COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DIVISION OF ADMINISTRATIVE HEARINGS HEALTH SERVICES
ADMINISTRATIVE HEARINGS BRANCH
DAH CON 15-2294

IN RE: PIKEVILLE MEDICAL CENTER, INC.
CON # 098-11-394(32)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER

INTRODUCTION

At issue in this matter is Pikeville Medical Center's ("PMC") certificate of need ("CON") application, CON # 098-11-394(32), (the "Application"),which seeks to add 39 acute care beds to PMC's existing facility in Pikeville, Kentucky. A public hearing was conducted on September 29, 2015 through October 2, 2015 beginning at 9:00 a.m. on each day in the Kentucky Transportation Cabinet, Conference Room C121 and on October 20, 2015 through October 21, 2015 at the Lexington offices of Wyatt, Tarrant & Combs, LLP. Janet A. Craig and K. Kelly White Bryant of Stites & Harbison, PLLC and Pamela May of Pam May Law Firm represented PMC. The affected parties, Appalachian Regional Healthcare, Inc. d/b/a Tug Valley ARH Regional Medical Center ("Tug Valley ARH") and Appalachian Regional Healthcare, Inc. d/b/a Whitesburg ARH Hospital ("Whitesburg ARH"), appeared in opposition to PMC's Application and were represented by Michael D. Baker and Lori Payne Eisele both of Wyatt, Tarrant & Combs, LLP. The third affected party, Highlands Hospital Corporation d/b/a Highlands Regional Medical Center ("Highlands"), also appeared in opposition and was represented by Mathew R. Klein, Jr. of Dressman, Benzinger & LaVelle, P.S.C. Tug Valley ARH, Whitesburg ARH and Highlands are sometimes referred to herein as the "Opposing Hospitals."

WITNESSES

PMC presented the testimony of the following witnesses during its case in chief in support of its Application:

1. **Walter May.** Mr. May is the President and Chief Executive Officer of PMC. (PMC Exhibit 2.) Mr. May has lived in Pikeville his entire life and has been affiliated with PMC in some capacity since the early 1960s. (Tr. Vol. I, p. 14.) Mr. May has been the President of PMC's Board of Directors since 1990 and has served as CEO from 1998 through 2001 and then from 2007 through the present. (Id.)

2. **Michelle Hagy.** Ms. Hagy, who began her career in health care finance in 1997, is PMC's current Chief Financial Officer. (PMC Exhibit 4.) As PMC's CFO, Ms. Hagy's primary responsibilities include providing financial oversight for PMC and ensuring that PMC meets financial compliance and regulatory requirements. (Id.) She holds a Bachelor's Degree in business administration and is a member of the Medical Group Management Associates and the Healthcare Financial Management Association. (Id.)

3. **Debra Parsons.** Ms. Parsons is PMC's Chief Nursing Officer and Assistant Chief Operating Officer. (PMC Exhibit 11; Tr. Vol. II, p. 8.) With over 26 years of experience in health care, she is a certified trauma nurse and also has a Master's of Business Administration. (Id.) In her roles as Chief Nursing Officer and Assistant Chief Operating Officer, Ms. Parsons oversees the nursing care at PMC and the trauma manager reports to her. Prior to joining PMC, Ms. Parsons worked as the director of the Emergency Department and Trauma Division at St. Mary's hospital in Huntington, West Virginia. (Id.)

4. **Bill Harris, MD.** Dr. Harris, an expert in cardiology, is an employed physician practicing at PMC. (Tr. Vol. II, p. 85 – 86.) He is board certified in Internal Medicine, General

Cardiology, and Interventional Cardiology, and is a Fellow of the American College of Cardiology, the Co-Medical Director of the Society of Chest Pain Centers of Pikeville, and a past Governor of the American College of Cardiology Chapter in the State of Kentucky. (Id.) Dr. Harris has been voted among the Best Doctors in American for many years, including in 2015. (Tr. Vol. II, p. 83.) Currently, Dr. Harris serves as PMC's Chairman of the Department of Cardiology and the Director of PMC's Cardiac Cath Lab. (Tr. Vol. II, p. 84.) Prior to moving to Pikeville 9 years ago, Dr. Harris practiced in Lexington, Kentucky at St. Joseph and Central Baptist Hospitals. (Tr. Vol. II, p. 116.)

5. **Fadi Al Akhrass, MD.** Dr. Akhrass, who has been practicing at PMC since 2010, is an expert in infectious disease. (PMC Exhibit 32; Tr. Vol. III, p. 14.) He is board certified in internal medicine and infectious disease. (PMC Exhibit 32.) Dr. Akhrass did his fellowship in immunocompromised infectious disease at the University of Texas, MD Anderson Cancer Center. (Id.) He has published multiple articles and has done educational lectures on the topic of infectious disease. (Tr. Vol. III, p. 9.)

6. **Aaron W. Crum, MD.** Dr. Crum, who has been practicing in Pike County for 15 years, is an expert in obstetrics and gynecology. Dr. Crum is board certified in obstetrics and gynecology, and is currently serving as PMC's Chief Medical Officer and the Chief of PMC's Medical Staff. (PMC Exhibit 33; Tr. Vol. III, p. 38.)

7. **Daniel J. Sullivan.** An expert in healthcare planning and healthcare finance, Mr. Sullivan is the President of Sullivan Consulting Group. (PMC Exhibit 37; Tr. Vol. IV, p. 10.) He is responsible for the overall responsibilities and day-to-day operations of the firm, but spends most of his time providing consulting services to individual clients exclusively in the healthcare field. (Id.) Mr. Sullivan has an undergraduate degree in economics and public policy

studies from Duke University and a Master's in Health Administration, also from Duke University. (Id.) He has experience preparing CON applications and providing expert testimony in CON hearings in thirteen states, including Kentucky. (Tr. Vol. IV, p. 9.) Mr. Sullivan has specific experience with Kentucky acute care CON projects. (Id.)

Tug Valley ARH and Whitesburg ARH presented the testimony of the following witnesses in opposition to the Application:

1. **Trena Hall.** Ms. Hall works for Appalachian Regional Healthcare, traveling between all of the ARH hospitals. (Tr. Vol. V, p. 20 - 21.) In her current role as ARH's Director of Capital Projects, Ms. Hall oversees ARH's capital projects and major ventures. (Id.)

2. **Tim A. Hatfield.** Mr. Hatfield has been in healthcare leadership for 20 years. He is currently the Community Chief Executive Officer at Tug Valley ARH, a position he has held for a little over eight years. (Tr. Vol. V, p. 165; ARH Exhibit 4.)

3. **Dena Sparkman.** Ms. Sparkman is the Community CEO of Whitesburg ARH Hospital, a position she has held since March of 2009. (ARH Exhibit 6; Tr. Vol. VI, p.6 - 7.)

4. **Jim Zembrodt.** Mr. Zembrodt is the Associate Vice President for Strategy for UK Healthcare. (Tr. Vol. VII, p. 6 - 8.) He has worked in various roles at UK since 1988 related to business development, business planning and strategic planning. (Id.)

Highlands presented the testimony of the following witness in opposition to the Application:

1. **Harold C. Warman, Jr.** Mr. Warman is the CEO of Highlands Regional Medical Center and Highlands Health System in Prestonsburg, Floyd County, Kentucky. (Tr. Vol. VIII, p. 6 - 7.) He has held this position for 17 ½ years. (Id.) Mr. Warman has a B.A. in Business

Administration from West Virginia University and a Graduate Degree from Xavier University in Hospital and Health Care Administration. (Id.)

The Opposing Hospitals jointly presented the following witness:

1. **Richard A. Baehr.** Mr. Baehr is an expert in healthcare planning, healthcare policy and healthcare finance. (Tr. Vol. IX, p. 11 – 12.) He has worked on preparing CONs, critiquing CON applications, defending CON applications in court and opposing CON applications in court. (Id.)

At the hearing, PMC recalled Michelle Hagy and Daniel Sullivan to present rebuttal testimony.

STANDARD OF REVIEW

Applications proposing to add acute care beds to existing hospitals are governed by the formal review provisions of KRS 216B.040, 900 KAR 6:070, and the State Health Plan. KRS 216B.040(2)(a)2a-e requires the Cabinet to establish criteria for the issuance and denials of certificates of need which shall be limited to the following considerations:

> a. *Consistency with plans.* Each proposal approved by the Cabinet shall be consistent with the state health plan . . . ;
>
> b. *Need and accessibility.* The proposal shall meet an identified need in a defined geographic area and be accessible to all residents of the area. A defined geographic area shall be defined as the area the proposal seeks to serve, including its demographics, and shall not be limited to geographic boundaries;
>
> c. *Interrelationships and linkages.* The proposal shall serve to accomplish appropriate and effective linkages with other services, facilities, and elements of the health care system in the region and state, accompanied by assurance of effort to achieve comprehensive care, proper utilization services, and efficient functioning of the health care system;
>
> d. *Costs, economic feasibility, and resources availability.* The proposal, when measured against the cost of alternatives for meeting needs, shall be judged to be an effective and economical

use of resources, not only of capital investment, but also ongoing requirements for health manpower and operational financing;

e. *Quality of services.* The applicant shall be prepared to and capable of undertaking and carrying out the responsibilities involved in the proposal in a manner consistent with appropriate standards and requirements assuring the provision of quality health care services, as established by the cabinet.

In addition to the statute, 900 KAR 6:070 also addresses the substantive standards governing the issuance and denial of CONs under formal review. Specifically, the CON regulation provides, in relevant part, as follows:

> Section 2. Considerations for Formal Review. In determining whether to approve or deny a certificate of need, the cabinet's review of applications under formal review shall be limited to the following considerations:
>
> (1) *Consistency with plans.*
>
> (a) To be approved, a proposal shall be consistent with the State Health Plan established in 900 KAR 5:020.
>
> (b) In determining whether an application is consistent with the State Health Plan, the cabinet shall apply the latest inventories and need analysis figures maintained by the cabinet and the version of the State Health Plan in effect at the time of the public notice.
>
> (2) *Need.* The cabinet shall determine:
>
> (a) If the applicant has identified a need for the proposal in the geographic service area defined in the application; and
>
> (b) If the applicant has demonstrated that it is able to meet the need identified in the geographic service area defined in the application.
>
> (3) *Accessibility.* The cabinet shall determine if the health facility or health service proposed in the application will be accessible in terms of timeliness, amount, duration, and personnel sufficient to provide the services proposed.

(4) *Interrelationships and linkages.* The cabinet shall determine:

(a) If the proposal shall serve to accomplish appropriate and effective linkages with other services, facilities, and elements of the health care system in the region and state; and

(b) If the proposal is accompanied by assurance of effort to achieve comprehensive care, proper utilization of services, and efficient functioning of the health care system.

(5) *Costs, economic feasibility, and resource availability.* The cabinet shall determine:

(a) If it is economically feasible for the applicant to implement and operate the proposal; and

(b) If applicable, if the cost of alternative ways of meeting the need identified in the geographic area defined in the application would be a more effective and economical use of resources.

(6) *Quality of services.*

(a) The cabinet shall determine if the applicant:

1. Is prepared to, and capable of undertaking and carrying out, the responsibilities involved in the proposal in a manner consistent with appropriate standards and requirements established by the cabinet; and

2. Has the ability to comply with applicable licensure requirements.

(b) Absence of an applicable licensure category shall not constitute grounds for disapproving an application. 900 KAR 6:070 § 2.

An application to add additional acute care beds to an existing licensed hospital shall be consistent with the 2013 – 2015 State Health Plan if the following criteria are met:

1. The hospital can document that transfer or conversion of special purpose acute care beds to acute care beds is not feasible because occupancy in the special purpose acute care beds is greater than sixty-five (65) percent or if the occupancy is less than sixty-five (65) percent, the transfer of beds would be insufficient to meet the hospital's total additional acute care bed need;

2. The hospital can document that:

   a. Its acute care occupancy rate has been higher than the target occupancy rate set forth in Table 1 below according to the most recent edition of the *Kentucky Annual Hospital Utilization and Services Report;* or

Table 1
Facility Target Acute Care Bed Occupancy Rates

Number of Licensed beds per Facility	Facility Target Acute Care Bed Occupancy Percentage
1-50	60%
51-100	65%
101-200	70%
201 and above	75%

   b. Its utilization of acute care beds has reached functional capacity for the prior twelve (12) months. In calculating functional capacity, consideration shall be given to the percentage of licensed acute care beds, psychiatric beds, or chemical dependency beds currently operational as well as other factors affecting the utilization at the hospital including the mix of private and semi-private rooms, patient matching limitations such as gender or the need for isolation beds required to address emergency patient needs, and limits created by special purpose acute care bed units; and

3. The maximum number of acute care beds that may be approved will be based on volume projected five (5) years from the date on which the hospital filed its application for additional acute care beds. Approval will be based on the higher of:

   a. The applicant's reasonable forecast of future utilization; or

   b. A regression analysis projection of patient day trends over a five (5) year timeframe.

Based upon a review of the Application, and having considered the testimony and documentary evidence introduced at the hearing, I make the following Findings of Fact, Conclusions of Law and Final Order:

FINDINGS OF FACT

Pikeville Medical Center

1. PMC is a not-for-profit, community-run hospital located in Pike County, Kentucky. (Tr. Vol. I, p. 16.) Its mission is to deliver quality regional healthcare in a Christian environment. (Id.)

2. Over the past 90 years, PMC has grown from a rural 50-bed hospital into a comprehensive 261 bed hospital encompassing more than one million square feet. (PMC Exhibit 3.)

3. Medicare has designated PMC as a Regional Referral Center. (Tr. Vol. I, p. 17.) PMC is the only Level II Trauma Center in Kentucky, and is the only Trauma Center of any level in its proposed service area. (Tr. Vol. II, p. 20 and 23.)

4. PMC has over 2,500 employees and approximately 140 active physicians on its medical staff. (Tr. Vol. I, p. 19; Tr. Vol. III, p. 39.) PMC has an additional 60 consulting medical staff members and 40 physicians who are courtesy staff members. (Id.) Additionally, PMC has close to 100 individuals who are credentialed as nurse practitioners or physician assistants. (Id.)

5. PMC provides over 400 services, including essentially every medical specialty and an extensive list of subspecialties. (Tr. Vol. III, p. 40; PMC Exhibit 34.) PMC has more than one physician practicing in most specialties with coverage twenty-four hours per day, seven days per week. (Id.) PMC offers bariatric surgery, cardiology, electrophysiology, interventional cardiology, cardiothoracic and vascular surgery, pediatric endocrinology, gastroenterology, general surgery, gynecological oncology, hand surgery, hematology oncology, infectious disease, interventional radiology, medical oncology, neonatology, obstetrics and gynecology, gynecologic oncology, nephrology, neurosurgery, ophthalmology, orthopedics, orthopedic trauma surgery, podiatry, otolaryngology, pain management, pathology, pediatrics, physical

medicine and rehabilitation, plastic and reconstructive surgery, pulmonology, radiation oncology, rheumatology, sports medicine, intensivists, hospitalists, internal medicine, and family practice. (PMC Exhibit 34.)

6. PMC has 221 licensed acute care beds and 40 licensed inpatient rehabilitation beds. (Tr. Vol. I, p. 66.) PMC is proposing to add 39 acute care beds, 10 of which will be used as general acute care beds and 29 of which will be used as intensive care unit ("ICU") beds. PMC's defined service area for its proposal includes Pike, Floyd, Letcher, Magoffin, Johnson, and Martin Counties in Kentucky and Mingo, West Virginia. (Tr. Vol. IV, p. 50.) This is PMC's first CON application to add acute care beds in at least 30 years. (Tr. Vol. X, p. 47.)

Tug Valley ARH

7. Appalachian Regional Healthcare is a large hospital system made up of 10 hospitals, including Tug Valley ARH. (Tr. Vol. X, p. 52.)

8. Tug Valley ARH is a 148 bed community hospital located in South Williamson, Pike County, Kentucky. (Tr. Vol. V, p. 165 – 166.) Tug Valley ARH has 113 acute care beds and 35 skilled nursing beds. (Id.)

9. Tug Valley ARH has approximately 430 employees. (Tr. Vol. V, p. 167.)

10. Tug Valley ARH has two clinics, one that is attached to its hospital and one that is a couple of miles away from the hospital. (Tr. Vol. V, p. 166.)

11. Tug Valley ARH provides services from internal medicine to family medicine, obstetrics, pediatrics, oncology, pulmonology, cardiology, orthopaedics, Emergency Room care, inpatient and outpatient surgery, orthopaedic surgery on site, cardiology on-site, outpatient rehabilitation services, and a Women's and Family Clinic. (Tr. Vol. V, p. 166-168).

12. As a community hospital, however, the service lines provided at Tug Valley ARH are

necessarily limited. Some services that Tug Valley does not provide, such as radiation therapy and a heart catheterization laboratory, are provided at health facilities that are nearly 40 minute drive away from Tug Valley. (Tr. Vol. V, p. 222, 227.)

13. Tug Valley ARH has recruited, and continues to recruit, physicians in the areas of OB/GYN, general surgery and oncology in order to reduce the number of patients it must transferring them out to other providers. (Tr. Vol. V, p. 171, 184.)

14. Tug Valley ARH is in the process of developing a Level IV Trauma Center, which should increase the number of patients it can treat and reduce the number of patients it must transfer to other providers. (Tr. Vol. V, pp. 168, 185.)

Whitesburg ARH

15. Whitesburg ARH is a 90 bed community hospital located in Whitesburg, Letcher County, Kentucky. (Tr. Vol. IV, p. 9.) The facility is at least 47 minutes from PMC. (Tr. Vol. VI, pp. 8-9; ARH Ex. 7).

16. Whitesburg's Community CEO, Ms. Sparkman, described the hospital as "a little larger than your critical access hospitals which are pretty much the basic of the emergency room and some inpatient beds." (Tr. Vol. VI, p. 10.) She went on to testify that, in addition to having an emergency room and inpatient beds, Whitesburg ARH has a large rehabilitation department, offering physical, occupational and speech therapy. (Id.)

17. Whitesburg ARH offers general surgery and also has a large obstetrics unit and labor and delivery wings. (Id.) Whitesburg ARH performs 500 deliveries per year and has the capacity to do more. (Tr. Vol. VI, p. 26.)

18. Ms. Sparkman conceded that, as a community hospital, it is not Whitesburg ARH's role to provide all the levels of specialty care that are available at a referral center like PMC; nor would attempting to do so be cost-effective. (Tr. Vol. VI, pp. 70-71)

19. Whitesburg ARH is in the process of obtaining a Level IV Trauma Designation. (Tr. Vol. IV, p. 14.)

20. Historically, Whitesburg ARH has transferred certain trauma patients to other facilities, including PMC, by ambulance, after they are stabilized, and that process will continue. (Tr. Vol. VI, p. 15.) For patients with severe trauma, helicopter transport services provided in the area are available to take patients to the highest level, Level I Trauma Center, at the University of Kentucky. (Id.)

Highlands

21. Highlands Regional Medical Center is a community hospital with 151 acute care beds and 12 psychiatric beds located in Prestonsburg, Floyd County, Kentucky. (Tr. Vol. VIII, p. 28.). It is located approximately 30 miles, or a 36 minute drive, from PMC. (Tr. Vol. VIII, p. 9; Highlands Exhibit 1).

22. Highlands operates 12 of its acute care beds as ICU beds. Additionally, Highlands has 23 behavioral health (psychiatric) beds. (Tr. Vol. VIII, p 28.)

23. Highlands has approximately 158 physicians on its medical staff, only 43 of which are active medical staff members. (Tr. Vol. VIII, p. 18.)

24. Highlands provides cardiology services twenty-four hours per day, seven days per week. (Tr. Vol. VIII, p. 10.) Highlands contracts with two cardiologists employed by King's Daughters Medical Center to provide cardiology services at Highlands. (Id.)

25. Highlands has a cardiac catheterization laboratory and provides diagnostic catheterization

services. (Tr. Vol. VIII, p. 11.) Highlands performs non-cardiac stenting. (Id.) Highlands is an accredited chest pain center. (Tr. Vol. VIII, p. 26.) Highlands plans to apply for a Certificate of Need to establish an interventional cardiology program. (Id.)

26. The second biggest category of transfers out of Highlands is for cardiology/ST segment elevation myocardial infarction ("STEMI"). (Tr. Vol. VIII, p. 25.) Highlands will no longer have to transfer chest pain/STEMI patients once its interventional catheterization program is implemented. (Id.)

27. Highlands provides general surgery services. (Tr. Vol. VIII, p. 12.) Highlands has four general surgeons who provide services and coverage at Highlands (Id.)

28. Highlands provides neurology services. (Id.) Highlands has one neurologist on its medical staff. (Id.)

29. Highlands provides obstetrics services. (Id.) Highlands has approximately six obstetricians who perform services at Highlands. (Tr. Vol. VIII, p. 13.) Highlands performs on average 600 deliveries per year. (Id.)

30. Highlands provides pulmonology services and has a board-certified pulmonologist on staff. (Id.) Additionally, Highlands' internal medicine group provides pulmonology coverage. (Id.)

31. Highlands has ophthalmologists on staff who provide ophthalmology services. (Id.)

32. Highlands has two full-time ENTs that provide services at a practice near Highlands. (Id.) The ENT practice is opening a second location in Harold, Floyd County, Kentucky and recruiting a third doctor. (Id.)

33. Highlands established the Highlands Cancer Center which houses the practice of Highlands' oncologist. (Tr. Vol. VIII, p. 14.) The Highlands Cancer Center provides medical

oncology and radiation therapy services. (Id.) Highlands Cancer Center also has a mobile PET scanner that largely remains on campus. Highlands in the process of recruiting an additional oncologist. (Id.)

34. Highlands has three orthopaedic surgeons who provide coverage twenty-four hours per day, seven days per week. (Tr. Vol. VIII, p. 15.)

35. Highlands has three nephrologists who provide services to Highlands' patients. (Tr. Vol. VIII, p. 46.) Additionally, the internal medicine group covers the need for nephrology when a nephrologist is not available. (Id.)

36. Highlands has two CT scanners located on the hospital's campus and a third CT scanner located at its Harold Primary Care location. (Tr. Vol. VIII, pp. 15-16.) Highlands has one closed, fixed-site MRI located at the hospital. (Tr. Vol. VIII, p. 16.) Highlands also has access to a mobile MRI unit that is available one day per week at the Archer Clinic located about two and a half miles from Highlands. (Id.)

37. Highlands contracts with a group in Huntington, West Virginia to provide interventional radiology services at least once a week and more on an as needed basis. (Tr. Vol. VIII, p. 17.)

38. Highlands provides trauma services. (Tr. Vol. VIII, p. 21.) In the case that a patient needs a higher level of trauma care than Highlands is capable of providing, Highlands will transfer the patient to an appropriate facility. (Tr. Vol. VIII, pp. 21-22.) In 2013, Highlands had approximately 23,206 ED visits, and it transfers approximately 800 ED patients per year. (Id.) The majority of Highlands' ED transfers are to University of Kentucky Medical Center or Cabell Huntington Hospital. (Tr. Vol. VIII, p. 22.) There are several helicopter services available to transfer trauma patients. (Tr. Vol. VIII, p. 22-23.)

39. Highlands' pathology and laboratory services are accredited by the College for American

Pathologists. (Tr. Vol. VIII, p. 26.)

40. Highlands ICU occupancy is generally about 77%. (Tr. Vol. VIII, p. 28.) Highlands has not transferred a patient due to a lack of ICU capacity, or gone on ICU diversion, in the past year. (Id.) In the event that Highlands needs additional ICU beds, it can use acute care beds to monitor patients. (Tr. Vol. VIII, p. 29.)

41. While it is rare that Highlands would put its ED on diversion status, it had to do just that once this past year because it did not have an available CT scanner for approximately four to eight hours. (Id.)

Criterion 1: Consistency with the State Health Plan

42. If an existing licensed hospital wishes to add acute care beds, it must comply with three review criteria set out in the 2013 – 2015 State Health Plan. (PMC Exhibit 39)

43. The first State Health Plan criterion requires that the:

> Hospital can document that transfer or conversion of special purpose acute care beds to acute care beds is not feasible because occupancy in the special purpose acute care beds is greater than sixty-five (65) percent or if the occupancy is less than sixty-five (65) percent, the transfer of beds would be insufficient to meet the hospital's total additional acute care bed need.

(PMC Exhibit 39.)

44. There are two parts to this criterion. First, the number of special purpose beds PMC maintains, and the occupancy rate of those beds. Second, if the occupancy rate for those beds is below 65%, will converting those beds meet the needs that PMC is proposing to address through its CON application? (Tr. Vol. IV, p. 13.)

45. The transfer or conversion of special care acute care beds is not feasible for PMC. (PMC Exhibit 1, p. 7.) PMC experiences high utilization in its ICU beds and its Neonatal Intensive Care Unit ("NICU") beds. (PMC Exhibit 38.) According to the *2014 Kentucky Annual Hospital*

Utilization and Services Report, PMC's 24 ICU beds are operating at 87.8% occupancy and its eight NICU beds are operating at 84.6% occupancy, well above the 65% standard found in the first State Health Plan criterion. (Id.)

46. With respect to PMC's obstetrics ("OB") beds, PMC had 28 OB beds as recently as April 2015 and already converted nine of those beds to ICU beds, leaving PMC with only 19 OB beds. (Tr. Vol. IV, p. 15.) PMC's 19 OB beds are well-utilized, with an occupancy rate of approximately 90% on Tuesdays, Wednesdays, Thursdays, and Fridays. (Tr. Vol. III, p. 58.) On these days, PMC performs six to eight deliveries per day, as well as additional surgeries. (Id.) Patients for whom deliveries are planned prefer to schedule on these days. (Id.)

47. On certain days of the week, PMC's OB/GYN bed occupancy is "full or greater." (Tr. Vol. III, p. 59.) While the birthrate nationwide is decreasing, PMC has had a steady growth in its number of deliveries per year. (Tr. Vol. III, p. 55.) Dr. Crum, who heads PMC's OB/GYN Department and is an expert in obstetrics and gynecology, opined that he expects PMC's occupancy will continue to grow. (Tr. Vol. III, p. 74.)

48. In Dr. Crum's opinion, converting PMC's nine OB beds to ICU beds will not be a good long-term solution. (Tr. Vol. III, p. 61.) In addition, PMC needs those beds for its OB/GYN patients. (Id.)

49. Given that not all deliveries can be planned, it is important to have additional bed capacity in OB to account for the uncertainty involved. (Tr. Vol. IV, p. 15.) There are significant spikes in OB unit utilization that reflect the unpredictability of demand for when patients are going to show up at the hospital and deliver. (Tr. Vol. IV, p. 34.)

50. To attempt to meet patient needs, PMC has already converted OB beds to ICU beds at PMC and, in Mr. Sullivan's expert opinion, remaining capacity in PMC's OB unit is insufficient to allow for a further significant conversion of beds. (Tr. Vol. IV, p. 16.)

51. "Given the magnitude of the bed need for PMC overall, transferring a small number of beds from any specialty unit would not address the overall need for additional bed capacity." (PMC Exhibit 1, p. 7.) Mr. Sullivan believes PMC's proposal is compliant with the first State Health Plan criterion. (Tr. Vol. IV, p. 13.)

52. The second State Health Plan criterion requires that PMC document that "[i]ts acute care occupancy rate has been higher than the target occupancy rate set forth in Table 1 [as shown on pages 7-8 above] according to the most recent edition of the *Kentucky Annual Hospital Utilization and Services Report*." The target occupancy rate for acute care hospitals with 201 beds or more is 75% occupancy. (PMC Exhibit 40; Tr. Vol. IV, p. 19 – 20.)

53. According to the *2014 Kentucky Annual Hospital Utilization and Services Report*, the most recent edition, PMC's occupancy rate is 75.5%. (PMC Exhibit 41; Tr. Vol. IV, p. 20.)

54. In Mr. Sullivan's expert opinion, PMC's application is consistent with the second State Health Plan criterion. (Tr. Vol. IV, p. 21.)

55. The third State Health Plan criterion requires that

> The maximum number of acute care beds that may be approved will be based on volume projected five (5) years from the date on which the hospital filed its application for additional acute care beds. Approval will be based on the higher of:
>
> a. The applicant's reasonable forecast of future utilization; or
>
> b. A regression analysis projection of patient day trends over a five (5) year timeframe.

(PMC Exhibit 42.)

56. Mr. Sullivan performed both a reasonable forecast of future utilization and a regression analysis projection of patient day trends over a five year timeframe, and the regression analysis was higher. (Tr. Vol. IV, p. 22.)

57. "Regression basically looks at historical data points and then fits a straight line to those data points." (Tr. Vol. IV, p. 23.) "[B]y doing that, implicitly it creates a rate of growth that's expected in the future." (Id.)

58. The number of patient days at PMC grew in 2012, 2013, 2014, and 2015 to date, and it continues to have significant growth. (Tr. Vol. IV, p. 23 - 24; PMC Exhibit 43 & 44.) As a result, Mr. Sullivan opines that "regression in this case at least is a good starting point for assessing what the maximum number of beds needed would be." (Id.) Mr. Sullivan looked at the historical growth of patient days at PMC and used these numbers to project what the patient day trends would be in five years, as required by the State Health Plan. (Id.)

59. According to Mr. Sullivan's regression analysis, PMC will have 69,778 patient days, excluding NICU days, in 2017, when PMC proposes implementing its 39 additional beds and, in 2020, five years from now, PMC will have 81,302 patient days, excluding NICU days. (PMC Exhibit 44.) Assuming PMC achieves these patient day levels and has 75% occupancy rate, PMC may need as many as 42 additional acute care beds to meet the need in 2017 and 84 additional acute care beds to meet the projected need in 2020. (Tr. Vol. IV, p. 25.)

60. According to Mr. Sullivan, "[i]n 2017, there would be a need for 42 additional beds, but the State Health Plan talks about the need five years from the date of filing. And, so, I looked at the need in 2020 as well; and using this regression analysis, Pikeville would need 84 additional beds, so more than double the number of beds that are being requested." (Tr. Vol. IV, p. 26.)

61. The regression analysis shows a need for more than 39 additional acute care beds at PMC. (Tr. Vol. IV, p. 43.)

62. Instead of simply accepting the results of the traditional regression analysis, Mr. Sullivan also did a more conservative analysis using half of the regression growth rate from PMC's historical growth. (Tr. Vol. IV, p. 26 – 27; PMC Exhibit 45.) This more conservative approach suggests that PMC may need as many as 50 additional acute care beds in five years, by 2020, further evidencing the need for the 39 beds that are being requested in PMC's CON Application. (Id.)

63. In Mr. Sullivan's opinion as an expert in health care planning and health care finance, PMC's project satisfies all required State Health Plan criteria for acute care beds. (Tr. Vol. IV, p. 12 and 49.)

64. Mr. Sullivan has been involved in a number of CON cases involving the addition of acute care beds, and he could not recall a time when a regression analysis was not used. (Tr. Vol. X, p. 43.)

Criterion 2: Need and Accessibility

65. Mr. May, PMC's President and CEO, testified that PMC needs the 39 acute care beds that it has requested. (Tr. Vol. I, p. 30 - 31.)

66. Dr. Harris, an expert in cardiology, testified that PMC needs the 39 acute care beds it proposes adding. (Tr. Vol. II, p. 115.) He testified that it has been a fairly common experience for PMC to receive a patient with an acute myocardial infarction, commonly known as a heart attack, the patient will then receive a stent in PMC's cardiac cath lab, and there will be no available hospital bed to put the patient in post-procedure. (Id.)

67. In Dr. Akhrass' opinion as an expert in infectious disease, PMC needs 39 additional acute care beds, as well as more ICU beds. (Tr. Vol. III, 15- 16.) He added, "[w]e see a lot of sick patients. We are busy all the time and most of the time we struggle to find a bed for these patients." (Id.)

68. In Debra Parson's experience as PMC's Chief of Nursing and the individual over PMC's Trauma Unit, PMC needs the additional 39 acute beds it proposes adding and will have no difficulty filling them with patients. (Tr. Vol. II, p. 40.)

69. Mr. Sullivan opined that PMC needs these additional acute care beds. (Tr. Vol. IV, p. 50.)

70. There are various community hospitals in PMC's proposed service area, including the Opposing Hospitals; however, PMC is different in the sense that it serves as a regional referral center that provides a broader scope of services. (Tr. Vol. IV, p. 51.) Eastern Kentucky is relatively isolated geographically and it is important for people to have access to both the community hospital services and the more specialized services provided at PMC. (Id.)

71. The community hospitals in PMC's proposed service area are transferring patients to PMC for more specialized services on a regular basis. (Tr. Vol. IV, p. 52.) From a health planning standpoint, this is the way it is supposed to work. (Id.) Where the community hospitals do not have coverage for whatever reason, PMC is there as a resource to serve the needs of those patients. (Id.) As a consequence, it is important for PMC to have a sufficient number of beds to serve these incoming patients. (Id.)

72. PMC has three employed infectious disease physicians, Dr. Akhrass, Dr. Muhannad Antoun, and Dr. Tamara Musgrave, who provide infectious disease specialist coverage at PMC twenty-four hours per day, seven days per week. (Tr. V. III, p. 9 - 10.)

73. Infectious disease specialists manage and treat infection of organs, mainly in the brain, lungs, and heart. (Tr. Vol. III, p. 11.) The infections range from bacterial infections, to viral infections, to parasitic infections. (Id.) PMC's infectious disease physicians manage all immunocompromised patients, including HIV patients, transplant patients, and Hepatitis C and B patients. (Id.)

74. Multiple medical specialists and subspecialists are often involved in the treatment of patients who have an infectious disease. (Tr. Vol. III, p. 13.) For example, if a patient arrives at the hospital with necratising fasciitis, which is a rapidly spreading, tissue eating infection of the skin, soft tissue and muscles, the patient may require a surgeon, an infectious disease physician, and a critical care physician, also referred to as an intensivist. (Id.)

75. The other hospitals in PMC's service area, including the Opposing Hospitals, do not have the required multiple disciplinary specialties available on a regular basis. (Id.) Specifically, Tug Valley ARH does not have an infectious disease physician to manage and treat its patients. (Tr. Vol. III, p. 11.)

76. The Opposing Hospitals do not provide infectious disease coverage twenty-four hours a day, seven days a week. (Tr. Vol. III, p. 11; Tr. Vol. VIII, p. 43.)

77. PMC frequently, almost on a daily basis, receives transfers from other hospitals of patients with infectious diseases, especially on the weekends, because it has the specialists required to treat the patients and these specialists are available twenty-four hours a day, seven days a week. (Tr. Vol. III, p. 12 - 13.)

78. If PMC cannot accept these transfers, the patients are required to present to another referral center, which requires traveling for at least an hour and a half. (Tr. Vol. III, p. 14.) In Dr. Akhrass' expert opinion, "this is very risky because you are compromising the care by

traveling with these patients." (Id.)

79. PMC currently does not have enough beds and the need for beds is going to increase during the winter months. (Tr. Vol. III, p. 16 – 17.) Dr. Akhrass testified that it is very well known that hospitals have increased hospitalizations during the winter months due to flu activity. (Id.)

80. PMC's Heart Institute offers comprehensive cardiac care. It provides the full spectrum of services with the exception of heart transplants. (Tr. Vol. II, p. 113.) Specifically, it provides services related to the prevention of heart disease, diagnostic testing, interventional cardiology, and surgical options, such as open heart surgery and cardiac rehab. (Tr. Vol. II, p. 91 – 95.)

81. PMC's Heart Institute is made up of two cardiothoracic surgeons, ten cardiologists, two interventional cardiologists, two electrophysiologists, two vascular surgeons, and interventional radiologists. (Tr. Vol. II, p. 98 – 99.)

82. PMC's cardiac surgeons are available year-round to provide heart surgeries twenty-four hours a day, seven days a week. (Tr. Vol. II, p. 94.) Neither Tug Valley ARH, Whitesburg ARH, nor Highlands Regional Medical Center provide open-heart surgeries. (Tr. Vol. II, p. 97; Tr. Vol. III, p. 45; Tr. Vol. VI, p. 77.)

83. PMC has a cardiac catheterization lab where diagnostic and interventional cardiology services are available year-round, twenty-four hours per day, seven days a week. (Tr. Vol. II, p. 94.)

84. Tug Valley ARH and Whitesburg ARH do not have cardiac catheterization labs and neither diagnostic nor interventional caths can be done at those facilities. (Tr. Vol. II, p. 96 – 97; Tr. Vol. V, p. 107 and 221; Tr. Vol. VI, p. 66.) Highlands has a catheterization lab, but it is used

for diagnostic purposes only, versus interventional – meaning they do not provide coronary stents. (Tr. Vol. II, p. 97; Tr. Vol. VIII, p. 45.)

85. It is very common for PMC to receive transfers from Tug Valley ARH, Whitesburg ARH, and Highlands Regional Medical Center for cardiac care. (Tr. Vol. II, p. 105 – 109.) The Opposing Hospitals send almost all of their STEMIs to PMC. (Tr. Vol. II, p. 106.) A STEMI is a kind of heart attack where an artery going to an area of the heart muscle closes off and, at that moment, the patient begins to lose heart muscle. (Id.) "[T]he earlier the artery is opened and that opening is sustained, the less chance of dying and the less chance of being crippled from the effects of a heart attack." (Id.) In these cases, "[t]ime is life. Time is heart muscle." (Tr. Vol. II, p. 108.)

86. "Every hour that goes by when you're having a heart attack, your chances of dying goes up and your chances of being able to return to the kind of life you want goes down." (Tr. Vol. II, p. 104.)

87. Dr. Harris an expert in cardiology, testified that when a patient comes in for a STEMI, which is more of an emergent procedure, he prefers that the patient be placed in an ICU bed for the first 24 hours after the procedure. (Tr. Vol. II, p. 135.) "The first 24 hours after a STEMI is the most unpredictable period of time. So, we more or less demand an ICU bed at that time." (Id.)

88. PMC operates the only Level II NICU in its service area. (Tr. Vol. III, p. 52 - 53.) Having a Level II NICU allows PMC to treat infants born at a gestation of 32 weeks or older in close proximity to the mother's home and support system. (Id.) Having a Level II NICU also permits PMC's obstetricians to treat women with higher-risk pregnancies. (Id.)

89. The incidence of complications in pregnancy is higher than average in PMC's service area. (Tr. Vol. III, p. 53 – 54.) PMC's service area has a high teen pregnancy rate, mothers of advanced maternal age, a baseline rate of obesity, a higher incidence of diabetes, mothers with Polycystic Ovarian Syndrome, and an extremely high rate of drug abuse. (Id.) All of these factors contribute to high-risk pregnancies. (Id.)

90. None of the Opposing Hospitals have NICUs. (Tr. Vol. V, p. 119; PMC Exhibit 66, p. 18.)

91. If Highlands has a high-risk delivery, it transfers the mother to another hospital. (PMC Exhibit 66, p. 18.)

92. As previously noted, PMC has seen steady growth in the number of deliveries per year, even though the birthrate nationwide has been decreasing. (Tr. Vol. III, p. 55.) Dr. Crum believes PMC's occupancy related to deliveries will continue to grow. (Tr. Vol. III, p. 74.)

93. PMC continues to expand the types of services it offers. Since 2009, PMC has increased or added the following service lines: pediatrics, endocrinology, plastics, gastroenterology, gynecological oncology, sports medicine, orthopedics trauma, rheumatology, otolaryngology, neurology, expanded optometry and ophthalmology, expanded pulmonology, nephrology, podiatrists, expanded infectious disease, bariatrics, a trauma surgeon, vascular surgery, interventional radiology, expanded interventional cardiology, and a hand surgeon (Tr. Vol. X, p. 24 – 25.)

94. Whitesburg ARH has six ICU beds that are at 70% occupancy. (Tr. Vol. VI, p. 58 – 59.)

95. Highlands ICU bed occupancy is at 77%. (Tr. Vol. VIII, p. 65.)

96. PMC has six chaplains, and at least one is available 24 hours a day, 7 days a week. (Tr. Vol. I, p. 16.) Every patient who would like to be seen by a chaplain can be visited every day. (Id.)

97. None of the Opposing Hospitals provide neurosurgery services. (Tr. Vol. V, p. 79.) 99. The only facility where a patient in PMC's proposed service area can get neurosurgery services is at PMC. (Tr. Vol. V, p. 87.)

98. Tug Valley ARH does not have a urologist, a gastroenterologist, a bariatric surgeon, a neonatologist, a perinatologist, an oral surgeon, an interventional cardiologist, an interventional radiologist, an intensivist, an endocrinologist, a rheumatologist, a vascular surgeon, a neurosurgeon, or an infectious disease specialist. (Tr. Vol. V., p. 202 – 218.)

99. Tug Valley does not have daily around-the-clock coverage for oncology, general surgery, pulmonology, hospitalist care, nephrology, ENT, anesthesiology, radiology, or orthopedics. (Tr. Vol. V, p. 210 – 218.)

100. Mr. Hatfield, Tug Valley's CEO, testified that Tug Valley has to transfer patients who need the specialties it does not offer to another facility and that he would expect not having these specialties affects Tug Valley's inpatient census. (Tr. Vol. V, p. 217.)

101. Whitesburg ARH does not offer any neurosurgery, bariatric surgery, open-heart surgery, intensivists, hospitalists, plastic surgery, neonatology, urology, gastroenterology, rheumatology, inpatient rehabilitation, or ENT. (Tr. Vol. VI, p. 66 – 72.)

102. Whitesburg ARH does not have full time coverage for electrophysiology, nephrology, orthopedic surgery, radiology, infectious disease, or oncology. (Id.)

103. Highlands does not offer plastic surgery, bariatric surgery, intensivists, hospitalists, open-heart surgery, neurosurgery, NICU care, oral surgery, or interventional cardiology. (Tr. Vol. VIII, p. 43 – 50; PMC Exhibit 66.)

104. Highlands does not have daily around-the-clock coverage for oncology, hematology, ophthalmology, and pulmonology. (Tr. Vol. VIII, p. 43 – 50; PMC Exhibit 66.)

105. PMC has a linear accelerator that provides radiation treatment to cancer patients that is available twenty-four hours a day, seven days a week. (Tr. Vol. III, p. 49.)

106. Neither Tug Valley ARH nor Whitesburg ARH has a linear accelerator. (Tr. Vol. VI, p. 67; Tr. Vol. V, p. 110 and 221.)

107. Highlands also does not own or operate a linear accelerator. (Tr. Vol. III, p. 47.)

108. PMC has a PET scanner. (Tr. Vol. III, p. 50.)

109. Tug Valley ARH has a PET scanner available one day every two weeks. (Tr. Vol. V, p. 219.)

110. Whitesburg ARH has a positron emission tomography ("PET") scanner available one to one and a half days per week. (Tr. Vol. VI, p. 68.) If a physician needs a PET scan on any other day of the week, the patient must be sent to another facility for these services. (Id.)

111. Highlands does not own a PET scanner. (PMC Exhibit 66, p. 58.)

112. PMC has five CT scanners. (Tr. Vol. III, p. 50.) It has two 320 slice CT scanners, two 64 slice CT scanners, and one 32 slice CT scanner. (Id.)

113. With higher slice CT scanners, "[y]ou get quicker information, clearer information, less artifacts; and, therefore, you make less mistakes, you make better diagnoses." (Tr. Vol. II, p. 89.)

114. Tug Valley ARH has a 16 slice CT scanner. (Tr. Vol. V, p. 219.)

115. Whitesburg ARH has a 16 slice CT scanner. (Tr. Vol. VI, p. 67.)

116. Highlands has one 16 slice CT scanner and one 64 slide CT scanner. (Tr. Vol. VIII, p.65.)

117. PMC has three MRIs, one 3 Tesla unit, which is an open MRI, and two 1.5 Tesla units. (Tr. Vol. III, p. 49.) The MRIs are available all day, every day. (Id.)

118. Tug Valley ARH has one closed MRI. (Tr. Vol. V, p. 219.)

119. Highlands has a stationary MRI that is 1.5 Tesla and access to a mobile MRI on Mondays. (PMC Exhibit 66, p. 57 - 58.) Both of Highland's MRIs are closed. (Id.) If Highlands has a patient that requires an open MRI, then the patient has to be transferred. (Id.)

120. A hospital's case mix index shows the acuity of the patients that they treat. (Tr. Vol. I, p. 87 – 88; Tr. Vol. VI, p. 64; Tr. Vol. VII, p. 122.) A higher case mix index indicates that a hospital is seeing a higher level of acuity patient. (Id.)

121. As a regional referral center with more specialties and subspecialties available, PMC's case mix index is higher than the Opposing Hospitals'. (Tr. Vol. I, p. 87 - 88.) PMC's case mix index is 1.72 and the Opposing Hospitals' case mix indexes are somewhere around 1.1. (Id.) Specifically, Whitesburg ARH's case mix index varies between 1.12 and 1.13. (Tr. Vol. VI, p. 64.)

122. Mr. Zembrodt, UK Healthcare's Associate VP of Strategy, testified that a case mix index of 1.7 "would be a higher level of case mix" and that a case mix index of 1.1 to 1.12 is about normal "for small community hospitals." (Tr. Vol. VII, p. 122 – 123.) "[I]f you have a case mix index of 1.7, which is approximately where Pikeville Medical Center's is, that indicates that you're serving a pretty complex mix of patients. The other hospitals in the service area generally have indexes in the 1.1 to 1.2 range which are consistent with what community hospitals typically would have." (Tr. Vol. IV, p. 75.)

123. PMC obtained Level II Trauma Center verification by The American College of Surgeons in March of 2015. (Tr. Vol. II, p. 9.) In order to obtain this verification, PMC was required to meet certain criteria and guidelines established by The American College of Surgeons and undergo a verification visit. (Tr. Vol. II, p. 9 – 10.)

124. To be a Level II Trauma Center, a hospital must have a fully functioning emergency department 24 hours a day, seven days a week, 365 days a year. (Tr. Vol. II, p. 10.) A hospital must also have all of the surgical specialists to qualify as a Level II Trauma Center, including orthopedics, neurology, urology, plastic surgery, anesthesia, and trauma. (Id.)

The organization accrediting trauma centers recommends that a hospital serving as a Level II Trauma Center offer inpatient rehabilitation services. (Id.) PMC has 40 inpatient rehabilitation beds. (Id.)

125. Neither Tug Valley ARH nor Whitesburg ARH has inpatient rehabilitation beds. (Tr. Vol. V, p. 116.)

126. Level II Trauma Centers must satisfy certain staffing requirements, such as nurse to patient ratios. (Tr. Vol. II, p. 11.) For instance, Level II Trauma Centers must provide one-to-one nursing for trauma patients in emergency departments, in intensive care units, and in recovery rooms. PMC provides one-to-one nursing for trauma patients in its emergency department, in its intensive care unit, and in the recovery room. (Id.)

127. Being a Level II Trauma Center requires integration within the hospital itself but also with pre-hospital care services. (Tr. Vol. II, p. 13.) Pre-hospital care services include Emergency Medical Services providers, for example. EMS plays a vital role in trauma and PMC has monthly meetings with EMS to provide education on the trauma guidelines and to go over cases with them. (Id.)

128. PMC is the only Level II Trauma Center in Kentucky. (Tr. Vol. II, p. 20.)

129. PMC is the only Trauma Center of any level in its proposed service area. (Tr. Vol. II, p. 23.)

130. There are two Level I Trauma Centers in Kentucky, one in Lexington and one in Louisville, and both are at least two hours away from Pikeville. (Id.) According to the trauma center guidelines, Level II Trauma Centers must function as Level I Trauma Centers when there are no Level I Trauma Centers in the vicinity. (Tr. Vol. II, p. 21.)

131. "Regulations require the trauma victims to be transported to the closest Trauma Center, either by ground or air ambulance. With the verification, PMC's Trauma Center is now serving a population of more than 400,000; increasing their chances of survival should they be injured." (Tr. Vol. II, p. 16 – 17.)

132. PMC's occupancy has increased since receiving its trauma verification. Specifically, since receiving its trauma verification, PMC has seen a 24% increase in trauma patients and a 21% increase in critical care unit admissions. (PMC Exhibit 22; Tr. Vol. II, p. 24.)

133. The number of patients being transferred to PMC from other facilities has increased significantly since PMC received its Level II Trauma Center verification. (Tr. Vol. II, p. 33.)

134. PMC receives transfers of patients from many hospitals, including the Opposing Hospitals. (PMC Exhibit 23; Tr. Vol. II, p. 28.) Highlands, Tug Valley, and Whitesburg ARH are among the hospitals that transfer the most patients to PMC. (PMC Exhibits 24 & 25.)

135. From January 1, 2015 to August 31, 2015, Highlands transferred 278 patients to PMC, Tug Valley transferred 223 patients to PMC, and Whitesburg ARH transferred 296 patients to PMC. (PMC Exhibit 23; Tr. Vol. II, p. 28.) The transfers to PMC from the Opposing Hospitals have increased since 2014. (PMC Exhibit 24 & 25; Tr. Vol. II, p. 30 – 31.)

136. PMC receives transfers from the Opposing Hospitals on a daily or almost daily basis. (Tr. Vol. III, p. 80.)

137. The number of patients that Highlands transfers to PMC has grown from 47 patients in 2007 to 391 patients in 2014. (Tr. Vol. VIII, p. 53 – 54.)

138. PMC's transfer records show that the Opposing Hospitals are transferring patients that need either a higher level of care or a specialist or subspecialist care that is provided at PMC. (PMC Exhibit 36; Tr. Vol. III, p. 79.)

139. The Opposing Hospitals continuously transfer patients to PMC to receive services that they do not offer. (PMC Exhibit 36; Tr. Vol. III, p. 82.) These services include cardiology, neurology, trauma, infectious disease, gastroenterology, urology, and electrophysiology, among others. (PMC Exhibit 36; Tr. Vol. III, p. 87.)

140. ER physicians often influence where their patients are transferred. (Tr. Vol. V, p. 102.)

141. Oftentimes, patients choose which facility they go to. (Tr. Vol. V, p. 201; Tr. Vol. VI, p. 58.)

142. At times, Highland transfers patients to PMC because of patient preference or because the patient requires a level of care not provided at Highlands. (Tr. Vol. VIII, p. 55.)

143. In addition to an increase in the number of patients being transferred to PMC, PMC has also experienced an increase in the number of calls that its referral center is receiving per day. (PMC Exhibits 27 & 28; Tr. Vol. II, p. 34.) These are calls from other facilities that want to transfer a patient to PMC. (Id.)

144. PMC has to decline transfers of patients because it does not have acute care beds available. (Tr. Vol. II, p. 36.) In the first six days of September, PMC had to decline 22 patients due to lack of ICU bed availability. (Id.; Tr. Vol. I, p. 102.)

145. PMC had to decline the transfer of 265 patients from April 2015 through September 2015 due to the unavailability of acute care beds. (Tr. Vol. X, p. 45.) These are patients who tried to

receive treatment at PMC and were denied admission because of lack of bed capacity at PMC. (Id.) PMC looked at the profile of the types of patients who were turned away and these patients typically have an average length of stay of 5.6 days. (Id.) Multiplying the 256 patients by a 5.6 day average length of stay equals 1,484 patient days for a six month time period, which is approximately 3,000 patient days for the year. (Id.) This number only includes actual patients who were turned away and does not take into consideration the hospitals that stopped calling to try and transfer patients to PMC after it went on diversion. (Tr. Vol. X, p. 46.)

146. Diversion is a term used when a hospital is unable to receive a patient from another facility due to either lack of beds, lack of service, or lack of specialty. (Tr. Vol. II, p. 35.) When transferring facilities learn that PMC does not have ICU beds available and, as a result, is on diversion, those facilities typically will not call PMC back to try and transfer additional patients. (Tr. Vol. II, p. 37.) Thus, it is reasonable to presume that there are patients not being transferred to PMC that are unaccounted for.

147. When PMC is on diversion, it is not able to receive transfers of patients from other facilities and there is no way of tracking how many patients would have been transferred to PMC but for its diversion status. (Tr. Vol. II, p. 37; Tr. Vol. IV, p. 32 – 33.)

148. Since receiving its Level II Trauma Center verification, PMC has been on diversion 67% of the time. (Tr. Vol. II, p. 37.)

149. When PMC is on diversion, patients that need certain hospital services, including trauma services, have to be transported out of the service area and likely will not receive treatment within the golden hour. (Tr. Vol. II, p 37.)

150. If Pikeville cannot provide a specialized service required because it does not have a bed available, then, in many cases, the patient will not be able to receive the service in the service

area. (Tr. Vol. IV, p. 54.) In these instances, the patient may have to travel as far away as Lexington, Kentucky to receive the service, or go to a hospital in Huntington or Charleston, West Virginia. (Id.)

151. In certain cases, if PMC does not have an ICU bed available and cannot accept a patient that needs to be transferred, the patient's ability to survive will be impacted. (Tr. Vol. VII, p. 140.)

152. "Studies have proven that patients suffering from severe traumatic injuries have a higher chance for survival and decreased rates of complications if they are treated in hospitals specializing in trauma care. The term golden hour refers to the time period from being injured until the time the patient receives definitive trauma care. Patients have better outcomes if they are treated within the 60-minute period." (Tr. Vol. II, p. 17.)

153. As PMC's President and CEO, Mr. May, testified, "it's not a good plan to put seriously-ill people who have been traumatized in an accident in an ambulance or in a helicopter and ship them off when they ought to be treated within that first hour of the accident, which we call the golden hour." (Tr. Vol. I, p. 30.)

154. Getting patients to treatment quickly is particularly important with patients who have suffered from a heart attack or stroke. For instance, and as acknowledged by Mr. Zembrodt, UK's Healthcare's Associate VP of Strategy, if a Tug Valley ARH patient has a heart attack and needs to be transferred to another facility, the patient is going to be better served if he or she is transferred to PMC as opposed to Hazard ARH, which is nearly two hours away, or UK, which is even farther away. (Tr. Vol. VII, p. 140.)

155. Moreover, due to the economic impact of hoisted upon persons and their family that is associated with traveling long distances, it is often better for patients in eastern Kentucky to

receive care closer to home. For instance, these patients often receive better follow-up care when their doctors are closer to home. (Tr. Vol. VII, p 79, 116.)

156. PMC received approximately 165 letters of support for its proposal to add 39 acute care beds. (PMC Exhibits 9 & 10; Tr. Vol. I, p. 97 - 98.) These letter are from PMC-employed physicians, non-affiliated area physicians, local business owners, local government officials, and local educators, including the superintendent of Pike County Schools. (Id.)

157. The Kentucky Hospital Associate asked PMC to be the lead Ebola Assessment Hospital for Eastern Kentucky. (PMC Additional Info., Appendix 16.) Since then PMC has been designated as an Ebola Assessment Center by the KHA and the Centers for Disease Control and Prevention, which is a qualification that only a few hospitals in the nation have. (Tr. Vol. III, p. 14.) If there is a suspected case of Ebola in the region, the patient will be sent to PMC for an assessment and management of the disease until the patient can be transferred to one of the few Ebola Treatment Centers in the United State. (Id.)

158. Because PMC is an Ebola Assessment Center, it has to maintain four special beds in negative pressure rooms for potential Ebola patients. (Tr. Vol. III, p. 15.) PMC has invested in these negative pressure rooms, in special equipment, and in training employees to take care of Ebola patients. (Id.)

159. The Affordable Care Act resulted in a significant expansion of health insurance coverage in Kentucky. (Tr. Vol. IV, p. 62.) Nearly 400,000 people in Kentucky have signed up for insurance through Medicaid expansion. (Id.) As a result, there are a lot more people in the proposed service area who now have health insurance. (Id.) While these people had health needs and were likely getting health care services before Medicaid expansion, these patients are, without question, getting health care services with greater frequency now. (Tr. Vol. IV, p. 63.)

160. "Not everyone who qualified for insurance under the Affordable Care Act had problems immediately after signing up....There's going to continue to be patients coming out of that pool and that pool is expected to expand over time." (Tr. Vol. IV, p. 63).

161. As Ms. Sparkman, Whitesburg ARH's CEO, acknowledged, newly insured residents in the proposed service area will have other health care needs and, to some extent, those needs will continue to reflect in utilization of the hospitals in the area. (Tr. Vol. VI, p. 64.)

162. Mr. Sullivan opined there is a potential for Medicaid Expansion to continue to contribute to the overall growth and utilization at Pikeville. (Tr. Vol. IV, p. 63.)

163. In conducting his need analysis, Mr. Sullivan considered the health status of PMC's proposed service area. (PMC Exhibits 60 & 61; Tr. Vol. IV, p. 67 - 69.) Overall, PMC's service area has a lot of health challenges. (Id.)

164. The Robert Wood Johnson Foundation in conjunction with the University of Wisconsin looks at a number of factors every year and assesses the health outcomes and health factors in each county in the United States to determine what the overall health status of each county is. (PMC Exhibit 61; Tr. Vol. IV, p. 68.) The counties in each state are then ranked in terms of how healthy they are relative to other counties in the state. (Id.)

In Kentucky, there are 120 counties and, unfortunately, most of the counties in PMC's proposed service area, with the exception of Johnson County, rank close the bottom in terms of both health outcomes and health factors. (PMC Exhibits 60 & 61; Tr. Vol. IV, p. 60.) 164. Mingo, West Virginia, which is also in PMC's proposed service area, also struggles from a health status standpoint. It ranks 53 out of West Virginia's 55 counties in terms of health outcomes and 54 out of West Virginia's 55 counties in terms of health factors. (Id.)

165. The health status rankings for PMC's proposed service area drive home why it is so important to have health care services readily available to this population. (Tr. Vol. IV, p. 69.)

166. In Mr. Sullivan's expert opinion, "given that this is a population that is experiencing greater health risks and health conditions, they obviously have a greater need for these types of services that Pikeville provides." (Tr. Vol. IV, p. 69.)

167. Mr. Baehr, the Opposing Hospitals' expert, contended that PMC should have assessed need by doing a community wide bed need analysis. (Tr. Vol. IX, p. 21.) Specifically, he testified that the "traditional way to look at regional planning is to look at population; look at use rates, which is the number of admissions per 1,000, to see whether that's going up or down; whether basically utilization is growing or declining; and then, look at market share." (Id.) Doing this analysis for PMC's proposed service area, Mr. Baehr's position is that there is less than 50% overall occupancy in the proposed service area, meaning that there are plenty of available beds to meet the need that PMC has identified. (Id.)

168. According to Mr. Sullivan, "this notion that somehow we ought to be forcing patients who don't want to go to a smaller community hospital to go to that hospital and receive care I think just flies in the face of what I consider to be good health planning today and it flies in the face of the Kentucky State Health Plan which recognizes that when a hospital reaches a certain level of utilization, they ought to have enough additional bed capacity to serve the demand that they're addressing." (Tr. Vol. IV, p. 83.)

169. No Kentucky hospital would be able to show a need for incremental beds if it were required to satisfy the need analysis Mr. Baehr discussed. (Tr. Vol. X, p. 56.) "[T]hey might as well just shut down that component of the State Health Plan that allows people to add beds because there would be no prospect of that happening." (Tr. Vol. X, p. 57.)

170. UK Hospital had a CON application approved in early 2015 to add 120 acute care beds, which resulted in a 21% increase in UK's bed capacity. (Tr. Vol. VII, p. 90; Tr. Vol. X, p. 49 and 56.) UK did not assess need for its proposal by doing a community wide bed need analysis, as Mr. Baehr suggests PMC should have done. (Id.) When UK applied for its 120 acute care CON, there were hospitals in its proposed service area with extremely low acute care bed utilization and, in turn, available bed capacity. (Tr. Vol. VII, p. 172 - 173.) Baptist Health Richmond had an occupancy of 32%; Bourbon County Hospital had an occupancy of 37%; Clark Regional Medical Center had an occupancy of 37%; Ephraim McDowell had an occupancy of 43%; Frankfort Regional Medical Center had an occupancy rate at 28%; and Georgetown Community Hospital had an occupancy rate of 23%. (Id.)

171. Hazard ARH recently implemented a CON to add 50 acute care beds, which was a 25% increase in beds for the hospital, and it did not conduct the type of community wide need analysis that Mr. Baehr suggested PMC be required to do. (Tr. Vol. X, p. 49 and 56.)

172. PMC provides care to people without respect to race, age, sex, religion, ethnicity, disability, or ability to pay. (PMC Exhibit 1, p. 9; Tr. Vol. I, p. 17.)

173. PMC has a non-discrimination policy. (Tr. Vol. I, p. 17.)

174. PMC accepts all insurances, including Medicare and Medicaid. (Tr. Vol. I, p. 78.)

175. PMC has been designed by Medicare as a Regional Referral Center. (Tr. Vol. I, p. 17.)

176. PMC has contracts with all of Kentucky's Medicaid Managed Care Organizations. (Tr. Vol. I, p. 78.) It is important for PMC to contract with all of the Managed Care Organizations because Medicaid is about 25% of its volume. (Id.)

177. The Opposing Hospitals do not contract with all of Kentucky's Medicaid Managed Care Organizations. (Tr. Vol. I, p. 78 – 79.)

178. The ARH organization does not contract with Coventry. (Id.) Coventry is one the largest MCOs in PMC's proposed service area, with approximately 47,000 covered lives in the region. (Tr. Vol. I, p. 79.) This is a very large population that the ARH hospitals do not have a contract to receive reimbursement for. (Id.)

179. Highlands does not contract with Anthem Medicaid Managed Care. (Tr. Vol. VIII, p. 58 - 61.) Highlands defined its service area to include Floyd, Johnson, Martin, and Magoffin Counties and Anthem has 2,077 covered lives in these counties. (Id.)

180. PMC provides a significant amount of charity care. (Tr. Vol. I, p. 75 – 76.) In 2014, PMC provided $29,447,000 of uncompensated charity care. (Id.)

181. At PMC, if a patient has difficulty paying their bill or does not have insurance, they are sent to PMC's Financial Counseling Department, where PMC attempts to qualify the patient for any insurance that may be available, including Medicaid or Medicare. If the patient does not qualify for insurance, then PMC turns to its internal policy and the patient can qualify for free health care based on their bring-home pay, after household expenses are deducted. (Tr. Vol. I, p. 76 – 77.)

182. With regard to PMC's charity care policy, Mr. Sullivan made clear that "Pikeville clearly provides a significant point of entry for a lot of folks without resources in this community. They are serving many more patients who are unfunded than the other hospitals in the service area." (Tr. Vol. IV, p. 73.)

183. Mr. Sullivan, an expert in healthcare planning, testified that he believes Pikeville is a "financially accessible provider" and he thinks "they serve all-comers." (Tr. Vol. IV, p. 73.)

Criterion 3: Interrelationships and Linkages

184. A transfer agreement is an agreement that allows other healthcare providers to send patients to PMC. (Tr. Vol. II, p. 26.) PMC has transfer agreements with multiple healthcare providers. (Id.) Specifically, PMC has transfer agreements in place with Buchanan General Hospital, Caballo Dialysis, Heritage Hill, Holston Valley Medical Center, Bristol Regional Medical Center, UK Albert B. Chandler Hospital, UK Good Samaritan Hospital, St. Mary's Medical Center, Signature HealthCARE of Pikeville, Salyersville Nursing and Rehabilitation, Riverview Health Care Center, Prestonsburg Healthcare Center, Parkview Manor Nursing Home, Mountain View Health Care Center, Mountain State Health Alliance – Johnson City Medical Center, Mountain Manor of Paintsville, Martin County Health Department, Hospice of Pike County, Home Care Health Services, Highlands Home Health, and Tug Valley ARH Regional Medical Center. (PMC Exhibit 1, Appendix 5.)

185. PMC also accepts transfers from facilities that it does not have a written transfer agreement with. (Tr. Vol. II, p. 26.)

186. Highlands and PMC have a good relationship and they attempt to work together to deliver healthcare. (Tr. Vol. VIII, p. 56.)

187. PMC has approximately 76 academic affiliates across the country. (Tr. Vol. III, p. 71 – 72; Application Appendix 7.) These affiliates are academic institutions that send students to PMC to train in different fields. (Id.) Students are trained in all different fields within the hospital. (Id.) For example, PMC's specialty and subspecialty physicians teach and train residents. (Id.) PMC's nursing staff teaches and trains nurses. PMC's ultrasound technicians teach and train other ultrasound techs. (Id.)

188. PMC has an osteopathic family practice residency program. (Tr. Vol. III, p. 69.) PMC has had more than 90 residents in the program since its inception. (Tr. Vol. III, p. 70.)

189. PMC is a member of the Mayo Clinic Care Network. (Tr. Vol. I, p. 20 – 21.) In order to become a member of Mayo's Network, PMC had to satisfy strict criteria and undergo a week long, on-site inspection by a team of individuals from Mayo. (Id.) No other hospital in PMC's service area is part of the Mayo Clinic Network. (Tr. Vol. I, p. 22.)

190. PMC's affiliation with Mayo benefits the residents of its service area. (Tr. Vol. I, p. 21.) Among other services, PMC physicians have access to an eConsult service where they can get second opinions from Mayo Clinic physicians for patients within 48 hours without the patient having to physically travel to the Mayo Clinic. (Tr. Vol. I, p. 22; Tr. Vol. II, p. 120.)

191. PMC is part of a nationwide program funded by the American Heart Association called Mission: Lifeline. (Tr. Vol. II, p. 104.) Duke University handles the logistics of the program and PMC serves as the center hospital for Eastern Kentucky. (Tr. Vol. II, p. 104 and 109.) One of the goals of Mission: Lifeline is to work on regionalization of cardiac care and cooperation to make care better for everyone. (Id.)

192. PMC is a member of the Kentucky Hospital Association. (PMC Exhibit 1, p. 19.)

193. As referenced above, PMC received approximately 165 letters of support for its proposal to add 39 acute care beds. (PMC Exhibits 9 & 10; Tr. Vol. I, p. 97 - 98.) PMC received letters of support from many of its employed physicians, from non-affiliated area physicians, from local business owners, local government officials, and local educators, including the superintendent of Pike County Schools. (Id.)

194. PMC received letters of support from physicians who are on the medical staffs of the Opposing Hospitals. (PMC Exhibits 9 & 10; Tr. Vol. I, p. 99; Tr. Vol. VI, p. 62.)

195. PMC received letters of support from physicians practicing in South Williamson, Pike County, where Tug Valley ARH is located, from physicians practicing in Floyd County, where Highlands Regional Medical Center is located, and from physicians practicing in Letcher County, where Whitesburg ARH is located. (Tr. Vol. I, p. 99 – 100.)

196. PMC received letters of support from multiple State Representatives and State Senators, from the Pike County Judge Executive, from multiple Pike County Fiscal Court Magistrates, from the Pikeville Mayor, from the City of Coal Run Mayor, from Pikeville Chief of Police, from Interim President of the University of Pikeville, from the Pikeville City Attorney, and the Pikeville City Commissioners, among others. (PMC Exhibits 9 & 10; Tr. Vol. I, p. 100.)

197. PMC routinely transfers patients to UK Healthcare when they believe the patients will receive more appropriate treatment at UK. (Tr. Vol. VII, p. 83.)

198. PMC also transfers patients to the community hospitals in and around its service area. (Tr. Vol. X, p. 17 – 18.) PMC transfers patients to Tug Valley ARH when Tug Valley can provide the appropriate level of care and the patient wants to be treated there. (Id.) PMC also transfers patients to Highlands, St. Joe Martin, and Hazard ARH. (Id.)

199. For example, PMC does not provide psychiatric services, so it routinely transfers patients requiring behavioral services to Highlands Regional Medical Center and Hazard ARH. (Tr. Vol. X, p. 27.)

200. Dr. Harris testified that PMC's cardiac program works very closely with community hospitals to send patients back to whatever community they came from to receive their cardiac rehabilitation because this results in better care for the patients. (Tr. Vol. II, p. 95 – 96.)

201. PMC has monthly meetings with EMS to provide education on the trauma guidelines and to go over cases with them. (Tr. Vol. II, p. 13.)

202. In Mr. Sullivan's opinion, PMC's proposal will further the objective of accomplishing appropriate and effective linkages with other services, facilities, and elements of the healthcare system. (Tr. Vol. IV,p. 79 – 80.) "I think not having this project makes it more difficult for Pikeville to fulfill the role that it plays in the community in terms of those relationships." (Id.)

Criterion 4: Costs, Economic Feasibility, and Resource Availability

203. The estimated capital cost for PMC's project is $14,586,789. (PMC Exhibit 1, p. 10.) This amount includes architectural/engineering costs of $643,601, renovation costs of $8,297,000, $89,873 for interest during construction, and $4,865,986 in equipment costs. (Id.) PMC also included $690,329 in its capital expenditure budget for contingencies. (Id.)

204. The specifics of what went into these numbers and how they were determined are detailed in PMC's application. (PMC Exhibit 1, Appendix 8.)

205. PMC's CFO testified that the proposal to add 39 beds is financially feasible. (Tr. Vol. I, p. 96.) PMC projects that in its first year of operating the 39 acute care beds, 2017, it will have 4,507 patient days and in its second year of operating the 39 acute care beds, 2018, it will have 7,795 patient days. (PMC Exhibit 1, p. 17.)

206. Based on PMC's projections, PMC anticipates that the project will break even in its first year of operation, which is fiscal year 2017. (Id.) Specifically, PMC projects a positive margin of $966,834 in year one. (Id.)

207. Mr. Sullivan, an expert in health care planning, testified that he thought Ms. Hagy's utilization projections, which her financial projections are based on, were more conservative than what he projected. (Tr. Vol. IV, p. 70.)

208. Mr. Sullivan testified that, "in this case, Pikeville Medical Center has demonstrated with their ability to fund the project and what was often referred to as short-term feasibility, the ability

to provide the resources needed to construct it and get it into operation." (Tr. Vol. IV, p. 70 – 71.) Mr. Sullivan also testified that he believes that PMC "demonstrated the long-term feasibility of the project in terms of the utilization and financial projections that are presented in the schedules under Criterion 4." (Id.)

209. PMC plans to fund a portion of its proposal, $5,509,587, using internal funding and the rest of the costs, $9,077,202, using a loan from the United State Department of Agriculture ("USDA"). (PMC Exhibit 1, p. 13.)

210. Ms. Hagy, PMC's CFO, testified that the USDA financing has been approved by the USDA's Senior Loan Committee in Washington, D.C. (Tr. Vol. I, p. 95.) She met with USDA officials on September 28, 2015 at their Lexington office and signed the Letter of Commitment. (Id.)

211. Even if PMC had not received the USDA loan, PMC's CFO testified that it currently has sufficient funds to pay for the entire project internally. (PMC Exhibit 1, Appendix 9; Tr. Vol. I, p. 95.)

212. PMC has taken steps to use its existing acute care beds to try and meet the need for additional ICU beds in its proposed service area. (Tr. Vol. II, p. 40.) Specifically, PMC converted 9 of its 28 OB beds to ICU beds in 2015 in attempt to meet the need. PMC's 19 OB beds are well-utilized, with an occupancy of approximately 90% on Tuesdays, Wednesdays, Thursdays, and Fridays. (Tr. Vol. III, p. 58.) On these days, PMC is doing six to eight deliveries a day and additional surgeries. (Id.) When deliveries can be planned, these are the days on which patients prefer to receive these services. (Id.)

213. Dr. Crum, the head of PMC's OB/GYN Department, testified that the conversion of 9 of PMC's OB beds to ICU beds is not a good long-term solution and that the OB/GYN Department

needs these beds back. (Tr. Vol. III, p. 61.) Dr. Crum testified that not only does his Department need the 9 beds back but "we are going to fight for those beds back." (Id.)

Even with these changes, PMC still needs its proposed 39 additional beds. (Tr. Vol. II, p. 40.) PMC is still turning away multiple patients per month due to no bed availability. (Tr. Vol. II, p. 41.)

214. In Mr. Sullivan's opinion as an expert in health care planning, PMC's proposal to add 39 acute care beds is a cost effective way to deliver the services needed in the proposed service area. (Tr. Vol. IV, p. 71." He testified that "[i]t's better to have certain types of services centralized in one facility rather than try to duplicate specialized services in multiple facilities. And, so, in my view, allowing Pikeville to expand and to also expand its role as a regional provider of services is a more cost-effective approach." (Id.)

215. It was suggested by the Opposing Hospitals that PMC could add observation beds instead of adding acute care beds to meet its need. (Tr. Vol. III, p. 90 – 91; Tr. Vol. IV, p. 38 - 39.) Observation beds are not the same thing as inpatient, acute care beds. (Id.) Observation beds are not licensed beds and they are for patients who are not admitted to the hospital. (Id.) Observation beds are for patients who are either going home or for patients who the provider thinks may go home and just need to be monitored. (Id.) For example, if a patient shows up in the emergency room with chest pains and the physician wants to monitor the patient before sending him or her home, the patient might be placed in an observation bed for a period of time. (Tr. Vol. IV, p. 37.)

216. According to Medicare rules, a patient may only be held in an observation beds for two midnights and then the patient must either be admitted to the hospital and put in an acute care bed or sent home. (Tr. Vol. IV, p. 40 – 41.)

217. PMC currently uses observation beds and puts individuals in these beds when it is appropriate. (Tr. Vol. IV, p. 41.) Similar to the increases in utilization for its inpatient beds, PMC has also had an increase in its number of observation patients. (Id.) The number of observation patients that PMC saw between August 2014 and August 2015 increased from 726 to 909, which is material. (Id.)

218. Observation beds are not for patients coming into the hospital with traumas or other serious illnesses. (Tr. Vol. III, p. 90 - 91.) Seriously ill patients could not be held in an observation bed because they would not receive the level of care required. (Tr. Vol. IV, p. 40.) Observation beds are not the answer to PMC's need for additional acute care beds, "particularly given that their need is skewed towards the critical care end of the spectrum...." (Id.)

219. Ms. Sparkman, Whitesburg ARH's CEO, testified that she would not put a critically ill patient or a trauma patient in an observation bed. (Tr. Vol. VI, p. 51.)

220. The Opposing Hospitals suggested the alternative of essentially constraining PMC's bed capacity in an effort to require patients to go to other hospitals. (Tr. Vol. VI, p. 82.) Mr. Sullivan testified that health planners realized a long time ago that this was a "terrible policy" because patients should be able to choose where they receive services. (Id.)

"[T]his notion that somehow we ought to be forcing patients who don't want to go to a smaller community hospital to go to that hospital and receive care I think just flies in the face of what I consider to be good health planning today and it flies in the face of the Kentucky State Health Plan which recognizes that when a hospital reaches a certain level of utilization, they ought to have enough additional bed capacity to serve the demand that they're addressing." (Tr. Vol. IV, p. 83.)

221. There was a lot of testimony about PMC's billed charges for hospital services. (Tr. Vol. I, p. 79 – 90.) "You would expect Pikeville to have higher charges because they have a much more robust set of services. They have higher staffing levels, they have more complex equipment, and, so they're supporting a much larger infrastructure than some of these hospitals." (Tr. Vol. IV, p. 72.)

222. Mr. Zembrodt agreed that he would expect the charges at teaching hospitals, like UK, and regional referral centers, like PMC, to be different than the charges at community hospitals because of infrastructure costs. (Tr. Vol. VII, p. 150.)

223. Medicare and Medicaid pay hospitals rates that often fall well short of hospital charges. (Tr. Vol. I, p. 78, 81.) A majority of PMC's patients, approximately 76%, are Medicare or Medicaid. (Tr. Vol. I, p. 81.)

224. The remaining 25% of PMC's patients have commercial insurance and PMC contracts with these commercial payers for the rates that it will be paid for the services provided. (Tr. Vol. I, p. 81.) PMC is not reimbursed by commercial insurance providers at its charged rate. (Id.)

225. In any event, PMC's charges have little to do with whether people in its area choose to seek care there. (Tr. Vol. IV, p. 72.)

Criterion 5: Quality of Services

226. PMC is licensed by the Cabinet for Health and Family Services, Office of Inspector General to operate an acute care hospital with 221 acute care beds and 40 physical rehabilitation beds. (PMC Exhibit 1, Appendix 11.)

227. PMC is accredited by The Joint Commission. (PMC Exhibit 1, Appendix 14.)

228. In December 2014, PMC was recognized a "Top Performer" by the Joint Commission. (Id.)

229. In addition to its accreditation by The Joint Commission, PMC also currently has accreditations or certifications from the following organizations: American College of Surgeons Commission on Cancer Programs; American Academy of Sleep Medicine; American College of Radiology-Mammography Accreditation of the Commission of Quality & Safety, MRI Accreditation of the Commission on Quality & Safety, CT Accreditation of the Commission on Quality & Safety; American Diabetes Association Certification for Diabetes Education; American Osteopathic Association's Council on Post-Doctorate Training; College of American Pathologists; Clinical Laboratory Improvement Act's deemed status under College of American Pathologists; FDA Blood Bank Certification; FDA Radiology; Kentucky medical Association; National Network of Libraries and Medicine; American Association of Cardiovascular and Pulmonary Rehabilitation; and Partner with Voluntary Hospitals of America. (PMC Exhibit 1, Appendix 13; Tr. Vol. 1, p. 72 – 73.)

230. PMC is continuously recognized as a health care leader in its region. (Tr. Vol. I, p. 23 – 29; PMC Exhibit 1, p. 8(a) – (b); PMC Exhibit 3.)

231. PMC is the Nation's only three time winner of National Hospital of the Year by The American Alliance of Healthcare Providers. (PMC Exhibit 3).

232. In October 2014, PMC's Chief of Cardiology, Dr. Bill Harris received the Health Impact Award from U.S. Congressman Harold "Hal" Rogers for he and his team's work to significantly improve the delivery of quality cardiac care to the people of Eastern Kentucky. (PMC Exhibit 1, p. 8(a))

233. In an effort to improve care, PMC tracks its patient satisfaction using an outside company, HealthStreams. (Tr. Vol. I, p. 73.) HealthStreams makes post-discharge calls to patients in order to track PMC's patient satisfaction. (Id.)

234. PMC recently received a Five-Star Rating from the Centers for Medicare & Medicaid Services based on patient satisfaction results. (Tr. Vol. I, p. 73.) PMC is among the top five percent of hospitals in America to achieve the highest patient satisfaction rating possible – five stars – from CMS. (PMC Exhibit 3.)

235. PMC has been awarded the Outstanding Patient Experience Award given by Healthgrades. (PMC Exhibit 1, p 19(e).)

236. In August 2014, PMC was named on of "America's 100 Best Hospitals for Patient Experience" by WomenCertified. (PMC Exhibit 1, p. 8(b).)

237. PMC has been named one of The Best Places to Work in Kentucky for seven years and ranked in the Top 10 Places to Work in the Nation by Modern Healthcare for four years. (PMC Exhibit 3.)

238. In December 2014, PMC was also awarded the Health Resources and Services Administration gold medal for promoting organ, eye and issue donation within the hospital and the community. (PMC Exhibit 1, p. 8(a) – (b).)

239. PMC has received the Kentucky Hospital Association Leadership and Governance award. (PMC Exhibit 1, p. 19(d).)

240. PMC was awarded the American Cancer Society's Multiple Team Excellence Award. (PMC Exhibit 1, p. 19(d).)

241. PMC received the Commission on Cancer's Outstanding Achievement Award, presented by the American College of Surgeons. (PMC Exhibit 1, p. 19(d).) This award is only given to the top 7 percent of cancer programs in the nation each year. (Id.)

242. PMC's Leonard Lawson Cancer Center was the recipient of the highly-acclaimed Judith Ann Cook Excellence Award and is the only hospital in Kentucky that has received this award. (PMC Exhibit 1, p. 19(e).)

243. PMC was awarded the American Diabetes Association's Recognition Award to PMC's Diabetes Education Department. (PMC Exhibit 1, p. 19(d).)

244. PMC was recognized as the Best Regional Hospital in three specialty areas, including gynecology, ENT and nephrology, in 2011/2012 by U.S. News & World Report. (PMC Exhibit 1, p. 19(e).)

245. PMC has been awarded the Gold Standard in Radiology Accreditation by the American College of Radiology. (PMC Exhibit 1, p. 19(e).)

246. PMC received the Get with the Guidelines – Stroke Gold Plus Quality Achievement Award from the American Heart Association/American Stroke Association. (PMC Exhibit 1, p. 19(e).)

247. PMC is a member of the Mayo Clinic Care Network. (Tr. Vol. I, p. 20 – 21.) In order to become a member of Mayo's Network, PMC was required to meet very strict criteria and undergo a week long, on-site inspection by a team of individuals from Mayo. (Id.)

CONCLUSIONS OF LAW

1. The Cabinet for Health and Family Services, Administrative Hearings Branch, has jurisdiction over this proceeding pursuant to KRS 216B and 900 KAR 6:070, Section 2.

2. PMC's Application is governed by the considerations set forth in KRS 216B.040(2), the formal review criteria established by 900 KAR 6:070, Section 2, and the State Health Plan, CON Review Standards.

3. Applicants before an administrative agency have the burden of proof. *Energy Regulatory Commission v. Kentucky Power Co.*, 605 S.W.2d 46 (Ky. Ct. App.1980).

4. The CON Applicant has the burden of proving, by a preponderance of evidence, that its CON application satisfies the review criteria. *Kentucky Board of Nursing v. Ward*, 800 S.W.2d 641 (Ky. Ct. App. 1994); *Commission for Health Economics Control in Kentucky v. Medical Consultants Imaging Co.*, 844 S.W.2d 437 (Ky. Ct. App. 1992); *Starks v. Kentucky Health Facilities*, 684 S.W.2d 5 (Ky. Ct. App.1984).

5. The purpose of the CON law as expressed in KRS 216B.010, is to "improve the quality and increase access to health care facilities, services, and providers, and to create a cost-effective health care delivery system to the citizens of the Commonwealth." Furthermore, the General Assembly notes "that the proliferation of unnecessary health care facilities, health services, and major medical equipment results in costly duplications and underuse of such facilities, services and equipment; and that such proliferation increases the cost of quality health care within the Commonwealth." KRS 216B.010.

6. **Criterion 1 – Consistency with Plans. KRS 216B.040(2)(a), 900 KAR 6:070 Section 2(1).** Each proposal approved by the Cabinet shall be consistent with the State Health Plan. KRS 216B.040(2)(a). To be approved, a proposal shall be consistent with the State Health Plan established in 900 KAR 5:020. In determining whether an application is consistent with the State Health Plan, the Cabinet shall apply the latest inventories and need analysis figures maintained by the Cabinet and the version of the State Health Plan in effect at the time of the Cabinet's decision. 900 KAR 6:070, Section 2(1).

7. PMC proved that its Application is consistent with the three applicable State Health Plan criteria. First, PMC established that the conversion of its current special care acute care beds,

including NICU beds, ICU beds, and OB beds, is not feasible because each of these bed categories are highly utilized at PMC. Further, such a conversion would not be sufficient to meet PMC's total need for 39 additional acute care beds.

8. Second, PMC established that its acute care occupancy rate as set forth in the *2014 Kentucky Annual Hospital Utilization and Services Report* is 75.5%, which is slightly higher than the target occupancy rate of 75%.

9. Third, PMC performed a regression analysis projection of patient day trends over a five year timeframe, as required by the State Health Plan, and the regression analysis projection demonstrated a need for substantially more than the 39 beds being requested.

10. Based on the Findings of Fact contained herein, PMC's Application is consistent with Criterion 1 – Consistency with Plans.

11. **Criterion 2 – Need and Accessibility. KRS 216B.040(2)(a)(2)(b); 900 KAR 6:070 Sections 2(2) and 2(3).** The proposal shall meet an identified need in a defined geographic area and be accessible to all residents of the area. A defined geographic area shall be defined as the area the proposal seeks to serve, including its demographics, and shall not be limited to geographic boundaries. KRS 216B.040(2)(a)(2.)(b.). The Cabinet shall determine if the applicant has identified a need for the proposal in the geographic area defined in the application; and if the applicant has demonstrated that it is able to meet the need identified in the geographic area defined in the application. 900 KAR 6:070, Section 2(2). The Cabinet shall determine if the health facility or health service proposed in the application will be accessible in terms of timeliness, amount, duration, and personnel sufficient to provide the services proposed. 900 KAR 6:070, Section 2(3).

12. PMC's proposal to add 39 acute care beds will meet an identified need in a defined geographic area and be accessible to all residents of the area. Specifically, PMC's proposal will meet the needs of the residents of Pike, Martin, Magoffin, Johnson, Letcher, and Floyd Counties in Kentucky and Mingo, West Virginia to receive the specialized health care services that they need closer to home.

13. PMC demonstrated that it offers a higher level of services than other hospitals in its proposed service area. PMC is a regional referral center that offers essentially every medical specialty and an extensive list of subspecialties. PMC has more than one physician practicing in and 24/7 coverage of most specialties. PMC is a verified Level II Trauma Center. The community hospitals in PMC's proposed service area, including the Opposing Hospital, do not provide all of the specialists or equipment required to provide the same high-level services and, as a result, frequently transfer patients to PMC to receive services.

14. PMC's existing acute care beds are oftentimes full, which means that PMC cannot accept patients requiring health care services. For many specialized services, including trauma, if PMC's beds are full and PMC cannot accept the patient, the patient will have to be transferred to a hospital over an hour away. In the case of traumas, heart attacks, strokes, or other serious illnesses, it is vital for patients to receive treatment as soon as possible and, most importantly, within the golden hour. PMC needs the 39 additional acute care beds so that it can meet the health care needs of its service area, eliminating the need to transfer patients far distances for services that can be provided closer to home. Approval of PMC's proposal will improve health outcomes and survival rates.

15. Based on the Findings of Fact contained herein, PMC's Application is consistent with Criterion 2 – Need and Accessibility.

16. **Criterion 3 – Interrelationships and Linkages. KRS 216B.040(2)(a)2.c; 900 KAR 6:070 Section 2(4).** The applicant must establish linkages with other health services, health facilities, and elements of the health care system in the region and the state in order to achieve comprehensive care, proper utilization of services, and efficient functioning of the health care system within the Commonwealth. The applicant must demonstrate that such linkages have been, or will be, established.

17. PMC established that it has strong linkages with other health services, health facilities, and elements of the health care system in the region, the state, and the country. PMC is a vital part of the health care system in Eastern Kentucky.

18. The evidence demonstrates that PMC, whether through transfer agreements or not, receives patient transfers from hospitals throughout its service area. Indeed, many of these transfers come from the Opposing Hospitals. The evidence also demonstrates that PMC transfers patients to other hospitals, including to UK, the Opposing Hospitals, and other community hospitals in its service area, when it cannot provide the service a patient requires.

19. PMC's linkages throughout its service area are further demonstrated by the 165 letters of support that PMC received in support of its proposal to add 39 acute care beds. PMC received letters of support from many of its employed physicians, from local business owners, local government officials, and local educators, including the superintendent of Pike County Schools, and, significantly, from physicians practicing in the Opposing Hospitals' communities.

20. PMC also has linkages with its many academic affiliates throughout the state and the country, and it supports the education of future health care providers through its residency and other training programs that are offered at its hospital.

21. PMC accepts transfers from other hospitals in and around Kentucky, transfers patients to other hospitals in and around Kentucky, provides academic training to medical school residents and other practitioners, meets with and educates local emergency medical services providers on a monthly basis, serves as the regional Ebola Assessment Center, serves as the regional hospital for the American Heart Association's Mission: Lifeline project, serves as the only verified Trauma Center in Eastern Kentucky, collaborates with the Mayo Clinic, and demonstrated through letters that it has the support of many of its employed physicians, physicians from the Opposing Hospitals' communities, multiple State Representatives and State Senators, from the Pike County Judge Executive, from multiple Pike County Fiscal Court Magistrates, from the Pikeville Mayor, from the City of Coal Run Mayor, from Pikeville Chief of Police, from Interim President of the University of Pikeville, from the Pikeville City Attorney, and from the Pikeville City Commissioners,

22. Based on the Findings of Fact contained herein, it is indisputable that PMC's Application is consistent with Criterion 3 – Interrelationships and Linkages.

23. **Criterion 4 – Costs, Economic Feasibility and Resources Availability. KRS 216B.040(2)(a)2.d; 900 KAR 6:070 Section 2(5).** The proposal, when measured against the cost of alternatives for meeting needs, shall be judged to be an effective and economical use of resources, not only of capital investment, but also ongoing requirements for health manpower and operation financing. KRS 216B.040(2)(a)(2.)(d.). The Cabinet shall determine if it is economically feasible for the applicant to implement and operate the proposal; and if applicable, if the cost of alternative ways of meeting the need identified in the geographic area defined in the application would be a more effective and economical use of resources. 900 KAR 6:070, Section 2(5)(a),(b).

24. It is economically feasible for PMC to implement and operate its proposal to add 39 acute care beds. PMC has the resources needed to add the proposed 39 acute care beds. PMC has been approved for a USDA loan for a portion of the project cost and has sufficient internal funding available for the remainder of the project cost.

25. PMC demonstrated the short-term economic feasibility of the project, which is the ability to fund the project, and the long-term economic feasibility of the project in terms of utilization projections and financial projections, which were conservative.

26. PMC's addition of the 39 beds is the most effective and economical way to meet the health care needs of the residents in PMC's proposed service area. No feasible alternative for meeting this need has been identified. PMC has attempted alternatives to meet the need, such as the conversion of existing OB beds, and these efforts have not been nearly sufficient. Further, the Opposing Hospitals suggested impracticable alternatives, such as the use of non-licensed observation beds or the use of the Opposing Hospitals' acute beds. The acuity of the patients that PMC is turning away due to lack of bed capacity is often higher than is appropriate for an observation bed. Further, the Opposing Hospitals do not have many of the specialized services, including a verified trauma program, required to accept and treat many of the patients that come to PMC.

27. Based upon the Findings of Fact contained herein, PMC's Application is consistent with Criterion 4 – Costs, Economic Feasibility, and Resources Availability.

28. **Criterion 5 – Quality of Services. KRS 216B.040(2)(a)2.e; 900 KAR 6:070 Section 2(6).** The applicant must demonstrate that it is prepared to and capable of undertaking and carrying out the responsibilities involved in the proposal in a manner consistent with appropriate

standards and requirements established by the Cabinet. The applicant must have the ability to comply with applicable licensure requirements.

29. PMC demonstrated that it is committed to making high quality specialty services available to meet its patients' needs, so that they can receive their health care locally. PMC strives to provide optimal facilities, state of the art equipment, qualified and satisfied staff, and specialized physicians to deliver care.

30. PMC has been operating for 90 years and has proven its ability to provide quality services in compliance with licensure requirements. PMC currently has a licensing in good standing from the Kentucky Cabinet for Health and Family Services, is accredited by the Joint Commission and various other health care accrediting agencies, and is continuously recognized for the quality health care services that it provides.

31. There is no evidence to dispute that PMC is prepared to and capable of undertaking and carrying out the responsibilities involved in implementing the 39 acute care beds in a manner that is consistent with the applicable licensure standards.

32. Based on the Findings of Fact contained herein, PMC's Application is consistent with Criterion 5 – Quality of Services.

FINAL ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, **IT IS HEREBY ORDERED** that the application of Pikeville Medical Center, Inc. (CON # 098-11-394(32)) for a certificate of need is **APPROVED.**

Pursuant to KRS 216B.090(1), the parties to this proceeding may file a request for reconsideration with the Cabinet for Health Services, Administrative Hearings Branch, within fifteen (15) days from the date of notice of this decision.

Pursuant to KRS 216B.115(1), the parties may file an appeal to the Franklin Circuit Court within thirty (30) days from the date of notice of this decision or within fifteen (15) days from the notice of a decision to deny reconsideration or a decision on reconsideration.

Entered this the 13th day of January, 2016.

Brian C. Baugh, Administrative Law Judge
Administrative Hearings Branch

Distribution to be made by the Office of Health Policy.