report the cash provided and used by operating activities, as well as other cash sources, such as investment income, and other cash uses, such as repayment of debt and purchase of capital.
- Notes to the basic financial statements provide additional information that is essential for a full understanding of the data provided in the basic financial statements. Required supplementary information relates to Atrium Health's progress in funding its obligation to provide pension benefits to its employees.

(Dollars in thousands)

Financial Analysis and Results of Operations

Assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position at December 31 are summarized in Table 1 and are discussed below:

Table 1 – Summary Balance Sheets

	2018	2017	2016
Current assets	$ 1,095,131	$ 1,124,103	$ 1,160,543
Capital assets – net	3,166,312	3,049,626	3,047,086
Other noncurrent assets	4,876,740	4,513,888	3,790,268
Total assets	9,138,183	8,687,617	7,997,897
Deferred outflows of resources	225,132	277,277	371,246
Total assets and deferred outflows of resources	$ 9,363,315	$ 8,964,894	$ 8,369,143

	2018	2017	2016
Current liabilities	$ 1,339,110	$ 1,024,356	$ 1,063,729
Long-term liabilities	2,874,989	2,728,365	2,906,362
Total liabilities	4,214,099	3,752,721	3,970,091
Deferred inflows of resources	65,086	58,330	39,530
Net investment in capital assets	1,231,053	1,185,504	1,147,721
Restricted – by donor	28,218	28,002	28,379
Unrestricted	3,824,859	3,940,337	3,183,422
Total net position	5,084,130	5,153,843	4,359,522
Total liabilities, deferred inflows of resources and net position	$ 9,363,315	$ 8,964,894	$ 8,369,143

Atrium Health classifies net position as net investment in capital assets, restricted – by donor, and unrestricted. The changes in net investment in capital assets over the three year period were driven by the issuance of the Series 2018 Revenue bonds, net of refunding the outstanding Series 2009 A Revenue bonds, debt principal payments and additional capital expenditures. The unrestricted net position decrease for the year ended December 31, 2018 was driven primarily by unfavorable investment returns offset by strong operating performance for the year.

(Continued)

The net position of Atrium Health at December 31, 2018 decreased $69,713 from December 31, 2017. The decrease in net position was due to nonoperating loss of $325,479, offset by positive results of operations of $247,846 and capital and other contributions of $7,920.

The net position of Atrium Health at December 31, 2017 increased $794,321 from December 31, 2016. The increase in net position was due to positive results of operations of $238,018, investment and other nonoperating income of $548,740, and capital and other contributions of $7,563.

Atrium Health's cash and investment position at December 31, 2018, 2017 and 2016 was $4,372,693, $4,338,138 and $3,645,910, respectively. Days cash on hand for the Combined Group, which consists of all entities that have either a direct obligation (Obligated Group) or indirect obligation (Designated Affiliates, of which there are currently none) to pay amounts due on Atrium Health's bonds, was 300, 312, and 278 at December 31, 2018, 2017 and 2016, respectively.

More detailed information about Atrium Health's cash, investments and other financial instruments is presented in notes 2 and 3 of the notes to basic financial statements.

(Dollars in thousands)

Revenue and Expenses

Revenue, expenses and changes in net position are summarized in Table 2 and are discussed below:

Table 2 – Statements of Revenues, Expenses, and Changes in Net Position

	2018	2017	2016
Operating revenues:			
Net patient service revenue	$ 5,600,035	$ 5,402,741	$ 5,136,830
Other revenue	628,176	562,832	520,571
Total operating revenue	6,228,211	5,965,573	5,657,401
Operating expenses:			
Personnel costs	3,505,673	3,461,411	3,305,457
Supplies	1,102,356	1,036,409	975,673
Purchased services	449,888	410,286	377,429
Other expenses	519,066	431,209	394,175
Depreciation and amortization	325,928	310,286	299,487
Interest expense	77,454	77,954	89,660
Total operating expenses	5,980,365	5,727,555	5,441,881
Operating income	247,846	238,018	215,520
Nonoperating (loss) income – net:			
Interest and dividend income	84,109	55,849	46,957
Net change in the fair value of investments	(404,748)	498,792	202,375
Other, net	(4,840)	(5,901)	(1,277)
Total nonoperating (loss) income – net	(325,479)	548,740	248,055
Revenue (under) over expenses before contributions	(77,633)	786,758	463,575
Capital contributions	8,282	7,651	5,945
Other contributions	(362)	(88)	124
(Decrease) increase in net position	(69,713)	794,321	469,644
Beginning net position	5,153,843	4,359,522	3,889,878
Ending net position	$ 5,084,130	$ 5,153,843	$ 4,359,522

(Continued)

Operating Revenue

Operating revenues in 2018 increased 4.4% from 2017 and in 2017 increased 5.4% from 2016, largely due to increases in hospital patient volumes and, in 2017, growth of the Medical Group. More detail of operating revenue can be found in notes 6 and 7 of the notes to basic financial statements.

Operating Expenses

Operating expenses in 2018 increased 4.4% from the prior year. Personnel costs, comprising 58.6% of the total Atrium Health operating expenses in 2018, increased due to 1.3% volume growth at the acute facilities, increases in Medical Group providers and staffing support, and annual market adjustments across Atrium Health. Other operating expenses, consisting primarily of pharmaceutical and supply costs, professional fees, rent and purchased services, increased 10.3%, primarily due to growth in patient volumes and inflationary cost increases, including the cost of new technologies, and increased legal and marketing fees.

Operating expenses in 2017 increased 5.2% from the prior year. Personnel costs, comprising 60.4% of the total Atrium Health operating expenses in 2017, increased 4.7% due to additional staffing to accommodate growth in the acute facilities, increases in Medical Group providers and volume growth, increased staffing to support the new providers and annual market adjustments across Atrium Health. Other operating expenses, consisting primarily of pharmaceutical and supply costs, professional fees, rent and purchased services, increased 7.5%, primarily due to growth in patient volumes and inflationary cost increases, including the cost of new technologies.

Nonoperating Income and Losses

Nonoperating income and losses, which consists primarily of realized and unrealized investment results, was impacted unfavorably in 2018 by the market value decline of Atrium Health's investments. As a governmental entity, Atrium Health is required to record all investment market value changes as a component of nonoperating income (loss).

Nonoperating activity from Atrium Health's equity, fixed income, and cash investments was a $320,639 loss in 2018 and a $554,641 gain in 2017. Nonoperating losses from Atrium Health's equity, fixed income and cash investments was $249,332 in 2016.

Interest and dividend income on Atrium Health's investment portfolio in 2018 was $84,109 and net realized and unrealized losses on the portfolio were $404,748. The net realized / unrealized losses were due to unfavorable performance in the fourth quarter, most notably in the decline in equities, which erased the positive year to date performance through the third quarter.

Interest and dividend income on the portfolio in 2017 was $55,849 and net realized and unrealized gains on the portfolio were $498,792. The net realized / unrealized gains were due to strong performance in the investment markets throughout the year, led by the equity portfolio, with 2017 total investment returns nearly double the investment returns of 2016.

Management presents portfolio performance to the Investment Oversight Committee of Atrium Health as well as the Board of Commissioners, on a quarterly basis. Management meets regularly with Atrium Health's investment consultant to review portfolio and investment manager performance and to identify and recommend changes to

(Dollars in thousands)

the investment strategy for consideration by the Investment Oversight Committee. Investment expenses consist of fees paid to Atrium Health's investment managers, investment consultant, and custodian.

Other net nonoperating expenses were $4,840, $5,901 and $1,277 for the years ended December 31, 2018, 2017 and 2016, respectively, due to capital disposals and donations.

Capital Assets and Debt Administration

Capital Assets

Capital assets, net of depreciation and impairment at December 31, 2018, 2017 and 2016 are summarized in Table 3 and are discussed below.

Table 3 – Capital Assets, Net of Depreciation and Impairment

	2018	2017	2016
Land	$ 219,986	$ 212,652	$ 197,514
Buildings and land improvements	3,429,518	3,341,291	3,226,186
Equipment	2,161,188	2,059,812	1,915,321
Construction in progress	409,162	211,774	217,626
Subtotal	6,219,854	5,825,529	5,556,647
Accumulated depreciation	(3,053,542)	(2,775,903)	(2,509,561)
Total	$ 3,166,312	$ 3,049,626	$ 3,047,086

During the current fiscal year, significant additions to capital assets in excess of $10,000 included the following:

Levine Cancer Institute	$ 68,754
CHS NorthEast Modernization	35,036
Atrium Health Pineville Medical Office Building	33,673

Ongoing capital requirements are funded from a combination of operating cash, debt proceeds, and contributions. Atrium Health's annual capital budget for 2018, 2017 and 2016 was $640,000, $527,500 and $470,184, respectively. Cash outflows related to capital additions, net of retirements, for 2018, 2017 and 2016 totaled $440,273, $300,869 and $300,859, respectively. Total depreciation expense on capital assets was $323,093, $308,171 and $297,892 for 2018, 2017 and 2016, respectively. At December 31, 2018, Atrium Health had planned future capital spending of approximately $3,099,210 for 2019-2023 for ongoing routine and significant strategic IT and facility expansion projects. More detailed information about Atrium Health's capital assets is presented in note 4 of the notes to the basic financial statements.

Long-Term Debt

Atrium Health can issue debt on behalf of Combined Group members as established under its Second Amended and Restated Bond Order, as further amended (the Bond Order).

- Atrium Health's debt service (scheduled principal and interest payments and net interest rate swap payments, excluding refinancing activity) for 2018, 2017 and 2016 totaled $126,070, $114,431 and $134,747, respectively.
- The actual annual debt service coverage ratio, as defined in the Bond Order, for 2018, 2017 and 2016 was 9.10, 8.56 and 6.18, respectively. The Bond Order requires an actual annual debt service coverage ratio of not less than 1.1.
- In November and December of 2018, Atrium Health issued $564,030 of Revenue and Refunding Revenue Bonds, a portion of which currently refunded $178,425 of the outstanding Series 2009A Revenue Bonds. The remainder of the funds will be used to pay certain expenses of issuing the bonds and to fund future capital investments.

More detailed information about Atrium Health's outstanding debt is presented in note 5 of the notes to the basic financial statements.

Events and Factors Expected to Impact Future Periods

Healthcare has historically been a capital-intensive industry that requires significant reinvestment to keep pace with patient care advancements and technology evolution in markets with growing populations. An entity's ability to re-invest to meet its long-term capital and program needs hinges largely on its ability to perform well financially. We believe that Atrium Health, with its geographic dispersion, world-class providers and specialty service lines, extensive primary care network and focus on growth, value and affordability, is well positioned to meet the demands of the fast-changing, capital-intensive industry in which we operate.

Recent years have seen growth in alternative payment models across substantially all payers as the industry is moving from traditional fee for service to models that emphasize value and quality of services. This transition is not without financial risk as these alternative payment models typically attribute a large percentage of potential reimbursement increases to the achievement of value-based targets or they will establish a fixed payment for an episode of care encompassing multiple different providers. We believe Atrium Health is well poised to provide value to its payers and consumers by excelling at delivering high-value patient care in financially sustainable models.

External pressures on revenue streams are not new to the industry as governmental payers have long tried to bend the growth curve in healthcare spending. North Carolina lawmakers approved a Medicaid reform plan in which provider-led entities and commercial insurers will co-exist in a fully capitated system expected to be operational in 2019. We believe healthcare providers, like Atrium Health, who are currently completing large scale data analytics, transforming care delivery and reducing the total cost of care will be more apt to withstand the future revenue pressures in a fully capitated Medicaid environment.

Employers have implemented high-deductible health plans and other plan design changes in an attempt to lower their health plan costs which, in turn, has led to greater consumerism. In a consumer-driven market, we believe that transparency, convenience and cost will ultimately drive consumers' decisions about their care, which means that becoming more accessible and affordable is critical to financial viability. Truly integrated systems, like Atrium Health, are best positioned to achieve sustainable efficiencies and reduce the cost of care for consumers.

From a Federal perspective, between CMS's proposed Medicare and Medicaid policy changes and the President's budget proposals for the upcoming year, there is heightened uncertainty on the future of Medicare and Medicaid reimbursement. At the state level, health policy discussions in North Carolina are ongoing and are related to critical issues such as Certificate of Need and Medicaid Expansion. Further, there is a transition in 2019 to Medicaid Managed Care and a proposal for significant reimbursement reductions in hospital payments from the State Health Plan for Teachers and State Employees. For the time being, we believe that the industry will remain in a period of great legislative uncertainty at the state and federal levels.

Atrium Health remains a financially viable entity with a strong governing board; an experienced management team; a broad, growing and connected continuum of highly specialized world-class clinical services, and a commitment to high levels of quality, safety, patient experience, cost efficiency and teammate engagement, which we believe, along with other attributes, will enable us to respond to future challenges and to be the first and best choice for care in the communities we serve.

Community Benefit

The mission of Atrium Health is to improve Health, elevate Hope and advance Healing – for all. Our commitment to this mission requires both "investments in" and "partnerships with" the community spanning the entire geographic region within which Atrium Health operates.

Atrium Health defines and measures Community Benefit consistent with the North Carolina Healthcare Association guidelines and includes costs associated with:

- patient care provided to uninsured and underinsured patients,
- medical education provided to the next generation of healthcare professionals,
- medical research to stay on the "cutting edge" for new treatments and cost effective care, volunteerism of Atrium Health teammates and contributions to community groups and local nonprofit organizations, and
- vital healthcare and community health improvement services as well as community building activities.

The community's uninsured and underinsured care constitutes both a challenge and an opportunity for Atrium Health. It is a challenge to ensure that the necessary clinical programs and facility infrastructures are in place to meet the demand for all patients. It is also an opportunity to provide access to needed healthcare services for the large uninsured and underinsured population. The cornerstone of Atrium Health's overall Community Benefit is its commitment to provide hospital and other healthcare services to all patients regardless of their ability to pay. North and South Carolina's Medicaid programs, while providing healthcare coverage for many of the poor, disabled, and elderly residents, do not cover all who are unable to pay for healthcare. Also, Medicaid, which reimburses healthcare providers at substantially less than actual cost and has not kept pace in recent years with the industry's rapidly rising cost of technology and enrollment. Within Mecklenburg, Cabarrus, Cleveland, Union, Lincoln, Stanly, and Anson counties, Atrium Health provides approximately 86% of the hospital services to the Medicaid and uninsured patient populations. In many cases, Atrium Health provides the only access to certain outpatient and physician specialty care for those in the community in need of financial assistance, as well as serving uninsured patients who are not eligible for financial assistance discounts, Medicaid, or other governmental funding. More detailed information about Atrium Health's net patient service revenue is presented in notes 1 and 6 of the notes to the basic financial statements.

Atrium Health operates often at a deficit, due to high levels of uninsured and underinsured patients, certain health services that are essential to the community. In 1993, the federal government, in conjunction with pharmaceutical companies, began a program to provide lower cost pricing for pharmaceutical purchases by healthcare facilities with large numbers of Medicaid patients. Identified as the 340B program, Congress' objective with the program was to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Carolinas Medical Center was an original safety-net hospital in the program and since then, six other Atrium Health hospitals have qualified for participation in the program. Those seven hospitals received a combined estimated value of $211 million in cost savings during 2018 thereby allowing opportunities for Atrium Health to enhance services for uninsured, underinsured, and Medicaid patients in the community such as: operating Atrium Health community clinics, which staff interpreters, dieticians, social workers, nurses and physicians, that provide free or nominally priced care for the most vulnerable in our community; providing dedicated pharmacists within these community clinics who offer medication assistance with education and treatment plans and operate clinic pharmacies where prescriptions can be filled for free or at a nominal price; operating in partnership with Cabarrus Health Alliance an obstetrics clinic for pregnant women without insurance; providing behavioral health services through multiple outlets including outreach and educational programs to the community, a call line available 24 hours a day at no charge to the client, and quality services to patients across Atrium Health's multiple healthcare treatment locations; operating the Carolinas Poison Center, one of 55 such centers in the United States certified by the American Association of Poison Control Centers, for the entire state of North Carolina whose mission is to serve the people and healthcare professionals of North Carolina by providing information and assistance in the prevention, treatment and surveillance of poisonings and overdoses; and operating numerous other community health improvement programs and community building activities as discussed below.

Atrium Health supports and subsidizes medical education and research, which benefits not only Atrium Health and the patients it serves, but the entire healthcare provider community. Carolinas Medical Center is the sponsoring institution for 40 training programs with 339 residents and fellows. In 2018, approximately 51% of the 122 residents and fellows that completed the program stayed in the Carolinas. Atrium Health continues to expand medical school access at the Charlotte campus of the University of North Carolina (UNC) School of Medicine by providing clinical education for medical students and growing the number of students that will be completing their third and fourth years of medical school. During the 2018-2019 academic year, the Charlotte campus of the UNC School of Medicine will have 26 full-time third year students and 287 fourth year students who will take advantage of CMC's medical student rotation options. The Family Medicine Residency program, Union Track, trains physicians to provide full-scope primary care to the underserved in small towns or rural settings. The program, which currently trains nine residents, is embedded in a local physician practice, and is designed as an "apprenticeship model" in which the residents learn by practicing side-by-side with private practitioners. CHS NorthEast sponsors the Cabarrus Family Medicine Residency Program and a primary care sports medicine fellowship. These two programs, accredited by the Accreditation Council for Graduate Medical Education, train 24 family medicine residents, and one sports medicine fellow each year. Since its inception in 1996, the Cabarrus Family Medicine Residency Program has graduated 152 family medicine residents, with 72% staying in the Carolinas to practice.

Through two of its hospitals, Atrium Health owns, operates and subsidizes two colleges that offer nursing and allied health programs culminating in certificates, diplomas and degrees at the associate, baccalaureate and master's degree levels. Carolinas College of Health Sciences, a part of Carolinas Medical Center, is located in Mecklenburg County, while Cabarrus College of Health Sciences, a part of CHS NorthEast, is located in Cabarrus County. In 2018, over 1,300 students were collectively enrolled in programs such as Nursing, Nurse Anesthetist, Surgical Technology, Pharmacy Technology, Clinical Laboratory Sciences, Interdisciplinary Health Studies, Radiation Therapy, Radiologic Sciences, Medical Assistant, and Occupational Therapy. With 385 graduates in 2018 alone, Atrium Health is one of the top producing nursing and allied health entities in North Carolina. Equally important, 88% of graduates accept positions in the Carolinas in their field of training providing a valuable workforce resource to alleviate projected clinical personnel shortages. In 2018, Carolinas College of Health Science was again ranked 14th nationally among trade schools by *Forbes*. Additionally, the Charlotte Area Health Education Center, operated and subsidized by Atrium Health, is the only organization providing continuing education to all area healthcare professionals from all settings, including hospitals, post-acute care and physician practices.

The ability to develop and advance medical discovery is a critical component to Atrium Health's giving back to the community locally, nationally and globally. As scientific technologies and medical breakthroughs advance, more patients experience enriched, longer lasting quality of life standards. The Division of Therapeutic Research and Development cultivates patient-centered projects that are clinically relevant and fundamentally important to improving healthcare quality and effectiveness. Research and other sponsored programs throughout Atrium Health, encompassing more than 250 investigators, almost 960 active research studies and programs and more than 3,100 patients participating in clinical trials, are focused on the development of new treatments, therapies, diagnostics, or devices as well as conducting population-based research, developing innovative care delivery models and analyzing healthcare economics. Atrium Health's research programs and initiatives leverage the scope and scale of the organization to provide patients with leading-edge treatments and therapies, as well as attract nationally respected physicians to the community.

Atrium Health and its team members together are "improving Health, elevating Hope and advancing Healing – for all" by becoming actively involved with, or contributing to, various organizations that seek to improve the overall health and well-being of the community. In 2018, Atrium Health teammates supported over 300 nonprofit organizations by volunteering nearly 45,000 work-hours in service projects including, but not limited to: distributing gifts across nine counties to more than 3,500 individuals and families as part of the *Holiday Cheer* project; providing 5,484 backpacks of nutritious food to low income children and families across the region; assembling non-perishable meal kits for disaster victims; sponsoring and delivering holiday meal kits to low income families and elderly citizens; engaging local schools in an educational and mentoring program designed to partner teammates with students through Big Brothers Big Sisters "Beyond School Walls" program and Tutor Charlotte reading programs; and contributing over 10,000 items during our Share the Warmth drive to Crisis Assistance Ministry and other non-profit organizations directly impacting over 300 individuals in our communities. Most of this volunteerism in 2018 was directed to organizations that support and promote community health priorities and other social determinants of health. In addition to teammate hours, Atrium Health also donated over $2 million in medical equipment, computer equipment and materials to international nonprofit organizations to help people in need as well as numerous other monetary and in-kind donations to local community partners such as The Spokes Group, MedAssist, Second Harvest Food Bank of Metrolina, and Crisis Assistance Ministry.

To further improve the physical, mental, and spiritual health of our community in 2018, Atrium Health:

- screened 2,935 athletes in Mecklenburg, Stanly, Union and Lincoln counties in North Carolina and York County in South Carolina during the annual Heart of a Champion Day and other sports screening events with 69 student athletes referred for additional medical evaluation,
- held 221 classes and trained 3,514 community members and Atrium Health teammates in the Mental Health First Aid program, a groundbreaking public education program that helps identify, understand, and respond to signs of mental illnesses and substance abuse disorders,
- added 17 new Faith Communities for a total of 142 in 10 counties within the Atrium Health Faith Community Health Ministry, a partnership program between Atrium Health and faith communities designed to promote better health through education, access to healthcare and encouragement toward wellness and wholeness,
- provided access to primary and specialty medical care to 8,287 eligible uninsured residents through Physician Reach Out in partnership with Care Ring,
- implemented and expanded the Healthy Together program to 26 schools where school leaders and staff committed to developing action plans to create policy, systems, and environmental changes. Atrium Health's efforts resulted in 13,105 students joining the 5-2-1-0 League and committing to the Healthy Together program focused on childhood obesity,
- and continued the One Charlotte Health Alliance partnership with Novant Health and Mecklenburg County Public Health to improve the health in Mecklenburg County's most vulnerable populations.

In addition to their time, Atrium Health teammates continue to donate millions of their own dollars to charitable organizations and other community based entities. In the 2018 Community Giving Campaign, Atrium Health teammates contributed over $3.59 million (not included in costs in note 1 of the notes to basic financial statements) to United Way and Arts Councils in Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanly, Union and York Counties and to Children's Miracle Network.

Additional detail regarding Atrium Health's financial commitment to the community (20.6% of the Primary Enterprise's operating expenses in 2018) is presented in note 1 of the notes to basic financial statements.

Finance Contact

Atrium Health's basic financial statements are designed to present users with a general overview of Atrium Health's finances and to demonstrate Atrium Health's accountability. If you have any questions about the report or need additional financial information, please contact the Group Vice President of Finance, Atrium Health, 1000 Blythe Boulevard, Charlotte, NC 28203.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Balance Sheets

December 31, 2018 and 2017

(Dollars in thousands)

Assets and Deferred Outflows of Resources	2018 Primary Enterprise	2018 Component Unit	2017 Primary Enterprise	2017 Component Unit
Current assets:				
Cash and cash equivalents	$ 82,900	$ 3,628	$ 131,540	$ 4,659
Short-term investments	—	9,180	198	10,329
Patient accounts receivable – net	720,375	—	729,164	—
Other accounts receivable	109,416	11,277	94,331	11,659
Assets limited as to use – investments	34,991	—	32,820	—
Inventories	71,863	—	67,405	—
Prepaid expenses	75,586	484	68,645	488
Total current assets	1,095,131	24,569	1,124,103	27,135
Capital assets	6,219,854	11,705	5,825,529	11,572
Accumulated depreciation	(3,053,542)	(7,064)	(2,775,903)	(6,445)
Total capital assets – net	3,166,312	4,641	3,049,626	5,127
Other noncurrent assets:				
Assets limited as to use:				
Bond proceeds held by trustee	304,424	—	—	—
Investments designated for capital improvements	4,245,909	—	4,175,386	—
Other long-term investments	43,884	265,333	31,014	285,768
Other assets limited as to use – investments	101,840	—	109,954	—
Other assets	180,683	36,966	197,534	37,236
Total other noncurrent assets	4,876,740	302,299	4,513,888	323,004
Total assets	9,138,183	331,509	8,687,617	355,266
Deferred outflows of resources	225,132	—	277,277	—
Total assets and deferred outflows of resources	$ 9,363,315	$ 331,509	$ 8,964,894	$ 355,266
Liabilities, Deferred Inflows of Resources and Net Position				
Current liabilities:				
Accounts payable	$ 349,043	$ 201	$ 261,025	$ 183
Salaries and benefits payable	391,554	—	323,837	—
Other liabilities and accruals	207,496	2,512	194,382	1,804
Estimated third-party payer settlements	220,035	—	176,647	—
Current portion of long-term debt	170,982	—	68,465	—
Total current liabilities	1,339,110	2,713	1,024,356	1,987
Long-term debt – less current portion	2,070,845	—	1,799,149	—
Interest rate swap liability	189,250	—	219,841	—
Pension liability	295,162	—	379,685	—
Other liabilities	319,732	3,114	329,690	3,310
Total liabilities	4,214,099	5,827	3,752,721	5,297
Commitments and contingencies (notes 1, 2, 5 and 9)				
Deferred inflows of resources	65,086	—	58,330	—
Net position:				
Net investment in capital assets	1,231,053	—	1,185,504	—
Restricted – by donor	28,218	303,100	28,002	317,524
Unrestricted	3,824,859	22,582	3,940,337	32,445
Total net position	5,084,130	325,682	5,153,843	349,969
Total liabilities, deferred inflows of resources and net position	$ 9,363,315	$ 331,509	$ 8,964,894	$ 355,266

See accompanying notes to basic financial statements.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Statements of Revenues, Expenses and Changes in Net Position

Years ended December 31, 2018 and 2017

(Dollars in thousands)

	2018		2017	
	Primary Enterprise	Component Unit	Primary Enterprise	Component Unit
Net patient service revenue	$ 5,600,035	$ —	$ 5,402,741	$ —
Other revenue	628,176	23,545	562,832	25,861
Total revenue	6,228,211	23,545	5,965,573	25,861
Operating expenses:				
Personnel costs	3,505,673	3,631	3,461,411	2,986
Supplies	1,102,356	—	1,036,409	—
Purchased services	449,888	—	410,286	—
Other expenses	519,066	31,244	431,209	31,254
Depreciation and amortization	325,928	637	310,286	637
Interest expense	77,454	—	77,954	—
Total operating expenses	5,980,365	35,512	5,727,555	34,877
Operating income (loss)	247,846	(11,967)	238,018	(9,016)
Nonoperating (loss) income:				
Interest and dividend income	84,109	4,538	55,849	2,517
Net change in the fair value of investments	(404,748)	(22,869)	498,792	37,891
Other – net	(4,840)	—	(5,901)	—
Total nonoperating (loss) income – net	(325,479)	(18,331)	548,740	40,408
Revenue (under) over expenses before contributions	(77,633)	(30,298)	786,758	31,392
Capital contributions	8,282	(981)	7,651	2,204
Other contributions	(362)	6,992	(88)	1,998
(Decrease) increase in net position	(69,713)	(24,287)	794,321	35,594
Net position:				
Beginning of year	5,153,843	349,969	4,359,522	314,375
End of year	$ 5,084,130	$ 325,682	$ 5,153,843	$ 349,969

See accompanying notes to basic financial statements.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Statements of Cash Flows

Years ended December 31, 2018 and 2017

(Dollars in thousands)

	2018		2017	
	Primary Enterprise	Component Unit	Primary Enterprise	Component Unit
Cash flows from operating activities:				
Receipts from third-party payers and patients	$ 5,653,467	$ —	$ 5,351,787	$ —
Payments to suppliers	(1,930,226)	(4,192)	(1,881,420)	(13,650)
Payments to employees	(3,474,959)	—	(3,503,421)	—
Other receipts – net	575,059	(16,941)	586,321	729
Net cash provided by (used in) operating activities	823,341	(21,133)	553,267	(12,921)
Noncapital financing activities				
Proceeds from the issuance of commercial paper	210,000	—	(135,000)	—
Retirements of commercial paper	(210,000)	—	135,000	—
Other activities	(6,683)	—	(3,052)	—
Net cash used in noncapital financing activities	(6,683)	—	(3,052)	—
Cash flows from capital and related financing activities:				
Purchase of capital assets	(440,273)	(151)	(300,869)	(70)
Donated funds designated for building and equipment purchases	8,812	1,052	5,652	1,275
Acquisition of health related businesses	—	—	(1,710)	—
Principal payments, refunding and retirements on short- and long-term debt	(217,044)	—	(198,385)	—
Interest payments on short- and long-term debt	(91,125)	—	(80,901)	—
Proceeds from issuance of long-term debt	590,251	—	164,855	—
Decrease in other assets affecting capital and related financing activities	—	9,024	23	648
Other contributions	—	6,991	(88)	1,998
Net cash (used in) provided by capital and related financing activities	(149,379)	16,916	(411,423)	3,851
Cash flows from investing activities:				
Withdrawal from investments limited as to use	—	—	—	9,000
Contributions to investments limited as to use	(401,614)	—	(152,500)	—
Investment earnings	(3,249)	3,186	4,676	43
Decrease in other trusteed assets	145	—	802	—
Purchase of investments	(6,777)	—	(2,955)	—
Net cash (used in) provided by investing activities	(411,495)	3,186	(149,977)	9,043
Net increase (decrease) in cash and cash equivalents	255,784	(1,031)	(11,185)	(27)
Cash and cash equivalents:				
Beginning of year	131,540	4,659	142,725	4,686
End of year	$ 387,324	$ 3,628	$ 131,540	$ 4,659
Reconciliation of cash and cash equivalents to the balance sheets:				
Cash and cash equivalents in current assets	$ 82,900	$ 3,628	$ 131,540	$ 4,659
Bond proceeds held by trustee	304,424	—	—	—
Total cash and cash equivalents	$ 387,324	$ 3,628	$ 131,540	$ 4,659
Reconciliation of operating income (loss) to net cash provided by (used in) operating activities:				
Operating income (loss)	$ 247,846	$ (11,967)	$ 238,018	$ (9,016)
Interest expense considered capital financing activity	77,454	—	77,954	—
Adjustments to reconcile operating income (loss) to net cash provided by (used in) operating activities:				
Depreciation and amortization	325,928	637	310,286	637
Decrease in patient accounts receivable – net	8,789	—	3,362	—
(Increase) decrease in inventories and other current assets	(25,096)	(10,504)	20,192	(4,257)
(Increase) decrease in other assets affecting operating activities	(2,065)	103	3,608	(173)
Increase (decrease) in accounts payable and other current liabilities	142,263	—	(37,089)	—
Increase (decrease) in other liabilities affecting operating activities	4,834	598	(45,571)	(112)
Increase (decrease) in estimated third party payer settlements	43,388	—	(17,493)	—
Net cash provided by (used in) operating activities	$ 823,341	$ (21,133)	$ 553,267	$ (12,921)

See accompanying notes to basic financial statements.

(1) Significant Accounting Policies

(a) Organization, Basis of Presentation, and Discretely Presented Component Unit

Atrium Health is one of the nation's leading and most innovative healthcare organizations, providing a full spectrum of healthcare and wellness programs throughout the Southeast region. Its diverse network of care locations includes academic medical centers, hospitals, freestanding emergency departments, physician practices, surgical and rehabilitation centers, home health agencies, nursing homes and behavioral health centers, as well as hospice and palliative care services. Atrium Health works to enhance the overall health and wellbeing of its communities through high quality patient care, education and research programs, and numerous collaborative partnerships. Atrium Health was organized in 1943 under the North Carolina Hospital Authorities Act. It is a public body and a body corporate and politic and, therefore, has been determined by the Internal Revenue Service to be exempt from federal and state income taxes. Atrium Health is headquartered in Charlotte, North Carolina.

For financial reporting purposes, Atrium Health is divided into the "Primary Enterprise" and "Component Unit." The Primary Enterprise consists of The Charlotte - Mecklenburg Hospital Authority (d/b/a Atrium Health) and all affiliates whose assets and income Atrium Health controls without limitation. The Atrium Health Foundation, Inc. (the Foundation), previously The Carolinas HealthCare System Foundation, Inc., Atrium Health's sole Component Unit, raises and holds economic resources for the direct benefit of Atrium Health. The Foundation operates to raise funds to enhance, promote and support medical services, scientific education and research. It solicits contributions for Atrium Health entities and, in the absence of donor restrictions, its Board of Directors has discretionary control over the amounts to be distributed. The Foundation is reported on a basis consistent with Atrium Health's calendar year and is discretely presented. Transactions between Atrium Health and the Foundation resulting in intercompany receivables, payables, revenues and expenses are not eliminated. Net capital and operating contributions to Atrium Health from the Foundation included in the statements of revenues, expenses and changes in net position were $32,563 and $29,646 for the years ended December 31, 2018 and 2017, respectively.

In February 2018, Atrium Health signed a Letter of Intent with Navicent Health, Inc. (Navicent), a nonprofit corporation headquartered in Macon, Georgia, to enter a strategic combination to enhance access, affordability, and equity of care for individuals and families in central and South Georgia. In December 2018, Atrium Health and Navicent signed an Agreement and Member Substitution (Agreement), effective January 1, 2019, pursuant to which AHNH Georgia, Inc., a newly-formed controlled affiliate of Atrium Health, became the sole corporate member of Navicent. Through this Agreement, Navicent will become a regional hub in, and an integral part of, the Atrium Health system. Under terms of the Agreement, Navicent retains and appoints a majority of its Board of Directors, but Atrium Health holds customary approval rights, including approving Navicent budgets and any borrowings or discharge of Navicent debt. In addition, Atrium Health agrees to ensure that Navicent does not default under any indebtedness agreements, notes or bonds, or other debt-related liabilities. On the effective date of the Agreement, Navicent became a component unit of Atrium Health and, because a controlled subsidiary of Atrium Health is the sole member of Navicent, its financial information will be blended with the Primary Enterprise for reporting periods beginning on or after January 1, 2019. Navicent reported net position of $1,131,222 and net patient service revenue of $628,327 as of and for its fiscal year ended September 30, 2017, in

accordance with accounting standards set by the Financial Accounting Standards Board. Atrium Health has committed to make certain capital expenditures at Navicent Health facilities that will equal at least $1,000,000 over the first 10 years following the combination. The source of the funds for these expenditures will include Navicent Health's existing cash and cash flows from the operations of Navicent Health following the closing of the transaction, but Atrium Health has committed to fund $425,000 of the total capital commitment.

Certain healthcare facilities in the Carolinas (the Regional Enterprise Facilities) are managed by Atrium Health or its affiliates pursuant to management agreements; however, only the management and contracted services fees earned by Atrium Health, not the financial position or results of operation of those facilities, are reflected in the financial statements of Atrium Health.

(b) The Combined Group

Atrium Health's Second Amended and Restated Bond Order authorizes the creation of a Combined Group, which consists of the Obligated Group and Designated Affiliates (there are no Designated Affiliates at this time). Only the Combined Group has a direct or indirect obligation to pay amounts due on Atrium Health's bonds. As of December 31, 2018 and 2017, the members of the Combined Group were substantially all of the members of the Primary Enterprise and the Foundation. There are some affiliates of the Primary Enterprise which are not part of the Combined Group. The affiliates that are part of the Primary Enterprise, but not part of the Combined Group, made up less than 1% of the total revenue and less than 1% of the total assets of the Primary Enterprise for each of the years ended December 31, 2018 and 2017. Supplemental financial information for the Combined Group as of and for the years ended December 31, 2018 and 2017 is presented as Other Financial Information following the notes to basic financial statements. In January 2018, Atrium Health admitted an entity into the Combined Group that is currently part of the Primary Enterprise but whose revenues and assets of less than 1% and 1% of the Primary Enterprise, respectively, are not material to Atrium Health.

(c) Recently Adopted Governmental Accounting Standards

In 2018, Atrium Health adopted GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. Statement 75 requires measurement and reporting of other postemployment benefits in a manner similar to pensions. The adoption of this Statement had no material impact on the basic financial statements of Atrium Health.

In 2018, Atrium Health adopted GASB Statement No. 85, *Omnibus 2017*, which addresses a variety of practice issues that relate to the application of certain GASB Statements. Those issues include blending component units, goodwill, fair value measurement and application, and postemployment benefits. The adoption of this Statement had no material impact on the basic financial statements of Atrium Health.

In 2018, Atrium Health adopted GASB Statement No. 86, *Certain Debt Extinguishment Issues*, which provides guidance for transactions in which cash and other monetary assets are placed in irrevocable trust for the sole purpose of extinguishing debt and for prepaid insurance on debt that is extinguished. The adoption of this Statement had no material impact on the basic financial statements of Atrium Health.

(Dollars in thousands)

(d) Basis of Accounting

The basic financial statements have been prepared on the accrual basis of accounting using the economic resources measurement focus in accordance with Generally Accepted Accounting Principles (GAAP) as prescribed by the GASB.

(e) Cash Equivalents

For purposes of the balance sheets and statements of cash flows, Atrium Health considers all investments purchased with a maturity of three months or less and which are not limited as to use to be cash equivalents.

(f) Patient Accounts Receivable – Net

Patient accounts receivable is recorded net of allowances for uncollectible accounts of approximately $607,000 and $521,000 at December 31, 2018 and 2017, respectively. Net patient revenue is shown net of provision for uncollectible accounts of $679,321 and $678,860 for the years ended December 31, 2018 and 2017, respectively.

(g) Other Accounts Receivable

Other accounts receivable consists primarily of amounts due from Regional Enterprise Facilities, other affiliates, federal and state governments and other nonpatient receivables from external parties.

(h) Capital Assets

Property, plant and equipment are stated at cost. Atrium Health capitalizes expenditures for equipment when the unit of acquisition cost is five hundred dollars or greater and the estimated useful life is greater than three years. Expenditures that materially increase values, change capacities, or extend useful lives are capitalized. Routine maintenance, repairs and replacements are charged to expense when incurred. Depreciation is determined using the straight-line method over the estimated useful lives of the depreciable assets.

Property classification	Estimated lives (years)
Land improvements	8–15
Buildings	5–40
Equipment	3–15

Atrium Health evaluates long-lived assets regularly for impairment. If circumstances suggest that assets may be impaired, an assessment of recoverability is performed prior to any write-down of assets. An impairment charge is recorded on those assets for which the estimated fair value is below its carrying amount. No material impairment charges to long-lived assets were recorded for the fiscal years ended December 31, 2018 and 2017.

(Dollars in thousands)

(i) Cost of Borrowing

Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the costs of acquiring these assets.

(j) Other Assets Limited as to Use – Investments

Other assets limited as to use include bond proceeds held by trustee until expended for capital additions in accordance with the requirements of the applicable bond agreements, amounts intended for future expenditures of Atrium Health, amounts Atrium Health holds as custodian and investments held in a revocable trust for the payment of contingencies not covered by insurance.

(k) Other Assets

Other assets consist of teammate benefit plan assets not subject to GASB Statement No. 68 and investments in certain healthcare-related businesses accounted for using the cost or equity method.

(l) Deferred Outflows of Resources

Deferred outflows of resources consist of the unamortized amounts related to long-term debt refunding transactions, the aggregate negative fair value of interest rate swaps that are effective hedges, benefit plan differences between expected and actual investment earnings, benefit plan differences between expected and actual experience related to demographic factors, benefit plan assumption changes and the excess cost of net position related to the acquisition of health-related businesses. The balance of the deferred outflows of resources at December 31, 2018 and 2017 is composed of the following:

	2018	2017
Refunding of debt	$ 205,172	$ 211,269
Aggregate (positive) negative fair value of interest rate swaps	(13,778)	7,597
Deferred outflows of resources related to Atrium Health DB Plan (note 8)	20,876	47,258
Deferred outflows of resources related to other plans (note 8)	1,864	4,263
Excess cost of net position acquired	10,998	6,890
	$ 225,132	$ 277,277

(m) Other Liabilities and Accruals

Other liabilities and accruals consists primarily of the current portion of benefit and incentive plan liabilities, current interest payable on long-term debt and other current accruals.

(n) Other Liabilities (Long-Term)

Other liabilities consist primarily of the long-term portions of self-insurance and benefit plan and incentive plan liabilities, a long-term liability payable to Union County (see note 9) and unearned rent. The provision for self-insurance claims includes estimates of the ultimate costs for both reported claims and claims incurred, but not reported.

(Dollars in thousands)

(o) Deferred Inflows of Resources

Deferred inflows of resources consist of the gain related to a 2008 sale-leaseback transaction, which is being amortized over the terms of the related leases, benefit plan differences between expected and actual experience related to demographic factors, and benefit plan assumption changes.

	2018	2017
Sale-leaseback gain	$ 21,736	$ 28,155
Deferred inflows of resources related to Atrium Health DB Plan (note 8)	36,877	27,132
Deferred inflows of resources related to other plans (note 8)	6,473	3,043
	$ 65,086	$ 58,330

(p) Net Position

The financial statements present net position at December 31, 2018 and 2017. Net position is categorized as net investment in capital assets, restricted – by donor, and unrestricted.

Net investment in capital assets consists of capital assets, net of accumulated depreciation, reduced by the outstanding balances of bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets. Restricted net position consists of assets generated from revenues that have third-party limitations on their use. Unrestricted net position has no third-party restrictions on use. When both restricted and unrestricted resources are available for use, generally it is Atrium Health's policy to use restricted resources first and then unrestricted resources when they are needed.

(q) Operating Revenues and Expenses

For purposes of financial reporting, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services, including interest costs, are reported as operating revenues and expenses; otherwise, they are reported as nonoperating income and losses.

(r) Financial Assistance and Community Benefit Costs

Atrium Health, under its coverage and financial assistance programs, provides care without charge or at discounted rates to certain uninsured patients as well as any patient, regardless of insurance coverage, who experiences financial hardship. Key elements used to determine eligibility for financial assistance include a patient's demonstrated inability to pay based on family size and household income relative to federal income poverty guidelines. Patients potentially eligible for other governmental programs, such as Medicaid, must pursue those options by fully cooperating in the eligibility process before receiving financial assistance from Atrium Health. Atrium Health's cost of care (estimated using applicable cost to charge ratios) extended to uninsured patients qualifying for financial assistance was $160,375 and $141,675 for the years ended December 31, 2018 and 2017, respectively.

(Dollars in thousands)

In addition to providing financial assistance to uninsured patients and in furtherance of its mission, Atrium Health provides a broad range of benefits and services, including medical education and research opportunities, to the community spanning the geographic region within which Atrium Health operates. These community benefits can be measured and categorized as follows:

- Unpaid Cost of Medicare and Medicaid Services – Represents the net unreimbursed cost, estimated using the applicable cost to charge ratios, of services provided to patients who qualify for federal and/or state government healthcare benefits.
- Community Benefit Programs – Includes the unreimbursed cost of various medical education programs, and costs of various research programs, nonbilled medical services, in-kind donations and other services that meet a community need, but do not pay for themselves and would not be provided if based solely on financial considerations alone.
- Cost of care extended to uninsured and underinsured patients who do not qualify for financial assistance, estimated using applicable cost to charge ratios.

The total estimated cost of financial assistance and the aforementioned programs and services that benefit the community is as follows for the years ended December 31:

	2018	2017
Cost of financial assistance to uninsured patients	$ 160,375	$ 141,675
Unpaid cost of Medicare and Medicaid services	712,124	715,394
Community benefit programs	101,010	102,820
Community benefit subtotal	973,509	959,889
Cost of care extended to uninsured and underinsured patients who do not qualify for financial assistance	260,863	239,324
Community benefit including cost of care for patients not qualifying for financial assistance	$ 1,234,372	$ 1,199,213
Percentage of the Primary Enterprise's operating expenses	20.6 %	20.9 %

(s) Capital Contributions and Grants

Funds donated to acquire property, plant and equipment are considered donations of capital and are included as a component of capital assets and net position.

(t) Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to makes estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting

period. Atrium Health considers critical accounting policies to be those that require more significant judgments and estimates in the preparation of its financial statements, including the following: recognition of net patient service revenues; valuation of accounts receivable, including contractual allowances and provisions for bad debts; reserves for losses and expenses related to teammate healthcare, professional liabilities, workers' compensation and general liabilities; valuation of pension and other retirement obligations; and estimated third-party payer settlements. Actual results could differ from those estimates.

(u) Future Accounting and Reporting Requirements

In 2017, the GASB issued Statement No. 83, *Certain Asset Retirement Obligations*, which establishes the definition of asset retirement obligations and guidelines for the recognition and disclosure of liabilities associated with the retirement of a tangible capital asset. The requirements of this Statement are required to be adopted no later than the year ending December 31, 2019. The adoption of this Statement is not expected to have a material impact on the basic financial statements of Atrium Health.

In 2017, the GASB issued Statement No. 84, *Fiduciary Activities*, which establishes criteria for identifying fiduciary activities of governments and how those activities should be reported. The requirements of this Statement are required to be adopted no later than the year ending December 31, 2019. Atrium Health has not yet determined the impact of this Statement on the basic financial statements.

In 2017, the GASB issued Statement No. 87, *Leases*, which requires recognition of certain lease assets and liabilities for leases that were previously classified as operating leases. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. The requirements of this Statement are required to be adopted no later than the year ended December 31, 2020. Atrium Health has not yet determined the impact of this Statement on the basic financial statements.

In 2018, the GASB issued Statement No. 88, *Certain Disclosures Related to Debt, Including Direct Borrowings and Direct Placements*, which provides guidance for additional disclosures in notes to government financial statements. The primary objective of this statement is to improve the information that is disclosed related to debt. The provisions of this Statement are required to be adopted no later than the year ended December 31, 2019. The adoption of this Statement is not expected to have a material impact on the basic financial statements of Atrium Health.

In 2018, the GASB issued Statement No. 89, *Accounting for Interest Cost Incurred before the End of a Construction Period*, which provides updated accounting requirements for interest cost incurred before the end of a construction period. This Statement requires that interest cost incurred before the end of a construction period be recognized as an expense in the period in which the cost was incurred. As a result, interest cost incurred before the end of a construction period will not be included in the historical cost of the related capital asset. The provisions of this Statement are required to be adopted no later than the year ended December 31, 2020. The adoption of this Statement will cause interest expense that is currently capitalized as part of the constructed cost of capital assets to be expensed in the period incurred (see note 4).

In 2018, the GASB issued Statement No. 90, *Majority Equity Interests—an amendment of GASB Statements No. 14 and No. 61*, which provides updated guidance related to a government's majority equity interest in a legally separate organization. This Statement requires that a majority equity interest in a legally separate organization should be reported as an investment if the equity holding meets the definition of an investment; otherwise, the government should report the legally separate organization as a component unit. The provisions of this Statement are required to be adopted no later than the year ended December 31, 2019. Atrium Health has not yet determined the impact of this Statement on the basic financial statements.

(v) Business Combinations and Certain Other Affiliations

Atrium Health accounts for the acquisition of healthcare-related businesses in accordance with GASB Statement No. 69. Any excess of purchase price over the net position acquired is recorded as a deferred outflow of resources and is attributed to future periods in a systematic manner based upon professional standards. Any purchase price in excess of net position acquired prior to January 1, 2013 is being amortized over periods that do not exceed 25 years. The results of operations of these acquired entities are included in Atrium Health's results of operations from the dates of acquisition.

(2) Cash, Investments and Other Financial Instruments

(a) Cash and Cash Equivalents

As of December 31, 2018, Atrium Health had cash and cash equivalents of $82,900 and $304,424 of bond proceeds. All of the bond proceeds and a portion of the cash and cash equivalents were invested with the North Carolina Capital Management Trust's Government Portfolio, which has a rating of AAAm from S&P Global Ratings, and a portion of the cash and cash equivalents was invested with the North Carolina Capital Management Trust's Term Portfolio, which is not rated but has maintained a stable net asset value since 2011. As of December 31, 2017, Atrium Health had cash and cash equivalents of $131,540 of which a portion was invested with the North Carolina Capital Management Trust's Government Portfolio and a portion was invested with the North Carolina Capital Management Trust's Term Portfolio.

For cash and cash equivalents, Atrium Health follows North Carolina General Statute 159-30, whereby all deposits of Atrium Health are held in depositories that are either insured or covered under statewide single financial institution collateral pools (the Pooling Method). Collateral is maintained for all the depositories' governmental units in the state. The North Carolina State Treasurer monitors the Pooling Method depositories for adequate collateralization. Under the Pooling Method, all uninsured deposits are collateralized with securities held by the State Treasurer's agent in the name of the State Treasurer. The amount of the pledged collateral is based on an approved averaging method for noninterest-bearing deposits and the actual current balance for interest-bearing deposits. Depositories using the Pooling Method report to the State Treasurer the adequacy of their pooled collateral covering uninsured deposits. The State Treasurer does not confirm this information with Atrium Health. Because of the inability to measure the exact amount of collateral pledged for Atrium Health under the Pooling Method, the potential exists for under collateralization, and this risk may increase in periods of high cash flows. However, each Pooling Method Depository is subject to financial stability standards and oversight by the State Treasurer of North Carolina.

(b) Investments Designated for Capital Improvements and Other Assets Limited as to Use

Atrium Health may, for funds not required for immediate disbursement, make investments that are permissible for trustees, executors, and other fiduciaries under North Carolina law. Funds that are not needed for immediate operating needs and that have been designated by the Board of Commissioners for capital improvements, along with other trusteed assets, are invested in cash equivalents, fixed income securities, equity securities, equity securities held in common collective trust funds, a real asset mutual fund and limited partnerships. Investments included in the portfolio are reflected at fair value at the balance sheet date, as noted in the table below, with gains and losses reflected in nonoperating income (loss) in the accompanying statements of revenues, expenses and changes in net position.

Atrium Health operates a regional integrated healthcare system, which has significant capital needs arising from both changes in medical technology and a growing demand for healthcare services. At December 31, 2018, the fair value of investments designated for capital improvements of $4,245,909 is substantially less than the historical cost of property, plant and equipment of $6,219,854.

Atrium Health's investments designated for capital improvements and other assets limited as to use (Bond proceeds held by trustee, Other long-term investments and Assets limited as to use – current and noncurrent), based on fair value as of December 31, 2018, and organized by investment type to provide an indication of the level of investment and deposit risks assumed, are as follows:

(Dollars in thousands)

	Ratings by nationally recognized agency	Effective duration in years	Designated for capital improvements	Other assets limited as to use
Cash equivalents			$ 158,080	$ 320,423
Fixed income:				
U.S. government treasuries and agencies	AA	8.26	219,953	9,925
	BBB	10.82	167	—
Mortgage pass-throughs	AAA	4.15	38,487	3,124
	AA	5.36	69,101	3,912
	A	3.19	1,683	242
Collateralized mortgage obligations	AAA	3.31	6,377	506
Corporate bonds	AAA	15.27	1,855	34
	AA	4.62	28,878	781
	A	3.42	143,400	5,036
	BBB	5.48	113,941	8,628
	BB	13.51	299	24
Municipal bonds	AAA	5.62	5,406	273
	AA	7.67	12,400	977
	A	7.18	4,054	93
	BBB	2.10	1,413	40
Asset-backed securities	AAA	1.86	42,425	3,382
	AA	4.01	17,470	927
	BBB	5.08	1,191	169

(Continued)

(Dollars in thousands)

	Ratings by nationally recognized agency	Effective duration in years	Designated for capital improvements	Other assets limited as to use
Fixed income – other	N/A	3.61	$ 382,731	$ 3,902
Long/short fixed income	N/A	N/A	280,992	8,919
Total fixed income (weighted average duration)		4.91	1,372,223	50,894
Equity:				
Domestic equities			1,192,437	34,538
International equities			620,817	20,039
Global equities			670,368	16,225
Total equity			2,483,622	70,802
Real asset funds			123,519	3,932
Multi-strategy hedge funds			306	2,391
Commodity funds			88,221	3,529
Private equity funds			19,938	33,168
Total reported value			$ 4,245,909	$ 485,139

(Continued)

(Dollars in thousands)

Atrium Health's investments designated for capital improvements and other assets limited as to use (Other long-term investments and Assets limited as to use – current and noncurrent), based on fair value as of December 31, 2017, and organized by investment type to provide an indication of the level of investment and deposit risks assumed, are as follows:

	Ratings by nationally recognized agency	Effective duration in years	Designated for capital improvements	Other assets limited as to use
Cash equivalents			$ 170,780	$ 17,248
Fixed income:				
U.S. government treasuries and agencies	AA	7.46	128,119	9,518
	A	9.82	54	72
	BBB	6.57	1,429	—
Mortgage pass-throughs	AAA	4.44	31,115	2,664
	AA	3.83	83,702	1,947
	A	3.99	918	—
	BBB	4.74	539	—
	B	3.19	1,242	—
	CCC	4.79	156	—
Collateralized mortgage obligations	AAA	2.49	4,310	416
	AA	3.25	6,567	417
	A	3.69	317	—
	BBB	6.31	2,552	127
Corporate bonds	AAA	13.15	4,022	181
	AA	7.66	13,230	834
	A	6.38	62,996	3,822
	BBB	5.97	118,699	7,477
	BB	5.47	8,467	—
	B	7.44	481	—
Municipal bonds	AAA	5.68	5,525	281
	AA	8.83	12,810	680
	A	4.93	3,363	122
	BBB	1.35	1,120	60
Asset-backed securities	AAA	1.81	42,469	3,026
	AA	3.66	20,196	1,043
	A	3.97	9,446	736
	BBB	5.84	999	137

(Continued)

(Dollars in thousands)

	Ratings by nationally recognized agency	Effective duration in years	Designated for capital improvements	Other assets limited as to use
Fixed income – other	N/A	3.62	$ 327,140	$ 3,167
Long/short fixed income	N/A	N/A	255,981	9,244
Total fixed income (weighted average duration)		5.26	1,147,964	45,971
Equity:				
Domestic equities			1,268,733	39,291
International equities			685,209	23,246
Global equities			645,427	18,391
Long/short equity			4,023	246
Total equity			2,603,392	81,174
Real asset funds			103,697	3,581
Multi-strategy hedge funds			21,420	2,402
Commodity funds			103,603	4,144
Private equity funds			24,530	19,268
Total reported value			$ 4,175,386	$ 173,788

(c) Custodial Credit Risk

Custodial credit risk is the risk that Atrium Health will not be able to recover the value of its bank deposits, which are exposed to custodial credit risk if they are uninsured and uncollateralized. As of December 31, 2018 and 2017, all of Atrium Health's bank deposits were either insured by federal depository insurance or collateralized by the Pooling Method.

Fixed income investments and equity securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of Atrium Health, and are held by either the counterparty or the counterparty's trust department or agent, but not in Atrium Health's name. As of December 31, 2018 and 2017, all of Atrium Health's fixed income investments and equity securities are held by Atrium Health's custodial bank in Atrium Health's name and are, therefore, not exposed to custodial credit risk.

(d) Credit Risk

With respect to fixed income investments, credit risk is the risk that an issuer or other counterparty to an investment will not fulfill their obligations as required by the fixed income security. Atrium Health's investment policy requires that the overall average credit quality of the core fixed income portfolios must be maintained at AA or higher, and the overall average credit quality of the core plus fixed income portfolios must be maintained at A or higher. As of December 31, 2018 and 2017, Atrium Health's fixed

income portfolio met these overall average requirements. The quality ratings of Atrium Health's investments in fixed income securities (excluding long/short fixed income), as determined by nationally recognized statistical rating organizations, are disclosed in the preceding tables.

(e) Concentration of Credit Risk

Credit concentration risk results from not adequately diversifying investments. Per Atrium Health's investment policy, equity and fixed income restrictions include, (1) no more than 7% of any investment manager's equity portfolio may be invested in securities of any one issuing corporation, and (2) fixed income investments in any single issuer (excluding obligations of the U.S. government and its agencies) may not exceed 5% of any investment manager's portfolio market value at the time of purchase. Although exceptions to these policy restrictions are at times granted to investment managers, at no time may an investment in any one corporation exceed 5% of that corporation's outstanding shares while fixed income investments in any single issuer (excluding obligations of the U.S. government and its agencies) may not exceed 5% of the total issue at the time of purchase. At December 31, 2018 and 2017, no investment in any one corporation or single issuer exceeded allowable thresholds.

(f) Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of a fixed income investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. Atrium Health monitors the interest rate risk inherent in its fixed income portfolio by measuring the effective duration in years, which measures the expected change in value of a fixed income security or portfolio for a given change in interest rates.

As a means of limiting interest rate risk, Atrium Health's investment policy (excluding long/short fixed income) limits the effective duration in years of the core fixed income portfolio to a range of 75% to 125% of the duration of its benchmark (Barclay's Capital Aggregate Bond Index) and limits the effective duration in years of the core plus fixed income portfolio to a range of 0% to 150% of the duration of its benchmark (blend of Barclay's Capital Aggregate Bond Index, Barclays Capital Government/Credit Bond Index and Citi World Government Bond Index (WGBI)) at all times.

As noted in the December 31, 2018 table above, the effective duration in years of Atrium Health's total core and core plus fixed income portfolios was 4.91 years while the Barclays Capital Aggregate Bond Index's effective duration was 5.9 years and the blend of the Barclay's Capital Aggregate Bond Index, Barclay's Capital Government/Credit Bond Index and the Citi WGBI was 7.8 years.

As noted in the December 31, 2017 table above, the effective duration in years of Atrium Health's total core and core plus fixed income portfolios was 5.26 years while the Barclays Capital Aggregate Bond Index's effective duration was 6.00 years and the blend of the Barclay's Capital Government/Credit Bond Index and the Citi WGBI was 7.91 years.

Atrium Health's fixed income investments also include asset-backed securities that are sensitive to interest rate fluctuations due to embedded prepayment options.

(g) Foreign Currency Risk

Foreign currency risk is the chance that changes in exchange rates will adversely affect the fair value of investments and deposits. Atrium Health's investment policy limits foreign currency investments to international and global managers who can utilize such investments for currency hedging purposes only.

At December 31, 2018, Atrium Health had $198,023 of exposure to foreign currency risk in the form of cash and cash equivalents of $1,074, mutual funds of $58,767 (including approximately 98% in the British Pound and approximately 2% in the Canadian Dollar) and common stock in foreign currencies of $138,182 (including approximately 18% in the Euro, approximately 14% in the Japanese Yen, approximately 31% in the British Pound, and the remaining 37% spread over other common stock in foreign currencies, none of which exceed 10%).

At December 31, 2017, Atrium Health had $199,560 of exposure to foreign currency risk in the form of cash and cash equivalents of $525, mutual funds of $98,953 (including approximately 99% in the British Pound and approximately 1% in the Canadian Dollar) and common stock in foreign currencies of $100,082 (including approximately 22% in the Euro, approximately 19% in the Japanese Yen, approximately 14% in the British Pound, approximately 12% in the South African Rand, and the remaining 33% spread over other common stock in foreign currencies, none of which exceed 10%).

(3) Fair Value Measurements

U.S. GAAP defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants at the measurement date. Additionally, the inputs used to measure fair value are prioritized based on a three-level hierarchy that requires entities to maximize the use of observable inputs and minimize the use of unobservable inputs. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. The following describes the three levels of inputs used to measure fair value on a recurring basis:

Level 1 – Level 1 inputs are unadjusted quoted market prices in active markets for identical assets or liabilities that are available as of the measurement date.

Level 2 – Level 2 inputs are inputs other than quoted prices included in Level 1 that are observable for the asset or liability through corroboration with market data at the measurement date.

Level 3 – Level 3 inputs are unobservable inputs that reflect Atrium Health management's best estimate of what market participants would use in pricing the asset or liability at the measurement date. Level 3 assets include financial instruments whose values are determined using pricing models, discounted cash flow methodologies, or similar techniques, or for which the determination of fair value requires significant management judgment or estimation.

Investments that do not have a readily determinable fair value are reported using net asset value (NAV) as a "practical expedient" as outlined in GASB 72.

(Dollars in thousands)

Although Atrium Health management believes the fair value accounting estimates reflected in its financial statements are reasonable, there can be no assurances that Atrium Health could ultimately realize these values.

The fair value hierarchy classification of Atrium Health's assets measured at fair value as of December 31, 2018 is summarized in the table below:

			Fair value at reporting date using		
	Designated for capital improvements	Other assets limited as to use	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Investments by fair value level:					
Cash equivalents	$ 158,080	$ 320,423	$ 478,503	$ —	$ —
Fixed income:					
U.S. government treasuries and agencies	220,120	9,925	—	230,045	—
Mortgage pass-throughs	109,271	7,278	—	116,549	—
Collateralized mortgage obligations	6,377	506	—	6,883	—
Corporate bonds	288,373	14,503	—	302,876	—
Municipal bonds	23,273	1,383	—	24,656	—
Asset-backed securities	61,086	4,478	—	65,564	—
Fixed income – other	382,731	3,902	386,633	—	—
Total fixed income	1,091,231	41,975	386,633	746,573	—
Equity:					
Domestic equities	1,192,437	34,538	1,226,975	—	—
International equities	620,817	20,039	640,856	—	—
Global equities	482,888	11,121	494,009	—	—
Total equity	2,296,142	65,698	2,361,840	—	—
Real asset funds	123,519	3,932	127,451	—	—
Total investments by fair value level	3,668,972	432,028	$ 3,354,427	$ 746,573	$ —

(Continued)

(Dollars in thousands)

			Fair value at reporting date using		
	Designated for capital improvements	**Other assets limited as to use**	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Investments measured at the NAV:					
Global equities	187,480	5,104			
Long/short fixed income	280,992	8,919			
Multi-strategy hedge funds	306	2,391			
Commodity funds	88,221	3,529			
Private equity funds	19,938	33,168			
Total investments measured at the NAV	576,937	53,111			
Total investments measured at fair value	$ 4,245,909	$ 485,139			

(Continued)

(Dollars in thousands)

The fair value hierarchy classification of Atrium Health's assets measured at fair value as of December 31, 2017 is summarized in the table below:

			Fair value at reporting date using		
	Designated for capital improvements	Other assets limited as to use	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Investments by fair value level:					
Cash equivalents	$ 170,780	$ 17,248	$ 188,028	$ —	$ —
Fixed income:					
U.S. government treasuries and agencies	129,602	9,590	—	139,192	—
Mortgage pass-throughs	117,672	4,611	—	122,283	—
Collateralized mortgage obligations	13,746	960	—	14,706	—
Corporate bonds	207,895	12,314	—	220,209	—
Municipal bonds	22,818	1,143	—	23,961	—
Asset-backed securities	73,110	4,942	—	78,052	—
Fixed income – other	327,140	3,167	330,307	—	—
Total fixed income	891,983	36,727	330,307	598,403	—
Equity:					
Domestic equities	1,268,733	39,291	1,308,024	—	—
International equities	685,209	23,246	708,455	—	—
Global equities	421,509	12,272	433,781	—	—
Total equity	2,375,451	74,809	2,450,260	—	—
Real asset funds	103,697	3,581	107,278	—	—
Total investments by fair value level	3,541,911	132,365	$ 3,075,873	$ 598,403	$ —
Investments measured at the NAV:					
Global equities	223,918	6,119			
Long/short fixed income	255,981	9,244			
Long/short equity	4,023	246			
Multi-strategy hedge funds	21,420	2,402			
Commodity funds	103,603	4,144			
Private equity funds	24,530	19,268			
Total investments measured at the NAV	633,475	41,423			
Total investments measured at fair value	$ 4,175,386	$ 173,788			

(Continued)

(Dollars in thousands)

Fixed income and equity securities classified in Level 1 of the fair value hierarchy are valued using prices quoted in active markets for those securities. Atrium Health accounts for these investments through the use of quoted market prices for those investments with readily determinable fair values. Fixed income and equity securities classified in Level 2 of the fair value hierarchy are valued using a matrix pricing technique provided by the external investment managers and Atrium Health's investment custodian. Matrix pricing is used to value securities based on the securities' relationship to benchmark quoted prices, benchmark yields, reported trades, broker-dealer quotes, issuer spreads and benchmark securities, among others. Atrium Health management reviews the valuations received from third parties.

The table below discloses the unfunded commitments, redemption frequency and redemption notice period for investments measured at net asset value as of December 31, 2018 and 2017:

Designated for Capital Improvements and Other Assets Limited as to Use Combined

	2018	2017	Unfunded commitments as of December 31 2018	Redemption frequency	Redemption notice period
Global equities	$ 192,584	$ 230,037	$ —	Monthly	6 days
Long/short fixed income limited partnerships	289,911	265,225	—	Quarterly	45–90 days
Long/short equity limited partnerships	—	4,269	—	Quarterly	60 days
Multi-strategy hedge fund limited partnerships	2,697	23,822	—	Annually	90 days
Commodities fund of funds limited partnerships	91,750	107,747	—	Daily	1 day
Private equity fund of funds partnerships	53,106	43,798	4,308	N/A	N/A
Total	$ 630,048	$ 674,898	$ 4,308		

Global equities are strategies that invest primarily in domestic and international public companies. Fund managers of each strategy have the ability to shift investments among geographies, sectors, and industries. The fair values of the investments in this type have been determined using the NAV per share of the investments.

Long/short fixed income limited partnership investments are hedge fund strategies that invest both long and short primarily in fixed income. Fund managers of each hedge fund strategy have the ability to shift investments among sectors, duration, yield, and from a net long position to a net short position. The fair values of the investments in this type have been determined using the NAV per share of the investments.

Long/short equity limited partnership investments are hedge fund strategies that invest both long and short primarily in equities. Fund managers of each hedge fund have the ability to shift investments among sectors,

styles, market capitalization, and from a net long position to a net short position. The fair values of the investments in this type have been determined using the NAV per share of the investments.

Multi-strategy hedge fund limited partnership investments are hedge fund strategies that invest both long and short primarily in relative value opportunities and special situations across equity, fixed income, and real estate. The fair values of the investments in this type have been determined using the NAV per share of the investments.

Commodities fund of funds limited partnerships are strategies that invest both long and short primarily in exchange traded commodities. Fund managers of each strategy have the ability to shift investments among commodities, sectors, timeframe, and from a net long position to a net neutral position. The fair values of the investments in this type have been determined using the NAV per share of the investments.

Private equity fund of funds partnerships are strategies that invest primarily in domestic and international public and private companies. Fund managers of each strategy have the ability to shift investments among geographies, sectors, industries, and the stage in the company's life cycle. The fair values of the investments in this type have been determined using the NAV per share of Atrium Health's ownership interest in partners' capital. Investments of this type do not allow for redemptions. Instead, investments in the strategies are returned through partnership distributions that generally coincide with liquidations of the underlying assets of the funds. It is estimated that the current liquidation period for these investments was five to ten years at December 31, 2018.

The fair values of Atrium Health's interest rate swaps (see note 5) were estimated using the zero coupon method. This method calculates the future net settlement payments required by the swap, assuming that the current forward rates implied by the yield curve correctly anticipate future spot interest rates. These payments are then discounted using the spot rates implied by the current yield curve for hypothetical zero coupon bonds due on the date of each future net settlement on the swaps. The spot rates used for discounting are further adjusted for the credit (nonpayment) risk associated with the party that is a net debtor as of the measurement date. The swap valuations are considered Level 2 liabilities and were valued at $189,250 and $219,841 at December 31, 2018 and 2017, respectively.

(Dollars in thousands)

The Atrium Health Foundation's Investments

The Foundation's investments at December 31, 2018 are as follows:

	2018	Fair value at reporting date using: Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Cash equivalents	$ 14,549	$ 14,549	$ —	$ —
Fixed income	47,648	26,399	21,249	—
Domestic equities	67,193	67,193	—	—
International equities	40,000	40,000	—	—
Global equities	27,230	27,230	—	—
Real asset funds	8,309	8,309	—	—
Total by fair value level	204,929	$ 183,680	$ 21,249	$ —
Investments measured at the NAV:				
Global equities	13,274			
Long/short fixed income	29,368			
Multi-strategy hedge funds	47			
Commodity funds	7,057			
Private equity funds	19,838			
Total assets measured at the NAV	69,584			
Total assets measured at fair value	$ 274,513			

(Continued)

(Dollars in thousands)

The Foundation's investments at December 31, 2017 are as follows:

	2017	Fair value at reporting date using: Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Cash equivalents	$ 18,291	$ 18,291	$ —	$ —
Fixed income	43,545	22,777	20,768	—
Domestic equities	71,042	71,042	—	—
International equities	48,716	48,716	—	—
Global equities	32,741	32,741	—	—
Real asset funds	7,904	7,904	—	—
Total by fair value level	222,239	$ 201,471	$ 20,768	$ —
Investments measured at the NAV:				
Global equities	15,911			
Long/short fixed income	29,777			
Long/short equity	457			
Multi-strategy hedge funds	225			
Commodity funds	8,288			
Private equity funds	19,200			
Total assets measured at the NAV	73,858			
Total assets measured at fair value	$ 296,097			

(Continued)

(Dollars in thousands)

(4) Capital Assets

Capital assets activity for the year ended December 31, 2018, was as follows:

	Beginning balance	Additions	Transfers	Retirements	Ending balance
Depreciable capital assets:					
Land improvements	$ 119,573	$ —	$ 524	$ (2,777)	$ 117,320
Buildings	3,221,718	10,130	92,421	(12,071)	3,312,198
Equipment	2,059,812	19,443	112,744	(30,811)	2,161,188
Depreciable capital assets – gross	5,401,103	29,573	205,689	(45,659)	5,590,706
Accumulated depreciation	(2,775,903)	(323,093)	—	45,454	(3,053,542)
Depreciable capital assets – net	2,625,200	(293,520)	205,689	(205)	2,537,164
Nondepreciable capital assets:					
Land	212,652	—	7,334	—	219,986
Construction in progress	211,774	410,411	(213,023)	—	409,162
Net capital assets	$ 3,049,626	$ 116,891	$ —	$ (205)	$ 3,166,312

(Continued)

(Dollars in thousands)

Capital assets activity for the year ended December 31, 2017, was as follows:

	Beginning balance	Additions	Transfers	Retirements	Ending balance
Depreciable capital assets:					
Land improvements	$ 118,378	$ —	$ 2,018	$ (823)	$ 119,573
Buildings	3,107,808	7,767	116,696	(10,553)	3,221,718
Equipment	1,915,321	25,602	154,084	(35,195)	2,059,812
Depreciable capital assets – gross	5,141,507	33,369	272,798	(46,571)	5,401,103
Accumulated depreciation	(2,509,561)	(308,171)	—	41,829	(2,775,903)
Depreciable capital assets – net	2,631,946	(274,802)	272,798	(4,742)	2,625,200
Nondepreciable capital assets:					
Land	197,514	—	15,138	—	212,652
Construction in progress	217,626	282,084	(287,936)	—	211,774
Net capital assets	$ 3,047,086	$ 7,282	$ —	$ (4,742)	$ 3,049,626

Net capitalized interest expense of $10,329 and $7,616 for the years ended December 31, 2018 and 2017, respectively, was included in the cost of projects. The cost of capital expenditures included in accounts payable was $42,249 and $30,890 as of December 31, 2018 and 2017, respectively.

(Continued)

(Dollars in thousands)

(5) Long-Term Debt

Long-term debt, net of related issuance premiums and unamortized gains on debt-related derivative agreements, consists of the following as of December 31:

	2018	2017
Series 2005 B, C, and D Variable Rate Refunding Revenue Bonds, maturing 2019 through 2026, bearing interest at variable rates which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 2.03%)	$ 50,750	$ 56,300
Series 2007 B Variable Rate Refunding Revenue Bonds, maturing 2019 through 2038, bearing interest at variable rates which are adjusted daily (weighted average rate for the year ended December 31, 2018 was 1.36%)	80,910	81,760
Series 2007 C Variable Rate Refunding Revenue Bonds, maturing 2027 through 2037, bearing interest at variable rates which are adjusted daily (weighted average rate for the year ended December 31, 2018 was 1.36%)	87,635	87,635
Series 2007 D Variable Rate Revenue Bonds, maturing 2041 through 2043, bearing interest at variable rates which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 2.14%)	67,140	67,140
Series 2007 E Variable Rate Revenue Bonds, maturing 2041 through 2044, bearing interest at variable rates which are adjusted daily (weighted average rate for the year ended December 31, 2018 was1.34%)	77,220	77,220
Series 2007 F Variable Rate Revenue Bonds, maturing 2030 through 2042, bearing interest at variable rates which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 2.14%)	57,055	57,055

(Continued)

(Dollars in thousands)

	2018	2017
Series 2007 G Variable Rate Revenue Bonds, maturing 2031 through 2041, bearing interest at variable rates which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 2.03%)	$ 113,825	$ 113,825
Series 2007 H Variable Rate Revenue Bonds, maturing 2027 through 2045, bearing interest at variable rates which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 1.80%)	166,050	166,050
Series 2008 A Refunding Revenue Bonds, maturing 2018, bearing interest at 4.25%	—	1,530
Series 2009 A Refunding Revenue Bonds, maturing 2019, bearing interest at 4.125%	3,650	185,605
Series 2011 A Revenue Bonds, maturing 2019 through 2042 bearing interest at 4.0% to 5.25%	132,145	134,170
Series 2012 A Revenue and Refunding Revenue Bonds, maturing 2019 through 2043 bearing interest at 3.0% to 5.0%	148,350	149,875
Series 2013 A Revenue and Refunding Revenue Bonds, maturing 2019 through 2039 bearing interest at 3.0% to 5.0%	117,225	119,640
Series 2015 A Taxable Refunding Revenue Bonds, maturing 2019 through 2024 bearing interest at 2.64%	9,090	10,470
Series 2015 B Taxable Commercial Paper Revenue Bonds (weighted average interest rate for the year ended December 31, 2018 was 2.10%)	30,000	30,000
Series 2016 A Refunding Revenue Bonds, maturing 2019 through 2047 bearing interest at 3.0% to 5.0%	376,960	390,560
Series 2018 A Refunding Revenue Bonds, maturing 2020 through 2039 bearing interest at 4.0% to 5.0%	164,030	—
Series 2018 B Variable Rate Revenue Bonds, maturing 2040 through 2048 currently bearing interest at 5.0% through the initial long-term rate period ending February 28, 2022	50,000	—

(Continued)

(Dollars in thousands)

	2018	2017
Series 2018 C Variable Rate Revenue Bonds, maturing 2040 through 2048 currently bearing interest at 5.0% through the initial long-term rate period ending February 28, 2023	$ 50,000	$ —
Series 2018 D Variable Rate Revenue Bonds, maturing 2040 through 2048 bearing interest at variable rates plus 0.60% through the initial index floating rate period ending November 30, 2023, which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 2.27%)	50,000	—
Series 2018 E Variable Rate Revenue Bonds, maturing 2040 through 2048 bearing interest at variable rates plus 0.45% through the initial index floating rate period ending November 30, 2021, which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 2.12%)	50,000	—
Series 2018 F Variable Rate Revenue Bonds, maturing 2040 through 2048 bearing interest at variable rates which are adjusted weekly (weighted average rate for the year ended December 31, 2018 was 1.67%)	100,000	—
Series 2018 G Variable Rate Revenue Bonds, maturing 2040 through 2048 bearing interest at variable rates which are adjusted daily (weighted average rate for the year ended December 31, 2018 was 1.67%)	50,000	—
Series 2018 H Variable Rate Revenue Bonds, maturing 2040 through 2048 bearing interest at variable rates which are adjusted daily (weighted average rate for the year ended December 31, 2018 was 1.67%)	50,000	
Other long-term debt	66,364	68,563
	2,148,399	1,797,398
Commercial paper, variable rate bonds with self liquidity program, and current portion	(170,982)	(68,465)
	1,977,417	1,728,933
Net unamortized premiums	90,687	67,084
Unamortized gains on debt-related derivative agreements	2,741	3,132
	$ 2,070,845	$ 1,799,149

(Continued)

(Dollars in thousands)

A summary of changes in long-term debt during 2018 is as follows:

	Beginning balance	Additions	Retirements	Ending balance
Fixed rate revenue bonds	$ 991,850	$ 164,030	$ (204,430)	$ 951,450
Variable rate revenue bonds	706,985	400,000	(6,400)	1,100,585
Commercial paper revenue bonds	30,000	210,000	(210,000)	30,000
Other long-term debt	68,563	—	(2,199)	66,364
	$ 1,797,398	$ 774,030	$ (423,029)	$ 2,148,399

A summary of changes in long-term debt during 2017 is as follows:

	Beginning balance	Additions	Retirements	Ending balance
Fixed rate revenue bonds	$ 1,017,145	$ —	$ (25,295)	$ 991,850
Variable rate revenue bonds	713,105	164,855	(170,975)	706,985
Commercial paper revenue bonds	30,000	135,000	(135,000)	30,000
Other long-term debt	70,678	—	(2,115)	68,563
	$ 1,830,928	$ 299,855	$ (333,385)	$ 1,797,398

Debt service requirements for long-term debt in future years, excluding commercial paper but including the impact of other long-term debt (a note payable to a financial services company and a note payable to Cleveland County) and interest rate swap transactions discussed later in this note, are shown in the table below. Debt service requirements, as reflected in the table, assume current interest rates on unhedged variable rate debt while net swap payments, are projected using the December 31, 2018 relationship between the Securities Information and Financial Markets Association (SIFMA) Municipal Swap Index and the one-month London InterBank Offered Rate (LIBOR) of approximately 68%, which is lower than interest projected using the 69% average relationship between SIFMA and LIBOR over the past 10 years.

(Continued)

(Dollars in thousands)

	Principal	Interest	Total
2019	$ 36,006	$ 81,843	$ 117,849
2020	37,261	84,455	121,716
2021	38,910	82,777	121,687
2022	40,468	80,586	121,054
2023	54,322	84,425	138,747
2024–2028	247,838	341,157	588,995
2029–2033	308,954	278,965	587,919
2034–2038	371,825	199,275	571,100
2039–2043	455,500	107,587	563,087
2044–2048	527,315	23,530	550,845
	$ 2,118,399	$ 1,364,600	$ 3,482,999

Atrium Health's Revenue Bonds (other than the Series 2015 A and Series 2015 B Revenue Bonds which are taxable) are tax-exempt and are secured by and payable from Atrium Health's revenues, the money and securities held in certain funds and accounts created by the applicable bond agreements and held by the bond trustee, and in the case of the Combined Group, amounts payable by the other members of the Combined Group under their respective Member Guaranty Agreement or Member Security Agreement. The tax-exempt fixed rate revenue bonds are redeemable at the option of Atrium Health at par value upon the expiration of the 10-year no call period subsequent to their respective issuance date. The Series 2018 D and Series 2018 E index floating rate bonds are redeemable at the option of Atrium Health at par value one year prior to their index floating rate purchase dates of December 1, 2023 and December 1, 2021, respectively.

In December 2005, Atrium Health issued Series 2005 B, C and D Variable Rate Refunding Revenue Bonds which, together with $2,855 of Atrium Health funds, currently refunded $96,760 of Series 1996 A Revenue Bonds. Interest on the Series 2005 B, C and D Variable Rate Refunding Revenue Bonds is payable monthly in arrears and principal is payable on January 15 of each year. In February 2011, Atrium Health utilized a mandatory tender process to substitute new direct pay letters of credit on these bonds. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance. In December 2016, Atrium Health utilized a mandatory tender process to convert Series 2005 B, C and D to direct purchase bonds. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance.

In August 2007, Atrium Health issued Series 2007 B and C Variable Rate Refunding Revenue Bonds, which advance refunded all $71,015 of the outstanding Series 2003 A Revenue Bonds and all $100,000 of the outstanding Series 2005 A Revenue Bonds. Interest on the Series 2007 B and C Variable Rate Refunding Revenue Bonds is payable monthly in arrears and principal is payable on January 15 of each year. In May 2017, Atrium Health utilized a mandatory tender process to convert Series 2007 C from the weekly interest rate mode to the daily interest rate mode. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance.

(Continued)

In September 2007, Atrium Health issued Series 2007 D, E and F Variable Rate Revenue Bonds insured by Financial Security Assurance, Inc., now known as Assured Guaranty Municipal Corp. (AGMC). Interest on the Series 2007 D, E and F Variable Rate Revenue Bonds is payable monthly in arrears and principal is payable on January 15 of each year. In May 2013, Atrium Health utilized a mandatory tender process to convert Series 2007 D and F to direct purchase bonds and to substitute a new direct pay letter of credit on Series 2007 E. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance. In November 2016, Atrium Health utilized a mandatory tender process to change the holder of the Series 2007 D direct purchase bonds. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance. In May 2017, Atrium Health utilized a mandatory tender process to convert Series 2007 E from the weekly interest rate mode to the daily interest rate mode. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance.

Also in September 2007, Atrium Health issued Series 2007 G Variable Rate Revenue Bonds insured by AGMC and Series 2007 H Variable Rate Revenue Bonds. The proceeds of the Series 2007 H Variable Rate Revenue Bonds were used to repay $159,930 of outstanding revenue bonds issued by the North Carolina Medical Care Commission (NCMCC) for the benefit of CHS NorthEast. Interest on the Series 2007 G Variable Rate Revenue Bonds and the Series 2007 H Variable Rate Revenue Bonds is payable monthly in arrears. Principal is payable on January 15 of each year. In May 2013, Atrium Health utilized a mandatory tender process to convert Series 2007 G to direct purchase bonds. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance. In November 2016, Atrium Health utilized a mandatory tender process to convert Series 2007 H to direct purchase bonds. As a result of this mandatory tender process, these bonds were deemed extinguished and the remarketed bonds were treated as a new issuance.

In June 2008, Atrium Health issued Series 2008 A Refunding Revenue Bonds which currently refunded all $70,020 of the outstanding Series 1996 B, C and D Variable Rate Revenue Bonds, all $66,175 of the outstanding Series 2003 B Variable Rate Revenue Bonds, all $100,000 of the outstanding Series 2005 E Variable Rate Revenue Bonds and all $71,200 of the outstanding Series 2007 I Variable Rate Revenue Bonds. Interest on the Series 2008 A Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

In August 2009, Atrium Health issued Series 2009 A Refunding Revenue Bonds which currently refunded all $7,810 of the outstanding Series 1997 A Revenue Bonds, all $76,075 of the outstanding Series 2007 J Variable Rate Revenue Bonds, all $78,225 of the outstanding Series 2007 K Variable Rate Revenue Bonds and all $50,365 of the outstanding Series 2007 L Variable Rate Revenue Bonds. Interest on the Series 2009 A Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

In May 2011, Atrium Health issued Series 2011 A Revenue Bonds. Interest on the Series 2011 A Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

In May 2012, Atrium Health issued Series 2012 A Revenue and Refunding Revenue Bonds which currently refunded all $88,535 of the outstanding Series 2001 A Revenue Bonds and $32,185 of outstanding revenue bonds issued by the NCMCC for the benefit of CHS Union. The Series 2012 A Revenue and Refunding Revenue Bonds also included $50,000 to finance a small portion of Atrium Health's capital plan. Interest on the Series 2012 A Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

In May 2013, Atrium Health issued Series 2013 A Revenue and Refunding Revenue Bonds which advance refunded $4,815 of the outstanding Series 2009 A Refunding Revenue Bonds and all $73,250 of outstanding revenue bonds issued by the NCMCC for the benefit of CHS Cleveland. The Series 2013 A Revenue and Refunding Revenue Bonds also included $50,000 to finance a small portion of Atrium Health's capital plan. Interest on the Series 2013 A Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

In January 2015, Atrium Health issued Series 2015 A Taxable Refunding Revenue Bonds which, together with funds held by CHS Stanly in Debt Service Reserve Funds, currently refunded all $16,030 of outstanding Series 1996 and Series 1999 Revenue Bonds issued by the NCMCC for the benefit of CHS Stanly. The Series 2015 A Revenue Bonds were purchased by a financial institution and will be held through their maturity on January 15, 2024 but Atrium Health may prepay the bonds at any time without penalty or premium except for any cost of prepayment (based upon U.S. Treasury obligations) that applies. Interest on the Series 2015 A Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

In October 2015, Atrium Health established a taxable commercial paper program providing for the issuance of up to $200,000 in aggregate taxable commercial paper revenue bonds. In November 2018, the issuance limit was increased to $400,000. The bonds issued under the commercial paper program currently carry short-term credit ratings of A-1+ from S&P Global Ratings and P-1 from Moody's Investors Service. Proceeds from the sale of commercial paper are used to pay for additional healthcare facilities or the costs of operating healthcare facilities, including general operating costs, routine capital expenditures and the acquisition and installation of healthcare equipment. Atrium Health has established a self-liquidity program that will be used to repurchase any commercial paper that is not remarketed. Commercial paper may be issued with maturity dates from one to 270 days from the date of issuance. While management may elect to continuously roll over all or portions of the commercial paper, the principal amount of all commercial paper must be repaid by October 2055. At December 31, 2018, commercial paper totaling $30,000, with a weighted average maturity and interest rate of 28 days and 2.45%, respectively, was outstanding and included within current portion of debt. In addition, in early 2019, Atrium Health sold $ 300,000 of new commercial paper under the program ($130,000 which has since been repaid) with various maturities through 2019.

In November 2016, Atrium Health issued Series 2016 A Refunding Revenue Bonds which currently refunded $121,240 of the outstanding Series 2007 A Revenue and Refunding Revenue Bonds and advance refunded $300,255 of the outstanding Series 2008 A Refunding Revenue Bonds. Interest on the Series 2016 A Refunding Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

(Dollars in thousands)

In November 2018, Atrium Health issued Series 2018 A Refunding Revenue Bonds which currently refunded $178,425 of the outstanding Series 2009 A Refunding Revenue Bonds. Interest on the Series 2018 A Refunding Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year.

Also in November 2018, Atrium Health issued Series 2018 B and 2018 C Variable Rate Revenue Bonds. Interest on the Series 2018 B and 2018 C Variable Rate Revenue Bonds is payable semiannually on January 15 and July 15 of each year and principal is payable on January 15 of each year. These bonds are subject to mandatory tender for purchase on March 1, 2022 and March 1, 2023, respectively, following the end of their initial long-term rate periods.

Also in November 2018, Atrium Health issued Series 2018 D and 2018 E Variable Rate Revenue Bonds. Interest on the Series 2018 D and 2018 E Variable Rate Revenue Bonds is payable monthly in arrears and principal is payable on January 15 of each year. These bonds are subject to mandatory tender for purchase on December 1, 2023 and December 1, 2021, respectively, following the end of their initial index floating rate periods.

Also in November 2018, Atrium Health issued Series 2018 F Variable Rate Revenue Bonds. Interest on the Series 2018 F Variable Rate Revenue Bonds is payable monthly in arrears and principal is payable on January 15 of each year. Atrium Health has established a self-liquidity program that will be used to repurchase any Series 2018 F Variable Rate Bonds that are not remarketed.

In December 2018, Atrium Health issued Series 2018 G and 2018 H Variable Rate Revenue Bonds. Interest on the Series 2018 G and 2018 H Variable Rate Revenue Bonds is payable monthly in arrears and principal is payable on January 15 of each year.

In the event bondholders elect to tender any or all of the Series 2007 B, C, and E Revenue Bonds or Series 2018 G and H Revenue Bonds for purchase and the bonds cannot be remarketed, liquidity facilities and a direct pay letter of credit provided by two financial institutions are utilized to purchase the unremarketed bonds. Bonds held by the liquidity facility and letter of credit providers generally require payment of a higher rate of interest. The terms of these liquidity facilities and direct pay letter of credit are described in the table below.

Series	Facility type	Expiration year	Repayment period
2007 B	Liquidity facility	2021	7 year
2007 C	Liquidity facility	2021	7 year
2007 E	Direct pay letter of credit	2020	5 year
2018 G	Liquidity Facility	2024	3 year
2018 H	Liquidity Facility	2024	3 year

(Continued)

(Dollars in thousands)

Atrium Health's Series 2005 B, C and D Variable Rate Refunding Revenue Bonds and Series 2007 D, F, G and H Revenue Bonds have been purchased by three financial institutions with holding periods noted in the table below that expire prior to the maturity of the respective bonds.

Series	Facility type	Expiration year
2005 BCD	Direct purchase bonds	2026
2007 D	Direct purchase bonds	2023
2007 F	Direct purchase bonds	2023
2007 G	Direct purchase bonds	2026
2007 H	Direct purchase bonds	2022

Atrium Health's Series 2018 B, C, D and E Variable Rate Revenue Bonds are subject to mandatory tender for purchase at the end of the initial holding periods noted in the table below that expire prior to the maturity of the respective bonds.

Series	Facility type	Expiration year
2018 B	Long-term rate period bonds	2022
2018 C	Long-term rate period bonds	2023
2018 D	Index floating rate period bonds	2023
2018 E	Index floating rate period bonds	2021

Interest expense, exclusive of amounts capitalized, was $77,454 and $77,954 for the years ended December 31, 2018 and 2017, respectively. Interest paid to bond holders and other lenders totaled $91,125 and $80,901 for the years ended December 31, 2018 and 2017, respectively.

There are various financial covenants and restrictions contained in Atrium Health's Bond Order, liquidity facilities, direct pay letter of credit and continuing covenant agreements for direct purchase bonds, including maintenance of a defined minimum level of annual long-term debt service coverage. As of December 31, 2018, Atrium Health was in compliance with these financial covenants.

In October 2014, Atrium Health became the sole member of Pineville LTACH/Rehab Hospital, LLC (the LLC), which owns and leases a facility to Atrium Health. Previously, the LLC was a joint venture between Atrium Health and an unaffiliated entity. The facility was constructed with the proceeds from a $30,101 loan to the LLC from a financial services company that is payable beginning September 2013 through August 2038 at an interest rate of 3.84%. The loan, which was not issued under Atrium Health's Bond Order, is secured by a leasehold deed of trust and assignment of facility leases and rents. The balance of $25,851 and $26,715 at December 31, 2018 and 2017, respectively is included in other long-term debt.

In March 2013, Atrium Health entered into an Amended and Restated Interlocal Agreement with Cleveland County, North Carolina for the purpose of more fully integrating CHS Cleveland with Atrium Health and enhancing Atrium Health's ability to provide services to the residents of Cleveland County. Atrium Health's

payment to Cleveland County included an unsecured, noninterest bearing note in the original amount of $77,000 payable through 2038 which is recorded as long-term debt at its net present value of $40,513 and $41,848 at December 31, 2018 and 2017, respectively.

Interest Rate Swaps

Atrium Health has adopted an Interest Rate Exchange Agreement Policy (the Policy) that governs its use of derivative agreements and restricts the use of such agreements to achieving desired interest cost savings, hedging interest rate risk in financing transactions, adjusting the mix of variable and fixed rate debt exposure to appropriate levels, providing flexibility to meet financial objectives not available under then-existing market conditions and improving cash flows. The Policy does not allow Atrium Health to speculate using derivative agreements.

On January 15, 2006, Atrium Health entered into an uninsured floating-to-fixed interest rate swap agreement on its Series 2005 B, C and D Variable Rate Refunding Revenue Bonds.

In August 2007, Atrium Health entered into four floating-to-fixed interest rate swaps under separate agreements insured by Ambac Assurance Corporation (Ambac) with two counterparties, in connection with its Series 2007 B and C Variable Rate Refunding Revenue Bonds, with an aggregate initial notional amount of $177,835. These swaps were entered into in conjunction with the refunding of the Series 2003 A and 2005 A Revenue Bonds.

In September 2007, Atrium Health entered into five AGMC-insured floating-to-fixed interest rate swaps under separate agreements with three counterparties, in connection with its Series 2007 D, E and F Variable Rate Revenue Bonds, with an aggregate initial notional amount of $201,415.

Also in September 2007, Atrium Health entered into two Ambac and two AGMC-insured floating-to-fixed interest rate swaps under separate agreements with two counterparties, in connection with its Series 2007 G and H Variable Rate Revenue Bonds, with an aggregate initial notional amount of $279,875.

(Dollars in thousands)

The significant terms and features of the above transactions as of and for the years ended December 31, 2018 and 2017, are summarized in the below table. The notional amounts of the swaps effectively match the principal amounts of the associated debt. The swaps contain scheduled reductions to outstanding notional amounts that are expected to follow scheduled or anticipated reductions in the associated bonds.

Associated bonds	2005 BCD	2007 B	2007 C	2007 D
Notional amount	$ 50,750	$ 80,910	$ 87,635	$ 67,140
Swap type	Floating-to-fixed	Floating-to-fixed	Floating-to-fixed	Floating-to-fixed
Origination date	January 15, 2006	August 28, 2007	August 28, 2007	September 19, 2007
Final bond maturity	January 15, 2026	January 15, 2038	January 15, 2037	January 15, 2043
Atrium Health pays	5.52 %	4.36 %	4.36 %	3.88 %
Atrium Health receives	75% of LIBOR	SIFMA	SIFMA	62.97% of LIBOR plus 0.29%
Fair value at December 31, 2018	$ (6,816)	$ (20,856)	$ (22,412)	$ (21,318)
Change in fair value during the year	2,331	3,618	3,672	3,064
Fair value at December 31, 2017	(9,147)	(24,474)	(26,084)	(24,382)
Change in fair value during the year	2,505	(440)	(259)	59

(Continued)

(Dollars in thousands)

Associated bonds	2007 E	2007 F	2007 G	2007 H
Notional amount	$ 77,220	$ 57,055	$ 113,825	$ 166,050
Swap type	Floating-to-fixed	Floating-to-fixed	Floating-to-fixed	Floating-to-fixed
Origination date	September 19, 2007	September 19, 2007	September 19, 2007	September 19, 2007
Final bond maturity	January 15, 2044	January 15, 2042	January 15, 2041	January 15, 2045
Atrium Health pays	3.89 %	3.89 %	3.90 %	3.88 %
Atrium Health receives	62.97% of LIBOR plus 0.29%	62.97% of LIBOR plus 0.29%	62.97% of LIBOR plus 0.29%	62.97% of LIBOR if LIBOR is equal to or greater than 3.5%; 77.5% of LIBOR if LIBOR is less than 3.5%
Fair value at December 31, 2018	$ (24,993)	$ (17,636)	$ (32,666)	$ (42,553)
Change in fair value during the year	3,586	2,556	4,897	6,867
Fair value at December 31, 2017	(28,579)	(20,192)	(37,563)	(49,420)
Change in fair value during the year	17	120	498	2,194

The swaps' aggregate negative fair value of $189,250 and $219,841, as of December 31, 2018 and 2017, respectively, is reported as a long-term liability on the balance sheets. Certain of the mandatory tender processes discussed above resulted in the termination of the related hedging relationships. Although hedging relationships have been subsequently re-established, the swaps are considered off-market swaps because the fixed rates of the swaps differed from the market rates for similar swaps at the time the hedging relationship was re-established. The negative fair value of the off-market swaps are being amortized using straight-line amortization. As of December 31, 2018, Atrium Health has determined that its 14 interest rate swaps are effective hedging derivatives. Because the swaps are effective hedges, aggregate changes in their fair value, including $30,591 and $4,694 for the years ended December 31, 2018 and 2017, respectively, are deferred and are reported on the balance sheets as a deferred outflow of resources. See note 3 for further discussion of the measurement techniques and inputs utilized in the measurement of the swaps' fair value. For the years ended December 31, 2018 and 2017, the swaps produced annual net cash outflows of approximately $18,368 and $22,961, respectively. Cash flows associated with the swaps are treated as interest expense.

As of December 31, 2018 and 2017, all swaps had a negative fair value. The negative fair value may be countered by a reduction in total interest payments required under Atrium Health's associated variable rate revenue bonds, creating a lower synthetic interest rate. Because the coupons on the variable rate revenue bonds adjust to changing interest rates, the bonds do not have corresponding fair value increases.

(Continued)

As of December 31, 2018 and 2017, Atrium Health was not exposed to credit risk because the swaps had negative fair values. However, should interest rates change and the fair values of the swaps become positive, Atrium Health would be exposed to credit risk in the amount of the swaps' fair value.

Atrium Health's 14 interest rate swaps are executed under six swap agreements with various counterparties. Seven swaps, approximating 49% of the notional amount of swaps outstanding, are provided by one counterparty that was rated A+ and Aa3 by S&P Global Ratings and Moody's Investors Service, respectively, as of December 31, 2018. Five additional swaps, approximating 39% of the outstanding notional value, are provided by another counterparty rated A+ and Aa2. The remaining two swaps are provided by a third counterparty rated A+ and A1 as of December 31, 2018.

In the event Atrium Health's credit ratings, as determined by S&P Global Ratings and Moody's Investors Service, fall below a level of A+ or A1, respectively, and the three uninsured swap agreements associated with Series 2005 B, C and D bonds and Series 2007 B, C and H bonds (with one counterparty) and with Series 2007 B and C bonds (with a different counterparty) each has a negative fair value of $25,000 or more, then Atrium Health must post collateral on these swap agreements equal to the amount of fair value in excess of $25,000. As of December 31, 2018, the fair values of these swap agreements were ($6,816), ($42,911) and ($21,634), respectively. As of December 31, 2017, the fair values of these swap agreements were ($9,147), ($49,989) and ($25,279), respectively. No collateral was required to be posted by Atrium Health for these swap agreements.

In the event Atrium Health's credit ratings, as determined by S&P Global Ratings and Moody's Investors Service, fall below a level of A+ or A1, respectively, and the uninsured swap agreement associated with Series 2007 H bonds has a negative fair value of $50,000 or more, then Atrium Health must post collateral on this swap agreement equal to the amount of fair value in excess of $50,000. As of December 31, 2018, the fair value of this swap agreement was ($21,277). As of December 31, 2017, the fair value of this swap agreement was ($24,710). No collateral was required to be posted by Atrium Health for this swap agreement.

With respect to the AGMC-insured swap agreement associated with Series 2007 E, F and G bonds, should the financial strength ratings of AGMC, as determined by S&P Global Ratings and Moody's Investors Service, fall below A– or A3, respectively, upon the request of the counterparty, Atrium Health, at its option, must either procure replacement swap insurance policies from counterparties rated at least AAA by S&P Global Ratings and Aaa by Moody's Investors Service, respectively, or agree to post collateral on those swap agreements equal to the amount of negative fair value in excess of $25,000 if Atrium Health's credit ratings, as determined by S&P Global Ratings and Moody's Investors Services, fall below a level of A+ or A1, respectively. As of December 31, 2018, the fair value of this swap agreement was ($37,645). As of December 31, 2017, the fair value of this swap agreement was ($43,165). No collateral was required to be posted by Atrium Health for this swap agreement given AGMC's ratings of AA and A2.

With respect to the AGMC-insured swap agreement associated with Series 2007 D, E, F and G bonds, should the financial strength ratings of AGMC, as determined by S&P Global Ratings and Moody's Investors Service, fall below A– or A3, respectively, upon the request of the counterparty Atrium Health, at its option, must either procure replacement swap insurance policies from counterparties rated at least AAA by S&P Global Ratings and Aaa by Moody's Investors Service, respectively, or agree to post collateral on this swap agreement equal

(Dollars in thousands)

to the amount of negative fair value in excess of $50,000 if Atrium Health's credit ratings, as determined by S&P Global Ratings and Moody's Investors Service, fall below a level of A+ or A1, respectively. As of December 31, 2018, the fair value of this insured swap agreement was ($58,967). As of December 31, 2017, the fair value of this insured swap agreement was ($67,551). No collateral was required to be posted by Atrium Health for this swap agreement given AGMC's ratings of AA and A2.

Atrium Health's Series 2007 B, C and E bonds bear interest at a rate that is equivalent to the SIFMA rate while the Series 2005 B, C and D bonds and Series 2007 D, F, G and H bonds bear interest at LIBOR plus a spread. For those swaps on the SIFMA-based variable rate revenue bonds for which it receives a variable rate based on LIBOR, Atrium Health is exposed to basis risk depending upon the relationship between SIFMA and LIBOR. If that relationship changes, the effective synthetic rate on the SIFMA-based variable rate revenue bonds may be higher than the intended synthetic rate. As of December 31, 2018, the SIFMA rate was 1.71% and LIBOR was 2.50%, resulting in a SIFMA to LIBOR relationship of approximately 68%.

Atrium Health or the counterparty may terminate any of the swaps if either party fails to perform under the terms of the agreement. If any of the swaps are terminated, the associated variable rate revenue bonds would no longer carry synthetic interest rates. Also, if the swap has a negative fair value at the time of termination, Atrium Health would be liable to the counterparty for a payment equal to the swap's fair value. Likewise, if the swap has a positive fair value at the time of termination, Atrium Health would be entitled to a payment equal to the swap's fair value from the counterparty terminating the swap.

Debt service requirements of Atrium Health's outstanding hedged variable rate revenue bonds and related net swap payments, assuming current SIFMA and LIBOR interest rates and the SIFMA to LIBOR relationship remain the same, as of December 31, 2018, were as follows:

	Variable rate bonds		Interest rate	
	Principal	Interest	swap – net	Total
2019	$ 6,820	$ 13,837	$ 15,448	$ 36,105
2020	7,255	13,672	15,197	36,124
2021	10,710	13,448	14,859	39,017
2022	625	13,428	14,830	28,883
2023	9,155	13,231	14,530	36,916
2024–2028	50,555	63,027	68,157	181,739
2029–2033	86,805	56,553	60,643	204,001
2034–2038	168,095	44,052	44,980	257,127
2039–2043	285,800	21,693	20,708	328,201
2044–2048	74,765	202	194	75,161
	$ 700,585	$ 253,143	$ 269,546	$ 1,223,274

(Continued)

(Dollars in thousands)

In January 2019, Atrium Health entered into a forward starting interest rate swap with a notional value of $126,010 in connection with the planned synthetic fixed rate refunding of its Series 2011A Bonds that are callable on January 15, 2021.

(6) Net Patient Service Revenue

Net patient service revenue is recorded when patient services are performed at the estimated net realizable amounts from patients, third-party payers and others for services rendered. The use of estimates is very common for health systems, since, with increasing frequency, even noncost-based governmental programs have become subject to retrospective adjustments. Often such adjustments are not known for a considerable period of time after the related services are rendered. The lengthy period of time between rendering services and reaching final settlement, compounded further by the complexities and ambiguities of governmental reimbursement regulations and the frequency of changes in payer guidelines, makes it difficult to estimate the net patient service revenue associated with these programs.

Under the Medicare and Medicaid programs, Atrium Health is entitled to reimbursements for certain patient charges at rates determined by federal and state governments. Differences between established billing rates and reimbursements from these programs are recorded as contractual adjustments to arrive at net patient service revenue. Final determination of amounts due from Medicare and Medicaid programs is subject to review by these programs. Changes resulting from final determination are reflected as changes in estimates, generally in the year of determination. In the opinion of management, adequate provision has been made for adjustments, if any, that may result from such reviews. Net patient service revenue increased approximately $5,600 and $21,000 for the years ended December 31, 2018 and 2017, respectively, due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer subject to audits and reviews.

Net patient service revenue consisted of the following for the years ended December 31:

	2018	2017
Gross patient charges at established rates, net of contractual adjustments – including charges forgone for patients qualifying for financial assistance	$ 7,287,364	$ 6,936,064
Adjustments for uninsured and underinsured patients both qualifying and not qualifying for financial assistance	(1,687,329)	(1,533,323)
Net patient service revenue	$ 5,600,035	$ 5,402,741

(Dollars in thousands)

The sources of Atrium Health's gross patient revenue by type of payer, expressed as a percentage of total gross patient revenue, consisted of the following for the years ended December 31:

	2018	2017
Medicare	39.9 %	39.2 %
Commercial	33.9	34.6
Medicaid	16.1	16.7
Direct from patient/other	10.1	9.5
	100.0 %	100.0 %

Atrium Health participates in the North Carolina Medicaid Supplemental Payment Program whereby, through intergovernmental transfers, certified public expenditures and assessments to the State, the State is able to increase payments to hospitals reducing the gap between Medicaid and uninsured costs and payments. Atrium Health reports assessments and receipts within other expenses and net patient service revenue, respectively, in the accompanying statements of revenues, expenses, and changes in net position. The following is a summary of the funds received and assessments paid under these programs for the years ended December 31:

	2018	2017
Net funds received	$ 263,617	$ 234,266
Less assessments paid	(38,843)	(46,033)
Net amounts recognized	$ 224,774	$ 188,233

(7) Other Revenue

Other revenue is composed of the following amounts for the years ended December 31:

	2018	2017
Medical education and research grants and contracts	$ 65,582	$ 63,797
Reimbursed services provided to affiliates	138,199	136,937
Pharmacy sales	215,017	171,449
Rental and other revenue	209,378	190,649
	$ 628,176	$ 562,832

(Continued)

(8) Benefit Plans

Retirement benefits are provided to teammates using both defined contribution plans and defined benefit plans. Atrium Health offers several defined contribution plans with the largest plan being a Section 401(k) defined contribution plan (the DC Plan) which covers all full-time teammates of Atrium Health and is funded by voluntary teammate contributions and certain matching contributions by Atrium Health. Defined contribution plan assets are not recorded in Atrium Health's balance sheet but are held in participant-directed individual accounts and were $2,647,200 and $2,852,999 at December 31, 2018 and 2017, respectively. Total matching contribution expense for the DC Plan was $159,281 and $94,104 for the years ended December 31, 2018 and 2017, respectively. In connection with changes to Atrium Health's defined benefit plans as described below, the DC Plan has been enhanced for teammates hired after January 1, 2014 and was further enhanced for all others effective January 1, 2018 with an increase in Atrium Health's matching contribution.

Atrium Health also maintains three single employer defined benefit plans (the Atrium Health DB Plan, which is the largest plan, the CHS Cleveland DB Plan and the CHS Stanly DB Plan). Late in 2013, Atrium Health undertook certain steps to modernize its retirement benefits by closing the Atrium Health DB Plan to teammates hired after January 1, 2014. The Atrium Health DB Plan was frozen for all teammates effective January 1, 2018, after which no additional benefits accrue under the Atrium Health DB Plan. Similarly, the CHS Cleveland DB Plan and the CHS Stanly DB Plan have also been closed to teammates hired after January 1, 2015 and January 1, 2016, respectively, and were also frozen for all teammates effective January 1, 2018, after which no additional benefits accrue under either Plan.

The following information pertains to the Atrium Health DB Plan. Separate financial statements for the Atrium Health DB Plan are not required to be issued.

Atrium Health DB Plan Description and Benefits Provided – The Atrium Health DB Plan provides pension benefits to all Atrium Health teammates hired before January 1, 2014 and who have attained five or more years of service. These benefits are based on years of service and the teammates' compensation. Effective January 1, 2009, the Atrium Health DB Plan became a cash balance plan and a small group of teammates meeting specified employment, age, and service criteria were grandfathered and accrued benefits under the Atrium Health pre-cash balance formula. The Board of Commissioners of Atrium Health (the Board) or an authorized committee of the Board has the authority to amend benefit provisions.

(Dollars in thousands)

The actuarial valuation establishing the net pension liability for the purposes of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*, was based on the Atrium Health DB Plan membership data as of January 1, 2018 and 2017, respectively, and rolled forward to the measurement date of July 1, 2018 and 2017, respectively. The Atrium Health DB Plan participant data as of July 1, 2018 and 2017, respectively, is as follows:

	2018	2017
Retirees and beneficiaries receiving benefits	1,703	1,594
Previously employed plan members entitled to but not yet receiving benefits	5,630	6,136
Employed plan members	20,039	21,232
Total	27,372	28,962

Contributions to the Atrium Health DB Plan – Annual contributions to the Atrium Health DB Plan are based upon actuarial calculations. Beginning in 2015, the Atrium Health DB Plan utilizes the entry age normal method to determine annual contributions. There are no teammate contributions to the Atrium Health DB Plan.

Atrium Health's funding policy is to contribute such actuarially determined amounts as are necessary to provide assets sufficient to meet the benefits to be paid to Atrium Health DB Plan participants. In addition, with the freezing of the Atrium Health DB Plan, Atrium Health has made contributions to the Atrium Health DB Plan in addition to the annual actuarially determined amounts in an effort to reduce the unfunded actuarially accrued liability in a systematic manner. During both 2018 and 2017, Atrium Health elected to contribute an additional $42,200 above the actuarially determined contributions. Atrium Health's contribution rates for the years ended December 31, 2018 and 2017 equaled 4.4% and 6.9% of covered payroll, respectively. These contribution rates are determined based on a measurement date of January 1, 2018 and 2017, respectively.

Atrium Health DB Plan Actuarial Assumptions – The total Atrium Health DB Plan pension liability on the July 1, 2018 and 2017, respectively, measurement date was determined using the following actuarial assumptions:

	2018	2017
Inflation rate	2.1 %	2.1 %
Investment rate of return (net of investment expenses, including inflation)	7.5	7.5
Lump sum interest rate	5.0	5.0
Projected salary increases	3.0	3.0

(Continued)

(Dollars in thousands)

Actuarial assumptions used in the July 1, 2018 valuation were based on the results of an actuarial experience study that is conducted every four years, most recently in 2017. Mortality rates were based on the RP-2014 table with MP-2017 Generational Projections. The long-term investment rate of return on pension assets was determined using a combination of benchmark return information and a building-block method in which best-estimated expected real rates of return are developed for each major asset class. These expected real rates of return are weighted by the target asset allocation percentage to produce an overall expected real rate of return which is then increased by expected inflation to produce a long-term investment rate of return on pension assets of 7.5%.

The target allocation, expected nominal return (which includes inflation) and the best estimates of geometric or compounded real rates of return (which are net of inflation) for each major asset class were established as of July 1, 2017, the beginning of the measurement period, and are summarized in the following table:

Asset class	Target allocation	Expected nominal return	Expected real rate of return
Fixed income	17.0 %	3.3%	0.5%
Long/short fixed income	10.0	5.7	2.9
Domestic equities	25.5	6.9–7.3	4.0–4.4
International equities	17.0	7.3	4.4
Global equities	17.0	7.3	4.4
Commodity funds	3.0	5.5	2.7
Private equity funds	7.5	8.3	5.3
Real asset funds	3.0	7.3	4.4
Total target allocation	100.0 %		

(Continued)

(Dollars in thousands)

The target allocation, expected nominal return (which includes inflation) and the best estimates of geometric or compounded real rates of return (which are net of inflation) for each major asset class as of July 1, 2016, the beginning of the measurement period, and are summarized in the following table:

Asset class	Target allocation	Expected nominal return	Expected real rate of return
Fixed income	15.0 %	3.8%	1.7%
Long/short fixed income	10.0	6.6	4.4
Domestic equities	22.5	6.5–7.0	4.3–4.8
International equities	15.0	7.4	5.2
Global equities	15.0	7.3	5.1
Long/short equity	10.0	6.6	4.4
Commodity funds	2.5	4.7	2.6
Private equity funds	7.5	8.8	6.6
Real asset funds	2.5	7.0	4.8
Total target allocation	100.0 %		

Rate of return – For the Atrium Health Plan fiscal year ended June 30, 2018 and June 30, 2017, the annual money-weighted rate of return on pension plan investments, net of pension plan investment expenses, was 8.0% and 15.0%, respectively. The money-weighted rate of return expresses investment performance, net of investment expenses, adjusted for the changing amounts actually invested.

Atrium Health DB Plan Discount rate – The discount rate used to measure the total Atrium Health DB Plan pension liability as of July 1, 2018 and 2017 was 7.5%. The projection of cash flows used to determine the discount rate assumed that employer contributions will be made in amounts equal to the actuarially determined contributions. Based on those assumptions, the Atrium Health DB Plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive teammates. Therefore, the long-term expected rate of return on pension assets of 7.5% was applied to all periods of projected benefit payments to determine the total pension liability.

(Continued)

(Dollars in thousands)

Changes in the Atrium Health DB Plan Net Pension Liability

Changes in the Atrium Health DB Plan net pension liability for the year ended December 31, 2018, are as follows:

	Increase (decrease)		
	Total pension liability (a)	**Plan fiduciary net position (b)**	**Net pension liability (a) – (b)**
Balances at December 31, 2017 (based on July 1, 2017 measurement date)	$ 1,358,962	$ 983,306	$ 375,656
Changes for the fiscal year:			
Service cost	—	—	—
Interest cost	96,417	—	96,417
Differences between expected and actual experience	(14,720)	—	(14,720)
Changes of assumptions	(2,402)	—	(2,402)
Contributions – employer	—	78,526	(78,526)
Investment gains and other, net	—	76,644	(76,644)
Benefit payments	(146,796)	(146,796)	—
Administrative expense	—	(312)	312
Net changes	(67,501)	8,062	(75,563)
Balances at December 31, 2018 (based on July 1, 2018 measurement date)	1,291,461	991,368	300,093
CHS Cleveland DB Plan and CHS Stanly DB Plan combined	126,446	131,377	(4,931)
Combined balances at December 31, 2018 (based on July 1, 2018 measurement date)	$ 1,417,907	$ 1,122,745	$ 295,162

(Continued)

(Dollars in thousands)

Changes in the Atrium Health DB Plan net pension liability for the year ended December 31, 2017, are as follows:

	Increase (decrease)		
	Total pension liability (a)	**Plan fiduciary net position (b)**	**Net pension liability (a) – (b)**
Balances at December 31, 2016 (based on July 1, 2016 measurement date)	$ 1,349,108	$ 848,709	$ 500,399
Changes for the fiscal year:			
Service cost	46,519	—	46,519
Interest cost	100,609	—	100,609
Differences between expected and actual experience	(23,718)	—	(23,718)
Changes of assumptions	(5,217)	—	(5,217)
Contributions – employer	—	124,181	(124,181)
Investment gains and other, net	—	118,972	(118,972)
Benefit payments	(108,339)	(108,339)	—
Administrative expense	—	(217)	217
Net changes	9,854	134,597	(124,743)
Balances at December 31, 2017 (based on July 1, 2017 measurement date)	1,358,962	983,306	375,656
CHS Cleveland DB Plan and CHS Stanly DB Plan combined	129,642	125,613	4,029
Combined balances at December 31, 2017 (based on July 1, 2017 measurement date)	$ 1,488,604	$ 1,108,919	$ 379,685

(Continued)

(Dollars in thousands)

Sensitivity of the Atrium Health DB Plan net pension liability to changes in the discount rate – The following table presents the net Atrium Health DB Plan pension liability as of July 1, 2018 and 2017, respectively, calculated using the discount rate of 7.5% and alternatively, as required by GASB 68, what the net pension liability would be under different scenarios assuming it were calculated using a discount rate that is 1% lower (6.5%) or 1% higher (8.5%):

	1% Decrease 6.50%	Current rate 7.50%	1% Increase 8.50%
Net pension liability at July 1, 2018	$ 404,905	$ 300,093	$ 209,386
Net pension liability at July 1, 2017	479,179	375,656	286,405

Atrium Health DB Plan Investments – Policies pertaining to the allocation of investments within the Atrium Health DB Plan are established and may be amended by the Investment Oversight Committee (IOC) of Atrium Health's Board. It is the policy of the IOC to invest pension assets in a wide range of permitted securities that maintain a balance between current income needs and the growth of principal for the future.

Atrium Health, as plan sponsor, has fiduciary responsibility for the Atrium Health DB Plan assets on behalf of the plan participants and beneficiaries.

The Plan categorizes its fair value measurements within the fair value hierarchy established by GAAP. The methods for determining fair value are consistent with Atrium Health's valuation techniques and presentation as detailed in note 3 above.

(Dollars in thousands)

Atrium Health DB Plan assets were invested as follows as of July 1, 2018:

	Defined benefit plan assets	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Cash and cash equivalents	$ 108,680	$ 108,680	$ —	$ —
Fixed income:				
U.S. government treasuries and agencies	17,226	—	17,226	—
Corporate bonds	23,290	—	23,290	—
Municipal bonds	1,452	—	1,452	—
Asset-backed securities	11,510	—	11,510	—
Fixed income – other	72,684	72,684	—	—
Total fixed income	126,162	72,684	53,478	—
Equity:				
Domestic equities	301,302	301,302	—	—
International equities	159,932	159,932	—	—
Global equities	55,810	55,810	—	—
Total equity	517,044	517,044	—	—
Real asset funds	31,184	31,184	—	—
Total investments by fair value level	783,070	$ 729,592	$ 53,478	$ —
Investments measured at the NAV:				
Global equities	45,917			
Long/short fixed income	88,681			
Multi-strategy hedge funds	264			
Commodity funds	27,112			
Private equity funds	46,324			
Total investments measured at the NAV	208,298			
Total investments measured at fair value	$ 991,368			

(Continued)

(Dollars in thousands)

Atrium Health DB Plan assets were invested as follows as of July 1, 2017:

	Defined benefit plan assets	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Cash and cash equivalents	$ 94,320	$ 94,320	$ —	$ —
Fixed income:				
U.S. government treasuries and agencies	28,391	—	28,391	—
Corporate bonds	33,101	—	33,101	—
Municipal bonds	1,435	—	1,435	—
Asset-backed securities	28,285	—	28,285	—
Fixed income – other	63,212	63,212	—	—
Total fixed income	154,424	63,212	91,212	—
Equity:				
Domestic equities	271,020	271,020	—	—
International equities	160,489	160,489	—	—
Global equities	52,802	52,802	—	—
Total equity	484,311	484,311	—	—
Real asset funds	29,835	29,835	—	—
Total investments by fair value level	762,890	$ 671,678	$ 91,212	$ —
Investments measured at the NAV:				
Global equities	44,886			
Long/short fixed income	82,824			
Long/short equity	18,641			
Multi-strategy hedge funds	667			
Commodity funds	25,255			
Private equity funds	48,143			
Total investments measured at the NAV	220,416			
Total investments measured at fair value	$ 983,306			

(Continued)

(Dollars in thousands)

The table below discloses the unfunded commitments, redemption frequency and redemption notice period for investments measured at net asset value as July 1, 2018 and 2017:

	Defined benefit plan assets				
	2018	2017	Unfunded commitments as of July 1 2018		Redemption notice period
Global equities	$ 45,917	$ 44,886	$ —	Monthly	6 days
Long/short fixed income limited partnerships	88,681	82,824	—	Quarterly	45–90 days
Long/short equity limited partnerships	—	18,641	—	N/A	N/A
Multi-strategy hedge fund limited partnerships	264	667	—	Annually	90 days
Commodities fund of funds limited partnerships	27,112	25,255	—	Daily	1 day
Private equity fund of funds limited partnerships	46,324	48,143	17,484	N/A	N/A
Total	$ 208,298	$ 220,416	$ 17,484		

The Plan's presentation of asset segments is consistent with Atrium Health's presentation as detailed in note 3.

Pension expense and deferred outflows of resources and deferred inflows of resources related to the Atrium Health DB Plan – For the year ended December 31, 2018, Atrium Health recognized pension expense of $39,090 for the Atrium Health DB Plan. At December 31, 2018, Atrium Health reported net deferred outflows of resources as follows based on July 1, 2018 measurement date:

	Deferred outflows of resources	Deferred inflows of resources
Difference between expected and actual experience related to demographic factors	$ 4,285	$ (31,161)
Assumption changes	12,237	(5,716)
Difference between expected and actual investment earnings	4,354	—
Total	$ 20,876	$ (36,877)

(Continued)

(Dollars in thousands)

For the year ended December 31, 2017, Atrium Health recognized pension expense of $102,315 for the Atrium Health DB Plan and, at December 31, 2017 reported net deferred outflows of resources as follows based on July 1, 2017 measurement date:

	Deferred outflows of resources	Deferred inflows of resources
Difference between expected and actual experience related to demographic factors	$ 5,220	$ (22,687)
Assumption changes	14,909	(4,445)
Difference between expected and actual investment earnings	27,129	—
Total	$ 47,258	$ (27,132)

Amounts reported above as deferred outflows of resources and deferred inflows of resources related to the Atrium Health DB Plan at December 31, 2018 will be recognized in pension expense for the years ended December 31, as follows:

	Amount
2019	$ 10,115
2020	2,154
2021	(17,446)
2022	(5,338)
2023	(3,720)
Thereafter	(1,766)
	$ (16,001)

CHS Cleveland DB Plan and CHS Stanly DB Plan Actuarial Assumptions and Reporting – The actuarial assumptions used for the CHS Cleveland DB Plan and the CHS Stanly DB Plan are similar to assumptions used for the Atrium Health DB Plan described above. The CHS Cleveland DB Plan had a net pension liability of $8,471 and $11,709 and reported net deferred (inflows) outflows of $(2,508) and $1,089 at December 31, 2018 and 2017, respectively. The CHS Cleveland DB Plan had actuarially valued assets of $75,032 and $73,651 at December 31, 2018 and 2017, respectively. The CHS Stanly DB Plan had a net pension (asset) of $(13,402) and $(7,680) and reported net deferred (inflows) outflows of $(2,101) and $131 at December 31, 2018 and 2017, respectively. The CHS Stanly DB Plan had actuarially valued assets of $56,345 and $51,962 at December 31, 2018 and 2017, respectively.

(Continued)

(9) Commitments and Contingencies

Atrium Health is subject to legal proceedings and claims that arise in the course of providing healthcare services. Atrium Health has instituted a limited self insurance program for professional liability and general liability claims. Self-insurance is limited to $10 million and $5 million per occurrence, with no aggregate limit for the years end December 31, 2018 and 2017, respectively. General liability and professional liability are also covered by umbrella liability insurance policies. In management's opinion, adequate provision has been made for amounts expected to be paid under the policy's deductible limits for asserted and unasserted claims not covered by the policy and any other uninsured liability.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In June 2016, the federal government and the State of North Carolina filed a civil antitrust lawsuit against Atrium Health alleging that Atrium Health has violated Section 1 of the Sherman Act by imposing steering restrictions in negotiated agreements with four insurance companies in the Charlotte, North Carolina area (the "2016 lawsuit"). In November 2018, Atrium Health reached a settlement with the government plaintiffs that includes no financial penalty or fine and does not include any admission of wrongdoing. The settlement enjoins Atrium Health from seeking or enforcing certain limited managed care contract terms and is subject to court approval, which is expected in the second quarter of 2019. In September 2016, an individual filed a proposed class action lawsuit in state court making similar allegations against Atrium Health. This lawsuit seeks treble damages for an unspecified amount, but no class has been certified. In March 2019, the court granted Atrium Health's motion to dismiss the state anti-trust claim. The entire matter is currently stayed pending appeal to the North Carolina Supreme Court. In February 2018, another individual filed a separate federal lawsuit on behalf of an additional proposed class of plaintiffs. This second lawsuit makes similar allegations and seeks treble damages for an unspecified amount. In March 2019, the court dismissed all claims for monetary relief in this federal lawsuit and stayed the claims for injunctive relief pending resolution of the 2016 lawsuit. The ultimate resolution of these lawsuits could have a material adverse effect on Atrium Health's condition (financial or otherwise) or operations. It is impossible to estimate the likelihood of an unfavorable outcome or the risk of exposure facing Atrium Health.

(Dollars in thousands)

On November 19, 2018, a group of five individuals filed a proposed class action lawsuit against Atrium Health and certain related entities alleging that the retirement and health benefit plans do not satisfy the "governmental plan" exemption under the Employment Retirement Income Security Act ("ERISA") and that Atrium Health, therefore, has violated various aspects of ERISA, such as minimum funding requirements, certain fiduciary duties to plan participants, minimum years of service requirements for vesting of benefits, reporting and disclosure requirements and engaging in prohibited transactions. The lawsuit seeks (i) to have the retirement and health benefit plans declared subject to ERISA, (ii) for Atrium Health to bring all the plans into compliance with ERISA, and (iii) monetary payments to certain benefit plans, participants and beneficiaries harmed by the failure to comply with ERISA. Atrium Health filed a motion to dismiss this lawsuit in February 2019 on the grounds that Atrium Health is a governmental entity under ERISA. The briefing on this matter is complete but the court has not issued a ruling or scheduled a hearing. Atrium Health intends to vigorously defend this lawsuit; however, the ultimate resolution of this lawsuit could have a material adverse effect on Atrium Health's condition (financial or otherwise).

On February 4, 2019, a plaintiff filed a proposed class action lawsuit against Atrium Health regarding the facility fees charged to all patients following their treatment in any Atrium or Atrium-affiliated facility's emergency department. The lawsuit alleges that Atrium Health does not disclose the existence of the facility fee or its amount or calculation in its standard treatment and financial authorization agreement (the "treatment agreement") or by any other means. The lawsuit contends that the facility fee therefore (i) is not authorized under the treatment agreement and (ii) is unconscionable. The lawsuit seeks a declaratory judgment to that effect, as well as an injunction prohibiting Atrium Health from continuing to impose facility fees on emergency department patients in the manner in which those fees are currently imposed. Although at present the plaintiff does not seek monetary damages, the complaint indicates that the proposed class may later seek supplemental relief in the form of restitution of the facility fees charged to members of the proposed class. This lawsuit is in its early stages. Atrium Health intends to vigorously defend this lawsuit; however, an adverse resolution of this lawsuit could have a material adverse effect on Atrium Health's condition (financial or otherwise).

Obligations under noncancelable operating leases with remaining terms of more than one year, principally real estate leases for medical office space, as of December 31, 2018, were as follows:

2019	$	70,856
2020		61,059
2021		51,236
2022		43,560
2023		39,325
2024–2028		71,736
2029–2033		45,430
2034–2038		19,301
2039 - Thereafter		7,535
	$	410,038

(Continued)

Atrium Health has entered into contracts for various construction and capital projects, for which remaining commitments totaled approximately $163,292 at December 31, 2018.

In connection with the merger with Cabarrus Memorial Hospital d/b/a NorthEast Medical Center in 2007, Atrium Health has committed to invest $600,000 in healthcare facilities and services in Cabarrus County, North Carolina. With expenditures exceeding $607,000 as of December 31, 2018, Management believes Atrium Health has fulfilled its commitment. Additional dollars have been approved to allow Atrium Health to continue to make significant capital contributions in the county.

Effective January 1, 2012, under the terms of a Lease Agreement between Atrium Health and Union County, Atrium Health leases hospital real estate from, and makes annual lease payments to, Union County. The initial term of the Lease Agreement remains in effect until December 31, 2061, unless earlier terminated, extended or renewed in accordance with the provisions of the Lease Agreement. Upon the expiration of the initial term, unless certain events of default exist, Atrium Health has the option to extend and renew the Lease Agreement for an initial renewal term of 25 years. During the term of the Lease Agreement, Union County has the right to require Atrium Health to purchase the hospital real estate at a stated price determined in accordance with the Lease Agreement. If Union County elects to require Atrium Health to purchase the hospital real estate, Atrium Health will have no further obligations under the Lease Agreement. As of December 31, 2018, the purchase price as stated in the Lease Agreement was $128,018. The present value of Atrium Health's obligation for the annual lease payments, discounted using an effective interest rate of 4.34%, was $122,774 and $123,577 as of December 31, 2018 and 2017, respectively, and is recorded on the balance sheet as a long-term liability. The liability and related interest are payable in annual installments of approximately $6,000 per year through 2061.

Additionally, as part of the Lease Agreement between Atrium Health and Union County, Atrium Health has committed to reinvest in healthcare related facilities and operations in Union County. As measured in 15-year increments commencing January 1, 2012, Atrium Health has committed to spending in Union County no less than 75% of the capital spending ratio of Atrium Health as a whole (defined as capital investments divided by net operating revenues), but limited to 75% of the operating income of the Union Healthcare Enterprise as defined in the Lease Agreement. Management believes Atrium Health has reinvested in excess of the commitment levels for the first six years of the 15-year period.

Atrium Health committed to invest $70,000 in CHS Stanly and its subsidiaries over a period of 12 years, which includes a five-year commitment of $48,830 before the end of 2018. Of those totals, Atrium Health committed to $36,680 of specifically identified projects by the end of 2018. As of December 31, 2018, Atrium Health has spent and/or approved $45,170 towards the full $70,000 commitment.

(10) Subsequent Events

In April 2019, Atrium Health, Wake Forest Baptist Health and Wake Forest University signed a Memorandum of Understanding to create a next-generation academic healthcare system with a goal of entering into a final agreement later in the year. As of the date of issuance, an agreement has not been signed.

REQUIRED SUPPLEMENTARY INFORMATION

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Required Supplementary Information

Schedule of Changes in Net Pension Liability and Related Ratios (in thousands)

(Unaudited)

	December 31				
	2018	**2017**	**2016**	**2015**	**2014**
Total pension liability:					
Service cost	$ —	$ 46,519	$ 53,214	$ 55,197	$ NA
Interest cost	96,417	100,609	95,929	93,442	NA
Differences between expected and actual experiences	(14,720)	(23,718)	7,092	(4,091)	NA
Changes of assumptions	(2,402)	(5,217)	20,252	—	NA
Benefit payments	(146,796)	(108,339)	(106,420)	(112,417)	NA
Net change in total pension liability	(67,501)	9,854	70,067	32,131	NA
Total pension liability – beginning	1,358,962	1,349,108	1,279,041	1,246,910	NA
Total pension liability – ending (a)	1,291,461	1,358,962	1,349,108	1,279,041	1,246,910
Plan fiduciary net position:					
Contributions – employer	78,526	124,181	132,884	92,405	NA
Investment gains and other, net	76,644	118,972	(36,909)	20,481	NA
Benefit payments	(146,796)	(108,339)	(106,420)	(112,417)	NA
Administrative expense	(312)	(217)	(364)	(696)	NA
Net change in plan fiduciary net position	8,062	134,597	(10,809)	(227)	NA
Plan fiduciary net position – beginning	983,306	848,709	859,518	859,745	NA
Plan fiduciary net position – ending (b)	991,368	983,306	848,709	859,518	859,745
Net pension liability – ending (a) – (b)	$ 300,093	$ 375,656	$ 500,399	$ 419,523	$ 387,165
Plan fiduciary net position as a percentage of the total pension liability	76.8 %	72.4 %	62.9 %	67.2 %	69.0 %
Covered-employee payroll	$ 1,804,814	$ 1,796,876	$ 1,959,073	$ 1,995,117	$ 1,909,014
Net pension liability as a percentage of covered-employee payroll	16.6 %	20.9 %	25.5 %	21.0 %	20.3 %

Note to schedule:
Measurement date is July 1 of prior fiscal year.
The schedules are intended to show information for 10 years. Additional years will be presented as the information becomes available.

See accompanying independent auditors' report.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Required Supplementary Information

Schedule of Pension Contributions (in thousands)

(Unaudited)

December 31	Actuarially determined contribution	Contributions in relation to the actuarially determined contribution	Contribution deficiency (excess)	Covered-employee payroll	Contributions as a percentage of covered-employee payroll
2018	$ 36,326	$ 78,526	$ (42,200)	$ 1,804,814	4.4 %
2017	81,981	124,181	(42,200)	1,796,876	6.9 %
2016	90,684	132,884	(42,200)	1,959,073	6.8 %
2015	92,405	92,405	—	1,995,117	4.6 %
2014	79,015	79,015	—	1,909,014	4.1 %

Notes to schedule:

Valuation date	Actuarially determined contribution rates are calculated as of January 1, one year prior to the end of the fiscal year in which contributions are reported.

Methods and assumptions used to determine contribution rate for 2018:

Actuarial cost method	Entry Age Normal with 20-year closed amortization period for initial unfunded and subsequent actuarial gains/losses
Asset valuation method	5-year smoothing
Cash balance interest credits	5.00 %
Salary increases	3.00 %
Investment rate of return	7.50%, net of pension plan investment expense, including inflation
Retirement age	Varies by age, same as for GASB 68
Mortality	RP-2014 with generational projection using scale MP-2017

The schedules are intended to show information for 10 years. Additional years will be presented as the information becomes available.

See accompanying independent auditors' report.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Required Supplementary Information

Schedule of Pension Plan Investment Returns

(Unaudited)

CHS Plan measurement date	Annual money-weighted rate of return net of investment expenses
July 1, 2018	8.0 %
July 1, 2017	15.0 %
July 1, 2016	(4.8)%
July 1, 2015	2.4 %
July 1, 2014	15.8 %

Notes to schedule:

The schedules are intended to show information for 10 years. Additional years will be presented as the information becomes available.

See accompanying independent auditors' report.

OTHER FINANCIAL INFORMATION

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Combining Schedule of Assets, Deferred Outflows of Resources, Liabilities, Deferred Inflows of Resources and Net Position – Combined Group

December 31, 2018 and 2017

(Dollars in thousands)

	2018				2017			
Assets and Deferred Outflows of Resources	Primary Enterprise	Atrium Health Foundation	Eliminations	Total	Primary Enterprise	Atrium Health Foundation	Eliminations	Total
Current assets:								
Cash and cash equivalents	$ 82,900	$ 3,628	$ —	$ 86,528	$ 131,540	$ 4,659	$ —	$ 136,199
Short-term investments	—	9,180	—	9,180	198	10,329	—	10,527
Patient accounts receivable – net	720,375	—	—	720,375	729,164	—	—	729,164
Other accounts receivable	109,416	11,277	(2,374)	118,319	94,331	11,659	(728)	105,262
Assets limited as to use – investments	34,991	—	—	34,991	32,820	—	—	32,820
Inventories	71,863	—	—	71,863	67,405	—	—	67,405
Prepaid expenses	75,586	484	—	76,070	68,645	488	—	69,133
Total current assets	1,095,131	24,569	(2,374)	1,117,326	1,124,103	27,135	(728)	1,150,510
Capital assets	6,219,854	11,705	—	6,231,559	5,825,529	11,572	—	5,837,101
Accumulated depreciation	(3,053,542)	(7,064)	—	(3,060,606)	(2,775,903)	(6,445)	—	(2,782,348)
Total capital assets – net	3,166,312	4,641	—	3,170,953	3,049,626	5,127	—	3,054,753
Other noncurrent assets:								
Assets limited as to use:								
Bond proceeds held by trustee	304,424	—	—	304,424	—	—	—	—
Investments designated for capital improvements	4,245,909	—	—	4,245,909	4,175,386	—	—	4,175,386
Other long-term investments	43,884	265,333	—	309,217	31,014	285,768	—	316,782
Other assets limited as to use – investments	101,840	—	—	101,840	109,954	—	—	109,954
Other assets	180,683	36,966	(4,332)	213,317	197,534	37,236	(1,899)	232,871
Total other noncurrent assets	4,876,740	302,299	(4,332)	5,174,707	4,513,888	323,004	(1,899)	4,834,993
Total assets	9,138,183	331,509	(6,706)	9,462,986	8,687,617	355,266	(2,627)	9,040,256
Deferred outflows of resources	225,132	—		225,132	277,277	—	—	277,277
Total assets and deferred outflows of resources	$ 9,363,315	$ 331,509	$ (6,706)	$ 9,688,118	$ 8,964,894	$ 355,266	$ (2,627)	$ 9,317,533
Liabilities, Deferred Inflows of Resources and Net Position								
Current liabilities:								
Accounts payable	$ 349,043	$ 201	$ (2,500)	$ 346,744	$ 261,025	$ 183	$ —	$ 261,208
Salaries and benefits payable	391,554	—	—	391,554	323,837	—	—	323,837
Other liabilities and accruals	207,496	2,512	(2,374)	207,634	194,382	1,804	(728)	195,458
Estimated third-party payer settlements	220,035	—	—	220,035	176,647	—	—	176,647
Current portion of long-term debt	170,982	—	—	170,982	68,465	—	—	68,465
Total current liabilities	1,339,110	2,713	(4,874)	1,336,949	1,024,356	1,987	(728)	1,025,615
Long-term debt – less current portion	2,070,845	—	—	2,070,845	1,799,149	—	—	1,799,149
Interest rate swap liability	189,250	—	—	189,250	219,841	—	—	219,841
Pension liability	295,162	—	—	295,162	379,685	—	—	379,685
Other liabilities	319,732	3,114	(1,832)	321,014	329,690	3,310	(1,899)	331,101
Total liabilities	4,214,099	5,827	(6,706)	4,213,220	3,752,721	5,297	(2,627)	3,755,391
Commitments and contingencies								
Deferred inflows of resources	65,086	—	—	65,086	58,330	—	—	58,330
Net position:								
Net investment in capital assets	1,231,053		—	1,231,053	1,185,504	—	—	1,185,504
Restricted – by donor	28,218	303,100	—	331,318	28,002	317,524	—	345,526
Unrestricted	3,824,859	22,582	—	3,847,441	3,940,337	32,445	—	3,972,782
Total net position	5,084,130	325,682	—	5,409,812	5,153,843	349,969	—	5,503,812
Total liabilities, deferred inflows of resources and net position	$ 9,363,315	$ 331,509	$ (6,706)	$ 9,688,118	$ 8,964,894	$ 355,266	$ (2,627)	$ 9,317,533

The Total column presented above represents the Combined Group, which consists of the Obligated Group and its Designated Affiliates (including non-Obligated Group affiliates that at December 31, 2018 represent less than 1% of the total revenue and less than 1% of the total assets of the Combined Group; these same non-Obligated Group affiliates represent less than 1% of the total revenue and less than 1% of the total assets of the Primary Enterprise column), as such terms are defined in Section 101 of the Charlotte-Mecklenburg Hospital Authority's Second Amended and Restated Bond Order adopted as of September 9, 1997, as amended. Because none of the members of the Obligated Group have Designated Affiliates at this time, the only members of the Combined Group are the members of the Obligated Group.

See accompanying independent auditors' report.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Combining Schedule of Revenues, Expenses and Changes in Net Position – Combined Group

Years ended December 31, 2018 and 2017

(Dollars in thousands)

	2018				2017			
	Primary Enterprise	Atrium Health Foundation	Eliminations	Total	Primary Enterprise	Atrium Health Foundation	Eliminations	Total
Net patient service revenue	$ 5,600,035	$ —	$ —	$ 5,600,035	$ 5,402,741	$ —	$ —	$ 5,402,741
Other revenue	628,176	23,545	(33,268)	618,453	562,832	25,861	(31,355)	557,338
Total revenue	6,228,211	23,545	(33,268)	6,218,488	5,965,573	25,861	(31,355)	5,960,079
Operating expenses:								
Personnel costs	3,505,673	3,631	—	3,509,304	3,461,411	2,986	—	3,464,397
Supplies	1,102,356	—	—	1,102,356	1,036,409	—	—	1,036,409
Purchased services	449,888	—	—	449,888	410,286	—	—	410,286
Other expenses	519,066	31,244	(28,288)	522,022	431,209	31,254	(29,555)	432,908
Depreciation and amortization	325,928	637	—	326,565	310,286	637	—	310,923
Interest expense	77,454	—	—	77,454	77,954	—	—	77,954
Total operating expenses	5,980,365	35,512	(28,288)	5,987,589	5,727,555	34,877	(29,555)	5,732,877
Operating income (loss)	247,846	(11,967)	(4,980)	230,899	238,018	(9,016)	(1,800)	227,202
Nonoperating (loss) income								
Interest and dividend income	84,109	4,538	—	88,647	55,849	2,517	—	58,366
Net change in the fair value of investments	(404,748)	(22,869)	—	(427,617)	498,792	37,891	—	536,683
Other – net	(4,840)	—	4,980	140	(5,901)	—	1,800	(4,101)
Total nonoperating (loss) income – net	(325,479)	(18,331)	4,980	(338,830)	548,740	40,408	1,800	590,948
Revenue (under) over expenses before contributions	(77,633)	(30,298)	—	(107,931)	786,758	31,392	—	818,150
Capital contributions	8,282	(981)	—	7,301	7,651	2,204	—	9,855
Other contributions	(362)	6,992	—	6,630	(88)	1,998	—	1,910
(Decrease) increase in net position	(69,713)	(24,287)	—	(94,000)	794,321	35,594	—	829,915
Net position:								
Beginning of year	5,153,843	349,969	—	5,503,812	4,359,522	314,375	—	4,673,897
End of year	$ 5,084,130	$ 325,682	$ —	$ 5,409,812	$ 5,153,843	$ 349,969	$ —	$ 5,503,812

The Total column presented above represents the Combined Group, which consists of the Obligated Group and its Designated Affiliates (including non-Obligated Group affiliates that at December 31, 2018 represent less than 1% of the total revenue and less than 1% of the total assets of the Combined Group; these same non-Obligated Group affiliates represent less than 1% of the total revenue and less than 1% of the total assets of the Primary Enterprise column), as such terms are defined in Section 101 of the Charlotte-Mecklenburg Hospital Authority's Second Amended and Restated Bond Order adopted as of September 9, 1997, as amended. Because none of the members of the Obligated Group have Designated Affiliates at this time, the only members of the Combined Group are the members of the Obligated Group.

See accompanying independent auditors' report.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY
(d/b/a Atrium Health)

Combining Schedule of Cash Flows – Combined Group

Years ended December 31, 2018 and 2017

(Dollars in thousands)

	2018				2017			
	Primary Enterprise	Atrium Health Foundation	Eliminations	Total	Primary Enterprise	Atrium Health Foundation	Eliminations	Total
Cash flows from operating activities:								
Receipts from third-party payers and patients	$ 5,653,467	$ —	$ —	$ 5,653,467	$ 5,351,787	$ —	$ —	$ 5,351,787
Payments to suppliers	(1,930,226)	(4,192)	—	(1,934,418)	(1,881,420)	(13,650)	(1,800)	(1,896,870)
Payments to employees	(3,474,959)	—	—	(3,474,959)	(3,503,421)	—	—	(3,503,421)
Other receipts – net	575,059	(16,941)	(4,980)	553,138	586,321	729	—	587,050
Net cash provided by (used in) operating activities	823,341	(21,133)	(4,980)	797,228	553,267	(12,921)	(1,800)	538,546
Noncapital financing activities								
Proceeds from the issuance of commercial paper	210,000	—	—	210,000	(135,000)	—	—	(135,000)
Retirements of commercial paper	(210,000)	—	—	(210,000)	135,000	—	—	135,000
Other activities	(6,683)	—	4,980	(1,703)	(3,052)	—	1,800	(1,252)
Net cash used in noncapital financing activities	(6,683)	—	4,980	(1,703)	(3,052)	—	1,800	(1,252)
Cash flows from capital and related financing activities:								
Purchase of capital assets	(440,273)	(151)	—	(440,424)	(300,869)	(70)	—	(300,939)
Donated funds designated for building and equipment purchases	8,812	1,052	—	9,864	5,652	1,275	—	6,927
Acquisition of health related businesses	—	—	—	—	(1,710)	—	—	(1,710)
Principal payments, refunding and retirements on short- and long-term debt	(217,044)	—	—	(217,044)	(198,385)	—	—	(198,385)
Interest payments on short- and long-term debt	(91,125)	—	—	(91,125)	(80,901)	—	—	(80,901)
Proceeds from issuance of long-term debt	590,251	—	—	590,251	164,855	—	—	164,855
Decrease in other assets affecting capital and related financing activities	—	9,024	—	9,024	23	648	—	671
Other contributions	—	6,991	—	6,991	(88)	1,998	—	1,910
Net cash (used in) provided by capital and related financing activities	(149,379)	16,916	—	(132,463)	(411,423)	3,851	—	(407,572)
Cash flows from investing activities:								
Withdrawal from investments limited as to use	—	—	—	—	—	9,000	—	9,000
Contribution to investments limited as to use	(401,614)	—	—	(401,614)	(152,500)	—	—	(152,500)
Investment earnings	(3,249)	3,186	—	(63)	4,676	43	—	4,719
Decrease in other trusteed assets	145	—	—	145	802	—	—	802
Purchase of investments	(6,777)	—	—	(6,777)	(2,955)	—	—	(2,955)
Net cash (used in) provided by investing activities	(411,495)	3,186	—	(408,309)	(149,977)	9,043	—	(140,934)
Net increase (decrease) in cash and cash equivalents	255,784	(1,031)	—	254,753	(11,185)	(27)	—	(11,212)
Cash and cash equivalents:								
Beginning of year	131,540	4,659	—	136,199	142,725	4,686	—	147,411
End of year	$ 387,324	$ 3,628	$ —	$ 390,952	$ 131,540	$ 4,659	$ —	$ 136,199
Reconciliation of cash and cash equivalents to the balance sheets:								
Cash and cash equivalents in current assets	$ 82,900	$ 3,628	$ —	$ 86,528	$ 131,540	$ 4,659	$ —	$ 136,199
Bond proceeds held by trustee	304,424	—	—	304,424	—	—	—	—
Total cash and cash equivalents	$ 387,324	$ 3,628	$ —	$ 390,952	$ 131,540	$ 4,659	$ —	$ 136,199
Reconciliation of operating income (loss) to net cash provided by (used in) operating activities:								
Operating income (loss)	$ 247,846	$ (11,967)	$ (4,980)	$ 230,899	$ 238,018	$ (9,016)	$ (1,800)	$ 227,202
Interest expense considered capital financing activity	77,454	—	—	77,454	77,954	—	—	77,954
Adjustments to reconcile operating income (loss) to net cash provided by (used in) operating activities:								
Depreciation and amortization	325,928	637	—	326,565	310,286	637	—	310,923
Decrease in patient accounts receivable – net	8,789	—	—	8,789	3,362	—	—	3,362
(Increase) decrease in inventories and other current assets	(25,096)	(10,504)	4,146	(31,454)	20,192	(4,257)	(1,249)	14,686
(Increase) decrease in other assets affecting operating activities	(2,065)	103	—	(1,962)	3,608	(173)	—	3,435
Increase (decrease) in accounts payable and other current liabilities	142,263	—	(4,146)	138,117	(37,089)	—	1,249	(35,840)
Increase (decrease) in other liabilities affecting operating activities	4,834	598	—	5,432	(45,571)	(112)	—	(45,683)
Increase (decrease) in estimated third party payer settlements	43,388	—	—	43,388	(17,493)	—	—	(17,493)
Net cash provided by (used in) operating activities	$ 823,341	$ (21,133)	$ (4,980)	$ 797,228	$ 553,267	$ (12,921)	$ (1,800)	$ 538,546

The Total column presented above represents the Combined Group, which consists of the Obligated Group and its Designated Affiliates (including non-Obligated Group affiliates that at December 31, 2018 represent less than 1% of the total revenue and less than 1% of the total assets of the Combined Group; these same non-Obligated Group affiliates represent less than 1% of the total revenue and less than 1% of the total assets of the Primary Enterprise column), as such terms are defined in Section 101 of the Charlotte-Mecklenburg Hospital Authority's Second Amended and Restated Bond Order adopted as of September 9, 1997, as amended. Because none of the members of the Obligated Group have Designated Affiliates at this time, the only members of the Combined Group are the members of the Obligated Group.

See accompanying independent auditors' report.

Table 5A: Acute Care Bed Need Projections

2018 Utilization Data from Truven Health Analytics compiled by the Cecil B. Sheps Center for Health Services Research
Target Occupancy Rates: ADC 1-99: 66.7%, ADC 100-200: 71.4%, ADC > 200 and <=400: 75.2%, ADC>400: 78%
Target Occupancy Factors: ADC 1-99: 1.50, ADC 100-200: 1.40, ADC > 200 and <=400: 1.33, ADC >400: 1.28

A	B	C	D	E	F	G	H	I	J	K	L
Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
Alamance	H0272	Alamance Regional Medical Center	182	0	35,922	-1.0279	35,922	98	148	-34	
Alamance Total			**182**	**0**							**0**
Alexander	H0274	Alexander Hospital (closed)*	25	-25		0.0000	0	0	0	0	
Alexander Total			**25**	**-25**							**0**
Alleghany	H0108	Alleghany Memorial Hospital	41	0	1,133	-1.1350	1,133	3	5	-36	
Alleghany Total			**41**	**0**							**0**
Anson	H0082	Atrium Health Anson	15	0	718	1.1233	1,143	3	5	-10	
Anson Total			**15**	**0**							**0**
Ashe	H0099	Ashe Memorial Hospital,Inc.	76	0	4,325	-1.0157	4,325	12	18	-58	
Ashe Total			**76**	**0**							**0**
Avery	H0037	Charles A. Cannon, Jr. Memorial Hospital**/†	30	0	1,733	-1.2357	1,733	5	7	-23	
Avery Total			**30**	**0**							**0**
Beaufort	H0188	Vidant Beaufort Hospital	120	0	12,052	1.0397	14,084	39	58	-62	
Beaufort	H0002	Vidant Pungo Hospital (closed)^	39	0		1.0397	0	0	0	-39	
Beaufort Total			**159**	**0**							**0**
Bertie	H0268	Vidant Bertie Hospital	6	0	1,398	-1.0247	1,398	4	6	0	
Bertie Total			**6**	**0**							**0**
Bladen	H0154	Cape Fear Valley-Bladen County Hospital**	48	0	3,706	1.0114	3,878	11	16	-32	
Bladen Total			**48**	**0**							**0**
Brunswick	H0150	J. Arthur Dosher Memorial Hospital**	25	0	2,575	-1.0186	2,575	7	11	-14	
Brunswick	H0250	Novant Health Brunswick Medical Center	74	0	14,909	-1.0186	14,909	41	61	-13	
Brunswick Total			**99**	**0**							**0**
Buncombe	H0036	Mission Hospital	708	25	193,482	1.0173	207,221	567	726	-7	
Buncombe/Graham/Madison/Yancey Total			**708**	**25**							**0**
Burke	H0062	Carolinas HealthCare System Blue Ridge	293	0	21,760	-1.0254	21,760	60	89	-204	
Burke Total			**293**	**0**							**0**
Cabarrus	H0031	Carolinas HealthCare System NorthEast	447	0	106,090	1.0469	127,416	349	464	17	

Projections based on four-year average county-specific growth rates, compounded annually over the next four years. Acute Care Days data from 2014, 2015, 2016, 2017 and 2018 were used to generate four-year growth rate.

(ADC= Average Daily Census)

Table 5A: Acute Care Bed Need Projections

2018 Utilization Data from Truven Health Analytics compiled by the Cecil B. Sheps Center for Health Services Research
Target Occupancy Rates: ADC 1-99: 66.7%, ADC 100-200: 71.4%, ADC > 200 and <=400: 75.2%, ADC>400: 78%
Target Occupancy Factors: ADC 1-99: 1.50, ADC 100-200: 1.40, ADC > 200 and <=400: 1.33, ADC >400: 1.28

A	B	C	D	E	F	G	H	I	J	K	L
Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
Cabarrus Total			**447**	**0**							**0**
Caldwell	H0061	Caldwell Memorial Hospital	110	0	18,839	1.0242	20,726	57	85	-25	
Caldwell Total			**110**	**0**							**0**
Carteret	H0222	Carteret General Hospital**	135	0	20,913	-1.0144	20,913	57	86	-49	
Carteret Total			**135**	**0**							**0**
Catawba	H0223	Catawba Valley Medical Center	200	0	38,978	1.0081	40,264	110	154	-46	
Catawba	H0053	Frye Regional Medical Center**	209	0	30,930	1.0081	31,950	87	131	-78	
Catawba Total			**409**	**0**							**0**
Chatham	H0007	Chatham Hospital	25	0	2,208	1.0315	2,500	7	10	-15	
Chatham Total			**25**	**0**							**0**
Cherokee	H0239	Erlanger Murphy Medical Center	57	0	5,810	-1.0387	5,810	16	24	-33	
Cherokee/Clay Total			**57**	**0**							**0**
Chowan	H0063	Vidant Chowan Hospital	49	0	5,325	1.0083	5,504	15	23	-26	
Chowan Total			**49**	**0**							**0**
Cleveland	H0024	Atrium Health Cleveland	241	0	33,706	1.0209	36,612	100	140	-101	
Cleveland	H0113	Atrium Health Kings Mountain	47	0	5,816	1.0209	6,317	17	26	-21	
		Atrium Health Total	288	0	39,522		42,929	118	166	-122	
Cleveland Total			**288**	**0**							**0**
Columbus	H0045	Columbus Regional Healthcare System	154	0	16,971	-1.0072	16,971	46	70	-84	
Columbus Total			**154**	**0**							**0**
Craven	H0201	CarolinaEast Medical Center	307	0	59,395	1.0437	70,470	193	270	-37	
Craven/Jones/Pamlico Total			**307**	**0**							**0**
Cumberland	H0213	Cape Fear Valley Medical Center	524	65	165,354	1.0082	170,847	468	599	10	
Cumberland Total			**524**	**65**							**0**
Dare	H0273	The Outer Banks Hospital	21	0	2,560	-1.0086	2,560	7	11	-10	
Dare Total			**21**	**0**							**0**
Davidson	H0027	Lexington Medical Center**	94	0	9,707	1.0509	11,839	32	49	-45	

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(ADC= Average Daily Census)

Table 5A: Acute Care Bed Need Projections

2018 Utilization Data from Truven Health Analytics compiled by the Cecil B. Sheps Center for Health Services Research
Target Occupancy Rates: ADC 1-99: 66.7%, ADC 100-200: 71.4%, ADC > 200 and <=400: 75.2%, ADC>400: 78%
Target Occupancy Factors: ADC 1-99: 1.50, ADC 100-200: 1.40, ADC > 200 and <=400: 1.33, ADC >400: 1.28

A	B	C	D	E	F	G	H	I	J	K	L
Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
Davidson	H0112	Novant Health Thomasville Medical Center	101	0	12,667	1.0509	15,450	42	63	-38	
Davidson Total			**195**	**0**							**0**
Davie	H0171	Davie Medical Center	50	0	2,992	1.1174	4,664	13	19	-31	
Davie Total			**50**	**0**							**0**
Duplin	H0166	Vidant Duplin Hospital**	56	0	10,158	1.0884	14,255	39	59	3	
Duplin Total			**56**	**0**							**0**
Durham		2019 Acute Care Bed Need Determination	0	34		1.0119	0	0	0	-34	
Durham	H0233	Duke Regional Hospital	316	0	63,361	1.0119	66,421	182	255	-61	
Durham	H0015	Duke University Hospital***	924	90	282,987	1.0119	296,655	812	1,040	26	
		Duke University Health System Total	1,240	90	346,348		363,076	994	1,294	-36	
Durham	H0075	North Carolina Specialty Hospital	18	6	2,969	1.0119	3,112	9	13	-11	
Durham/Caswell Total			**1,258**	**130**							**0**
Edgecombe	H0258	Vidant Edgecombe Hospital	101	0	14,435	1.0212	15,697	43	64	-37	
Edgecombe Total			**101**	**0**							**0**
Forsyth	H0011	North Carolina Baptist Hospital	802	4	230,618	1.0198	249,430	683	874	68	
Forsyth	H0209	Novant Health Forsyth Medical Center††††	865	0	215,058	1.0198	232,601	637	815	-50	
Forsyth	H0229	Novant Health Medical Park Hospital	22	0	2,810	1.0198	3,039	8	12	-10	
		Novant Health Total	887	0	217,868		235,640	645	828	-59	
Forsyth Total			**1,689**	**4**							**68**
Franklin	H0261	Franklin Medical Center (closed)^^/††	70	0		0.0000	0	0	0	-70	
Franklin Total			**70**	**0**							**0**
Gaston		2019 Acute Care Bed Need Determination	0	33		1.0626	0	0	0	-33	
Gaston	H0105	CaroMont Regional Medical Center	372	0	101,011	1.0626	128,762	353	469	97	
Gaston Total			**372**	**33**							**64**
Granville	H0098	Granville Health System	62	0	7,160	-1.0367	7,160	20	29	-33	
Granville Total			**62**	**0**							**0**
Guilford	H0159	Cone Health**	777	-23	177,633	1.0033	179,969	493	631	-123	

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2018 Utilization Data from Truven Health Analytics compiled by the Cecil B. Sheps Center for Health Services Research
Target Occupancy Rates: ADC 1-99: 66.7%, ADC 100-200: 71.4%, ADC > 200 and <=400: 75.2%, ADC>400: 78%
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Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
Guilford	H0052	High Point Regional Health	307	0	55,319	1.0033	56,046	153	215	-92	
Guilford Total			**1,084**	**-23**							**0**
Halifax	H0230	Halifax Regional Medical Center	184	0	20,123	1.0019	20,276	56	83	-101	
Halifax		Our Community Hospital (closed as of 10/25/17)**	0	0	10	1.0019	10	0	0	0	
Halifax/Northampton Total			**184**	**0**							**0**
Harnett	H0224	Betsy Johnson Hospital**	151	0	16,837	-1.0971	16,837	46	69	-82	
Harnett Total			**151**	**0**							**0**
Haywood	H0025	Haywood Regional Medical Center	126	0	18,059	1.0929	25,761	71	106	-20	
Haywood Total			**126**	**0**							**0**
Henderson	H0019	AdventHealth Hendersonville**	62	0	9,999	1.0231	10,955	30	45	-17	
Henderson	H0161	Margaret R. Pardee Memorial Hospital	201	0	23,086	1.0231	25,294	69	104	-97	
Henderson Total			**263**	**0**							**0**
Hertford	H0001	Vidant Roanoke-Chowan Hospital	86	0	13,260	1.0371	15,338	42	63	-23	
Hertford/Gates Total			**86**	**0**							**0**
Hoke	H0288	Cape Fear Valley Hoke Hospital	41	0	3,018	1.7648	29,277	80	120	79	
Hoke	H0287	FirstHealth Moore Regional Hospital - Hoke Campus	8	28	1,855	1.7648	17,995	49	74	38	
Hoke Total**			**49**	**28**							**117**
Iredell	H0248	Davis Regional Medical Center	102	0	8,230	-1.0160	8,230	23	34	-68	
Iredell	H0259	Lake Norman Regional Medical Center	123	0	14,753	-1.0160	14,753	40	61	-62	
		Community Health Systems Total	225	0	22,983		22,983	63	94	-131	
Iredell	H0164	Iredell Memorial Hospital**	199	0	35,661	-1.0160	35,661	98	146	-53	
Iredell Total			**424**	**0**							**0**
Jackson	H0087	Harris Regional Hospital	86	0	12,985	1.0072	13,363	37	55	-31	
Jackson Total			**86**	**0**							**0**
Johnston	H0151	Johnston Health	179	0	31,161	1.0115	32,616	89	134	-45	
Johnston Total			**179**	**0**							**0**

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2018 Utilization Data from Truven Health Analytics compiled by the Cecil B. Sheps Center for Health Services Research
Target Occupancy Rates: ADC 1-99: 66.7%, ADC 100-200: 71.4%, ADC > 200 and <=400: 75.2%, ADC>400: 78%
Target Occupancy Factors: ADC 1-99: 1.50, ADC 100-200: 1.40, ADC > 200 and <=400: 1.33, ADC >400: 1.28

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Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
Lee	H0243	Central Carolina Hospital	127	0	15,092	-1.0384	15,092	41	62	-65	
Lee Total			**127**	**0**							**0**
Lenoir	H0043	UNC Lenoir Health Care	218	0	24,370	-1.0038	24,370	67	100	-118	
Lenoir Total			**218**	**0**							**0**
Lincoln	H0225	Atrium Health Lincoln	101	0	18,953	1.0402	22,189	61	91	-10	
Lincoln Total			**101**	**0**							**0**
Macon	H0034	Angel Medical Center	59	0	5,000	1.0360	5,761	16	24	-35	
Macon	H0193	Highlands-Cashiers Hospital**	24	0	2,784	1.0360	3,208	9	13	-11	
Macon Total			**83**	**0**							**0**
Martin	H0078	Martin General Hospital	49	0	3,719	-1.0612	3,719	10	15	-34	
Martin Total			**49**	**0**							**0**
McDowell	H0097	Mission Hospital McDowell	65	0	7,663	1.0175	8,213	22	34	-31	
McDowell Total			**65**	**0**							**0**
Mecklenburg		2019 Acute Care Bed Need Determination	0	76		1.0278	0	0	0	-76	
Mecklenburg	H0042	Atrium Health Pineville	206	53	67,508	1.0278	75,334	206	274	15	
Mecklenburg	H0255	Atrium Health University City	100	0	27,132	1.0278	30,277	83	124	24	
Mecklenburg	H0071	Carolinas Medical Center/Center for Mental Health	1,010	45	311,337	1.0278	347,430	951	1,218	163	
		Atrium Health Total	1,316	98	405,977		453,041	1,240	1,616	202	
Mecklenburg		Novant Health Ballantyne Medical Center	0	36		1.0278	0	0	0	-36	
Mecklenburg	H0282	Novant Health Huntersville Medical Center	91	60	25,022	1.0278	27,923	76	115	-36	
Mecklenburg	H0270	Novant Health Matthews Medical Center	154	0	37,968	1.0278	42,370	116	162	8	
Mecklenburg	H0290	Novant Health Mint Hill Medical Center	36	14		1.0278	0	0	0	-50	
Mecklenburg	H0010	Novant Health Presbyterian Medical Center	567	-84	127,756	1.0278	142,566	390	519	36	
		Novant Health Total	848	26	190,746		212,859	583	796	-78	
Mecklenburg Total			**2,164**	**200**							**126**
Mitchell	H0169	Blue Ridge Regional Hospital**	46	0	4,294	-1.0448	4,294	12	18	-28	

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Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
Mitchell Total			**46**	**0**							**0**
Montgomery	H0003	FirstHealth Montgomery Memorial Hospital**	37	0	782	1.0518	957	3	4	-33	
Montgomery Total			**37**	**0**							**0**
Moore	H0100	FirstHealth Moore Regional Hospital and Pinehurst Treatment	337	22	93,683	1.0297	105,322	288	384	25	
Moore Total			**337**	**22**							**25**
Nash	H0228	Nash General Hospital	262	0	44,912	-1.0240	44,912	123	172	-90	
Nash Total			**262**	**0**							**0**
New Hanover	H0221	New Hanover Regional Medical Center	647	31	185,420	1.0237	203,616	557	714	36	
New Hanover Total			**647**	**31**							**36**
Onslow	H0048	Onslow Memorial Hospital	162	0	30,453	1.0036	30,892	85	127	-35	
Onslow Total			**162**	**0**							**0**
Orange	H0157	University of North Carolina Hospitals	810	121	240,129	1.0205	260,386	713	913	-18	
Orange Total			**810**	**121**							**0**
Pasquotank	H0054	Sentara Albemarle Medical Center**	182	0	21,088	1.0104	21,982	60	90	-92	
Pasquotank/Camden/Currituck/Perquimans Total			**182**	**0**							**0**
Pender	H0115	Pender Memorial Hospital	43	0	1,394	-1.0585	1,394	4	6	-37	
Pender Total			**43**	**0**							**0**
Person	H0066	Person Memorial Hospital	38	0	3,064	-1.1331	3,064	8	13	-25	
Person Total			**38**	**0**							**0**
Pitt	H0104	Vidant Medical Center	847	85	232,926	1.0038	236,442	647	829	-103	
Pitt/Greene/Hyde/Tyrrell Total			**847**	**85**							**0**
Polk	H0079	St. Luke's Hospital	25	0	4,067	1.0042	4,136	11	17	-8	
Polk Total			**25**	**0**							**0**
Randolph	H0013	Randolph Hospital**	145	0	13,733	-1.0831	13,733	38	56	-89	
Randolph Total			**145**	**0**							**0**
Richmond	H0265	FirstHealth Moore Regional Hospital - Hamlet (closed)**	54	0	52	-1.0639	52	0	0	-54	

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Service Area	**License Number**	**Facility Name**	**Licensed Acute Care Beds**	**Adjustments for CONs/ Previous Need**	**Inpatient Days of Care**	**County Growth Rate Multiplier**	**Projected Days of Care**	**2022 Projected Average Daily Census (ADC)**	**2022 Beds Adjusted for Target Occupancy**	**Projected 2022 Deficit or Surplus (surplus shows as a "-")**	**2022 Need Determination**
Richmond	H0158	FirstHealth Moore Regional Hospital - Richmond	99	0	9,282	-1.0639	9,282	25	38	-61	
		FirstHealth of the Carolinas Total	153	0	9,334		9,334	26	38	-115	
Richmond Total			**153**	**0**							**0**
Robeson	H0064	Southeastern Regional Medical Center	292	0	56,777	-1.0142	56,777	155	218	-74	
Robeson Total			**292**	**0**							**0**
Rockingham	H0023	Annie Penn Hospital	110	0	12,312	-1.0200	12,312	34	51	-59	
Rockingham	H0072	UNC Rockingham Health Care	108	0	9,373	-1.0200	9,373	26	38	-70	
Rockingham Total			**218**	**0**							**0**
Rowan	H0040	Novant Health Rowan Medical Center	203	0	37,770	1.0059	38,670	106	148	-55	
Rowan Total			**203**	**0**							**0**
Rutherford	H0039	Rutherford Regional Medical Center	129	0	14,378	-1.0443	14,378	39	59	-70	
Rutherford Total			**129**	**0**							**0**
Sampson	H0067	Sampson Regional Medical Center	116	0	10,508	-1.0074	10,508	29	43	-73	
Sampson Total			**116**	**0**							**0**
Scotland	H0107	Scotland Memorial Hospital	97	0	19,353	1.0203	20,971	57	86	-11	
Scotland Total			**97**	**0**							**0**
Stanly	H0008	Carolinas HealthCare System Stanly	97	0	11,434	1.0041	11,622	32	48	-49	
Stanly Total			**97**	**0**							**0**
Stokes	H0165	LifeBrite Community Hospital of Stokes	53	0	860	-1.1490	860	2	4	-49	
Stokes Total			**53**	**0**							**0**
Surry	H0049	Hugh Chatham Memorial Hospital	81	0	12,267	1.0042	12,475	34	51	-30	
Surry	H0184	Northern Hospital of Surry County*	100	-17	13,198	1.0042	13,421	37	55	-28	
Surry Total			**181**	**-17**							**0**
Swain	H0069	Swain Community Hospital	48	0	456	-1.1906	456	1	2	-46	
Swain Total			**48**	**0**							**0**
Transylvania	H0111	Transylvania Regional Hospital	42	0	5,405	-1.0825	5,405	15	22	-20	
Transylvania Total			**42**	**0**							**0**

Projections based on four-year average county-specific growth rates, compounded annually over the next four years. Acute Care Days data from 2014, 2015, 2016, 2017 and 2018 were used to generate four-year growth rate.

(ADC= Average Daily Census)

Table 5A: Acute Care Bed Need Projections

2018 Utilization Data from Truven Health Analytics compiled by the Cecil B. Sheps Center for Health Services Research
Target Occupancy Rates: ADC 1-99: 66.7%, ADC 100-200: 71.4%, ADC > 200 and <=400: 75.2%, ADC>400: 78%
Target Occupancy Factors: ADC 1-99: 1.50, ADC 100-200: 1.40, ADC > 200 and <=400: 1.33, ADC >400: 1.28

A	B	C	D	E	F	G	H	I	J	K	L
Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
Union	H0050	Atrium Health Union	182	0	33,459	1.0455	39,974	109	153	-29	
Union Total			**182**	**0**							**0**
Vance	H0267	Maria Parham Health	91	11	17,293	-1.0483	17,293	47	71	-31	
Vance/Warren Total			**91**	**11**							**0**
Wake	H0238	Duke Raleigh Hospital	186	0	43,805	1.0162	46,710	128	179	-7	
Wake	H0065	Rex Hospital	439	0	114,684	1.0162	122,288	335	445	6	
Wake		Rex Hospital Holly Springs	0	50		1.0162	0	0	0	-50	
		UNC Health Care Total	439	50	114,684		122,288	335	445	-44	
Wake	H0199	WakeMed	628	36	160,470	1.0162	171,110	468	600	-64	
Wake	H0276	WakeMed Cary Hospital	178	30	45,294	1.0162	48,297	132	185	-23	
		WakeMed Total	806	66	205,764		219,408	601	785	-87	
Wake Total			**1,431**	**116**							**0**
Washington	H0006	Washington County Hospital	49	-37	606	-1.1247	606	2	2	-10	
Washington Total			**49**	**-37**							**0**
Watauga	H0077	Watauga Medical Center	117	0	13,894	1.0068	14,274	39	59	-58	
Watauga Total			**117**	**0**							**0**
Wayne	H0257	Wayne UNC Health Care	255	0	47,205	1.0007	47,329	130	181	-74	
Wayne Total			**255**	**0**							**0**
Wilkes	H0153	Wilkes Regional Medical Center	120	0	11,816	-1.0475	11,816	32	49	-71	
Wilkes Total			**120**	**0**							**0**
Wilson	H0210	Wilson Medical Center†††	270	0	24,634	-1.0569	24,634	67	101	-169	
Wilson Total			**270**	**0**							**0**
Yadkin	H0155	Yadkin Valley Community Hospital (closed)^^^	22	0		0.0000	0	0	0	-22	
Yadkin Total			**22**	**0**							**0**

Projections based on four-year average county-specific growth rates, compounded annually over the next four years. Acute Care Days data from 2014, 2015, 2016, 2017 and 2018 were used to generate four-year growth rate.

(ADC= Average Daily Census)

Table 5A: Acute Care Bed Need Projections

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A	B	C	D	E	F	G	H	I	J	K	L
Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2022 Projected Average Daily Census (ADC)	2022 Beds Adjusted for Target Occupancy	Projected 2022 Deficit or Surplus (surplus shows as a "-")	2022 Need Determination
		Grand Total All Hospitals	**21,247**	**769**	**4,481,364**		**4,860,884**				**435**

* Acute care beds in the "Adjustments for CONs/Previous Need" column are to be converted to inpatient psychiatric beds. This conversion is exempt from certificate of need review, pursuant to G.S. 131E-184(c).

** IBM Watson Health acute inpatient days of care data and the Division of Health Service Regulation Hospital License Renewal Application days of care data have a greater than ± 5% discrepancy between the two data sources

*** Duke University Hospital is licensed for 14 acute care beds under Policy AC-3. The 14 beds are not counted when determining acute care bed need.

**** The State Health Coordinating Council voted to remove the need for 117 beds in Hoke County.

^ The Division of Health Service Regulation received notices from two different buyers regarding the designation of Vidant Pungo Hospital as a legacy medical care facility. The prospective buyers have 36 months from the date of their respective notices to reopen the hospital. One notice was effective on May 16, 2016, and the other was effective on June 14, 2016.

^^ Effective October 23, 2017, the acute care beds at Franklin Medical Center were licensed as part of Maria Parham Medical Center pursuant to G.S. 131E-77(e1).

^^^ Yadkin Valley Community Hospital has requested to extend its designation as a legacy medical care facility by an additional 36 months. The facility has until January 18, 2022 to reopen the hospital.

† Charles A. Cannon, Jr. Memorial Hospital received a grant from the Dorothea Dix Hospital Property Fund to convert 27 acute care beds to adult psychiatric beds. This project is exempt from certificate of need review and the beds are not yet accounted for in Table 5A.

†† Duke LifePoint Maria Parham Medical Center received a grant from the Dorothea Dix Hospital Property Fund to renovate and convert 33 acute care beds to adult psychiatric beds on the site of the closed Franklin Medical Center. This project is exempt from certificate of need review and the beds are not yet accounted for in Table 5A.

††† One acute care bed was converted to a psychiatric bed on November 13, 2017, and has been removed from the acute care bed inventory.

†††† 42 long-term acute care beds from Select Specialty Hospital were reconverted back to general acute care beds and added to Novant Health Forsyth Medical Center's license, effective 12/13/2017.

Note: The decimal part of a number resulting from a calculation is not displayed, but it is used in subsequent calculations. Therefore, calculated totals may not be identical to displayed totals.

Projections based on four-year average county-specific growth rates, compounded annually over the next four years. Acute Care Days data from 2014, 2015, 2016, 2017 and 2018 were used to generate four-year growth rate.

(ADC= Average Daily Census)

Atrium Health

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Frisone:

The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health Pineville is submitting a Certificate of Need application to develop 12 additional acute care beds.

Atrium Health Pineville is currently licensed by the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Acute and Home Care Licensure and Certification Section as a general acute care hospital. Please accept this letter as documentation that Atrium Health Pineville meets all relevant licensure requirements.

Atrium Health Pineville is approved for participation in the Medicare and Medicaid programs. Please accept this letter as documentation that Atrium Health Pineville meets all requirements for certification and participation in the Medicare and Medicaid programs.

Atrium Health Pineville is accredited by The Joint Commission. Please accept this letter as documentation that Atrium Health Pineville holds a current accreditation from The Joint Commission.

Please also accept this letter as documentation of the current availability of all necessary ancillary and support services required for the project. As a full-service acute care hospital, Atrium Health Pineville already has all necessary ancillary and support service infrastructure in place. This infrastructure, as well as existing ancillary and support staff, will be sufficient to support the services proposed in this application. Inpatients may require the use of any of Atrium Health Pineville's ancillary and support services including laboratory, radiology, pharmacy, housekeeping, maintenance, and administration among others. These services are currently available at Atrium Health Pineville and will continue to be made available following completion of the proposed project.

Please let me know if you have any questions regarding this documentation.

Sincerely,

Michael Lutes
Sr. Vice President – Market President South
Atrium Health Pineville

Physician Support Letters

Atrium Health
Levine Cancer Institute

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my strong support for the CON applications submitted by The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health Pineville to develop two additional operating rooms and 12 additional acute care beds pursuant to need determinations identified in the *2019 State Medical Facilities Plan (SMFP)* for Mecklenburg County.

As a physician practicing in the area, I am aware of the growth in demand and the need for additional operating room and acute care bed capacity at Atrium Health Pineville. In 2005, Atrium Health Pineville began the first of two phases to expand capacity and add tertiary services. These projects were designed as a response to the growing population in Atrium Health Pineville's service area and the need to provide access closer to patients' homes. As a result, Atrium Health Pineville has experienced rapid and consistent growth that has outpaced its capacity, and I see a clear need for the hospital to ensure sufficient access to its growing number of patients.

I am aware that Atrium Health is submitting six concurrent and complementary applications to meet the needs identified in the *2019 SMFP* for acute care beds and operating rooms in Mecklenburg County. In addition to the proposed Atrium Health Pineville projects, Carolinas Medical Center, Atrium Health University City, and Atrium Health Lake Norman propose to develop operating rooms and/or acute care beds. I understand that this project is part of Atrium Health's overall plan to meet the needs of patients in Mecklenburg County. I am in support of this overall plan as well as the specific projects at Atrium Health Pineville.

I appreciate Atrium Health Pineville's commitment to its patients as well as its willingness to seek the input of local physicians. In an effort to enable me to focus on patient care, this letter may resemble the format of those signed by my colleagues; however, that should not detract from the fact that I fully support Atrium Health Pineville's proposals.

Sincerely,

Aakanksha Asija, MD
Department of Medical Oncology

US Acute Care Solutions

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: ADAM LANGENBRUNNER, MD

Specialty: EMERGENCY MEDICINE

USACS Center
East Ohio
330.493.6383
800.829.0678
fax 330.493.9677

Scope Anesthesia of North Carolina

October 15, 2019

Ms. Martha Frisone, Chief

Healthcare Planning and Certificate of Need Section

Division of Health Service Regulation

2704 Mail Service Center

Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Anthony Chillura MD

Specialty: Anesthesiologist

310 Arlington Avenue #418
Charlotte, NC 28203

Atrium Health
Levine Cancer Institute

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Atrium Health
Levine Cancer Institute

Sincerely,

Signature. Antoinette Tan

Name: Antoinette Tan

Specialty: Medical Oncology

PO Box 32861 • Charlotte, NC 28232-2861

Atrium Health
Levine Cancer Institute

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Atrium Health
Levine Cancer Institute

Sincerely,

Signature: [signature]

Name: Arielle Heeke, MD

Specialty: medical oncology

October 15, 2019

Atrium Health

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Ashleigh Owen Maiers, MD

Name: Ashleigh Owen Maiers, MD

Specialty: Cardiology - Adult

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Brad J Bissell

Specialty: Emergency Medicine

USACS Central
4535 Dressler Rd. NW
Canton, Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8677

US Acute Care Solutions

www.usacs.com

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Brad Watson

Specialty: Orthopedic Medicine

USACS Center
Canton, OH 44718
330.493.4483
800.938.0858
fax 330.493.8677

Atrium Health
Levine Cancer Institute

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Atrium Health
Levine Cancer Institute

Sincerely,

Signature. Brinda Koya

Name: BRINDA. KOYA

Specialty: Oncology (levine Cancer Institute)

PO Box 32861 • Charlotte, NC 28232-2861

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
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Sincerely,

Signature: _____

Name: Caleb Gerhart, DO

Specialty: Emergency Medicine

USACS Centra
4535 Dressler Rd NW
Canton, Ohio 4471
330-493-444
800-828-089
fax 330-493 867

US Acute Care Solutions

www.usacs.com

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: [signature]

Name: Carmella Percy, DO, FACEP, FACOEP

Specialty: Emergency Medicine

USACS Central
4535 Dressler Rd NW
Canton Ohio 44718
330 493-4443
800-828-0898
fax 330-493 8677

Atrium Health
Levine Cancer Institute

October 15, 2019

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Raleigh, NC 27699-2704

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Sincerely,

Claud M. Grigg, Jr., MD
Department of Medical Oncology

PO Box 32861 • Charlotte, NC 28232-2861

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: 

Name: CORLAN EBOH, MD

Specialty: GI

Atrium Health
Levine Cancer Institute

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Sincerely,

Daniel E. Haggstrom, MD
Department of Medical Oncology

US Acute Care Solutions

October 15, 2019

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Sincerely,

Signature: [signature]

Name: Daniel Rashid

Specialty: Emergency Medicine

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Raleigh, NC 27699-2704

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Sincerely,

Signature: _____ MD

Name: David C. Olson

Specialty: Gastroenterology

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Donovan Thompson

Specialty: Emergency Medicine

USACS Central
4535 Dressler Rd NW
Canton, Ohio 44718
330-493-4444
800-828-0899
fax 330-493-8677

Atrium Health
Levine Cancer Institute

October 15, 2019

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Atrium Health
Levine Cancer Institute

Sincerely,

Signature: _____

Name: Earl Burgess, MD

Specialty: Medical Oncology

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Raleigh, NC 27699-2704

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Signature: [signature]

Name: Eileen Hitchcock, MD

Specialty: Emergency Medicine

USACS Centre
4545 Fressler Rd NW
Canton, Ohio 4471
330-493-444
800-828-089
fax 330-493-867

US Acute Care Solutions

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October 15, 2019

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Signature: [signature] DO

Name: Fredric Cordain DO

Specialty: Emergency Medicine

USACS Central
4535 Dressler Rd NW
Canton, Ohio 44718
330-493-4443
800-878-0898
fax 330-493-8617

US Acute Care Solutions

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Sincerely,

Signature: 

Name: G Brent Mullis, MD

Specialty: Emergency Medicine

USACS.com
Cary, NC
Fax: 330-493-86

October 15, 2019

Atrium Health

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Signature: _____

Name: George K. Davis, MD

Specialty: Internal Medicine

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Signature: 

Name: GREGORY L GEERS

Specialty: Emergency Medicine

Atrium Health

October 15, 2019

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Signature: _____

Name: J. Jenkins Thompson, MD

Specialty: Cardiology

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Sincerely,

Signature: 

Name: Jaclyn Davis MD

Specialty: Emergency Medicine

USACS Central
3535 Dressler Rd NW
Canton Ohio 44718
330 493 4443
800 828 0898
fax 330-493 8677

US Acute Care Solutions

www.usacs.com

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: 

Name: Jayne Kendall MD

Specialty: Emerg Med

USACS Central
4525 Dressler Rd NW
Canton, Ohio 44718
330 493 4443
800 828 0898
Fax 330 493-8677

Atrium Health

October 15, 2019

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Sincerely,

Signature: John C. Cedarholm MD FACC

Name: JOHN C. CEDARHOLM MD FACC

Specialty: CARDIOLOGY

Atrium Health
Levine Cancer Institute

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Atrium Health
Levine Cancer Institute

Sincereiy,

Signature: Jonathan Levine

Name: Jonathan Levine

Specialty: Hematology

PO Box 32861 • Charlotte, NC 28232-2861

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Sincerely,

Signature: 

Name: Dr. Jonathan Zygowicz

Specialty: EM

USACS Centra
4535 Dressler Rd. NV
Canton, Ohio 4471
330-493-444
800-828-089
Fax 330-493-867

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Sincerely,

Signature: _____

Name: Joseph B. Dore MD

Specialty: E.D.

USACS Central
4535 Dressler Rd. NW
Canton, Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8677

US Acute Care Solutions

October 15, 2019

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Sincerely,

Signature: _____

Name: K Campbell

Specialty: Emergency Medicine

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Signature: K.L. Strawhun MD

Name: K.L. Strawhun

Specialty: critical care

US Acute Care Solutions

October 15, 2019

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Signature: _____

Name: Dr. Kathryn Walters

Specialty: Emergency Department

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Sincerely,

Signature: _____

Name: Kevin Corrigan

Specialty: Emergency Medicine

USACS Centr
4535 Dressler Rd. N
Canton, Ohio 447
330-493-44
800-828-08
fax 330-493 86

Atrium Health
Levine Cancer Institute

October 15, 2019

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Atrium Health
Levine Cancer Institute

Sincerely,

Signature: LBHellner MD.

Name: Lane B. Hellner. MD

Specialty: Medical Oncology

PO Box 32861 • Charlotte, NC 28232-2861

US Acute Care
Solutions
www.usacs.com

October 15, 2019

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Sincerely,

Signature: [signature]

Name: MANNY GUPTA, DO

Specialty: ER

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Sincerely,

Signature: 

Name: Mark Gonzales, DO

Specialty: Emergency Medicine

USACS Central
4535 Dressler Rd. NW
Canton Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8677

US Acute Care Solutions

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October 15, 2019

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Signature: [signature]

Name: Michael Bryant, DO

Specialty: Emergency Medicine

USACS Central
4535 Dressler Rd. NW
Canton, Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8677

Atrium Health
Levine Cancer Institute

October 15, 2019

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Sincerely,

Michael Livingston, MD
Department of Medical Oncology

Scope Anesthesia of North Carolina

October 15, 2019

Ms. Martha Frisone, Chief

Healthcare Planning and Certificate of Need Section

Division of Health Service Regulation

2704 Mail Service Center

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Sincerely,

Signature: _____

Name: Mukesh Nigam

Specialty: Anesthesiology

310 Arlington Avenue #418
Charlotte, NC 28203

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: NAnthony MD

Name: Nicholas Anthony, MD

Specialty: Gastroenterology

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: [signature]

Name: Niles Ruins

Specialty: Emergency Department

USACS Centre
4535 Dressler Rd. NW
Canton, Ohio 44718
330 493 4443
800-828-0898
fax 330-493-8677

October 15, 2019

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Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Ravi Attaluwath

Specialty: Consult Psychiatry

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Raleigh, NC 27699-2704

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Sincerely,

Signature: [signature]

Name: Tracie Wilson

Specialty: EM

USACS Central
4535 Dressler Rd NW
Canton, Ohio 44718
330 493-4443
800 828-0898
fax 330 493 8677

Atrium Health

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: MUSIALOWSKI

Specialty: Cardiology

Scope Anesthesia of North Carolina

October 15, 2019

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Healthcare Planning and Certificate of Need Section

Division of Health Service Regulation

2704 Mail Service Center

Raleigh, NC 27699-2704

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Sincerely,

Signature: Richard R Pagano M.D

Name: Richard R. Pagano M.D.

Specialty: Anesthesiology

310 Arlington Avenue #418
Charlotte, NC 28203

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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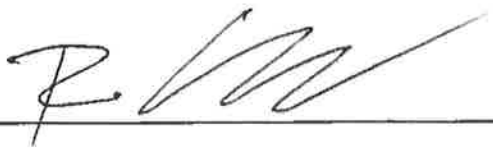
Signature: 

Name: Ryan M. Gleason, MD

Specialty: Neurology

Scope Anesthesia of North Carolina

October 15, 2019

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Healthcare Planning and Certificate of Need Section

Division of Health Service Regulation

2704 Mail Service Center

Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Steven W. Grayson, MD

Specialty: Anesthesiology

310 Arlington Avenue #418
Charlotte, NC 28203

Scope Anesthesia of North Carolina

October 15, 2019

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Healthcare Planning and Certificate of Need Section

Division of Health Service Regulation

2704 Mail Service Center

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Sincerely,

Signature: Sanjay Anand

Name: Sanjay Anand M.D.

Specialty: Anesthesiology

310 Arlington Avenue #418
Charlotte, NC 28203

Scope Anesthesia of North Carolina

October 15, 2019

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Sincerely,

Signature: [signature] MD 10/03/2019 12:42 pm

Name: SCOTT PALMER MD

Specialty ANESTHESIOLOGIST

310 Arlington Avenue #418
Charlotte, NC 28203

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Signature: 

Name: Scott Schmidt MD

Specialty: GM

USACS Central
4536 Dressler Rd. NW
Canton, Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8677

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Sincerely,

Signature: Sean Cavanaugh, MD

Name: Sean Cavanaugh

Specialty: Emergency Medicine

USACS Central
4535 Dressler Rd NW
Canton, Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8677

Atrium Health
Levine Cancer Institute

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Sridhar E. Pal, MD
Department of Medical Oncology

Scope Anesthesia of North Carolina

October 15, 2019

Ms. Martha Frisone, Chief

Healthcare Planning and Certificate of Need Section

Division of Health Service Regulation

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Raleigh, NC 27699-2704

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Sincerely,

Signature: [signature]

Name: SRINIVASAN ADAYAPALAM

Specialty: ANESTHESIOLOGY

310 Arlington Avenue #418
Charlotte, NC 28203

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Signature: 

Name: Stephen Chow, DO

Specialty: Co-Medical Director
Carolinas Hospitalist Group

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: 

Name: Stephanie Stanley

Specialty: EM

USACS Center
330-493-4443
800-826-6896
Fax 330-493-0677

US Acute Care Solutions

www.USACS.com

October 15, 2019

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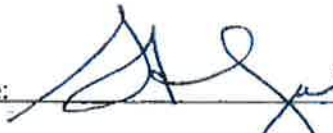
Signature: 

Name: STEVE GASKIN

Specialty: EMERGENCY MEDICINE

USACS Carolinas
[illegible] Rd NW
Canton, OH 44718
330-493-4443
800-838-0694
Fax 330-493-8677

Scope Anesthesia of North Carolina

October 15, 2019

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Healthcare Planning and Certificate of Need Section

Division of Health Service Regulation

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Sincerely,

Signature: S. T. Leder MD.

Name: STEVEN T. LEDER MD.

Specialty: ANESTHESIOLOGIST

310 Arlington Avenue #418
Charlotte, NC 28203

US Acute Care Solutions

www.usacs.com

October 15, 2019

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Sincerely,

Signature: 

Name: Swarup Misra

Specialty: Emergency Medicine

USACS Central
[redacted] Rd. NW
Canton, Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8677

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Sincerely,

Signature: TF MD

Name: Tamara Fox, MD

Specialty: OB/Gyn

US Acute Care Solutions

www.usacs.com

October 15, 2019

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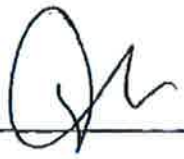
Signature: 

Name: Tracy Fane MD

Specialty: Emergency Medicine

USACS Centre
4535 Dressler Rd NW
Canton, Ohio 44718
330 493 4443
800 828 0898
fax 330 493 8677

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Specialty: Hospitalist

US Acute Care Solutions

www.usacs.com

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Sincerely,

Signature: Yolanda Herndon

Name: Yolanda Herndon

Specialty: Emergency medicine USACS

USACS Central
[illegible] Dressler Rd NW
Canton, Ohio 44718
330-493-4443
800-828-0898
fax 330-493-8673

Department of Surgery
Brent D. Matthews, MD
Chair; Surgeon-in-Chief

Bradley R. Davis, MD
Vice Chair of Education

Susan L. Evans, MD
Vice Chair of Research

Kent W. Kercher, MD
Vice Chair of Clinical Affairs

Dionisios Vrochides, MD, PhD
Vice Chair of Quality

Lauren Rorabaugh, MBA, MSHA
Vice President, Surgery Care Division

Division of Abdominal Transplant Surgery
Vince P. Casingal, MD; Chief
Roger Denny, MD
Lon B. Eskind, MD
David M. Levi, MD
J. Raul Soto, MD, MPH

Division of Acute Care Surgery
Addison K. May, MD, MBA; Chief
David G. Jacobs, MD
Rita Brintzenhoff, MD
A. Britt Christmas, MD
Toan Huynh, MD
Ronald F. Sing, DO
Bradley W. Thomas, MD
John M. Green, MD; Program Director, General Surgery
Kyle W. Cunningham, MD, MPH
William Miles, MD
Susan L. Evans, MD
Gaurav Sachdev, MD
Cynthia Lauer, MD
Samuel W. Ross, MD, PhD
Michael L. Ekaney, PhD

Division of General and GI Surgery
Bradley R. Davis, MD; Chief
B. Todd Heniford, MD,
Kent W. Kercher, MD,
Brent D. Matthews, MD
Paul D. Colavita, MD
Lynn Schiffern, MD
Caroline E. Reinke, MD, MSPH, MSHP
B. Lauren Paton, MD
Vedra A. Augenstein, MD
Kevin R. Kasten, MD
Selwan Barbat, MD
Keith S. Gersin, MD
Timothy Kuwada, MD
Abdel Nimeri, MD
John Tomcho, MD, RD
Lisa Bellanfonte, MD
Lisa Summers, MD, RD
Kathleen Hickey, MD
Michael Dobson, MD*
Renee Rusnak-Zrnich, MD
Amy Lincourt, PhD

Division of HPB Surgery
David Iannitti, MD; Chief
John B. Martinie, MD
Dionisios Vrochides, MD, PhD
Erin Baker, MD
Lee Ocuin, MD
Iain H. McKillop, PhD
Kyle Thompson, PhD

Division of Pediatric Surgery
Steve Teich, MD
Graham Cosper, MD*
Daniel Bambini, MD*
Andrew M. Schulman, MD*
Thomas Smeltzer, MD*

Division of Plastic and Reconstructive Surgery
Michael Robinson, MD, Chief
Nicholas Clavin, MD
J.F Lefaivre, MD
Edward Teng, MD
Jason Korn, MD
David C. Fisher, MD
Briana Heniford, MD
Sneha Kulkarni, MD

Division of Surgical Oncology
Richard L. White, MD; Chief
Terry Sarantou, MD
Jonathan, Salo, MD
Megan R. Forster, MD
Deba Sarma, MD
Lejla Hadzikadic-Gusic, MD
Josh S. Hill, MD, MS
Zvonimir Milas, MD
Ashley A. Stewart, MD
Danny S. Brickman, MD*
Catherine Frenkel, MD
Amy Voci, MD
M. Hart Squires, MD, MS

*affiliated faculty

Mission: Improve perioperative health, elevate hope and advances healing for all

Vision: Create a leadership culture that advances surgical science, transforms education, and inspires innovation to be the first and best choice for comprehensive, interdisciplinary surgical care

Atrium Health

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Respectively,

Brent D. Matthews, MD, FACS
Professor and Chair, Department of Surgery
Surgeon-in-Chief, Atrium Health
Carolinas Medical Center
University of North Carolina Charlotte Campus

October 15, 2019

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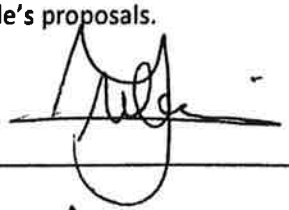
Signature: 

Name: Halim Yammine, MD

Specialty: Vascular Surgery

Atrium Health

October 15, 2019

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Sincerely,

Signature: _____

Name: Jeffrey A. Hagen

Specialty: Chief, Thoracic Surgery

Atrium Health
Musculoskeletal Institute

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Sincerely,

Signature: 

Name: Jeffrey S. Kneisl, MD, FACS

Specialty: Orthopaedic Surgery

Atrium Health

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Atrium Health

Sincerely,

Signature: 

Name: Kevin Stepp, MD

Specialty: Urogynecology

Clinic: Women's Center for Pelvic Health, 2001 Vail Avenue, Suite 360, Charlotte, NC 28207

Atrium Health

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Signature: Larry Watts MD

Name: Larry Watts MD

Specialty: Cardiothoracic Surgery

SURGICAL specialists OF CHARLOTTE, P.A.

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Leslie T. Webster III, MD

Specialty: General Surgery

CHARLOTTE
1918 Randolph Rd. Ste. 130
Charlotte, NC 28207
704.364.8100
Fax: 704.365.2073

2001 Vail Ave. Ste. 320
Charlotte, NC 28207
704.333.0741
Fax: 704.333.3356

UNIVERSITY
101 East W. T. Harris Blvd.
Ste. 5103
Charlotte, NC 28262
704.547.9196
Fax: 704.547.8775

HUNTERSVILLE
10030 Gilead Rd. Ste. 245
Huntersville, NC 28078
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Fax: 704.464.5948

PINEVILLE
10512 Park Rd., Ste. 101
Charlotte, NC 28210
704.542.3631
Fax: 704.542.3646

MATTHEWS
1450 Matthews Township
Parkway, Suite 250
Matthews, NC 28105
704.841.1444
Fax: 704.849.2520

ROCK HILL
1721 Ebenezer Rd., Ste. 175
Rock Hill, SC 29723
803.324.5256
Fax: 803.328.0440

FORT MILL
1700 First Baxter Crossing
Suite 102
Fort Mill, SC 29708
803.324.5256
Fax: 803.328.0440

www.ssclt.com

Atrium Health

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: Louis A. Zbinden III, M.D. F.A.C.S.

Specialty: General Surgery

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: 

Name: Matthew Schwartz

Specialty: Orthopaedic Surgery

Atrium Health

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Sincerely,

Signature: _____

Name: S. Taylor Jarrell, MD

Specialty: Neurosurgery

Atrium Health

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Sincerely,

Signature: Shirley K Scott MD

Name: Shirley K Scott

Specialty: Breast Oncology / Surgery

October 15, 2019

Atrium Health

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Signature: _____

Name: P. Stratten Bale MD.

Specialty: OB/GYN.

Atrium Health

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Sincerely,

Signature: _____

Name: Stephen E. McKiernan, MD

Specialty: Carolina Urology Partners

Atrium Health

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Sincerely,

Signature: Steven D. Thies

Name: Steven D. Thies

Specialty: General Surgery

October 15, 2019

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Sincerely,

Signature: Suzanna Fox, MD

Name: Suzanna Fox, MD

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Signature: William S. Revell, MD

Name: William S. Revell

Specialty: OB-GyN

Urology Specialists
OF THE CAROLINAS, PLLC
www.urologyspecialistsnc.com

Zane K. Basrawala, MD
Manish N. Damani, MD
Roberto F. Ferraro, MD
Nicholas J. Fitzsimons, MD
Tom Sledge Floyd, Jr., MD
Jacques P. Ganem, MD
David E. Kang, MD
John A. Kirkland Jr., MD
Daniel J. Linn, MD
Samuel J. Peretsman, MD
Thomas H. Phillips, MD
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Daniel L. Watson, MD
Bradley K. Weisner, MD
Matthew G. Baker, PA-C
Jessica R. Brooks, FNP-C
L. Jason Byrd, FNP-C
Jennifer Christenbury, PA-C
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Xavier Harrison, PA-C
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Cristine Mattis, ARNP-C
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M. Catherine Meadows, PA-C
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Shenna J. Shaw, NP-C
A. Holly Thomas, PA-C
Celeste J. Watts, NP-C

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As a surgeon practicing in the area, I am aware of the growth in demand and the need for additional operating room and acute care bed capacity at Atrium Health Pineville. In 2005, Atrium Health Pineville began the first of two phases to expand capacity and add tertiary services. These projects were designed as a response to the growing population in Atrium Health Pineville's service area and the need to provide access closer to patients' homes. As a result, Atrium Health Pineville has experienced rapid and consistent growth that has outpaced its capacity. As a surgeon currently performing surgical cases at Atrium Health Pineville, I see a clear need for the hospital to ensure sufficient access to its growing number of patients. I intend to continue performing surgical cases at Atrium Health Pineville following the completion of the proposed project, and I expect my surgical volumes to continue to increase in the future, driving the need for additional capacity.

I am aware that Atrium Health is submitting six concurrent and complementary applications to meet the needs identified in the *2019 SMFP* for acute care beds and operating rooms in Mecklenburg County. In addition to the proposed Atrium Health Pineville projects, Carolinas Medical Center, Atrium Health University City, and Atrium Health Lake Norman propose to develop operating rooms and/or acute care beds. I understand that this project is part of Atrium Health's overall plan to meet the needs of patients in Mecklenburg County. I am in support of this overall plan as well as the specific projects at Atrium Health Pineville.

☐ 325 Hawthorne Ln., Suite 300, Charlotte, NC 28204 • (704) 372-5180 • Fax (704) 376-6280
☐ 101 W. T. Harris Blvd. East, Suite 5201, Charlotte, NC 28262 • (704) 547-1495 • Fax (704) 547-1861
☐ 1450 Matthews Township Pkwy., Suite 350, Matthews, NC 28105 • (704) 841-8877 • Fax (704) 841-8188
☐ 10660 Park Road, Suite 4100, Charlotte, NC 28210 • (704) 541-8207 • Fax (704) 540-8288
☐ 16455 Statesville Road, Suite 420, Huntersville, NC 28078 • (704) 892-2949 • Fax (704) 892-2946
☐ 1328 Patterson Street, Monroe, NC 28112 • (704) 993-2107 • Fax (704) 993-2115
☐ 1085 Northeast Gateway Ct., N.E., Suite 180, Concord, NC 28025 • (704) 707-2200 • Fax (704) 707-2203

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Zane K. Basrawala, MD
Manish N. Damani, MD
Roberto F. Ferraro, MD
Nicholas J. Fitzsimons, MD
Tom Sledge Floyd, Jr., MD
Jacques P. Ganem, MD
David E. Kang, MD
John A. Kirkland Jr., MD
Daniel J. Linn, MD
Samuel J. Peretsman, MD
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Harrison K. Rhee, MD
Ralph N. Vick, MD
Daniel L. Watson, MD
Bradley K. Weisner, MD
Matthew G. Baker, PA-C
Jessica R. Brooks, FNP-C
L. Jason Byrd, FNP-C
Jennifer Christenbury, PA-C
Laurel Drayton, PA-C
Tyler G. Hahn, PA-C
Xavier Harrison, PA-C
Dakota G. Irwin, PA-C
Melissa Lemnah, PA-C
Michelle Hopkins, PA-C
Lauren A. Leggett, AGACNP
Cristine Mattis, ARNP-C
Lindsey McCormick, NP-C
M. Catherine Meadows, PA-C
Michelle D. Schrager, FNP-C
Shenna J. Shaw, NP-C
A. Holly Thomas, PA-C
Celeste J. Watts, NP-C

I appreciate Atrium Health Pineville's commitment to its patients as well as its willingness to seek the input of local physicians. In an effort to enable me to focus on patient care, this letter may resemble the format of those signed by my colleagues; however, that should not detract from the fact that I fully support Atrium Health Pineville's proposals.

Sincerely,

Signature: _____

Name: ZANE BASRAWALA

Specialty: UROLOGY

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Patient/Community Support Letters

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to inform you of my strong support for the CON applications submitted by The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health Pineville. Atrium Health Pineville has a long history of being a good corporate citizen and a provider of care to all patients. As a highly utilized tertiary care provider in a growing community, it is imperative that Atrium Health Pineville have sufficient capacity to care for its growing number of patients.

Those of us who live and work in the southern Charlotte region are very aware of the rapid growth of our community. As a result of this growth, our community needs additional healthcare resources like acute care beds and operating rooms. As you are aware, the State has identified a need for 76 additional acute care beds and six additional operating rooms in Mecklenburg County. In light of its commitment to the residents of the southern Charlotte community and its vital role in providing patient care, Atrium Health Pineville is proposing to develop two additional operating rooms and 12 additional acute care beds.

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This letter may resemble the format of those signed other supporters; however, that should not detract from the fact that I fully support Atrium Health Pineville's proposals.

Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Alice H Sloan

Name: October 10, 2019

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Alvane B Deal

Name: Alvane B Deal

4306

10/8/19

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Ashley Garris

Name: Ashley Garris

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Audrey D. Gantt

Name: Audrey D. Gantt

4333

10/8/19

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: _____

Name: _____

October 8, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Carrie E Sanford

Name: Carrie Sanford 980-297-6891

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Chris Green

Name: Chris Green

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Fred A Rives

Name: FRED A RIVES

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Harriett Trapp

Name: Harriett Trapp

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: James G Bond

Name: October 10th 2019. - James Bond.

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: John F Mussman

Name: JOHN F MUSSMAN

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Joy Rives

Name: JOY RIVES

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Joe L Sajrano

Name: Joseph L. SajRANO

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: 

Name: Kelsey Allen

October 8, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Kim McBee

Name: Kim McBee

704-619-3172

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Lindy Naseikos

Name: LINDY NASEIKOS

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Lori Pagliarini

Name: Lori Pagliarini

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Mary Lou Stilwell

Name: MARY LOU STILWELL

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Mary M. Downing

Name: Mary M. Downing

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Raleigh, NC 27699-2704

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Sincerely,

Signature: Mary Pitchey

Name: Mary Pitchey

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Raleigh, NC 27699-2704

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Sincerely,

Signature: Nancy J. Warnement

Name: Nancy J. Warnement

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Sincerely,

Signature: Patricia S. Graml

Name: Patricia S. Graml

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Patsy Lowe

Name: Patsy Lowe

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Raleigh, NC 27699-2704

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Sincerely,

Signature: 

Name: Sukesh Dhanja.

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Sincerely,

Signature: Susan Gribbin

Name: Susan Gribbin

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Sincerely,

Signature: Terrie D. Minton

Name: Terrie D Minton

October 8, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Sincerely,

Signature: Timothy Sanford

Name: Timothy Sanford 704-649-6039

PINEVILLE CHURCH

8614 Pineville-Matthews Rd
Charlotte, NC 28226
T: 704.542.3618
F: 704.817.3063
office@pineville.church

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Sincerely,

Aaron Horton
Lead Pastor
Pineville Church

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Sincerely,

Signature: Jane Shutt

Name: Jane Shutt

Position and Organization: Executive Director, Pineville Neighbors Place

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: John Edwards

Position and Organization: Mayor Town of Pineville N.C.

October 15, 2019

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Division of Health Service Regulation
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Sincerely,

Signature: Karen Murphy

Name: Karen Murphy

Position and Organization: Director of Sponsorship, Isabella Santos Foundation

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
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Sincerely,

Signature: Kelly Barnhardt

Name: Kelly Barnhardt

Position and Organization: Executive Director / Matthews Chamber of Commerce

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
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Sincerely,

Signature: Kevin Kennick

Name: KEVIN KENNICK, 15712 COUNTRY LAKE DR. PINEVILLE

Position and Organization: BOARD MEMBER-PINEVILLE NEIGHBORS PLACE

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Please let me know if I can be of further assistance in your efforts.

Sincerely,

Signature: Kristy Detwiler

Name: Kristy Detwiler

Position and Organization: Director - Pineville Parks & Recreation

BALLANTYNE
magazine

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Lindsey Scheumeister

Account Executive, Ballantyne Magazine

13860 Ballantyne Corporate Pl | Suite 300 | Charlotte | NC | 28277 | 704.248.2000 (p) | 704.248. 2002 (f)

October 15, 2019

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Sincerely,

Signature: Mary Jo Patterson

Name: Mary Jo Patterson

Position and Organization: Treasurer + Board Member - Pineville Neighbors Place

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
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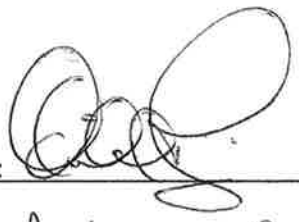
Signature: 

Name: Michael T. Gerin

Position and Organization: Fire Chief Pineville (NC) Fire Dept.

October 15, 2019

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Division of Health Service Regulation
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Sincerely,

Signature: Paige McKinney

Name: Paige McKinney

Position and Organization: Executive Director - Mint Hill Chamber of Commerce

PINEVILLE POLICE DEPARTMENT

★ INTEGRITY ★ COURAGE ★ KNOWLEDGE ★

October 15, 2019

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Sincerely,

Signature: _____

Name: Robert K. Merchant

Position and Organization: Chief of Police, Pineville Police Department

427 Main Street ★ P.O. Box 249 ★ Pineville, NC 28134 ★ Tel: 704-889-2231 ★ Fax: 704-889-2300

October 15, 2019

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Signature: Sandra Conway

Name: Sandra Conway

Position and Organization: Executive Director
Matthews HELP Center

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: Sarah Gallagher

Name: Sarah Gallagher

Position and Organization: Development Manager / Matthews HELP Center

October 15, 2019

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
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Sincerely,

Signature: Stephen Rosenbaugh

Name: Stephen ROSENBAUGH

Position and Organization: Chair South Charlotte Partners

Atrium Health

October 15, 2019

Ms. Martha Frisone, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my strong support for the CON applications submitted by The Charlotte Mecklenburg Hospital Authority d/b/a Atrium Health Pineville to develop two additional operating rooms and 12 additional acute care beds pursuant to the need determinations identified in the *2019 State Medical Facilities Plan (SMFP)* for Mecklenburg County.

I currently serve as the Chief Medical Officer for Atrium Health Pineville and intend to continue to serve in this role following the completion of these projects.

In my role, I am aware of the growth in demand and the need for additional operating room and acute care bed capacity at Atrium Health Pineville. In 2005, Atrium Health Pineville began the first of two phases to expand capacity and add tertiary services. These projects were designed as a response to the growing population in Atrium Health Pineville's service area and the need to provide access closer to patients' homes. As a result, Atrium Health Pineville has experienced rapid and consistent growth that has outpaced its capacity, and I see a clear need for the hospital to ensure sufficient access to its growing number of patients.

I am aware that Atrium Health is submitting six concurrent and complementary applications to meet the needs identified in the *2019 SMFP* for acute care beds and operating rooms in Mecklenburg County. In addition to the proposed Atrium Health Pineville projects, Carolinas Medical Center, Atrium Health University City, and Atrium Health Lake Norman propose to develop operating rooms and/or acute care beds. I understand that this project is part of Atrium Health's overall plan to meet the needs of patients in Mecklenburg County. I am in support of this overall plan as well as the specific projects at Atrium Health Pineville.

Sincerely,

Sheela S. Myers, MD, MS
Chief Medical Officer
Atrium Health Pineville

Atrium Health

PFS Billing and Collection Policy

Applicability

This policy applies to the following Atrium Health facilities:

Atrium Health Cleveland
Atrium Health Kings Mountain
Carolinas HealthCare System Anson
Carolinas HealthCare System Behavioral Health – Charlotte
Carolinas HealthCare System Behavioral Health - Davidson
Carolinas HealthCare System Lincoln
Carolinas HealthCare System NorthEast
Carolinas HealthCare System Pineville
Carolinas HealthCare System Stanly
Carolinas HealthCare System Union
Carolinas HealthCare System University
Carolinas Medical Center
Carolinas Medical Center – Mercy
Carolinas Rehabilitation
Levine Children's Hospital

Objective

The Billing and Collection (B&C) policy supports the Atrium Health goal of assisting patients with the complexities of billing third-party insurers, providing patient specific payment options, reviewing uninsured patient's eligibility for coverage assistance and financial assistance and taking actions concerning amounts due for services.

Atrium Health policy is to provide care for emergency medical conditions regardless of the patient's ability to pay and without consideration of the patient's prior payment history. Atrium Health does reserve the right to take collection actions as permitted by law concerning balances due from either the patient or third-party insurer.
Atrium Health has the following five major objectives for billing and collection:

- demonstrating Atrium Health's core value of "Caring";
- obtaining necessary patient specific third-party insurer and personal information in advance of any scheduled services;
- complying with third-party insurer policies and State and Federal regulations related to billing and collection;
- assisting the patient to navigate the complexities of seeking reimbursement from third-party insurers; and
- establishing billing and collection processes consistent with industry standards.

Atrium Health will achieve these objectives by implementing the following B&C strategies:

- maintaining up-to-date patient and third-party insurer information as provided by the patient or patient representative.
- assisting patients with verification of coverage and working with third-party insurers to provide patients estimates of patient cost-sharing amounts for scheduled services;
- providing various payment options for patients;
- establishing reasonable efforts to determine patient's eligibility for financial assistance programs;
- evaluating and implementing healthcare industry best practices in billing and collections; and

- maintaining a robust compliance and patient satisfaction monitoring program.

Definitions

1. Average Amount Generally Billed (AGB): The average of Medicare and all private third-party insurer allowables for all claims allowed in a 12 month period.
2. Bad Debt: Accounts that have been categorized as uncollectible because the patient has failed to pay for services rendered and are not eligible for CAFA.
3. Elective: Services that, in the opinion of a physician, are not needed or can be safely postponed.
4. Extraordinary Collection Action (ECA) – any collection activity taken against an individual that requires a legal or judicial process, involves selling an individual's debt to another party, reporting adverse information to consumer credit reporting agencies/credit bureau or denying medically necessary services due to insufficient payment.
5. Financial Assistance Score (FAS Score): A score computed by a third-party vendor to provide a proactive, consistent, and automated mechanism to substantiate a patient's financial profile. The FAS Score is not a credit score, but relies on various databases with more than 9,000 sources and 2 billion records to determine the likelihood that a patient lives in poverty. A component of the FAS Score is a Household Income Index that is calibrated to Federal Poverty Guidelines. Other components of the FAS Score include, but are not limited to, a review of census data, consumer transaction history, asset ownership files and utility files.
6. Household Financial Income: An assessment of a patient's income, as measured against annual Federal Poverty Guidelines, that includes, without limitation the following:
    - Annual household pre-tax job earnings
    - Unemployment compensation
    - Workers' compensation
    - Social Security and Supplemental Security Income
    - Veteran's payments
    - Pension or retirement income
    - Other applicable income, including for example, rents, alimony, child support and any other miscellaneous income regardless of source
7. Third-party Insurers: Any party insuring payment on behalf of a patient, including: insurance companies, workers' compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, or third-party liability resulting from automobile or other accidents.
8. Uninsured: Patients who are not covered under a third-party insurer.

Policy

Pre-Service

Atrium Health encourages each patient to pay based on their ability to pay all or a portion of the patient's estimated balance for medically necessary services prior to the scheduled service. The Atrium Health Pre-Service team may contact the patient to obtain third-party insurer and other information needed to bill for services and may provide an estimate of the patient's out-of-pocket expenses. For insured individuals, the estimate is based on the determination of the patient specific third-party coverage for the services. The Atrium Health Pre-Service team may request that the patient pay all or a portion of the estimated patient balance. If the patient is uninsured, the estimate of the patient's balance is based on the amount after the Atrium Health uninsured discount is applied.

Coverage Assistance and Financial Assistance

Coverage Assistance and Financial Assistance (CAFA) is available to all uninsured North Carolina and South Carolina patients receiving medically necessary services in Atrium Health facilities. Atrium Health

follows two different processes based on place of service when determining eligibility for financial assistance for uninsured patients.

Category I is for all patients receiving inpatient or outpatient services with a patient balance greater than or equal to $10,000 who are reviewed for CAFA by the Financial Counseling Department. A financial counselor will interview the patient and determine if the patient is eligible for other coverage opportunities. If a patient fully cooperates with this process and no coverage is available, the patient's account will be evaluated for financial assistance based on the patient's household financial income as compared to federal poverty guidelines (FPG). Any patient balance due, if any, will be less than the "average amount generally billed" as defined below. To further assist these patients, interest-free payment plan options are available for any remaining balance.

Category II is for all patients receiving any other outpatient services resulting in a patient balance less than $10,000 who are automatically reviewed for financial assistance. Each account is automatically reviewed for a financial assistance discount prior to billing. Eligibility is based on a Financial Assistance Score (FAS) from a third-party vendor that indicates the likelihood a patient lives in poverty. Patients with qualifying accounts will be extended a 100% adjustment and will not receive a bill. A patient found ineligible automatically will be extended a 50% uninsured discount. Those ineligible can also apply for a manual review by downloading an application on the Atrium Health website.

For Emergency Department services, Atrium Health will request a $75 copay at the time of service. Atrium Health will review balances incurred through the Emergency Department greater than $75 for financial assistance through one of the above processes based on the patient balance.

Atrium Health will make reasonable efforts to communicate the Atrium Health CAFA policy to uninsured patients and determine eligibility for the Atrium Health CAFA program prior to any extraordinary collection action.

Reasonable efforts include:

- Wide publication of the Atrium Health CAFA policy and plain language summary of the policy to include on the Atrium Health website, at Atrium Health facility admission offices and on billing statements
- Application accessible for download on the Atrium Health website or available by mail upon request
- Multiple language translations of CAFA policy, plain language summary and application available on the Atrium Health website
- Oral notification of the Atrium Health CAFA policy by PFS Customer Service and/or third-party collection agencies
- A minimum of 3 billing statements. Plain language summary is included with all billing statements.
- 30 day notice is sent to patients notifying them of their financial obligation, pending collection action and information regarding the Atrium Health CAFA policy prior to collection agency referral or an extraordinary collection action (ECA) occurring. Notice includes the plain language summary.
- Automated Financial Assistance Scoring (FAS) presumptive eligibility process prior to patient billing for uninsured patients. Those who are found ineligible are notified via a letter with the plain language summary detailing how to apply for CAFA should they feel their FAS based eligibility was not accurate.
- Atrium Health provides all patients with 240 days from the first post-discharge bill date to apply for financial assistance prior to any extraordinary collection action. All patients have 30 days to make financial arrangements regarding their bill before an ECA will occur whether within the 240 day window or outside the 240 day window.

- All ECAs will be suspended if an application for CAFA is received during the 240 day application window or 30 day notice period. ECAs will not resume until a financial assistance determination has been made and the patient is found ineligible for financial assistance. ECAs will be reversed for any patient found eligible for financial assistance. Patients who submit incomplete applications will also have their ECA suspended and will be notified in writing of the needed information to complete their application and given 30 days to provide that information.
- The Atrium Health Unified Business Office has the final authority in ensuring reasonable efforts have been made to communicate the Atrium Health CAFA policy and determine an individual's eligibility and whether an ECA can be initiated.

Average Amount Generally Billed

Atrium Health will never bill any financial assistance eligible individual more than the "average amount generally billed" (AGB). Atrium Health uses a look-back method to determine AGB based on all private insurer and Medicare allowables for all claims allowed within a 12 month period. All uninsured patients automatically receive a 50% uninsured discount. Patients approved for financial assistance receive at minimum a 50% financial assistance discount in addition to the 50% uninsured discount which totals a minimum of 75% off gross charges. If a patient is still responsible for any portion of the bill after all discounts, the patient's bill will indicate how the patient may obtain information on how the bill was calculated to be below AGB. Remaining balances after all discounts are eligible for the "Choice Outreach" interest free payment plan option described below.

Hardship Settlement Discount

The Hardship Settlement program is a discount program designed to assist any North Carolina or South Carolina resident who has had a catastrophic medical event that has resulted in very large hospital bills in comparison to the patient's financial resources. A patient who has incurred a balance after all third-party payments that is greater than 10% of the patient's total household financial resources may be eligible for a Hardship Settlement discount. A patient seeking a hardship settlement discount should inquire about this program by calling the customer service department after receiving the patient's first statement. Patient balances must be greater than or equal to $2,500 to qualify for a hardship settlement.

Initial Billing

As a courtesy to patients residing in the United States, Atrium Health bills all third-party insurers on their behalf. Atrium Health will assist the patient with all known hospital pre-authorizations and other approvals required for services as a benefit to the patient. The patient is responsible, however, for all of the insurer's prerequisites for covering services. In situations when services are denied by a third-party insurer, Atrium Health will assist the patient in any appeal process with third-party insurers.

For insured patients, Atrium Health submits a claim on behalf of the patient to the patient's insurance provider. If there is a patient responsibility portion after the third-party insurer pays or denies the claim, Atrium Health will send the patient a minimum of 3 billing statements indicating the balance owed.

For uninsured patients, Atrium Health automatically applies a 50% uninsured discount to gross charges and reviews their balance for financial assistance. Those receiving partial financial assistance or are ineligible will receive a bill in the mail.

Collection of Patient Balances

Atrium Health reserves the right to utilize outside vendors to assist Atrium Health and patients regarding balances due and process payment plans. When a balance is owed by the patient, Atrium Health expects full payment and considers the account to be "Self-Pay."

- An account is determined to be Self-Pay if:
  - There is no third-party insurer on record.
  - All expected payments from the third-party insurers have been received.
  - The patient has been uncooperative with the Atrium Health Coverage Assistance Services department to determine other coverage opportunities or financial assistance in accordance with the Atrium Health CAFA Policy.
- Atrium Health will generate at minimum three billing statements and send it to the physical address on file provided by the patient or representative. Patients who have opted for paperless billing will receive a minimum of 3 email notifications that their billing statements are available in the MyCarolinas Patient Portal on the Atrium Health website.
- Each statement includes a plain language summary of the Atrium Health CAFA policy regarding coverage and financial assistance.
- Atrium Health will perform Medicaid eligibility checks on uninsured accounts on behalf of the patient after discharge and prior to collection activity. If Medicaid coverage is identified, the account will be reclassified to Medicaid from Self-Pay and billed to Medicaid.
- The last communication will occur at least 90 days from the first post-discharge bill date and will include communication to the patient that if there is no action, the patient account will be referred for additional collection actions in 30 days. This communication also includes a plain language summary detailing the Atrium Health CAFA policy.
- On each billing statement, it is communicated that an itemized bill can be requested by contacting the Atrium Health Customer Service call center at 704-512-7171.
- Patients can access the MyCarolinas Patient Portal on the Atrium Health website and request an itemized bill, ask questions, pay bills, and submit questions to the Atrium Health Customer Service team.
- All communications 30 days prior to bad debt placement, including oral communications by third-party collectors, include communication of the Atrium Health CAFA policy.

Patient Payment Plans

If a patient has the means to pay his or her bill but cannot pay in full, they can set up a payment plan administered by a third-party vendor, AccessOne. Patients can call the Atrium Health Patient Financial Services Customer Service Department at 704-512-7171 or AccessOne at 1-888-458-6272 to set up a payment plan.

Three plans are available:

1. "Choice" is available to any patient with a balance less than or equal to $10,000. The program includes an interest free payment option for up to 24 months.

2. "Choice 10" is available to any patient with a balance greater than $10,000. The program expands the interest free payment for up to 100 months (based on account balance). The program also offers a fixed low interest payment option as well.

3. "Choice Outreach" is available to patients who have a high likelihood of living in poverty. For example, a patient may have already received financial assistance through the CAFA or Hardship Settlement Discount Programs but may still have a balance for which the patient is responsible for paying. Patients who are found to be below 400% of the FPG qualify for this payment arrangement. For accounts with a balance less than $2,500, the minimum payment

is set to $25 a month until the balance is paid in full. For accounts over $2,500, the minimum payment is set to a percentage of the total ranging from .50% to 1% of the balance due. All patients who were found eligible for financial assistance or a hardship discount are automatically eligible for the “Choice Outreach” payment plan program.

Refunds:

Patient refunds are processed within 45 days of the notice of overpayment. Patients who are owed a refund will receive a paper check to the address on file. Refunds may also be credited back to the credit card used at the time of payment.

Bill Inquiry:

Patients who have questions about charges on their bill can call the Atrium Health Patient Financial Services Customer Service Department at 704-512-7171. A customer service representative will review the charges with the patient and provide them with an itemized bill upon request. If the patient still has questions regarding specific charges, the patient may request a charge audit. The Patient Financial Service Medical Audit team will validate the charges billed to the services documented in the medical record. A resolution letter will be mailed to the patient regarding the audit findings.

Collection Agency Referral:

Atrium Health may refer certain patient accounts to contracted third-party collection agencies. All collection agencies working on behalf of Atrium Health are expected to comply with applicable Atrium Health Billing and Collections and CAFA policies. Atrium Health and/or third-party collection agencies may report adverse information to a consumer credit reporting agency or credit bureau as a result of insufficient payment. Agency placement may occur no earlier than 120 days from the first post-discharge bill date and credit reporting may occur no earlier than 240 days from the first post-discharge bill date. Atrium Health and external collection agencies will follow all regulations related to healthcare collections including the Fair Debt Collection Practices Act in conducting collection activities.

Collection Agency Review:

After a patient has received at least three billing statements, an account is reviewed for collection agency referral. Prior to the referral, Atrium Health takes the following action:

- All accounts are reviewed for current Medicaid eligibility.
- Uninsured accounts reviewed for collection agency referral that were not classified as uninsured at discharge and never reviewed for financial assistance eligibility through the CAFA or FAS process will be reviewed for presumptive financial assistance through the FAS process. Those found eligible for financial assistance are extended a financial assistance discount and not referred. Those found ineligible are notified in writing with the Atrium Health CAFA plain language summary with information on how to apply for a full CAFA review.
- Accounts are not referred if information has been obtained that would assist in resolving the account balance prior to further collection activity.

Collection Agency Placement:

- Accounts are automatically submitted to a Atrium Health contracted primary collection agency. Accounts remain with the primary collection agency for a period of at least 270 days.
- The primary collection agency will make each patient that they contact for purposes of debt collection aware of the Atrium Health CAFA policy.

- The primary bad debt placement agency will not credit report until 240 days from the first post-discharge bill date.

Secondary Bad Debt placement occurs 270 days after primary placement for all accounts that have had no or insufficient payment activity.

Legal Collection Actions

Legal action will be considered if an account goes unpaid and reasonable efforts have been made to determine if the account is eligible for CAFA. The Atrium Health Unified Business Office has the final authority of determining if a legal action should be pursued and reasonable efforts, defined in this policy, have been made to communicate the Atrium Health CAFA policy and determine if a patient is eligible for coverage or financial assistance. Legal action will not occur until 240 days from the first post-discharge bill date. Patients will be given 30 days' notice before a legal action occurs. The 30-day notice will include a plain language summary detailing the Atrium Health CAFA policy and all subsequent communications will inform the patients of the Atrium Health CAFA policy. Patients have 30 days from the date of the notification to apply for a CAFA review or resolve the debt before the legal action occurs. If a patient is found eligible for coverage or financial assistance after a legal action has been initiated, legal action will be temporarily ceased, and coverage assistance will be initiated, or financial assistance discounts will be applied. Unfortunately, legal action is required to encourage a very small minority of patients to respond and cooperate with the coverage assistance and financial assistance process. All Atrium Health legal action is compliant with applicable state and federal legislation.

Legal actions are outlined below:

- Small Claims Collections – accounts with balances $300 - $5000 may be referred to local County small claims court.
- Lawsuits – Account balances >$5000 may be referred to an attorney for pursuit of judgments according to appropriate state laws.
- South Carolina (SC) Tax Debt Set-Off – Working through the S.C. Association of Counties, Atrium Health files a set-off claim against any SC tax refund due the patient.

Atrium Health

PFS 1.01 Hospital Coverage Assistance and Financial Assistance Policy

Objective

The Hospital Coverage Assistance and Financial Assistance (CAFA) policy supports the Atrium Health's goal to provide appropriate levels of charity care, commensurate with Atrium's resources and the community needs. Atrium Health is committed to assisting patients in obtaining coverage from various programs as well as providing financial assistance (FA) to every person in need of medically necessary hospital inpatient, outpatient or emergency treatment. Atrium will always provide emergency medically necessary care regardless of the patient's ability to pay.

This policy applies to hospital services received at the following Atrium facilities:

Atrium Health Anson
Atrium Health Behavioral Health
Atrium Health Cabarrus
Atrium Health Cleveland
Atrium Health Kings Mountain
Atrium Health Lincoln
Atrium Health Mercy
Atrium Health Pineville
Atrium Health Stanly
Atrium Health Union
Atrium Health University City
Carolinas Medical Center
Carolinas Rehabilitation
Levine Children's Hospital

Atrium Health has the following five major objectives for providing Coverage Assistance and Financial Assistance to patients:

- **To model at all times Atrium's core value of "Caring."**
- **To ensure the patient exhausts other appropriate coverage opportunities prior to qualifying for Atrium Health financial assistance.**
- **To provide financial assistance based on the patient's ability to pay.**
- **To ensure Atrium Health complies with applicable Federal or State regulations related to financial assistance.**
- **To establish a process that minimizes the burden on the patient and is cost efficient to administer.**

Definitions

The terms used within this policy are to be interpreted as follows:

1. Clinic Sliding Scale: A program allowing Mecklenburg County indigent patients to utilize outpatient clinic services for a co-pay based on income.
2. Elective: Those services that, in the opinion of a physician, are not needed or can be safely postponed.

3. Emergency Care: Immediate care that is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs or body parts.
4. Financial Assistance Score (FAS Score): A score developed with the assistance of a third-party vendor to provide a proactive, consistent and automated mechanism to substantiate a patient's financial profile.
    - FAS Score is not a credit score.
    - FAS Score relies on various databases with more than 9,000 sources and 2 billion records to determine the likelihood that a patient lives in poverty.
    - A component of FAS Score is a Household Income Index that is calibrated to Federal Poverty Guidelines.
    - Other components include, but are not limited to, a review of census data, consumer transaction history, asset ownership files and utility files.
5. Household Financial Income: Income including but is not limited to the following:
    - Annual household pre-tax job earnings
    - Unemployment compensation
    - Workers' Compensation
    - Social Security and Supplemental Security Income
    - Veteran's payments
    - Pension or retirement income
    - Other applicable income to including, rents, alimony, child support and any other miscellaneous source
6. Medically Necessary: Hospital services, provided to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
7. Other Coverage Options: Options that would yield a third-party payment on account(s) under CAFA review including, but not limited to: Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

Policy

Atrium Health follows two different processes based on place of service when determining eligibility for financial assistance for uninsured patients. Place of service types are categorized into two different groups:

1. Category I – All Inpatient and observation services, as well as outpatient hospital services with balances greater than or equal to $10,000. Reference lab, clinic sliding scale and outpatient pharmacy accounts are excluded.

2. Category II – All other hospital outpatient or emergency services with balances less than $10,000. Reference lab, clinic sliding scale and outpatient pharmacy accounts are excluded.

Category I

All uninsured patients with Category I services will be reviewed by the Atrium Health Coverage Assistance Services team. Patients with Category I services will be required to complete a Coverage Assistance/Financial Assistance (CAFA) application prior to being considered for financial assistance. The CAFA application gathers information needed to determine if the patient is eligible for any other coverage options. If the CAFA process indicates a high likelihood of coverage, then the patient, with Atrium Health assistance, will be required to pursue those opportunities before the patient will be considered for Atrium Health financial assistance. Atrium Health representatives are available to help those who are mentally and/or physically disabled

in applying for assistance. Atrium Health will keep financial information confidential and will treat patients seeking coverage assistance and financial assistance with dignity. The financial assistance application process will not officially start until the coverage assistance process is completed and the patient is found ineligible for other coverage options. If the patient fully cooperates when seeking other coverage options, but such coverage is unlikely or properly denied, Atrium Health will determine the patient's eligibility for financial assistance. **A Patient who fails to fully cooperate with this process is deemed ineligible for financial assistance.**

Category I Eligibility Criteria

1. **Services Eligible:**
   - All medically necessary (as determined by a physician) inpatient services.
   - All medically necessary (as determined by a physician) outpatient services with balances greater than or equal to $10,000.
   - All hospital emergency medical services provided in an emergency room setting with balances greater than or equal to $10,000.
   - All non-elective, medically necessary (as determined by a physician) outpatient hospital services provided in response to life-threatening circumstances in a non-emergency room setting with balances greater than or equal to $10,000.

2. **Services Ineligible:**
   - Elective and cosmetic services
   - Reference lab services
   - Outpatient pharmacy services
   - Clinic Sliding Scale eligible services (Clinic visits, outpatient diagnostics, and emergency department services covered by the Clinic Sliding Scale co-pay)

3. **Patients Eligible:**
   - Household income is between 0% and 400% of the Federal Poverty Guidelines (FPG)
   - Uninsured and ineligible for other coverage options for the account(s) under CAFA review
   - North Carolina and South Carolina residents
   - Fully cooperate with the determination of other coverage options

4. **Patients Ineligible:**
   - Household income is greater than 401% of the Federal Poverty Guidelines
   - Eligible for assistance through the Clinic Sliding Scale Program
   - Have current insurance coverage
   - Have other coverage options available for the account(s) under review
   - Do not reside in North Carolina or South Carolina
   - Fail to fully cooperate with the determination of other coverage options

Determination of Category I FA Discount:

- Completion of the CAFA application to determine if other coverage options are available for medically necessary and non-elective services.
- Eligibility for a financial assistance discount is based on a patient's total Household Financial Income for the prior 90 days reported at the time of evaluation.
- Financial need will be determined by comparing total Household Financial Income to Federal Poverty Guidelines (FPG) in effect at the time of determination.
- Patients who can demonstrate that their total Household Financial Income is at or below 200% of FPG is eligible for a 100% discount for an eligibility period of 180 days.
- Patient with total Household Financial Income between 201% and 400% of FPG is eligible for partial discounts for an eligibility period of 180 days.
- For patients with Category I services whose third-party vendor verification indicates that the patient has substantial financial resources, those resources may be considered when determining eligibility.
- Patient payments received prior to any financial assistance adjustment will not be refunded.

Category I Patient Financial Assistance Scale

*Max Income Range	0-200% FPG	201%-300% FPG	301-400% FPG	≥401% FPG
Adjustment %	100%	75%	50%	0%
# in Household				
1	0-$24,980	$24,981-$37,470	$37,471-$49,960	≥$49,961
2	0-$33,820	$33,821-$50,730	$50,731-$67,640	≥$67,641
3	0-$42,660	$42,661-$63,990	$63,991-$85,320	≥$85,321
4	0-$51,500	$51,501-$77,250	$77,251-$103,000	≥$103,001
5	0-$60,340	$60,341-$90,510	$90,511-$120,680	≥$120,681
6	0-$69,180	$69,181-$103,770	$103,771-$138,360	≥$138,361
7	0-$78,020	$78,021-$117,030	$117,031-$156,040	≥$156,041
8	0-$86,860	$86,861-$130,290	$130,291-$173,720	≥$173,721

** Max income ranges based on 2019 Federal Poverty Guidelines*

Category I Verification of Household Financial Resources and Eligibility Period:

Typically, CAFA applications are completed at or after the time that services are rendered. Atrium Health registrars or coverage assistance services counselors will attempt to interview all patients

unable to pay for services. Atrium Health will utilize, where appropriate, any external third party data to validate information provided by the patient on the CAFA application.

- Verification Period - Total Household Financial Income will be based on a look-back period of the prior 90 days from the application date and validated using third party vendors. If there is a discrepancy between what is reported by third party vendors and the patient, the patient may be asked to provide further documentation of income.
- Eligibility Period - Once approved, the eligibility period for Financial Assistance is 180 days from the date of approval for medically necessary and non-elective services. Any changes occurring within the eligibility period that would result in a high likelihood that the patient would be newly eligible for other coverage options must be pursued by the patient to retain financial assistance eligibility.
- Documentation - Patients may be asked to provide documentation from employers and banking institutions to further verify income. Financial statements and verification of income and third party vendor documentation will be retained by Atrium Health for a period of 10 years or as required by law. Falsification of financial information including withholding information will be reason for denial of financial assistance.
- Fraud – Atrium Health reserves the right to reverse financial assistance adjustments provided by this policy if the information provided by the patient during the information gathering process is determined to be false or if Atrium Health obtains proof that the patient has received compensation for the medical services from other sources not disclosed to Atrium Health.

Category II

Atrium Health will use a presumptive process to determine financial assistance eligibility for Category II services. All uninsured patients with Category II services will be evaluated automatically for a financial assistance discount based on a financial assistance score (FAS.) The patient is not required to complete a CAFA application for assistance. The FAS score is assigned prior to the first billing statement. The FAS will be assigned based on proprietary scoring algorithms from experienced third-party experts selected by Atrium Health. Atrium Health will periodically test the algorithms to ensure they are consistently applied and will adjust the FAS thresholds as needed.

Patients found eligible will receive a 100% financial assistance discount on eligible services and will not receive a bill. Each Emergency Department patient will be required to pay a co-pay of $75.00 for service in the Emergency Department. Patients with Category II services found ineligible for a presumptive financial assistance discount will receive a bill and will be notified of their ineligibility via a letter.

1. **Services Eligible:**
   - All medically necessary (as determined by a physician) outpatient services determined by a physician with balances less than $10,000
   - All hospital emergency medical services provided in an emergency room setting with balances less than $10,000

2. **Services Ineligible:**
   - Elective and cosmetic services
   - Reference lab services
   - Outpatient pharmacy services

- Clinic Sliding Scale eligible services (Clinic visits, outpatient diagnostics, and emergency department services covered by the Clinic Sliding Scale co-pay)

3. **Patients Eligible:**
   - FAS Score calibrated to Federal Poverty Guidelines
   - Do not have current health insurance coverage
   - North Carolina and South Carolina residents

4. **Patient Ineligible:**
   - Have current insurance coverage
   - Eligible for other coverage options
   - Eligible for assistance through the Clinic Sliding Scale Program
   - Do not reside in North Carolina or South Carolina

Determination of Category II FA Discount

- Eligibility for FA for Category II services is based on the Atrium Health FAS Score that is obtained from a third-party vendor prior to the first billing statement.
- Each patient with Category II services that has an eligible FAS Score will receive a 100% discount.
- Ineligibility for a FA discount will be communicated via a letter.
- Patient payments received prior to any financial assistance adjustment will not be refunded.
- Each billable encounter of care for Category II services as determined by Medicare billing rules will be evaluated separately for FA eligibility.

Applying for Coverage Assistance and Financial Assistance:

CAFA applications are for patients who have received Category I services. As stated above, Atrium Health teammates will strive to interview all uninsured Category I patients and assist them in the completion of a CAFA application. Atrium Health will determine eligibility for financial assistance once the coverage assistance process is completed. In those situations, where the patient cooperates with the CAFA application, Atrium Health will automatically determine financial assistance eligibility at the completion of the coverage assistance process. If Atrium Health teammates are unable to interview a patient with Category I services, the patient may download a paper Coverage Assistance/Financial Assistance Application online and mail the application to Atrium Health. A patient may also request a paper application via phone by calling 704/512-7171 and an application will be sent to the patient via mail. Patients with Category I services can also apply in person at the time of service.

Patients who have received Category II services are not required to complete an application for coverage assistance or financial assistance. Patients with Category II services will be automatically screened for financial assistance eligibility at final billing. A patient found eligible will receive a 100% discount. A patient found ineligible through this process will receive written notification via mail. If the patient believes that she should be eligible for financial assistance, even though the FAS Score deemed the patient ineligible, she can apply for CAFA by downloading a CAFA application online and mailing it to Atrium Health. A Patient may also request a paper CAFA application via phone by calling 704/512-7171 and a CAFA application will be sent to the patient via mail. Only fully completed CAFA applications will be reviewed. Patients who choose to apply for CAFA will be required to pursue other coverage options before being considered for a financial assistance discount.

All paper applications should be mailed to:

Atrium Health Business Office
ATTN: Coverage Assistance Services
PO Box 32861
Charlotte, NC 28232

Once an application is received, an Atrium Health Coverage Assistance Services team member will contact the patient if necessary.

Communication of Policy:

Atrium Health communicates the availability of its CAFA process to all patients through the following:

- Atrium Health's website
- On all hospital billing statements
- Information posted in the Emergency Department and at Admissions
- Onsite Coverage Assistance Services interviews with patient and families
- Patient Accounting Customer Service Department

Actions In the Event of Non-Payment

The actions Atrium Health hospitals may take in the event of non-payment for services are described in a separate billing and collections policy which can be obtained by asking for a free copy from the Patient Accounting Service Department at 704-512-7171.

Quality Assurance and Other Provisions:

Atrium Health teammates are prohibited from making recommendations and/or process CAFA applications for family members, friends, acquaintances and co-workers. The PFS Quality Assurance Department will conduct periodic audits of accounts processed for FA discounts for Category I patients to ensure the appropriate documentation is on file. The PFS Quality Assurance Department will also test the Category II process to ensure appropriate adjustments are being made (PFS Policy 3.01).

Created:	*10/1/2013*	*Approved Version:*	*03/01/2019*
		Revised:	*03/01/2019*

Carolinas HealthCare System
PFS 1.02 Hospital Hardship Settlement Discount Policy

Created:	*10/01/2013*	*Approved Version:*	*02/23/2016*
		Revised:	*02/23/2016*

Objective

The Hospital Hardship Settlement Discount Policy provides an opportunity for patients to request discounts on balances due to the hospital in excess of $2,500. The purpose of this policy is to recognize that even after the administration of the hospital's automatic discount for all uninsured patients and even after third party payments for insured patients, there could still be situations where the patient is experiencing a financial hardship to pay the balance due in full. This policy also applies to insured patients who may also experience a financial hardship when paying their balance after all third party payments.

Carolinas HealthCare System (CHS) has the following objectives for the hardship settlement discount process:

- **To model at all times CHS's core value of "Caring"**
- **To provide discounts based on the patient's ability to pay**
- **To establish a process that minimizes the burden on the patient and is cost efficient to administer**

Definitions

The terms used within this policy are to be interpreted as follows:

1. Assets: Includes real property equity and checking, savings, and investment account balances.
2. Bad Debt: Accounts that have been categorized as uncollectible because the patient has been unwilling to pay for their medical care.
3. Elective: Those services that are, in the opinion of a physician, not needed or can be safely postponed.
4. Emergency Care: Immediate care which is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs or body parts.
5. Financial assistance: Financial assistance is designed to assist qualifying patients who are unable to pay for all or part of their health care expenses.
6. Household Financial Resources: Household Financial Resources as measured against annual Federal Poverty Guidelines are determined from a sum of annual household income plus any bank balances for checking and savings accounts. Sources of household financial resources include, but are not limited to, the following:
    - Annual household pre-tax job earnings
    - Personal and business checking, savings, and investment balances in excess of $10,000
    - 50% of home equity in excess of $100,000
    - Unemployment compensation
    - Workers' Compensation

- Social Security and Supplemental Security Income
- Veteran's payments
- Pension or retirement income
- Health Savings Account and/or Flexible Spending Account Balances
- Other applicable income to include, but not limited to, rents, alimony, child support, and any other miscellaneous sources

7. Medically Necessary: Hospital services provided to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
8. Clinic Sliding Scale: A program allowing Mecklenburg County indigent patients to utilize outpatient clinic services for a co-pay based on their income.
9. Underinsured: Patients covered by a source of third party funding, but at risk of high out-of-pocket expenditures due to their plan's benefit package. This may include, but is not limited to, high deductible plans, high coinsurance/copay plans, low per diem policies, etc.
10. Uninsured: Patients who are not covered under an insurance health plan, an ACA subsidized insurance plan, Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Physicians Reach Out, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

Policy

Patients who do not qualify for financial assistance under the guidelines of the PFS 1.01 CHS Hospital Coverage Assistance and Financial Assistance policy may request to be reviewed for a hardship settlement discount.

The granting of a hardship settlement discount shall be based on a request from a patient and on the determination of financial need. Financial need will be determined by comparing a patient's total household financial resources and assets to the patient's total remaining hospital balance after payment by all third parties. To be eligible for a hardship settlement discount, the following criteria must be met:

- The remaining hospital balance after all third party payments must be greater than $2,500 and has not been categorized as bad debt.
- The remaining hospital balance after all third party payments must be greater than 10% of the patient's total household financial resources and has not been categorized as bad debt.
- Applicant's income must not exceed $200,000

CHS will uphold confidentiality of information and maintain the dignity for all patients seeking a hardship settlement discount.

Eligibility Guidelines

1. **Services Eligible:**
   - All medically necessary (as determined by a physician) inpatient services
   - All medically necessary (as determined by a physician) outpatient services
   - All hospital emergency medical services provided in an emergency room setting

- All Non-elective medically necessary (as determined by a physician) outpatient hospital services provided in response to life-threatening circumstances in a non-emergency room setting.

2. **Services Ineligible**
   - Elective and cosmetic services
   - Reference lab services
   - Outpatient pharmacy services
   - Clinic Sliding Scale eligible services (Clinic visits, outpatient diagnostics, and emergency department services covered by the clinic sliding scale co-pay)
   - Accounts categorized as bad debt

3. **Patients Eligible**
   - North Carolina and South Carolina residents
   - Patients who properly and truthfully complete a Hardship Settlement Discount Application

4. **Patients Ineligible**
   - Patients provided financial assistance based on the CAFA policy
   - Uninsured patients who did not cooperate with the process under the CHS Hospital Coverage Assistance and Financial Assistance policy.
   - Patients eligible for assistance through the Clinic Sliding Scale program
   - Patients who do not reside in North Carolina or South Carolina
   - Patients who provide false information to CHS
   - Patents who have an income of $200,000 or more

5. **Balances Eligible**
   - Remaining hospital balances after all third party payments in excess of $2,500 that has not been categorized as bad debt.
   - Remaining hospital balances after all third party payments in excess of 10% of a patient's total household financial resources that has not been categorized as bad debt.

Eligibility Determination

If a patient cooperated with but is ineligible for the CHS Hospital Coverage Assistance and Financial Assistance process, they may choose to apply for a hardship settlement discount by downloading a CHS Hospital Hardship Settlement Discount application from the CHS website. Patients can also request an application via mail by contacting the CHS System Business Office Customer Service department at 704/512-7000. Only completed applications will be reviewed.

Completed applications will be reviewed upon receipt and must be submitted within two weeks after requesting an application. Eligibility is based on a patient's total household financial resources and assets for the prior 90 days reported at the time of evaluation. Household financial resources and assets will be verified using a third party vendor. If there is a discrepancy between what the patient reported and what the third party vendor reported, additional documentation from employers and banking institutions may be required. The patient must fully cooperate with this process to be eligible for a hardship settlement discount.

Patients who can demonstrate that their remaining balance is at least 10% of their total household resources and the balance is greater than $2,500 will be eligible for a discount outlined in the table below.

Hardship Settlement Discounts	
Balance Due	**Discount**
Balance Due is equal to or greater than 50% of the patient's total Household Financial Resources	75%
Balance Due is equal to or greater than 35% and less than 50% of the patient's total Household Financial Resources	50%
Balance Due is equal to or greater than 10% and less than 35% of the patient's total Household Financial Resources	25%

Example: If a patient's outstanding obligation is $20,000 and the patient's total household financial resources is $50,000, they would qualify for a 50% discount and the balance due would be $10,000.

Payment plans may be required to assist in payment of balances after financial assistance discounts.

CHS reserves the right to reverse hardship settlement discounts provided by this policy if the information provided by the patient during the information gathering process is determined to be false or if CHS obtains proof that the patient has received compensation for services from other sources.

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Care Directives
Number: PR 120.05
Date of Issue: 10/93 Reviewed / Revised: 05/15

EMTALA COMPLIANCE, INCLUDING PATIENT TRANSFERS (EMERGENCY MEDICAL TREATMENT AND LABOR ACT)

SUMMARY STATEMENT

Emergency services and care, including an appropriate Medical Screening Examination, will be provided to individuals who "come to the emergency department" and request examination or treatment of a medical condition, as defined in this policy. A Medical Screening Examination will be done to determine if an Emergency Medical Condition exists. If the individual has an Emergency Medical Condition, the hospital will either stabilize the medical condition within its available staff, facilities, and resources, or, if stabilization at the hospital is not possible, appropriately transfer the individual to a qualified receiving facility.

SCOPE OF POLICY

This policy applies to individuals presenting on Hospital Property. This policy does not apply to inpatients who are covered by the Medicare Conditions of the Participation. This policy applies to every infant who is born alive, at any stage of development, as stated in the Born Alive Infants Protection Act of 2002.

DEFINITIONS

"**Emergency Medical Condition**" or "**EMC**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

If the individual is a pregnant woman having contractions, "Emergency Medical Condition" means:

- There is not enough time to effect a safe transfer to another hospital before delivery.
- Transfer may pose a threat to the health or safety of the woman or the unborn child.

In the case of psychiatric emergencies, an "Emergency Medical Condition" means the individual is expressing suicidal or homicidal thoughts or gestures, and is determined to be dangerous to himself/herself or others.

"**Hospital Property**" means the main hospital building and any physical areas immediately adjacent to the main hospital buildings (and any other area CMS has determined to be part of the hospital's campus), including the parking lot, sidewalk, and driveway, and any buildings that are owned by the hospital within 250 yards of the main hospital buildings. Hospital Property does not include any other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

"**Medical Screening Exam**" or "**MSE**" means examinations, tests, studies, monitoring, and procedures that are appropriate given the individual's presenting signs and symptoms and reasonably calculated to determine if an EMC is present, including ancillary services routinely available to the emergency department.

"**Representative**" means a third party that is acting as a surrogate decision maker for the patient due to the patient's incapacity. Please refer to CHS Policy PR 120.06, *Consent for Treatment*, for who can appropriately serve as a representative.

"**Stable**" or "**Stabilized**" means that no material deterioration of the individual's condition is likely, within a reasonable medical probability, to result from or occur during the transfer of the individual. In other words, the EMC that caused the individual to seek care is Stable, even though the underlying condition may still exist.

- For a pregnant woman with an EMC, "Stable" means the woman has delivered the child and the placenta.
- For an individual with a psychiatric EMC, "Stable" means the individual is protected and prevented from injuring or harming himself/herself or others. Special care should be taken in determining stability if the individual has been given chemical or physical restraints.

PROCEDURE

I. <u>Medical Screening Examination</u>

A. <u>Request for MSE</u>: An appropriate Medical Screening Examination will be performed on any individual who "**comes to the emergency department**", which means:

1. The individual presents to the hospital's dedicated Emergency Department, and, either personally or through someone else, requests examination or treatment for a medical condition.

2. The individual presents anywhere on the Hospital Property and, either personally or through someone else, requests examination or treatment for what may be an Emergency Medical Condition.

In either situation, even if there has been no formal request for treatment, a request is considered to have been made if a prudent layperson observer would believe that the individual needs emergency examination or treatment.

B. Appropriate MSE. The purpose of the MSE is to determine whether the individual has an EMC.

1. The MSE should be appropriate based on the signs and symptoms of the individual, and in keeping with the professional standard of care.

2. The MSE must be done within the capacity and capability of the hospital, including using all ancillary services routinely available to the Emergency Department.

3. The individual should be appropriately monitored as part of the MSE until the qualified medical personnel (defined in Section II) confirms that the individual does not have an EMC, or an EMC has been identified and the individual is Stabilized or appropriately transferred .

4. Triage may be an appropriate beginning of a MSE, but it is not a substitute for the MSE.

C. Non-Discrimination. The MSE will be done without discrimination, and be the same MSE that would have been performed on any individual with the same presenting signs and symptoms, except to the extent that a factor, such as age, sex, pre-existing medical condition, or physical or mental handicap, is medically significant. An individual will not be discriminated against based on the ability to pay or source of payment.

D. No Delay.

1. The MSE and Stabilizing treatment will not be delayed in order to inquire about method of payment, insurance status or to obtain authorization for payment from the individual's insurance carrier.

2. Registration of an individual may take place concurrently with the MSE, so long as it does not delay or interfere with the MSE.

3. If the individual is a minor, and his/her parent or representative is not available to consent to the MSE, the MSE should still proceed. *See also* CHS Policy PR 120.06.01, *Emergency Treatment of Minors*.

II. **Personnel**

A. Qualified Medical Personnel.

1. The MSE will be performed by qualified medical personnel ("QMP") as designated by the Carolinas HealthCare System Board of Commissioners. The current Board of Commissioners Resolution is attached as **Exhibit A**.

2. When medically appropriate, a MSE will include consultation with the on-call physician.

B. On-Call Physicians.

1. Physicians, including specialists and sub-specialists, who serve on an on-call basis to the emergency department must be available to provide necessary treatment to stabilize individuals with EMCs after the initial MSE.

   a) The on-call physician must respond in a reasonable amount of time to requests for his/her services, including requests by the QMP for the on-call physician to personally appear to treat the individual.
   b) Each hospital will strive to provide adequate on-call coverage that reflects the services (including specialty services) and available resources provided at the hospital.
   c) A list of on-call physicians will be maintained by each hospital. The on-call physicians will be appropriately privileged members of the hospital's medical staff.
   d) The on-call list will be current and accurate. Individual physicians are to be listed on the on-call list; group practices are not to be listed.
   e) The on-call physician is obligated to fulfill his/her on-call obligations, regardless of whether or not the individual has been terminated from the on-call physician's private practice.

2. If an on-call physician refuses to appear or is not available in the time needed for a response, then the hospital will have a back-up plan, which may include calling the next on-call physician on the list. Diligent efforts must be made to provide the MSE and any stabilizing treatment for the EMC at the originating hospital before arranging for transfer.

3. Each CHS hospital may implement guidelines or procedures addressing other on-call parameters, such as:

   a) Whether the on-call physician is allowed to do elective surgery while on call.
   b) Whether the on-call physician can have simultaneous on-call duties.
   c) Whether the hospital wishes to participate in a community call plan; if so, the EMTALA requirements for a community call plan will be followed.

III. **Emergency Medical Condition**

A. EMC Found. If it is determined that an EMC exists, then the following apply:

1. Emergency Services and Stabilizing Care. Stabilizing treatment will be provided to Stabilize the EMC within the capabilities of the staff, ancillary services, and facilities available to the hospital.

a) All individuals with similar presenting signs and symptoms should receive similar Stabilizing treatment, as medically appropriate.
b) Once the individual is determined to be Stable, Stability will be documented in the medical record.
c) An EMC can be deemed Stable, even though the individual may continue to have an unresolved underlying chronic condition, such as asthma or cancer.

2. Admission as Inpatient. If, in the good faith clinical judgment of the attending physician, the individual should be admitted as an inpatient for further treatment, then the individual may be admitted and the EMTALA obligations are satisfied. Inpatient care is subject to the Medicare Conditions of Participation. **Under no circumstances should an individual be admitted to avoid EMTALA obligations.**

3. Transfer. If the hospital is unable to Stabilize the individual within its capacity and capabilities, an appropriate transfer should be implemented, as discussed below.

B. No EMC Found or EMC Resolved. If an appropriate MSE has been performed, and it has been determined that an EMC does not exist, the obligations under EMTALA are satisfied. If the individual had an EMC but it has been Stabilized, then the obligations under EMTALA are satisfied.

1. Additional Treatment. If the individual's EMC has been Stabilized, but s/he requires additional care, s/he may be admitted per standard admissions procedure or transferred to another facility, as appropriate.

2. Follow-Up Care. If the individual requires follow-up care, s/he may be discharged and referred to a facility or provider for follow-up care. Follow-up care could be on an outpatient or inpatient basis.

3. Discharge with Self-Care. If the individual does not require follow-up care, s/he may be discharged with appropriate self-care instructions.

IV. **Transfer of Unstabilized Individual for Medically Indicated Reasons**

A. Transfer Determination.

1. If possible, an individual with an unstable EMC should not be transferred. If the EMC cannot be Stabilized with the capacity and capabilities of the hospital and transfer to a facility with higher capacity and capability is deemed necessary, then the individual may be transferred, subject to the following requirements:

a) The transfer is an Appropriate Transfer, as defined in Section B below; and,

b) Either:

(1) The individual/representative has requested the transfer. The hospital must inform the individual/representative of its obligations under EMTALA, as well as explained the risks and benefits of transfer.

(a) The individual/representative must sign a written request for transfer using the *CHS EMTALA Transfer Form.* The Form should indicate why the transfer is being requested, as well as confirmation that the individual is aware of the risks and benefits of transfer.

(b) The request for transfer will also be documented in the medical record.

Or

(2) The physician certifies in writing that the expected benefits of the transfer outweigh the increased risks of transfer to the individual (and to the unborn child of a pregnant woman). The physician must sign a certification. The *CHS EMTALA Transfer Form* serves as the certification of transfer as required by EMTALA.

(a) The emergency physician/on-call physician will complete and sign the *CHS EMTALA Transfer Form*, stating that, based on the information available at the time of transfer, the medical benefits reasonably expected from the care anticipated at the receiving hospital outweigh the risks of transfer (including to the woman in labor or her unborn child).

(b) A summary of the risks and benefits upon which this conclusion is based will be documented in the *CHS EMTALA Transfer Form*.

(c) If the physician is not physically present to sign the *CHS EMTALA Transfer Form* at the time of transfer, the QMP may sign it after consulting with the physician and confirming his/her agreement to transfer. The physician must countersign the *CHS EMTALA Transfer Form* as soon as practicable after the transfer.

(d) The *CHS EMTALA Transfer Form* may not be backdated.

(e) If possible, the individual/representative should confirm their consent to the transfer on the *CHS EMTALA Transfer Form.* If the individual/representative is not reasonably available, then consent may be implied.

See CHS Policy and Clinical Practice Guideline *EMTALA Transfer Form* for further instructions on how to complete it.

B. "Appropriate Transfer". All EMTALA transfers must qualify as an "Appropriate Transfer". The elements of an "Appropriate Transfer" include all of the following:

1. Minimize Risk. The transferring hospital must provide medical treatment within its capacity to minimize the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child. If possible, all

results from tests should be received and reviewed before the individual is transferred. Monitoring of the individual by hospital should be ongoing while the individual is within the control of the hospital.

2. Receiving Facility Consent. Contact will be established between the attending emergency physician or on-call physician, and the receiving facility regarding the request for transfer.

    a) The transferring hospital will provide the receiving facility with a report on the individual's condition and why there is a need for transfer.
    b) The receiving facility will confirm that it has the available space, qualified personnel, and equipment to treat the individual.
    c) The receiving facility agrees to accept the transfer, and to provide appropriate medical care for the individual upon arrival. No individual will be transferred without acceptance by an appropriate receiving facility.
    d) Confirmation of acceptance of the transfer will be documented in the medical record, including the date and time of the transfer request, and the name and title of the person at the receiving facility who accepted the transfer. This information may be documented using the *CHS EMTALA Transfer Form*.

3. Medical Records to Receiving Facility. An Appropriate Transfer requires that the transferring hospital provide the receiving facility with:

    a) A copy of all medical records relating to the individual's EMC examination and treatment that are available at the time of transfer, including:

        (1) Available history
        (2) Records related to individual's EMC
        (3) Observations of signs and symptoms
        (4) Preliminary diagnosis
        (5) Results of diagnostic studies or tests (or telephone reports of the same)
        (6) Treatment already provided
        (7) A copy of all lab tests and x-rays performed
        (8) A copy of appropriate nurse, QMP, and physician notes
        (9) Individual consents/requests and physician Certification form (*CHS EMTALA Transfer Form)*

    b) If relevant, the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
    c) Any other relevant records, results, or documentation relating to the individual's treatment or condition that becomes available after transfer.

Transfer should not be delayed to retrieve records or results if the individual's condition warrants an immediate transfer. Any information received after the

individual has left should be communicated to the receiving facility as soon as possible by telephone, fax, or encrypted email.

4. Transportation. The transfer will be effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. The physician at the transferring hospital is responsible for determining the appropriate mode, method, and attendants for transfer.

C. Movements That Are Not EMTALA Transfers.

1. Movement within a Facility. It is not considered a transfer to move an individual from one department to another within the same hospital for further screening or stabilization. Available resources within a hospital should be exhausted before transferring the individual to another facility.

2. Facilities with Shared Licenses. EMTALA requires that a hospital use its full capabilities and capacity to do the MSE and Stabilize the EMC. For multiple provider-based facilities on the same license (such as a free-standing emergency department on the same license as a main hospital, or a mental health hospital on the same license as an acute care hospital), the individual should be sent to the main hospital for additional resources and not transferred to another facility unless the main facility does not have the necessary capabilities or capacity to Stabilize the individual's EMC.

3. Transfer of Stable Individual. EMTALA does not apply to the transfer of an individual who is Stable or who did not have an EMC. The Medicare Conditions of Participation should be followed, as appropriate.

D. Other Requirements. The transfer will meet such other relevant requirements that are subsequently issued by federal, state or local regulations.

V. **Refusal of Emergency Services and Care**

A. Refusal of MSE or Stabilizing Treatment. An individual/representative with capacity may choose to refuse to consent to medical examination and treatment. *See* CHS Policy PR 120.08, *Refusal to Submit to Treatment.* In such case, the hospital will do the following:

1. Inform individual/representative of the hospital's obligations to screen for, and treat, EMCs.

2. Explain the risks and benefits of both receiving and refusing the examination and treatment.

3. Confirm that the individual/representative has the necessary capacity to make an informed refusal, and document the same in the medical record.

4. Make all reasonable efforts to secure the individual/representative's written informed consent to refuse, which can be done using the *Refusal to Submit to Treatment Form*. If s/he refuses to sign the form, hospital personnel will document such refusal on the form.

5. Refusal of emergency care will be documented in the medical record by the physician when the individual is transferred or discharged against medical advice in accordance with hospital policy. Documentation in the medical record will include (i) a description of the examination, treatment or both that were offered and refused, (ii) confirmation that the risks and benefits of both accepting and refusing the examination and treatment were explained to the individual/representative, and (iii) documentation that the examination and/or treatment were offered, but refused.

B. Refusal of Transfer.

1. If the individual/representative refuses to consent to a medically indicated transfer in accordance with this policy, the hospital will:

   a) Inform the individual/representative of the hospital's obligation to screen or treat.
   b) Offer the transfer in accordance with the law.
   c) Explain risks and benefits of the transfer and the refusal thereof.
   d) Confirm that the individual/representative has the necessary capacity to make an informed refusal, and document the same in the medical record.
   e) Make all reasonable efforts to secure written informed refusal of the transfer by having the individual/representative sign the *Refusal to Submit to Treatment Form*. If s/he refuses to sign the form, hospital personnel will document such refusal on the form.

2. Documentation in the medical record will include (i) a description of the proposed transfer that was refused, (ii) that the risks and benefits were explained, and the treatment was offered, but refused, by the individual, and (iii) the reason for the refusal.

C. Minors. If the individual is a minor, and his/her parent or guardian refuses medically necessary treatment or transfer, please refer to CHS Policy PR 120.06.01, *Emergency Treatment of Minors*.

VI. **Receiving Transfers from Outside Facilities**.

A. Receiving Transfers. Medicare-participating hospital that has specialized capabilities or facilities (including burn units, shock-trauma units, neonatal intensive care units, or [with respect to rural areas] regional referral centers) may not refuse to accept an appropriate transfer of an individual who needs such specialized capabilities or facilities if the receiving hospital has the capacity and capabilities to treat the individual.

1. A receiving facility cannot condition acceptance of the transfer on use of a specific mode of transportation or transportation service.

2. A receiving facility should not unreasonably delay in treating a transferred individual.

B. Scope.

1. Receiving facilities are subject to this requirement regardless of whether they have a dedicated emergency department.

2. Receiving hospitals are not required to accept inpatients of the transferring hospital. Individuals in observation status are not considered inpatients.

3. This requirement only applies to transferring hospitals within the boundaries of the United States.

VII. **Notice and Documentation Requirements.**

A. Posting Notices. Each hospital subject to EMTALA will conspicuously post a notice listing an individual's rights to examination and treatment for an EMC, including for women in labor. In addition, each such hospital will conspicuously post information about whether the hospital participates in the Medicaid program. These notices are to be posted in places likely to be noticed by individuals in the Emergency Department, as well as in areas where individuals are likely to be waiting for EMTALA examination and treatment, such as the entrance, waiting room, and treatment area.

B. Individual Log. The hospital will maintain a log identifying at least (i) each individual who "comes to the hospital emergency department" as defined in Section I seeking assistance, and (ii) the disposition of the case (individual refused treatment, was refused treatment, was transferred, was admitted and treated, was stabilized and transferred, or was discharged).

C. On-Call Physician List. Each hospital will maintain a list of all on-call physicians who are on the hospital's medical staff or who have privileges at the hospital, and who are available on-call to provide treatment necessary after the initial examination to stabilize individuals with EMCs.

D. Medical Records**.** Medical records will be maintained for all individuals receiving emergency services and care. Medical records should include documentation of the MSE, the capabilities used in the screening, the status of the EMC, any Stabilizing treatment, and any transfer, discharge or admission determinations and documentation.

E. Transfer Records. Medical and other records of the individuals who were transferred to or from the hospital will be maintained for five (5) years from the date of transfer.

F. Quality Assurance. A review of emergency department and in-house transfers of individuals to another facility will be conducted periodically for compliance by designated employees in the ED and inpatient units.

VIII. **Reporting**

A. Inappropriate Transfer. Any transfer of an unstable individual received into the hospital that is deemed inappropriate by the receiving physician will be reported to the Administrator On-Call, and to CHS Office of General Counsel.

B. Non-Retaliation. The hospital will not penalize or take adverse action against a physician or qualified medical personnel for refusing to authorize a transfer of an individual with an EMC that has not been Stabilized, or against an employee who reports a violation of the transfer requirements.

REFERENCES

42 U.S.C. § 1395cc(a)(1)(I)
42 U.S.C. § 1395dd
42 C.F.R. § 413.65
42 C.F.R. § 489.20
42 C.F.R. § 489.24
CMS State Operations Manual - Appendix V

APPROVALS

Policy Coordinator	Donna Owen, Director, Policy & Clinical Practice
Policy Approvers	Grace Sotomayor, Vice President, Administration
	Spencer Lilly, Chief Operating Officer, Central Division
	Dennis Phillips, Executive Vice President, Metro Group

-End-

CAROLINAS HEALTHCARE SYSTEM

RESOLUTION
OF THE
BOARD OF COMMISSIONERS
AT ITS JUNE 12, 2012, MEETING

Designation of qualified medical personnel to provide medical screening examinations under the Emergency Medical Treatment and Active Labor Act

Under the provisions of the Emergency Medical Treatment and Active Labor Act ("EMTALA") and implementing regulations, qualified medical personnel are required to provide a medical screening examination to any individual who comes to a hospital emergency department and requests examination for an emergency medical condition. The Board of Commissioners of The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("CHS") believes it is in the best interests of CHS to formally designate the personnel who are qualified medical personnel for purposes of providing a medical screening examination.

The Board of Commissioners therefore resolves as follows:

A. that the following individuals are designated as qualified medical personnel, in the respective departments of hospitals for which the Board of Commissioners serves as the governing body (each, a "CHS Hospital") to perform medical screening examinations on individuals who come to the emergency department and request examination or treatment for an emergency medical condition, as required by EMTALA:

1. physicians (both house staff and medical staff);
2. physician assistants, in consultation with a physician;
3. nurse practitioners, in consultation with a physician; and
4. qualified registered nurses, in consultation with a physician.

B. that the appropriate departmental chairs at each CHS Hospital are authorized and directed to determine the qualifications of registered nurses in order to be considered qualified medical personnel to perform medical screening examinations.

This 12th day of June, 2012.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Ref: Carolinas Healthcare System Cleveland, 340021

October 12, 2018

Mr. Brian Gwyn, President
Carolinas Healthcare System Cleveland
201 E Grover Street
Shelby, North Carolina 28150

Dear Mr. Gwyn:

Based on the findings of the North Carolina State Survey Agency's revisit conducted on October 4, 2018, it has been determined that your hospital is now in compliance with the Medicare Conditions of Participation.

Accordingly, we are removing your facility from state survey agency jurisdiction. Your hospital's "deemed status" as a facility accredited by the Joint Commission (JC) has been restored.

If you have any questions, please contact Karmen Billingslea at (404) 562- 7586 or karmen.billingslea@cms.hhs.gov.

Sincerely,

Karmen T. Billingslea -S
Digitally signed by Karmen T. Billingslea -S
Date: 2018.10.12 09:48:07 -04'00'

Linda Smith
Associate Regional Administrator
Division of Survey & Certification

cc: North Carolina State Agency