REPORT OF THE
DEPARTMENT OF HEALTH

ANNUAL REPORT ON THE STATUS OF VIRGINIA'S MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED PROGRAM

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

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Executive Summary

This annual report to the Governor and the General Assembly of Virginia on the status of Virginia's Certificate of Public Need (COPN) program has been developed pursuant to § 32.1-102.12 of the *Code of Virginia*. The report is required to address the activities of the program in the previous fiscal year; review the appropriateness of continued regulation of at least three specific project categories; and to discuss the issues of access to care by the indigent, quality of care within the context of the program, and health care market reform. A copy of the enabling *Code* section is reproduced at Appendix A. This report includes data for the most recent fiscal year (FY 2004).

Program activity for the period covered in this report includes the issuance of 98 decisions. The State Health Commissioner authorized 89 projects with a total expenditure of $981,180,725 and denied 9 projects with proposed capital expenditures of $32,947,407. Appendix D summarizes the authorization decisions. Additional program activities are described in the "Summary of the State Health Commissioner's Actions" beginning on page 1.

The following project categories are analyzed in this report: medical rehabilitation services, long-term care hospitals, nursing home services, and mental retardation facilities. The section on project analysis addresses the history of COPN regulation for these project categories, the nature of the specific services, the current state of the service in the Commonwealth and three potential options for the future of each of the categories with a recommended action.

The Virginia Department of Health (VDH) recommends continuing to employ the COPN program and request for application process as it has been used in the regulation of nursing homes and nursing home beds. VDH recommends initiating a request for application-like process similar to that used for the regulation of nursing homes for medical rehabilitation services and long-term care hospitals. Finally, VDH recommends completing the partial deregulation of intermediate care facilities for mental retardation initiated in 2004.

Applicants that have not demonstrated a historical commitment to charity care, consistent with other providers in their health service area, may have a "condition" to provide some level of indigent care placed upon any COPNs they are awarded. Compliance with the conditions to provide indigent care remains relatively poor. Historically, many conditioned COPN holders have either not reported their compliance with conditions or have reported that they have been unable, for various reasons, to reach the required level of indigent care. Language for the "conditioning" of COPNs is now being augmented to include the second type of condition allowed in the *Code*, namely that the applicant facilitate access through the development and operation of primary health care services for special populations. A guidance document was issued to clarify the conditioning process and provide definition to the elements of a condition. These initiatives helped remove the barriers to compliance most often cited by facility managers as their reason for failing to satisfy indigent care conditions. Sufficient time has not passed since the publication of the guidance document for there to have been any positive effects realized.

During FY 04 the application review process was completed as directed by the *Code*. There were no delays in receiving recommendations from regional health planning agencies that adversely affected timely decision making.

Preface

This 2004 annual report to the Governor and the General Assembly of Virginia on the status of Virginia's Certificate of Public Need (COPN) program has been developed pursuant to § 32.1-102.12 of the *Code of Virginia*. It includes data for the most recent fiscal year (2004). A copy of the enabling *Code* section is provided in Appendix A.

The COPN program is a regulatory program administered by the Virginia Department of Health (VDH). The program was established in 1973. The law states the objectives of the program are: (i) promoting comprehensive health planning to meet the needs of the public; (ii) promoting the highest quality of care at the lowest possible cost; (iii) avoiding unnecessary duplication of medical care facilities; and (iv) providing an orderly procedure for resolving questions concerning the need to construct or modify medical care facilities. In essence, the program seeks to contain health care costs while ensuring financial and geographic access to quality health care for Virginia citizens at a reasonable cost. The current regulatory scope of the COPN program is shown in Appendix B.

The statute establishing Virginia's COPN program is found in Article 1 of Chapter 5 of Title 32.1 of the *Code* (§ 32.1-102.1 et seq.). The State Health Commissioner (Commissioner) authorizes capital projects regulated within the COPN program prior to implementation. The Commissioner must be satisfied that the proposed project meets public need criteria. The *Code* specifies 20 factors (Appendix C) that must be considered in the determination of public need.

SUMMARY OF THE STATE HEALTH COMMISSIONER'S ACTIONS AND OTHER COPN PROGRAM ACTIVITY DURING FISCAL YEAR 2004

Project Review

Decisions

During FY04, the Division of Certificate of Public Need (DCOPN), which assists the Commissioner in administering the COPN program, received 173 letters of intent to submit COPN requests and 134 applications for COPNs. There were 24 applications withdrawn by applicants during the year. The balance of letters of intent and applications are those for which the appropriate review cycles have crossed fiscal years. Letters of intent are required of all persons intending to become applicants for COPNs. These letters describe the proposed project in enough detail to enable DCOPN to batch the project in an appropriate review cycle based on the information, and provide the applicant with the appropriate COPN application package for the proposed project. A letter of intent will lapse if a COPN application is not submitted within a year of the time the letter of intent was submitted.

Table 1 summarizes COPN review activity for FY 2004. Graph 1 puts this activity in historical context. The Commissioner issued 98 decisions on applications to establish new medical care facilities or modify existing medical care facilities. Eighty-nine of these decisions were to approve or conditionally approve, for a total authorized capital expenditure of

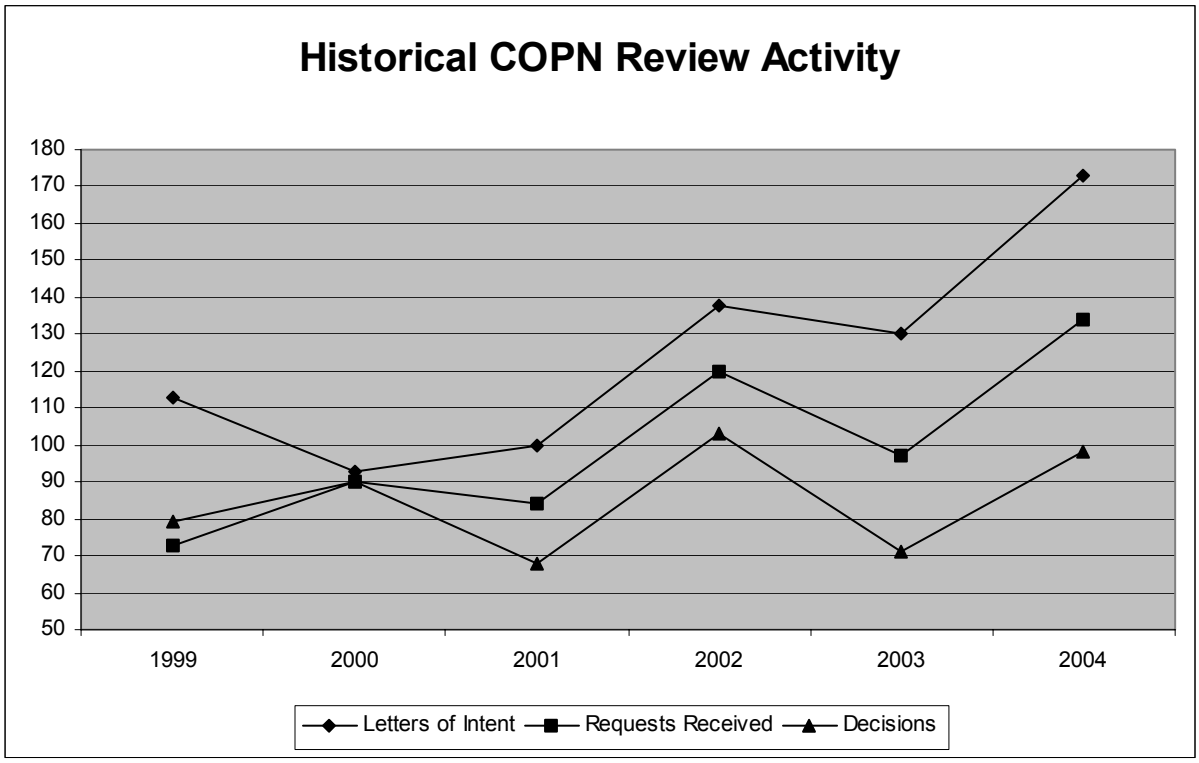
$981,080,725. Nine requests were denied. These nine denied projects had proposed total capital expenditures of $32,947,407. COPN decisions in FY04 are profiled in Appendix D.

Table 1. COPN Activity Summary

Fiscal Year	Total Letters of Intent Received	Total COPN Applications Received	Applications Withdrawn	Approvals	Denials	Appeals to Circuit Court	Determined to be Not Reviewable
2004	173	134	24	89	9	10	0

The number of decisions does not equal the number of requests due to review cycles overlapping the fiscal year.
Source: DCOPN

Graph 1



Source: DCOPN

In addition to assisting the Commissioner in the administration of the COPN program, DCOPN provides written recommendations addressing the merits of approval or denial of COPN applications. The DCOPN provides advisory reports on all completed applications that are not subsequently withdrawn.

COPN reports and recommendations are also provided to the Commissioner by the regional health planning agencies. The regional health planning agencies are not-for-profit corporations that receive state funding to conduct regional health planning and to provide an independent recommendation to assist the Commissioner in the COPN decision process. The regional health planning agencies conduct public hearings and make recommendations to the Commissioner concerning the public's need for proposed projects in their respective regions. The five health planning regions in Virginia are shown on the map in Appendix E.

Adjudication

If the DCOPN or one of the regional health planning agencies recommends denial of a COPN project, or if requested by any person seeking to demonstrate good cause, an informal fact-finding conference (IFFC) is held. The IFFC is the central feature of an informal adjudication process that serves as an administrative appeal prior to final decisions on projects by the Commissioner. These conferences, conducted in accordance with the Administrative Process Act, are held to provide the applicant an opportunity to submit information and testimony in support of a project application. An IFFC is also held when two or more requests are competing to provide the same or similar services in the same jurisdiction and one or more of the requests are denied. Another purpose for IFFCs is to permit persons opposed to a project, who have shown good cause, to voice their concerns.

There were 45 COPN applications heard before a VDH Adjudication Officer at 21 IFFCs in FY04. Thirty-one of the COPN requests warranting an IFFC were approved in FY04. Ten requests were denied after the IFFC. Four projects heard in an IFFC in FY04 still have decisions pending and will be resolved in the Fall of 2004.

Table 2 illustrates the types of projects that were forwarded to an IFFC in FY04.

Table 2 Projects at IFFC in FY04

Project Type	Approved	Denied	Pending	Total
Outpatient Surgery Hospitals	7	2	0	9
Magnetic Resonance Imaging	4	3	0	7
Computed Tomography Services	1	0	0	1
Radiation Therapy / Establish Comprehensive Cancer Care Center	8	2	1	11
Establish/Relocate/Replace Hospital	1	1	0	2
Medical Rehabilitation Services	3	0	0	3
Add Hospital Beds	1	0	0	1
Positron Emission Tomography Services	1	2	0	3
Cardiac Catheterization	5	0	2	7
Organ Transplant Program	0	0	1	1
TOTAL	31	10	4	45

Source: DCOPN

Judicial Review

COPN decision challenges are not limited to administrative appeals. Once an applicant has exhausted his administrative remedies, he can take his claim to state court for judicial review. Five decisions were appealed in FY04, from four competing review batches involving a total of nine COPN requests, and a single separate request, being heard in court.

The Sheltering Arms Corporation appealed the June 2003 denial of their request to establish a 28-bed rehabilitation hospital on the campus of the Bon Secours St. Francis Medical Center in Planning District 15. CJW Medical Center also appealed the denial of their competing request to add 10 medical rehabilitation beds to an existing inpatient medical rehabilitation program at the Johnston-Willis campus of the CJW Medical Center, also in Planning District 15.

Chesapeake General Hospital appealed the decision to approve two competing requests to establish a specialized center for radiation therapy, computed tomography (CT) imaging and positron emission tomography (PET) imaging in Planning District 20. These types of facilities are typically known as comprehensive cancer care centers. Chesapeake General Hospital was successful in gaining certificate of public need approval for the addition of radiation therapy equipment in the same review cycle as the two competing requests whose decisions are being appealed.

Loudoun Healthcare, Inova Health System and the Health Systems Agency of Northern Virginia have each appealed the decision to approve the replacement and relocation of Northern Virginia Community Hospital as the Broadlands Regional Medical Center in Loudoun County. Loudoun Healthcare has also appealed the approval of Inova Health Systems' request to add 33 beds at Inova Fair Oaks Hospital and the denial of Loudoun Healthcare's request to establish a 33-bed acute care hospital in Leesburg. All three appealed decisions were for competing requests in Planning District 8.

Colonial Ophthalmology, P.C., d/b/a Advance Vision Institute Cataract Laser Surgery appealed the denial of their request to establish an outpatient surgical hospital for eye surgery in Planning District 21. Colonial Ophthalmology's request was competing with a request to establish a pediatric outpatient surgical hospital and two requests to establish general outpatient surgical hospitals. Colonial Ophthalmology's request was the only one of the four competing requests to be denied.

In June 2004 three diagnostic imaging requests in Planning District 15 were approved, one to introduce CT imaging at an outpatient cancer center, one to establish a specialized center for MRI and CT imaging and one to add an MRI at an existing center. Richmond West End Diagnostic Imaging, the applicant requesting the addition of an MRI at their existing facility, has appealed the approval of the other two decisions of approval.

All of these appeals are still pending with the circuit court.

Certificate Surrenders

Infrequently, an applicant awarded a COPN may have reasons to surrender it. A typical reason is the applicant's inability to proceed with the project. In FY04 three certificates were surrendered: (a) a certificate to establish a specialized center for CT imaging in Planning District 20 was surrendered because the applicant's plans for the service changed; and (b) a certificate for SPECT imaging and a certificate for MRI imaging at the same hospital in Planning District 19 were surrendered because the applicant's plans for the service changed.

Significant Changes

A significant change results when there has been any alteration, modification, or adjustment to a reviewable project for which a COPN approval has been issued. To be considered a significant change, the alteration, modification, or adjustment must change the site, increase the

authorized capital expenditure by 10% or more, change the service proposed to be offered, or extend the schedule for completion of the project beyond three years (36 months) from the date of certificate issuance or beyond the time period approved by the Commissioner at the date of certificate issuance.

The Commissioner reviewed two requests for significant changes in FY04. Both of the significant changes were for time extensions beyond the three-year generic time limit or the time authorized on the certificate and both requests were authorized.

Competitive Nursing Home Review

Beginning in 1988, a general prohibition on the issuance of COPNs that would increase the supply of nursing home beds in the Commonwealth, commonly known as the "nursing home bed moratorium," was imposed. Effective July 1, 1996 the moratorium was replaced with an amended process governing COPN regulation of increases in nursing home bed supply (*Code of Virginia* §32.1-102.3:2). The new process requires the Commissioner to issue, at least annually in collaboration with Virginia's Department of Medical Assistance Services, a Request for Applications (RFA) which will target geographic areas for consideration of increased bed supply and establish competitive review cycles for the submission of applications.

On August 4, 2003, an RFA for 60 nursing home beds in Planning District 9 and 60 nursing home beds in Planning District 19 was issued. In April 2004 three COPN's were issued authorizing a total of 60 nursing home beds in Planning District 9. The decision for the 60 nursing home beds in Planning District 19 was still pending at the end of FY 04 with a decision expected in early August 2004.

Timeliness Of COPN Application Review

As a result of legislative changes in 1999 and 2000, all COPN recommendations by DCOPN must be completed by the 70th day of the review cycle. Review cycles begin on the 10th day of each month. In FY04 all COPN applications were reviewed within the statutory limit. A flow chart illustrating COPN timelines as a result of these and other bills can be found at Appendix F. The flow chart identifies the time periods within which VDH is to perform certain COPN functions.

The *Code* also specifies that the Commissioner has 90 days to render a decision. Failure to do so results in a deemed approval of the request. In FY04, all of the Commissioner's decisions were rendered within this time period.

Although the timeliness for COPN application review represents a success, there remain opportunities for improvement in the timeliness of action on project registrations and extensions of certificates, as well as in response time to significant change requests. DCOPN's response to registrations, extensions and significant change requests continues to improve, but there continues to be opportunities to improve the timeliness of responses. Registrations and

extensions generally take four to six weeks to process and significant changes, depending on when they are received, often take as much as two months to process (60 days verses the 45 days allowed). Changes in internal processes and personnel should have a marked impact on the timeliness of responses such that significant changes are processed within the allowable time and registrations and extensions are processed within two weeks.

Legislation

In the 2004 session of the General Assembly, there were five Senate bills and five House bills that addressed some aspect of the COPN program. There was no central theme to the types of bills considered during the session.

Table 3 COPN Bills in the 2004 Session of the Virginia General Assembly

Bill	Patron	Topic in Relation to COPN	Status
HB 391	Del. Amundson	Requires consideration of the effect on access of relocating a facility. Also requires notification of local governments of public hearings and inclusion of comments from local governments in the record. Companion with SB 86.	Passed
HB 413	Del. Purkey	Would exempt outpatient surgical hospitals with practices limited to eye surgery from COPN.	PBI
HB740	Del. O'Bannon	Would allow a request for applications for pediatric nursing home beds in Planning District 15.	Continued to 2005
HB 1290	Del. Reid	Would require abortion clinics to be licensed as outpatient surgical hospitals, and therefore would require abortion clinics to get a COPN prior to opening.	PBI
HB 1333	Del. Hogan	Exempted inpatient hospices from the requirement to obtain a COPN prior to opening. Companion with SB 625.	Continued to 2005
SB 86	Sen. Puller	Requires consideration of the effect on access of relocating a facility. Also requires notification of local governments of public hearings and inclusion of comments from local governments in the record. Companion with HB 391.	Passed
SB 197	Sen. Reynolds	Exempts intermediate care facilities for the mentally retarded of less than 13 beds from the requirement to obtain a COPN.	Passed
SB 388	Sen. Norment	Extended for a third 3-year term the open enrollment period at Patriot's Colony, a continuing care retirement community.	Passed
SB 611	Sen. Stolle	Would establish that the staff or Board members of the Regional Health Planning Agencies would be parties at all informal fact-finding conferences considering COPN requests.	Continued to 2005
SB 625	Sen. Houck	Exempted inpatient hospices from the requirement to obtain a COPN prior to opening. Companion with HB 1333.	Continued to 2005

PBI = passed by indefinitely

Source: Virginia Legislative Information System

Regulation

The State Medical Facilities Plan (SMFP) is being reviewed and revised with the assistance of an advisory committee consisting of industry representatives and representatives of the

Virginia Association of Regional Health Planning Agencies. The revised SMFP has been approved by the Department of Planning and Budget and the Governor's Office. The revised SMFP will advance to the public comment period in early FY 05.

FIVE-YEAR SCHEDULE FOR ANNUAL PROJECT CATEGORY ANALYSIS

Overview

For purposes of understanding the pattern of change in supply of many types of medical care facilities and services in Virginia since 1973, the year of the COPN program's inception, it is useful to understand that the program's 31 years can be segmented into three distinct periods. These periods can be characterized as regulatory, non-regulatory, and return to regulation. Those periods are: 1) 1973 to 1986, a period of relatively consistent regulation; 2) 1986 to 1992, a period of dramatic deregulation; and 3) 1992 to the present, a period in which Virginia not only revived COPN regulation but also began, in 1996, a process of review and consideration of the scope of the new regulatory environment.

Between 1973 and the mid-1980s, there was an effort, with mixed results, to ground COPN decision-making in established plans and standards of community need, based on an assumption that controlling the supply of medical care facilities and equipment is a viable strategy for aiding in the containment of medical care costs. Increases in the supply of medical care facilities in Virginia during this period were, in most cases, gradual and tended to be in balance with population growth, aging of the population, and increases in the population's use of emerging technological advances in medical diagnosis and treatment.

Beginning around 1986 and through 1992, there was a period of "de facto" (1986 to mid-1989) and formal (mid-1989 to mid-1992) deregulation. Few proposed non-nursing home projects were denied during this period, followed by the actual deregulation of most non-nursing home project categories. There was a growth of most specialized diagnostic and treatment facilities and services that were deregulated.

On July 1, 1992, Virginia "re-regulated" in response to the perceived excesses of the preceding years of deregulation, however no process had been set up to evaluate whether there were actually any service capacity excesses. Re-regulation brought the scope of COPN regulation on non-nursing home facilities and services to a level similar to that in place prior to 1989. Project review standards were updated and tightened and a more rigorous approach was taken to controlling growth in the supply of new medical care facilities and the proliferation of specialized services.

In recent years, VDH has taken an incremental approach to reviewing COPN regulation in response to legislative initiatives, by de-emphasizing regulation of replacement and smaller, non-clinically related expenditures, and focusing COPN regulation on new facilities development, new services development, and expansion of service capacity.

As a result of legislation passed during the 2000 session of the General Assembly, the Joint Commission on Health Care (JCHC) developed a plan for the phased deregulation of COPN in a

manner that preserved the perceived positive aspects of the program. Due to the high cost of implementing the plan, it failed to gain General Assembly support in the 2001 session and was not enacted. No action was taken regarding the plan in either the 2002, 2003 or the 2004 sessions of the General Assembly.

In accordance with section 32.1-102.12 of the *Code*, VDH has established a five-year schedule for analysis of all project categories within the current scope of COPN regulation that provides for analysis of at least three project categories per year. The five-year schedule is shown in Appendix G.

PROJECT CATEGORY ANALYSES

Section 32.1-102.12 of the *Code* provides guidance concerning the content of the project analysis. It requires the report to consider the appropriateness of continuing the certificate of public need program for each of the project categories. It also mandates that, in reviewing the project categories, the report address:

- The review time required during the past year for various project categories;
- The number of contested or opposed applications and the categories of these proposed projects;
- The number of applications upon which the health systems agencies (regional health planning agencies) have failed to act in accordance with the timelines of Section 32.1-102.B of the *Code*, and the number of deemed approvals from the Department because of their failure to comply with the timelines required by statute; and
- Any other data determined by the Commissioner to be relevant to the efficient operations of the program.

Section 32.1-102.12 of the *Code* requires this report to consider at least three COPN project categories. For FY 2004, the project categories are:

> Medical rehabilitation; long-term care hospital services, nursing home services and mental retardation facilities

The following list is the specific project definitions for the categories considered in this report:

- Establishment of a medical rehabilitation hospital,
- Introduction by an existing medical care facility of any new medical rehabilitation service,
- Conversion of beds in an existing medical care facility to medical rehabilitation beds,
- Establishment of a long-term care hospital,
- Establishment of a nursing home,
- Establishment of an intermediate care facility,
- Establishment of an extended care facility,
- Introduction by an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing

facility services, regardless of the type of medical care facility in which those services are provided,
- Establishment of a mental retardation facility.

In addition to the JCHC comprehensive plan for deregulation of the COPN program that has already been presented to the General Assembly, another option for the modification of the program is presented below as an alternative for each of the services reviewed except for nursing home services. The option, which would require legislative approval, expands the current concept of a request for applications (RFA) by applying a prospective need analysis to the regulated service and accepting COPN applications for only those services proposed in locations identified in the RFA. These targeted RFAs would limit COPN review to just those services and areas in which an identified public need exists, potentially stimulating development in some areas and limiting submission of more speculative applications elsewhere.

As the following discussions will note, the majority of COPN requests are approved. This does not imply that the COPN process is ineffective at limiting the number of new services or capital expenditures. Indications are that, for the most part, applicants are only submitting requests for projects that meet the criteria for approval and that the number of speculative requests has declined.

Medical Rehabilitation

The SMFP defines medical rehabilitation services as "services provided to individuals who are primarily physically disabled for the restoration of normal form and function after injury or illness. The objective of these restorative services is self-sufficiency and a return to suitable gainful employment in the shortest possible time or both. Medical rehabilitation services do not include services provided to individuals whose primary disability is psychiatric illness or substance abuse. However, medical rehabilitation services include mental health services needed by individuals whose disability is primarily physical in nature. The medical rehabilitation services subject to certificate of public need review are comprehensive inpatient medical rehabilitation services and specialized inpatient medical rehabilitation."

Table 3 below lists the inpatient medical rehabilitation programs that are units in a general hospital and the free standing medical rehabilitation hospitals (in italics) in Virginia. There are 19 general acute care hospitals that offer inpatient medical rehabilitation services and 4 free standing medical rehabilitation hospitals in Virginia offering a total of 672 licensed inpatient medical rehabilitation beds. These facilities and beds are generally well distributed across the Commonwealth. The notable exception is in Health Planning Region IV where the inpatient medical rehabilitation beds are concentrated in a single Planning District (Planning District 15, Richmond and surrounding jurisdictions).

Table 3 Rehabilitation Beds and Facilities

	Planning Region	Planning District	Licensed Beds
Augusta Health Care	1	6	3
Winchester Medical Center	1	7	30
University of Virginia Health System	1	10	39
UVA HealthSouth Rehabilitation Hospital	*1*	*10*	*50*
Health Planning Region I Total			122
Inova Mt. Vernon Hospital	2	8	67
Health Planning Region II Total			67
Lee Regional Medical Center	3	1	5
Norton Community Hospital	3	1	11
Clinch Valley Medical Center	3	2	10
Carilion Roanoke Memorial Hospital	3	5	28
Lewis Gale Medical Center	3	5	35
Virginia Baptist Hospital	3	11	20
Danville Regional Medical Center	3	12	10
Health Planning Region III Total			119
HealthSouth Rehabilitation Hospital of Virginia	*4*	*15*	*40*
Children's Hospital	4	15	10
Henrico Doctors' Hospital-Parham	4	15	36
Johnston-Willis Medical Center	4	15	34
Sheltering Arms Hospital	*4*	*15*	*40*
VCU Health System	4	15	46
Health Planning Region IV Total			206
Bon Secours - Maryview Hospital	5	20	25
Bon Secours - DePaul Medical Center	5	20	14
Children's Hospital of The King's Daughters	5	20	8
Riverside Rehabilitation Institute	*5*	*21*	*75*
Sentara Norfolk General Hospital	5	20	36
Health Planning Region V Total			158
State Total			672

Source: Virginia Health Information (VHI)

In the five years prior to FY 04 (1999-2003) there were three COPN decisions involving medical rehabilitation services. One, a request to add five medical rehabilitation beds to an existing rehabilitation program in southwestern Virginia, was approved in late 2002. The other two decisions were denial of a request to establish a 28-bed medical rehabilitation hospital in Planning District 15 and denial of a competing request to add 10 medical rehabilitation beds to an existing rehabilitation program, also in Planning District 15. The two denial decisions were made in late FY 03 and both are the subjects of current appeals before the circuit court.

In FY 04 ten letters of intent and seven applications were received for projects involving medical rehabilitation services. Four of these requests will not be decided upon until FY 05. The remaining three requests were all approved, two were revised versions of the two requests

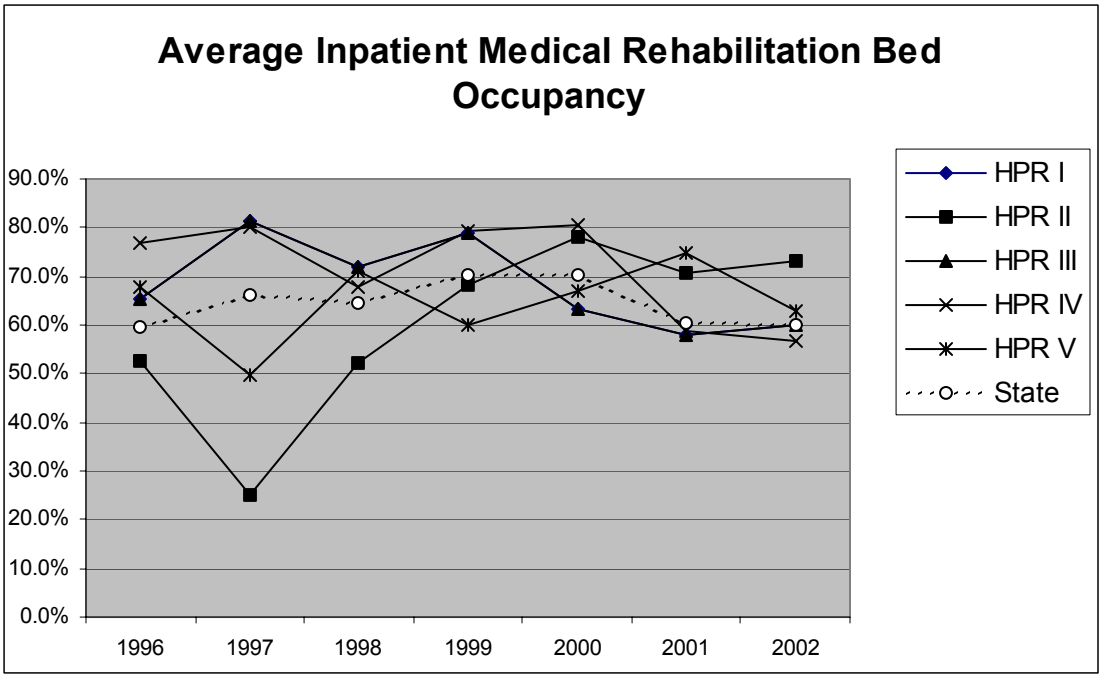
denied in FY 03 and the third authorized the conversion of 15 medical/surgical beds to medical rehabilitation beds in Planning District 12 (Martinsville).

For at least four years there were no decisions involving medical rehabilitation services. Then, in the last two years there have been ten requests for medical rehabilitation services or facilities. These ten requests represent just six different applicants. Six of the requests are grouped in batches of two competitive requests for the same or similar services in the same area and probably represent competitive responses from one of the applicants in each batch.

In January 2002 the Medicare payment mechanism for inpatient medical rehabilitation services changed from a cost based system to a prospective payment system. Under prospective payment facilities are reimbursed for care on a per patient discharge basis, with the rate set based on the severity of the conditions treated. In FY 04 the Centers for Medicare and Medicaid Services increased the payment rates for medical rehabilitation services by 3.2%.

On the whole, occupancy of inpatient medical rehabilitation beds is declining in Virginia (Graph 2). Northern Virginia (HPR II) and Southwestern Virginia (HPR III) are showing very slight recent increases in occupancy of medical rehabilitation beds.

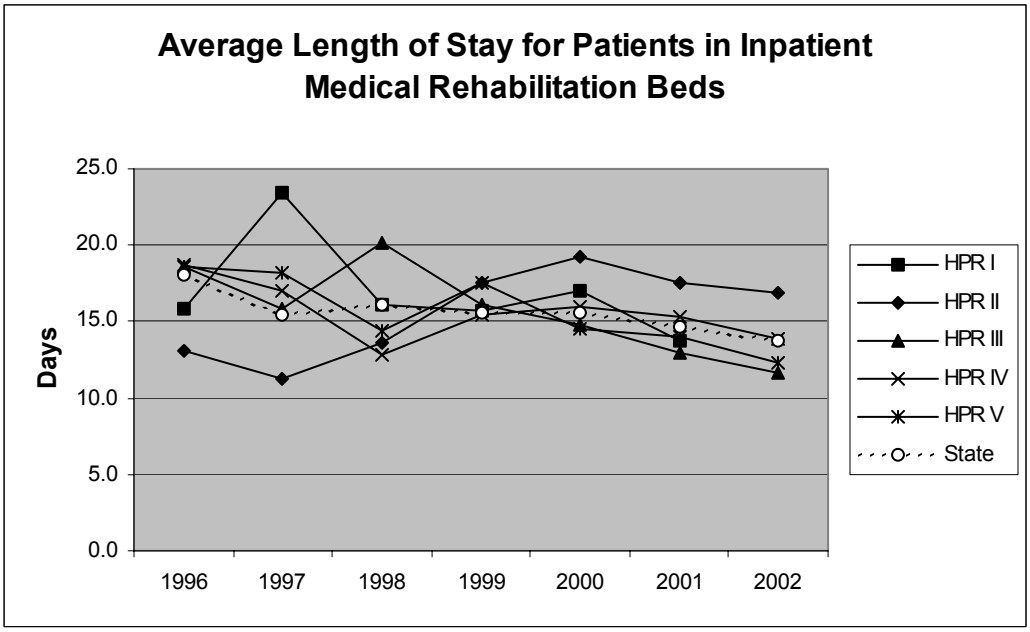
Graph 2



Source: VHI

The decrease in occupancy is most likely due to a general decline in the average length of stay for patients receiving inpatient medical rehabilitation. Graph 3 below demonstrates this general declining trend across the State and in each of the Health Planning Regions.

Graph 3



Source: VHI

The *Code of Virginia*, at §32.1-102.1, (Appendix B) defines a project requiring COPN authorization, in part, as "The establishment of a medical care facility", "The introduction into an existing medical care facility of any new … medical rehabilitation, … service which the facility has never provided or has not provided in the previous 12 months" and "The conversion of beds in an existing medical care facility to medical rehabilitation beds…" A medical care facility is defined, in part, as "Rehabilitation hospitals" and "Any facility licensed as a hospital."

Appropriateness of Continuing COPN for Medical Rehabilitation Services

The COPN experience concerning medical rehabilitation services supports a contention that the program is appropriate for these services. As mentioned earlier the presence of a COPN program is thought to serve as a deterrent to speculative requests. It must be further presumed that absent the tempering effect of a COPN program these otherwise un-requested projects would be carried forth, resulting in, potentially, gross duplication of services. One of the goals of the COPN program is the promotion of comprehensive health planning to meet the needs of the public. Planning that results in the decision to not pursue the development of a service is the successful meeting of that goal. However, there are alternatives to consider.

Options:

No Change: Continue applying the COPN program to the establishment of new medical care facilities for medical rehabilitation and the addition of medical rehabilitation beds at existing programs as currently mandated. Ongoing efforts to review, and where appropriate, update the SMFP, will address necessary changes to the review criteria. All key stakeholders would likely support this option.

Minimal Change: In collaboration with the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for the various facilities and service capacity subject to COPN regulation, and by way of a targeted RFA, publicize the locations where a demonstrated need for new or additional facilities/capacity exists as a means of stimulating interest in requesting authorization for development of the service. Most providers, except some providers seeking competitive advantage despite actual public need, would likely support this option.

Deregulation: Support efforts outside the comprehensive JCHC plan to deregulate medical rehabilitation services. It is doubtful key stakeholders would support this option.

RECOMMENDATION: Expand the Request for Applications (RFA) process to include the establishment of medical rehabilitation hospitals, the introduction of medical rehabilitation services, and the addition of medical rehabilitation beds based on a collaborative review with affected parties to determine the need for, and location of, such additional facilities and services. This would meet the planned need for new services in appropriate planning districts in a market competitive manner and improve access.

Long-Term Care Hospital

The Balanced Budget Act of 1997 (BBA) changed Medicare reimbursement for skilled nursing facilities (SNF) from a cost-based reimbursement to a prospective payment system based on resource utility groups. The result has been an overall reduction in Medicare payments to SNF's such that they now appear to be reluctant to accept the more clinically complex patients. It also appears that many SNF's, in an effort to reduce costs in response to the BBA, have managed their resources such that they may no longer be appropriate sites for the sickest, long-term acute patients. For example, many nursing homes have made staffing changes such that they are not staffed to care for patients who are appropriate for LTACHs. The general hospitals are then left as the sole provider of care for these patients.

Long-term acute care hospitals (LTACH) are those with an average length of stay of 25 days or more, and are established to provide extended medical care for clinically complex patients. LTACHs were excluded from the prospective payment system (PPS) and were reimbursed on a reasonable cost based system. In FY 03 the Centers for Medicare and Medicaid Services established the Long-Term Care Hospital Prospective Payment System (LTACH PPS). The LTACH PPS pays LTACHs on a per discharge basis based on Long-Term Care Diagnostic Related Groups (LTC DRG). LTACH's must separately meet the Medicare Conditions of Participation for Hospitals, apart from any host hospital.

Many, but not all, LTACHs are established as hospitals within existing hospitals. In order for an LTACH to be established within a hospital additional conditions must be met, namely:

- Both the host and "tenant" hospitals must have separate governing bodies and cannot be controlled by a common third body;
- Both the host and "tenant" hospitals must have a separate chief medical officer;
- Each facility must maintain separate medical staff;

- The chief executive officer of the LTACH cannot be an employee of or under contract to the host hospital or any common third party;
- The LTACH will provide, directly or through contract with entities other than the host hospital or any common third party, all the basic hospital functions. (Food/dietetic services, housekeeping, and maintenance can be contracted from the host hospital).
- During the (at least) six month period used in establishing occupancy for exclusion from PPS no more than 15% of the LTACH's operating costs can be for services contracted from the host hospital or any common third party.
- During the (at least) six month period used in establishing occupancy for exclusion from PPS no more than 25% of the LTACH's inpatients can be patients referred from the host hospital.

The Centers for Medicare and Medicaid Services has proposed a number of rules that are still under consideration to try and curb the rapid growth in the number of LTACHs. These proposed rules include a requirement that at least 75% of the patients at a tenant LTACH located within an existing "host" hospital are referred from another hospital, and that an LTACH cannot be under the direct or indirect ownership of any person or entity that has any ownership interest in a hospital in the same building or on the same campus as the LTACH.

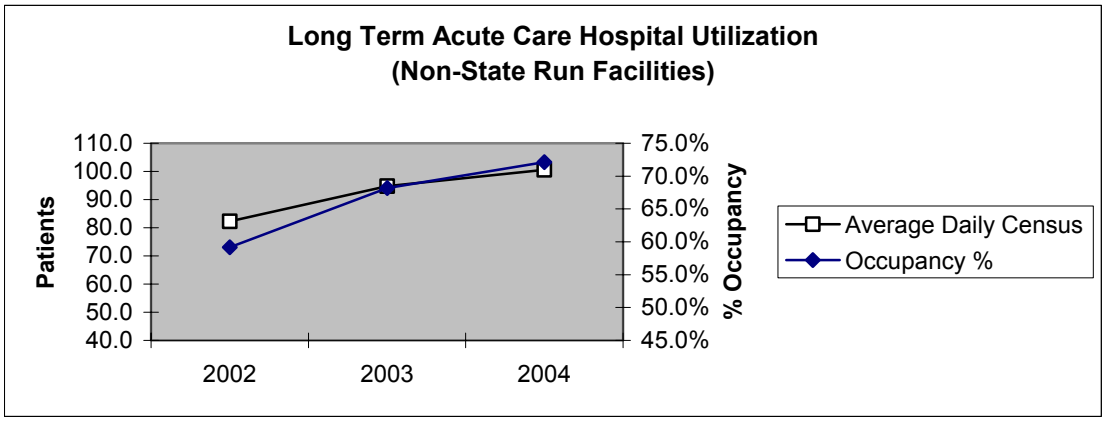
A medical care facility is defined in part, as it applies to the COPN program, as any facility licensed as a hospital. Virginia licenses LTACHs as general acute care hospitals.

There are currently four LTACHs in the Commonwealth. Two are located in State Mental Health Facilities, Lake Taylor Hospital in Norfolk is the third and The Hospital for Extended Recovery, located within Norfolk General Hospital is the fourth. The Hospital for Extended Recovery began operation in FY 02 as a separately licensed hospital within Sentara Norfolk General Hospital's facility. Both non-State run LTACH's are located in Planning District 20.

As Graph 4 illustrates, the utilization of the two non-State run LTACHs, in aggregate, have shown an increase in the average daily census of the 139 beds available. This growth is due to the start-up and growing utilization of the Hospital for Extended Recovery. Lake Taylor Hospital has actually seen a decrease of almost three patients per day in their average daily census since the Hospital for Extended Recovery opened.

In June 2004 an application for a COPN for an LTACH was received. This LTACH is proposed for Planning District 21, which is in the same Health Planning Region as the other two existing non-State run LTACHs. A decision on this request is not expected before February 2005.

Graph 4



Source: VHI, Lake Taylor Hospital and the Hospital for Extended Recovery

Appropriateness of Continuing COPN for Long-Term Acute Care Hospitals

The COPN experience concerning LTACHs also supports a contention that the program is appropriate for these services. As mentioned earlier the presence of a COPN program is thought to serve as a deterrent to speculative requests. It must be further presumed that absent the tempering effect of a COPN program these otherwise un-requested projects would be carried forth, resulting in, potentially, gross duplication of services. The Federal rules for LTACHs and hospitals within existing hospitals also serve to control the growth in the number of these facilities.

One of the goals of the COPN program is the promotion of comprehensive health planning to meet the needs of the public. To date all existing non-State run LTACHs and requests for LTACHs are concentrated in a single geographic region of the Commonwealth. This situation does not address the potential needs of the rest of the State. Planning that results in the decision to not pursue the development of a service is the successful meeting of that goal. However, there are alternatives to consider.

Options:

No Change: Continue applying the COPN program to the establishment of new long-term acute care hospitals as currently mandated. Ongoing efforts to review, and where appropriate, update the SMFP, will address necessary changes to the review criteria. This option would likely be supported by key stakeholders, except some hospitals that might look to the development of LTACHs as an option to keeping these patients in the general hospital.

Minimal Change: In collaboration with the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for the various facilities and service capacity subject to COPN regulation and by way of a targeted RFA, publicize the locations where a demonstrated need for new or additional facilities/capacity exists as a means of stimulating interest in requesting authorization for development of the service. All key stakeholders would likely support this option.

Deregulation: Support efforts outside the comprehensive JCHC plan to deregulate LTACHs. Existing LTACHs and other existing hospitals will likely oppose it.

RECOMMENDATION: Expand the Request for Applications (RFA) process to include the establishment of long-term acute care hospitals and the addition of long-term acute care beds based on a collaborative review with affected parties to determine the need for, and location of, such additional facilities and services. This would meet the planned need for new services in appropriate planning districts in a market competitive manner and improve access.

Nursing Homes and Nursing Home Beds

Currently, there are 296 nursing homes or hospital long-term care units with a total of 32,907 long-term care beds in Virginia. These nursing home beds are configured as shown in Table 4 below.

Table 4 Profile of Nursing Homes in Virginia

	Number of Facilities	Number of Beds	Certified for	
			Medicare	Medicaid
Nursing Home Facilities Subject to COPN				
Beds Not Certified for Either Medicaid or Medicare	17	1,374	0	0
Nursing Homes Certified Just for Medicaid	27	1,740		1,740
Nursing Homes Certified Just for Medicare	8	419	419	
Nursing Homes Dually Certified for Medicaid and Medicare	138	15,905	15,905	15,905
Balance of Facilities with Some Combination of Beds	101	12,760	5,292	11,612
Total Subject to COPN	291	32,198	21,616	29,257
Nursing Home Facilities Not Subject to COPN				
Virginia Veterans Care Center	1	180		
Department of Mental Health, Mental Retardation and Substance Abuse Services facilities	4	529	164	529
Total Not Subject To COPN	5	709	164	529
Total Nursing Home Facilities / Beds Available	296	32,907	21,780	29,786
Distribution of Nursing Homes and Beds By Provider Type				
Nursing Homes	234	28,763	20,864	27,109
Nursing Homes that are Part of a Continuing Care Retirement Community	35	2,274		933
Hospital Long-Term Care Units Certified for Nursing Home Reimbursement	22	1,161	752	1,215

Source: VDH

Approximately 75 percent of Virginia nursing homes (excluding CCRC nursing home units) are operated by for-profit entities. Most of the remaining nursing homes are operated by private, not-for-profit entities, primarily hospital organizations, while two or three percent are operated by local governments or by authorities or commissions established by local governments.

Revenue Sources and Financial Conditions

For 2002, the 251 nursing homes (about 90% of Virginia nursing home beds) that provided their financial data to Virginia Health Information reported total patient services net revenue of nearly $1.335 billion from the following sources:

- Medicaid – 49%
- Medicare – 29%
- Self-pay – 18%
- All other – 4%

These 251 nursing homes reported total operating expenses of nearly $1.350 billion, indicating an operating deficit in terms of net patient services revenue of about $15 million. When the hospital long-term care units and a few special-situation nursing homes are removed from the data, the remaining approximately 225 nursing homes covered by the VHI data reported an operating deficit in terms of net patient services revenue of $2.2 million, or about 0.17% of net patient services revenue.

When revenue from other than patient care services and other operating gains are added to the net patient services revenue, the 251 reporting nursing homes showed positive net operating income of $10.4 million, or about 0.77% of total revenue and operating gains. When the hospital long-term care units and a few special-situation nursing homes are removed from the data, the remaining approximately 225 reporting nursing homes had positive net operating income of $23.5 million, or about 1.8% of total revenue and operating gains.

Nursing Home Utilization and Utilization Trends

Although the need for nursing home beds is often discussed with reference to the population age 65 and older, the actual need for nursing home beds is largely accounted for by the population age 80 and older. Division of COPN projections for nursing home bed need in 2007 find that 50% of occupied nursing home beds will be used by persons age 85 and older, while another 19% will be used by persons age 80-84. Only 21% of occupied nursing home beds will be serving persons less than 75 years old.

During the current decade the number of elderly Virginians is expected to increase by age group as shown in Table 5 below. As shown, the number of elderly Virginians, especially those in the prime age groups for nursing home care, is expected to increase extremely rapidly during the present decade and substantially more rapidly than during the prior decade.

Table 5

	2000 - 2010		1990 - 2000	
Age Cohort	**% Change**	**Persons Per Year**	**% Change**	**Persons Per Year**
65+	28%	22,200	19%	12,800
80+	47%	9,100	40%	5,500
85+	67%	5,800	46%	2,800
All Ages	12%	81,400	14%	89,100

Source: Virginia Employment Commission, DCOPN

This would seem to imply a large and growing demand for nursing home beds in Virginia. According to the most recent (2002) nursing home patient survey conducted by the Virginia regional health planning agencies and the DCOPN, about 13% of Virginians age 85 and above reside in a nursing home. This population group is expected to increase by approximately 5,800 persons per year in the current decade. The growth of this age group alone implies a need for about 750 additional nursing home beds in Virginia each year.

Every four years the Department of Health and the five Regional Health Planning Agencies conduct a nursing home patient origin and utilization survey. These quadrennial nursing home patient origin surveys have found that over a number of years the age-specific use rates of Virginia nursing homes have been steadily declining. Therefore, the growth in use of nursing home beds in Virginia has not kept pace with the growth of the prime nursing home population, especially persons age 80 and above. It seems likely that this well-established trend of declining age-specific use rates of nursing home beds will continue, although that cannot confidently be predicted.

Since September 2000 the number of nursing home beds in Virginia subject to COPN increased from 31,258 to 32,198, a gain of 940 beds, or only 3.0% over a four-year period. However, during this four-year period, the prime nursing home population in Virginia is projected to have increased about 19%.

Yet, in spite of the minor increase in nursing home beds and the far larger increase in the prime nursing home population, nursing home occupancy has shown a slight but steady *decline* over recent years. It fell from 93.1% for Medicaid-certified nursing home beds in 2000 to 90.8% for Medicaid certified nursing home beds in 2002. Possible reasons for this include the increased availability of alternative options for care and the generalized improved health of the elderly population.

The negligible growth in usage of Virginia nursing homes in recent years, in spite of the large increase in the prime nursing home population of Virginia, is entirely consistent with the findings from the last several nursing home patient origin surveys that age-specific use rates of nursing homes are declining in Virginia. If these trends continue the growth of Virginia's supply of nursing home beds can be kept to a modest level of perhaps 200-400 additional nursing home beds per year. This would be growth of roughly one percent per year in the number of Virginia nursing home beds, even though the relevant population will be growing about four percent per year.

Nursing Home COPN Activity in the Last Five State Fiscal Years

Additions to the supply of nursing home beds in any planning district are controlled by the provisions of § 32.1-102.3:2 A of the Code of Virginia, which states:

> *Except for applications for continuing care retirement community nursing home bed projects filed by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2, which comply with the requirements established in this section, the Commissioner of Health shall only approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article for any project which would result in an increase in the number of beds in a planning district in which nursing facility or extended care services are provided when such applications are filed in response to Requests For Applications (RFA).*

The practical effect of this requirement is that applications to increase the supply of nursing home beds, except projects within continuing care retirement communities, may only be accepted for review when they are filed in response to a request for applications (RFA) issued by the Virginia State Board of Health based on a predetermined need for nursing home beds.

During the last five fiscal years 2000 through 2004, the Virginia State Board of Health and the Virginia Department of Medical Assistance Services, acting jointly, have issued the following RFAs for development of additional nursing home beds, or have issued statements in lieu of an RFA that no planning district qualified for an RFA.

- November 1999: RFA to develop 30 additional nursing home beds in Planning District 4 (New River Valley).
- March 2000: RFA to develop 17 additional Medicaid-certified nursing home beds in Planning District 15 (Richmond Regional) dedicated to the provision of services to adult patients (over age 18) with irreversible physical disabilities.
- September 2001: statement that no planning district qualified for an RFA based on the projected need for nursing home beds in 2004.
- July 2002: RFA, pursuant to Senate Bill 490 (Chapter 168, Acts of the Assembly), to develop 60 additional nursing home beds in Planning District 11 (Central Virginia) and to develop 120 additional nursing home beds in Planning District 13 (Southside).
- August 2003: RFA to develop 60 additional nursing home beds in Planning District 9 (Rappahannock-Rapidan) and 60 additional nursing home beds in Planning District 19 (Crater).

Consequently, since the beginning of FY 00, four RFAs have been issued for the development of 347 additional nursing home beds in six planning districts. All beds authorized by these RFAs were applied for and were issued COPNs authorizing their development.

CCRC Nursing Home Projects.

Projects to develop additional nursing home beds within continuing care retirement communities are exempt from the RFA process, but this exemption is strictly limited in the number of beds that may be approved at a particular CCRC in any one application. However,

given the strict limitations that the RFA process imposes on non-CCRC development of nursing home beds, CCRC development of nursing home beds has become a moderately significant component of all development of additional nursing home beds in Virginia.

During fiscal years 2000 through 2004, the Commissioner of Health approved five projects to add 150 nursing home beds at CCRCs. This number, while quite small relative to the existing nursing home beds under the purview of the COPN program, is significant relative to the mere 347 additional nursing home beds authorized for development under RFAs issued during the past five fiscal years.

Other Nursing Home Projects.

Although the number of COPN projects to increase the supply of nursing home beds is strictly limited by provisions of the Code of Virginia, the COPN program also deals with a considerably larger number of other nursing home projects that do not increase the supply of nursing home beds within a planning district. These projects are most often for the purpose of relocating existing nursing home beds from one place to another in the same planning district.

These projects typically involve acquisition or downsizing of older nursing homes with low occupancy and in areas of little or no population growth, in order to combine the beds with an existing facility with high occupancy in a superior location or to create a new nursing home in a high-growth location. These projects almost always improve the geographical distribution of nursing home services and usually improve the physical environment and effectiveness of operation of the relocated nursing home beds. This is a little noticed benefit of the RFA process that, by limiting development of new capacity to well documented areas of need, the rebuilding, replacement, and relocation of outmoded facilities throughout the state has been encouraged. During the last five fiscal years, the Commissioner has approved 23 projects to relocate nursing home beds within a planning district.

Current issues in administration of the COPN program relative to nursing homes are:

- CCRC nursing home units are not required to report data to VHI, and some who are expected to report do not report.
- The Planning District wide occupancy standard of 95% for determining need for additional beds is so high that additional beds often cannot be developed even if most nursing homes in the PD are operating at practical capacity. This is addressed in the proposed revisions to the SMFP.
- There is no clear provision or authority for permitting development of special-purpose nursing home beds, such as for children or for the chronically disabled non-elderly population, and it is impractical to develop SMFP standards to address such special-purpose needs.

As use rates and occupancy levels of nursing homes have decreased, the likelihood that an elderly person in Virginia will require nursing home care has decreased markedly over the past 20 years. The population that has required nursing home care has changed considerably. Compared with nursing home residents over the last two decades, nursing home patients today are admitted to nursing facilities at a significantly older age, are more likely to be admitted from

an acute care hospital, have shorter average lengths of stay in nursing homes, are likely to have more debilitating and activity-limiting conditions, and are more likely to be Medicare patients. All of the factors tend to make caring for nursing homes patients more difficult and more costly.

Options:
No Change: Continue applying the COPN program to the establishment of new nursing home facilities and the addition of nursing home beds using the RFA process as currently mandated. Ongoing efforts to review, and where appropriate, update the SMFP, will address necessary changes to the review criteria. All key stakeholders would likely support this option.

Minimal Change: By linking regulatory processes and decisions to planning-based development policies and analyses, the RFA process has been key in accommodating and reflecting market circumstances and changes in Virginia. As now formulated, the RFA process works best in relatively stable markets. Given recent and projected trends, consideration could be given to improving the process by incorporating use-rate trend analyses in the methodology used to estimate likely future demand. All key stakeholders would likely support this option.

Deregulation: Support efforts outside the comprehensive JCHC plan to deregulate nursing home services. It is likely that existing nursing home providers will vigorously oppose it.

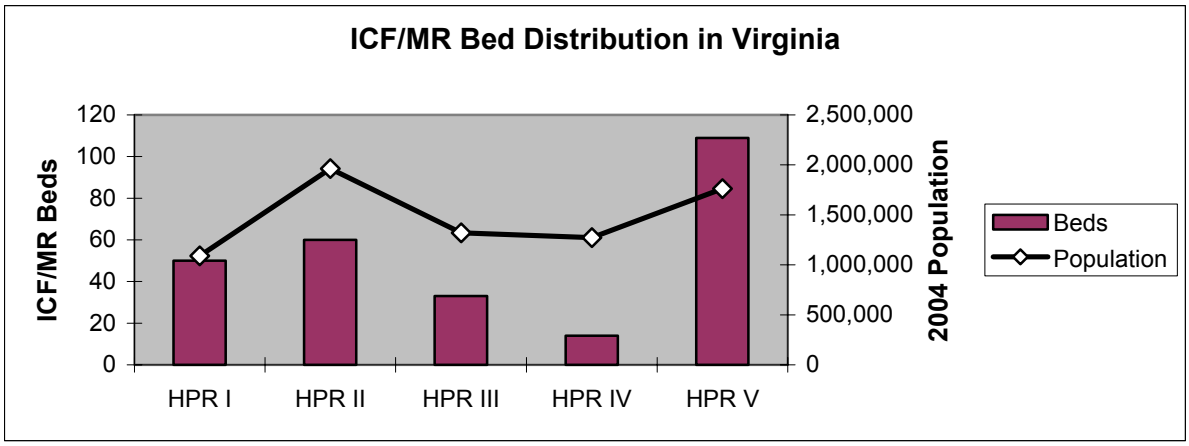
RECOMMENDATION: Continue to apply the COPN program, with the Request for Applications element, to nursing home services with the modification of the State Medical Facilities Plan, as needed.

Intermediate Care Facility for Mental Retardation

A medical care facility is defined in part, as it applies to the COPN program, as an intermediate care facility and as a mental retardation facility. Intermediate care facilities for mental retardation (ICF/MR) qualify as medical care facilities subject to COPN review. The 2004 session of the Virginia General Assembly passed a bill (SB 197, Reynolds) that specifically excluded ICF/MRs of no more than twelve beds from the definition of a medical care facility. The result is that effective July 1, 2004 such facilities will no longer require COPN authorization as long as they will be located in an area in need of such services as determined by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Only ICF/MRs with more than 12 beds and those proposed for locations not specifically identified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as in need of ICF/MR services require COPN authorization.

Certification for reimbursement by the Centers for Medicare and Medicaid Services sets four beds as the minimum size of ICF/MRs. ICF/MRs in Virginia range in size from 4 beds to 28 beds, with the average size being 9 beds. There are 31 non-State run ICF/MRs authorized and/or in operation in Virginia, with a total of 266 beds authorized. As Graph 5 below shows ICF/MR beds are available in every Health Planning Region in the State and are marginally distributed based on population.

Graph 5



Since January 1, 2002, COPNs were issued for 131 ICF/MR beds in 20 facilities. No COPN requests for ICF/MR beds were denied during that period.

The Department of Mental Health, Mental Retardation and Substance Abuse Services has delineated a strategy in their 2002 – 2008 Comprehensive State Plan. The plan states, "*The directions established in the Comprehensive State Plan 2002-2008 would enable the Commonwealth to accelerate the shift to a more community-based system while preserving the important roles and service responsibilities of state mental health and mental retardation facilities in Virginia's public services system. A delicate balance has been achieved between state facility and community services. On the state facility side, this balance is based on smaller community demand for state hospital inpatient psychiatric services, reduced state facility average daily census, improved quality of state facility care, and slightly larger appropriations. On the community side, this balance is based on greatly increased appropriations, expanded targeted services, diversions of inappropriate state facility admissions, and more use of private sector inpatient psychiatric beds.*"

This strategy was reiterated in a presentation the Department of Mental Health, Mental Retardation and Substance Abuse Services made to the House Appropriations Committee on January 22, 2003. The Commissioner of Mental Health, Mental Retardation and Substance Abuse Services outlined Governor Warner's Reinvestment Initiative, Expanding Community Mental Health Services Through the Reinvestment of State Facility resources. This initiative provides positive steps toward improving the availability of ICF/MR services in the community.

Initiatives from the Governor, the Department of Mental Health, Mental Retardation and Substance Abuse Services and the relaxing of the requirements for COPN for ICF/MRs are all designed to increase the availability of this resource in the home community of the residents and decrease dependence on the use of centralized State facilities.

Options:
No Change: Continue applying the COPN program to ICF/MRs as currently mandated. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the

review criteria. Current providers of ICF/MR services would probably be neutral to this option. There would probably be no opposition.

Minimal Change: In collaboration with the ICF/MR industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for ICF/MR services and by way of a targeted RFA publicize the locations where a demonstrated need for new ICF/MRs exist as a means of stimulating interest in requesting authorization for development of the service. This option has little utility as it is believed the providers wishing to develop ICF/MRs are doing so. Current providers of ICF/MR services would probably be neutral to this option. There would probably be no opposition.

Deregulation: Support efforts outside the comprehensive JCHC plan to fully deregulate ICF/MR services. It is expected there would be no resulting proliferation of providers. Current providers of ICF/MR services would probably be neutral to supportive of this option. There would probably be no opposition.

RECOMMENDATION**: **Support any effort to complete the deregulation of ICF/MR services.

Effectiveness of the COPN Application Review Procedures for FY04 Project Categories

The statute defining the contents of this study requires an analysis of the effectiveness of the application review procedures used by the regional health planning agencies and VDH. An analysis of effectiveness must detail the review time required during the past year for various project categories. To ensure consistency the project categories, for purposes of this document, are the same project categories that were selected for review during FY04. The statute also dictates that this report address the number of contested or opposed applications and the project categories of these contested or opposed projects. Information concerning all contested or opposed COPNs for FY04 can be found under the section entitled "Judicial Review" as well as the section labeled "Adjudication." Finally, the statute requires the report to identify the number of projects automatically approved from the regional health planning agencies because of their failure to comply with the statutory timelines.

The application review process was completed in a timely manner as dictated by the *Code*. The number of requests automatically considered as recommended for approval from the regional health planning agency or DCOPN due to their failure to act in accordance with statutory timelines was one in FY04. The Eastern Virginia Health Systems Agency elected to not review and forward a recommendation on a COPN request for an ICF/MR and the recommendation was forwarded to the Commissioner of Health as one of approval in accordance with the *Code* (§32.1-102.6.B). At no time did delays occur in receipt of a recommendation from a regional health planning agency such that there was an impact in DCOPN's ability to make a recommendation or in the Commissioner's ability to make a decision. Where appropriate, projects were authorized, but more importantly, projects were denied and prevented from proceeding when there was no need for the project demonstrated. This avoided duplication of services and costs without adversely impacting access to care.

Other Data Relevant to the Efficient Operation of COPN Program

The final consideration in the analysis of project categories is that the Commissioner include any other data he determines to be relevant to the efficient operation of the COPN program.

The 2003 session of the Virginia General Assembly passed a bill (HB1621 Hamilton, SB 1226 Williams) that directs that the process of batching like projects together in cycles for competitive review allows for the simultaneous review of computed tomography, magnetic resonance, positron emission tomography and nuclear medicine imaging, in the same cycles as radiation therapy. This would allow providers seeking to develop a comprehensive center for the treatment of cancer to obtain a single COPN for the authorization of all the regulated services needed for the comprehensive center.

Between July 1, 2003 and June 30, 2004, 18 requests for COPNs for comprehensive cancer care centers were received. Seven of the requests were authorized (1 in HPR III and 6 in HPR V), two were denied (both in HPR V), four were withdrawn by the applicant (1 in HPR III and 3 in HPR V), and five have either pending decisions or were delayed by the applicant to a review cycle in FY 05 (all 5 in HPR III).

Table 6 COPN Requests for Comprehensive Cancer Care Centers Since July 1, 2003

Applicant	Request	HPR	Status
Johnston Memorial Hospital, Inc	Establish a Cancer Care Center Including a Linear Accelerator and a CT	III	VA-03760
Virginia Oncology Associates	Establish a Cancer Care Center in Norfolk, Including a Linear Accelerator, a CT and Mobile PET	V	VA-03784
Sentara Healthcare	Establish a Cancer Care Center Including a Linear Accelerator, a CT, PET, in VA Beach	V	VA-03785
Riverside Regional Medical Center	Establish a Cancer Care Center Including 2 Linear Accelerator, a CT, in Newport News	V	VA-03786
Bon Secours DePaul Medical Center	Establish a Cancer Care Center Including a Linear Accelerator	V	VA-03787
Williamsburg Radiation Therapy Center	Addition of a Second Linear Accelerator	V	VA-03789
Mid-Rivers Cancer Center, L.L.C.	Establish a Specialized Center for Radiation Therapy Services	V	VA-03797
Virginia Oncology Associates	Establish a Cancer Care Center in Hampton, Including a Linear Accelerator, a CT and Mobile PET	V	Denied
Sentara Healthcare	Establish a Cancer Care Center Including a Linear Accelerator, a CT, MRI, PET, and Nuclear Medicine (Upper Peninsula)	V	Denied
Oncology and Hematology Associates of Southwest Virginia, Inc.	Establish a Cancer Care Center in Christiansburg, Including a Linear Accelerator, a CT and Mobile PET	III	Delayed
Montgomery Cancer Center, LLC	Establish a Specialized Center for Radiation Therapy Services	III	Delayed
The Center for Cancer Care of Virginia	Establish a Specialized Center for Radiation Therapy Services	III	Delayed
Princeton Community Hospital	Establish a Cancer Care Center Including a Linear Accelerator, MRI, CT and PET	III	Decision Pending
Breast and Cancer Care Consortium of the Virginias	Establish a Specialized Center for Radiation Therapy Services	III	Decision Pending
Virginia Oncology Associates	Establish a Cancer Care Center in Va Beach, Including a Linear Accelerator, a CT and Mobile PET	V	Withdrawn
Sentara Healthcare	Establish a Cancer Care Center Including a Linear Accelerator, a CT, MRI, PET, and Nuclear Medicine	V	Withdrawn
Sentara Healthcare	Establish a Cancer Care Center Including a Linear Accelerator, a CT, MRI, PET, and Nuclear Medicine (Lower Peninsula)	V	Withdrawn
Jain & Olmstead Partnership	Establish a Cancer Care Center Including a Linear Accelerator, CT, Mobile MRI, and Mobile PET	III	Withdrawn

As expected, there was a flurry of requests for COPNs for the services needed to develop comprehensive cancer care centers with the first review cycle that allowed the combined review. These requests were concentrated in Eastern Virginia where the most ardent proponents of the comprehensive center concept were located. Since the initial stream of COPN requests the submission of requests has been more in line with other project types.

Accessibility of Regulated Health Care Services by the Indigent

One of the 20 factors considered in the COPN process is whether the indigent have access to health care services. Applicants that have not demonstrated a historical commitment to charity care, consistent with other providers in their health service area, may have a "condition" to provide some level of charity care placed upon any COPNs they are awarded.

Beginning in June 2002, the DCOPN began recommending that the certificate language for the "conditioning" of COPNs be augmented to include the second type of condition allowed in the *Code*, namely that the applicant facilitate the development and operation of primary care for special populations. This added condition requirement allows an applicant a further opportunity for meeting the conditions placed on a COPN. Facilities that are unable to meet the conditioned requirement to provide service directly as charity care to the indigent can meet the obligation by supporting, including by direct monetary support, the development and operation of primary care through safety net providers such as the free clinics or community health centers. COPN holders opting to meet their condition obligation in this manner do so by making their contribution to the Virginia Association of Free Clinics, the Virginia Health Care Foundation, and/or the Virginia Primary Care Association, Inc., each of which has a memorandum of understanding with the Virginia Department of Health to distribute all such funds received. Since this option became available in March 2004 no COPN holder has availed themselves of this option. With the new language there should be no reason for a facility to not be able to satisfy the requirements of a conditioned COPN.

In March 2004 a Guidance Document was issued to provide direction for compliance with indigent care and primary care conditions on COPNs. This Guidance Document established a definition of indigent that includes individuals whose household income is at or below 200% of the Federal non-farm poverty level (prior practice had defined indigent as 100% of the Federal non-farm poverty level). It also provided a simplified mechanism for COPN holders to report compliance with conditions.

In FY 04 there were 44 COPNs issued with conditions to provide free or reduced rate care for indigent patients. All but two of these COPNs included the new primary care language. The table presented in Appendix H lists all COPNs issued with a condition for provision of free or reduced cost care for the indigent and those containing the new language that includes the development and operation of primary care for special populations.

Failure to comply with obligations accepted as conditions on the receipt of a COPN can have negative consequences for providers. There are provisions for fines, revocation of the COPN,

and conditioning the issuance or renewal of a facility license for failure to meet the obligations of the condition. The Guidance Document already discussed was developed, at least in part, to help providers meet their agreed upon conditions when, for a host of legitimate reasons, they could not meet the condition through the provision of the conditioned service.

Attachment I is a cumulative list of COPNs that were issued conditioned on the performance of a certain level of charity, indigent and/or primary care. There are 186 projects authorized with such conditions. Table 7 is a display of the types of facilities with conditions.

Table 7

Type of Facility	Number of Conditioned COPNs
General Hospitals	45
Health Care Systems	8
Outpatient Surgical Hospitals	13
Diagnostic Imaging Centers	26
Radiation Therapy / Cancer Treatment Centers	6

Source: DCOPN

In 2001 the wording used in writing conditions changed from requiring the COPN holder to report on compliance with the condition for three years to require a report annually for the life of the service. There are 120 COPNs with annual reporting requirements or with remaining time on the three-year reporting requirement. Just 48 of those projects have reported completion of construction or installation and are expected to report. For FY 2004 only 14 (29.2%) have reported and only 7 (14.6%) reported compliance. Non-reporting facilities are being contacted with reminders and those failing to meet their conditioned obligation are being reminded of the options in the Guidance Document.

Relevance of COPN to Quality of Care Rendered by Regulated Facilities

One of the features attributed to the COPN program is its goal of assuring quality by instituting volume thresholds. One study from the University of California at San Francisco concluded that there is scientific evidence supporting the contention that, for some procedures or diagnoses, higher hospital volume is associated with lower patient mortality. Other studies refute any correlation between COPN programs and quality of services rendered. However, there is little dispute about the relationship between quality and patient volume in open-heart surgery, cardiac catheterization and organ transplant services. By using COPN to limit the number of service providers, patient care is concentrated in centers where the service volume is maintained at a high level, which statistically allows for better patient outcomes.

Equipment Registration

The legislation defining the scope of this report requires an analysis of equipment registrations, including the type of equipment, whether the equipment is an addition or a replacement, and the equipment costs.

In FY04, there were seventeen equipment replacement registrations (Table 8) and thirteen to register capital expenditures in excess of $1 million (Table 9). All registered expenditures appeared to be appropriate to the mission of the facility and to the life cycle of the equipment being replaced.

Table 8 Equipment Registrations

Project Type	Number of Registrations	Capital Expenditure
Replace cardiac catheterization equipment	5	$6,064,948
Replace MRI Equipment	2	$3,744,376
Replace computed tomography equipment	8	$5,907,284
Replace linear accelerator	2	$5,378,683
TOTAL	17	$21,095,291

Table 9 Capital Expense Registrations

Project Type	Number of Registrations	Capital Expenditure
Hospital renovations	6	$13,903,782
Outpatient center renovations	1	$1,995,000
Nursing Home renovations	2	$3,646,667
Build a medical office building	1	$1,790,000
Build a parking structure	1	$4,483,686
Major software/computer upgrades	2	$8,266,150
TOTAL	13	$34,085,285

Appendix A

§ 32.1-102.12. Report required.

The Commissioner shall annually report to the Governor and the General Assembly on the status of Virginia's certificate of public need program. The report shall be issued by October 1 of each year and shall include, but need not be limited to:

1. A summary of the Commissioner's actions during the previous fiscal year pursuant to this article;

2. A five-year schedule for analysis of all project categories, which provides for analysis of at least three project categories per year;

3. An analysis of the appropriateness of continuing the certificate of public need program for at least three project categories in accordance with the five-year schedule for analysis of all project categories;

4. An analysis of the effectiveness of the application review procedures used by the health systems agencies and the Department required by § 32.1-102.6 which details the review time required during the past year for various project categories, the number of contested or opposed applications and the project categories of these contested or opposed projects, the number of applications upon which the health systems agencies have failed to act in accordance with the timelines of § 32.1-102.6 B, and the number of deemed approvals from the Department because of their failure to comply with the timelines required by § 32.1-102.6 E, and any other data determined by the Commissioner to be relevant to the efficient operation of the program;

5. An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates the need for the certificate of public need program;

6. An analysis of the accessibility by the indigent to care provided by the medical care facilities regulated pursuant to this article and the relevance of this article to such access;

7. An analysis of the relevance of this article to the quality of care provided by medical care facilities regulated pursuant to this article; and

8. An analysis of equipment registrations required pursuant to § 32.1-102.1:1, including the type of equipment, whether an addition or replacement, and the equipment costs.

(1997, c. 462; 1999, cc. 899, 922.)

Appendix B

12VAC5-220-10. Definitions.

"Medical care facility" means any institution, place, building, or agency, at a single site, whether or not licensed or required to be licensed by the board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or operated or owned or operated by a local governmental unit, (i) by or in which facilities are maintained, furnished, conducted, operated, or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical, or nursing attention or services as acute, chronic, convalescent, aged, physically disabled, or crippled or (ii) which is the recipient of reimbursements from third party health insurance programs or prepaid medical service plans. For purposes of this chapter, only the following medical care facility classifications shall be subject to review:

1. General hospitals.

2. Sanitariums.

3. Nursing homes.

4. Intermediate care facilities.

5. Extended care facilities.

6. Mental hospitals.

7. Mental retardation facilities.

8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, or such other specialty services as may be designated by the board by regulation.

10. Rehabilitation hospitals.

11. Any facility licensed as a hospital.

For purposes of this chapter, the following medical care facility classifications shall not be subject to review:

1. Any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

2. Any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive Plan.

3. Any physician's office, except that portion of the physician's office which is described in subdivision 9 of the definition of "medical care facility."

4. The Woodrow Wilson Rehabilitation Center of the Virginia Department of Rehabilitative Services.

"Project" means:

1. The establishment of a medical care facility. See definition of "medical care facility."

2. An increase in the total number of beds or operating rooms in an existing or authorized medical care facility.

3. Relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of 10% of its beds as nursing home beds as provided in §32.1-132 of the Code of Virginia.

4. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in §32.1-123 of the Code of Virginia.

5. The introduction into an existing medical care facility of any new cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care services, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, organ or tissue transplant service, radiation therapy, nuclear medicine imaging, psychiatric or substance abuse treatment, or such other specialty clinical services as may be designated by the board by regulation, which the facility has never provided or has not provided in the previous 12 months.

6. The conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds.

7. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the board by regulation, except for the replacement of any medical equipment identified in this part which the commissioner has determined to be an emergency in accordance with 12VAC5-220-150 or for which it has been determined that a certificate of public need has

been previously issued for replacement of the specific equipment according to 12VAC5-220-105.

8. Any capital expenditure of $5 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between $1 million and $5 million shall be registered with the commissioner.

Note that the General Assembly modified the definition of a medical care facility in the 2004 session to exclude, in addition to the 4 exclusions already listed;

(iii) an intermediate care facility for the mentally retarded that has no more than 12 beds and is in an area identified as in need of residential services for people with mental retardation in any plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

The additional language became effective July 1, 2004.

Appendix C

§ 32.1-102.3. Certificate required; criteria for determining need.

B. In determining whether a public need for a project has been demonstrated, the Commissioner shall consider:

1. The recommendation and the reasons therefor of the appropriate health planning agency.
2. The relationship of the project to the applicable health plans of the Board and the health planning agency.
3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.
4. The need that the population served or to be served by the project has for the project, including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.
5. The extent to which the project will be accessible to all residents of the area proposed to be served.
6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed, in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.
7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.
8. The immediate and long-term financial feasibility of the project.
9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.
10. The availability of resources for the project.
11. The organizational relationship of the project to necessary ancillary and support services.
12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.
13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

16. In the case of a construction project, the costs and benefits of the proposed construction.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

Note that the General Assembly modified the fifth criterion in the 2004 session to read;

5. The extent to which the project will be accessible to all residents of the area proposed to be served *and the effects on accessibility of any proposed relocation of an existing service of facility*.

The additional language (in italics) became effective July 1, 2004.

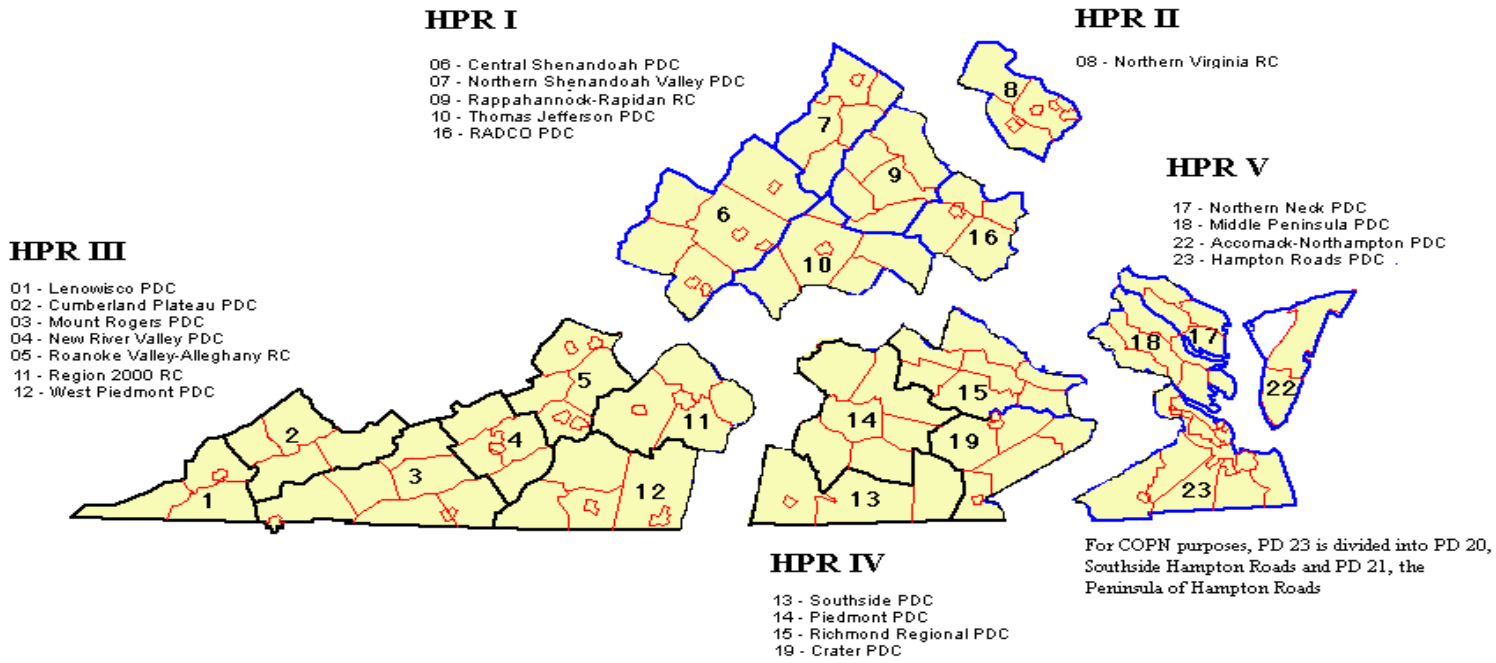
Appendix D

Authorized COPN Requests in Fiscal Year 2004

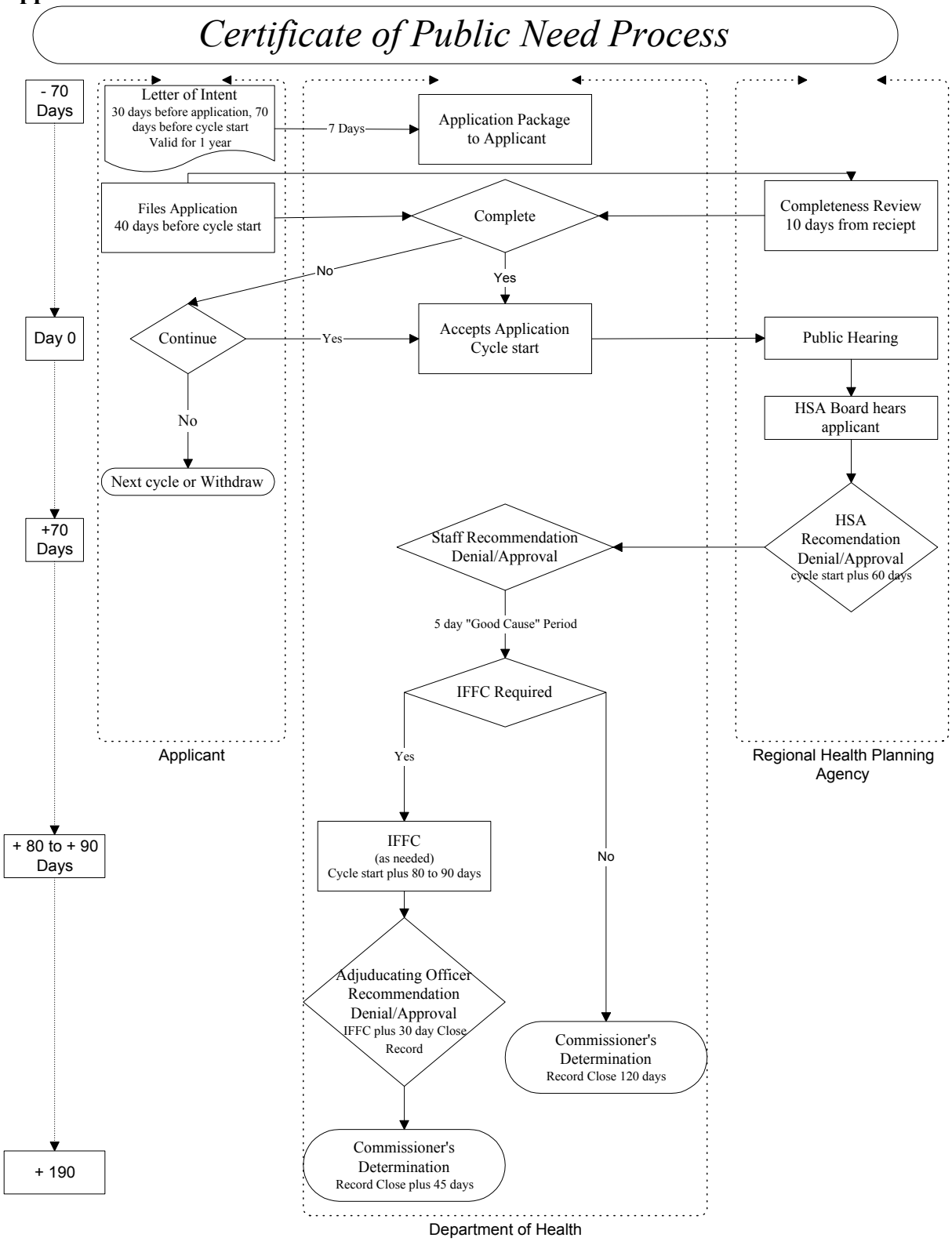
Project Categories	Number of Projects	Capital Costs
Batch Group A General hospitals, obstetrical services, neonatal special care services	9	
Subtotal		**$785,002,527**
Batch Group B Open heart surgery, cardiac catheterization, ambulatory surgery centers, operating room additions, transplant services	22	
Subtotal		**$49,792,987**
Batch Group C Psychiatric facilities, substance abuse treatment, mental retardation facilities	11	
Subtotal		**$5,165,241**
Batch Group D Diagnostic imaging	18	
Subtotal		**$31,344,501**
Batch Group E Medical rehabilitation	1	
Subtotal		**$100,000**
Batch Group F Gamma knife surgery, lithotripsy, radiation therapy, comprehensive cancer care centers	17	
Subtotal		**$69,777,159**
Batch Group G Nursing home beds, capital expenditures	11	
Subtotal		**$40,098,310**
COPN Program Total	**89**	**$981,180,725**

Appendix E

Virginia's Health Planning Regions
Virginia's Planning Districts



Appendix F


Certificate of Public Need Process
- 70 Days
Day 0
+70 Days
+ 80 to + 90 Days
+ 190
Letter of Intent
30 days before application, 70 days before cycle start
Valid for 1 year
7 Days
Application Package to Applicant
Files Application
40 days before cycle start
Complete
Completeness Review
10 days from reciept
No
Yes
Continue
Yes
Accepts Application
Cycle start
Public Hearing
No
Next cycle or Withdraw
HSA Board hears applicant
HSA Recomendation Denial/Approval
cycle start plus 60 days
Staff Recommendation Denial/Approval
5 day "Good Cause" Period
IFFC Required
Yes
No
IFFC
(as needed)
Cycle start plus 80 to 90 days
Adjuducating Officer Recommendation Denial/Approval
IFFC plus 30 day Close Record
Commissioner's Determination
Record Close 120 days
Commissioner's Determination
Record Close plus 45 days
Applicant
Regional Health Planning Agency
Department of Health

Appendix G

FIVE YEAR PROJECT CATEGORY GROUPING FOR ANNUAL REPORTS ON THE STATUS OF CERTIFICATE OF PUBLIC NEED

Eighth Annual Report - 2004

Group 3 Medical rehabilitation; long-term care hospital services, nursing home services and mental retardation facilities

- Establishment of a medical rehabilitation hospital
- Introduction by an existing medical care facility of any new medical rehabilitation service
- Conversion of beds in an existing medical care facility to medical rehabilitation beds
- Establishment of a long-term care hospital
- Establishment of a nursing home
- Establishment of an intermediate care facility
- Establishment of an extended care facility
- Introduction by an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided
- Establishment of a mental retardation facility

Ninth Annual Report - 2005

Group 4 Radiation therapy, lithotripsy, obstetrical services and neonatal special care

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of radiation therapy, including gamma knife surgery
- Introduction into an existing medical care facility of any new radiation therapy, including gamma knife surgery, service
- Addition or replacement by an existing medical care facility of equipment for the provision of radiation therapy, including gamma knife surgery
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of lithotripsy
- Introduction into an existing medical care facility of any new lithotripsy service
- Addition or replacement by an existing medical care facility of equipment for the provision of lithotripsy
- Establishment of an outpatient maternity hospital (non-general hospital birthing center)
- Introduction into an existing medical care facility of any new obstetrical service
- Introduction into an existing medical care facility of any new neonatal special care service

Tenth Annual Report – 2006

Group 5 Psychiatric services, substance abuse treatment services and miscellaneous capital expenditures

- Establishment of a sanitarium
- Establishment of a mental hospital
- Establishment of a psychiatric hospital
- Establishment of an intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts
- Introduction by an existing medical care facility of any new psychiatric service
- Introduction by an existing medical care facility of any new substance abuse treatment service
- Conversion of beds in an existing medical care facility to psychiatric beds
- Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of the definition of "project," by or in behalf of a medical care facility

Eleventh Annual Report - 2007

Group 1 General hospitals, general surgery, specialized cardiac services and organ and tissue transplantation

- Establishment of a general hospital
- Establishment of an outpatient surgical hospital or specialized center or clinic or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery
- An increase in the number of operating rooms in an existing medical care facility
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new cardiac catheterization service
- Addition or replacement by an existing medical care facility of equipment for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new open heart surgery service
- Addition or replacement by an existing medical care facility of equipment for the provision of open heart surgery
- Introduction into an existing medical care facility of any new organ or tissue transplantation service

Twelfth Annual Report – 2008

Group 2 Diagnostic Imaging

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of computed tomography (CT)
- Introduction by an existing medical care facility of any new CT service
- Addition or replacement by an existing medical care facility of CT equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic resonance imaging (MRI)
- Introduction by an existing medical care facility of any new MRI service
- Addition or replacement by an existing medical care facility of MRI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic source imaging (MSI)
- Introduction by an existing medical care facility of any new MSI service
- Addition or replacement by an existing medical care facility of MSI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of nuclear medicine imaging
- Introduction by an existing medical care facility of any new nuclear medicine imaging service
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of positron emission tomography (PET)
- Introduction by an existing medical care facility of any new PET service
- Addition or replacement by an existing medical care facility of PET equipment

Thirteenth Annual Report – 2009

Group 3 Medical Rehabilitation, long-term care hospital services, nursing home services and mental retardation facilities

- Establishment of a medical rehabilitation hospital
- Introduction by an existing medical care facility of any new medical rehabilitation service
- Conversion of beds in an existing medical care facility to medical rehabilitation beds
- Establishment of a long-term care hospital
- Establishment of a nursing home
- Establishment of an intermediate care facility
- Establishment of an extended care facility
- Introduction by an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided
- Establishment of a mental retardation facility

Project Categories Presented in the First Seven Years of Annual Reports (1997 – 2003)

First Annual Report – 1997

Group 1 General Hospitals, general surgery, specialized cardiac services and organ and tissue transplantation

- Establishment of a general hospital
- Establishment of an outpatient surgical hospital or specialized center or clinic or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery
- An increase in the number of operating rooms in an existing medical care facility
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new cardiac catheterization service
- Addition or replacement by an existing medical care facility of equipment for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new open heart surgery service
- Addition or replacement by an existing medical care facility of equipment for the provision of open heart surgery
- Introduction into an existing medical care facility of any new organ or tissue transplantation service

Second Annual Report – 1998

Group 2 Diagnostic Imaging

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of computed tomography (CT)
- Introduction by an existing medical care facility of any new CT service
- Addition or replacement by an existing medical care facility of CT equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic resonance imaging (MRI)
- Introduction by an existing medical care facility of any new MRI service
- Addition or replacement by an existing medical care facility of MRI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic source imaging (MSI)
- Introduction by an existing medical care facility of any new MSI service
- Addition or replacement by an existing medical care facility of MSI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of nuclear medicine imaging
- Introduction by an existing medical care facility of any new nuclear medicine imaging service
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of positron emission tomography (PET)
- Introduction by an existing medical care facility of any new PET service
- Addition or replacement by an existing medical care facility of PET equipment

Third Annual Report – 1999

Group 3 Medical Rehabilitation, long-term care hospital services, nursing home services and mental retardation facilities

- Establishment of a medical rehabilitation hospital
- Introduction by an existing medical care facility of any new medical rehabilitation service
- Conversion of beds in an existing medical care facility to medical rehabilitation beds
- Establishment of a long-term care hospital
- Establishment of a nursing home
- Establishment of an intermediate care facility
- Establishment of an extended care facility
- Introduction by an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided
- Establishment of a mental retardation facility

Fourth Annual Report – 2000

Group 4 Radiation therapy, lithotripsy, obstetrical services and neonatal special care

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of radiation therapy, including gamma knife surgery
- Introduction into an existing medical care facility of any new radiation therapy, including gamma knife surgery, service
- Addition or replacement by an existing medical care facility of equipment for the provision of radiation therapy, including gamma knife surgery
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of lithotripsy
- Introduction into an existing medical care facility of any new lithotripsy service
- Addition or replacement by an existing medical care facility of equipment for the provision of lithotripsy
- Establishment of an outpatient maternity hospital (non-general hospital birthing center)
- Introduction into an existing medical care facility of any new obstetrical service
- Introduction into an existing medical care facility of any new neonatal special care service

Fifth Annual Report - 2001

Group 5 Psychiatric services, substance abuse treatment services and miscellaneous capital expenditures

- Establishment of a sanitarium
- Establishment of a mental hospital
- Establishment of a psychiatric hospital
- Establishment of an intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts
- Introduction by an existing medical care facility of any new psychiatric service
- Introduction by an existing medical care facility of any new substance abuse treatment service
- Conversion of beds in an existing medical care facility to psychiatric beds
- Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of the definition of "project," by or in behalf of a medical care facility

Sixth Annual Report - 2002

Group 1 General hospitals, general surgery, specialized cardiac services and organ and tissue transplantation

- Establishment of a general hospital
- Establishment of an outpatient surgical hospital or specialized center or clinic or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery
- An increase in the number of operating rooms in an existing medical care facility
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new cardiac catheterization service
- Addition or replacement by an existing medical care facility of equipment for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new open heart surgery service
- Addition or replacement by an existing medical care facility of equipment for the provision of open heart surgery
- Introduction into an existing medical care facility of any new organ or tissue transplantation service

Seventh Annual Report - 2003

Group 2 Diagnostic Imaging

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of computed tomography (CT)
- Introduction by an existing medical care facility of any new CT service
- Addition or replacement by an existing medical care facility of CT equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic resonance imaging (MRI)
- Introduction by an existing medical care facility of any new MRI service
- Addition or replacement by an existing medical care facility of MRI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic source imaging (MSI)
- Introduction by an existing medical care facility of any new MSI service
- Addition or replacement by an existing medical care facility of MSI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of nuclear medicine imaging.
- Introduction by an existing medical care facility of any new nuclear medicine imaging service
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of positron emission tomography (PET)
- Introduction by an existing medical care facility of any new PET service
- Addition or replacement by an existing medical care facility of PET equipment

Appendix H

FY 2004 Certificates of Public Need Issued With Conditions Requiring the Provision of Indigent Care and/or the Development and/or Operation of Primary Care For Underserved Populations

COPN #	Applicant/Project Location	Batch	Project	Conditions
VA- 03741	Riverside Behavioral Center dba Peninsula Behavioral Center	C	Transfer 60 Psychiatric Beds from Riverside Regional Medical Center	1.8% charity care
VA- 03744	Loudoun Hospital Center	C	Addition of Psychiatric Beds	1.4% charity / primary care
VA- 03748	Buford Road Imaging, L.L.C.	D	Introduce CT Services into an Existing Medical Care Facility	1.6% indigent / primary care
VA- 03749	Urosurgical Center of Richmond - South	D	Establish a Specialized Center for CT Services	1.7% indigent / primary care
VA- 03751	Fairfax Radiology Consultants, P.C.	D	Introduce CT Services into an Existing Medical Care Facility	1.9% indigent / primary care
VA- 03754	Riverside Regional Medical Center	A	Capital Expenditure of More Than $5 Million	1.8% charity / primary care
VA- 03757	Carilion New River Valley Medical Center	B	Establish an OSH with 3 ORs & 1 Minor Procedure Room	1.9% charity / primary care
VA- 03759	Falls Church Lithotripsy, L.L.C.	F	Add 3 Sites (podiatric) for Mobile Lithotripter (ortho)	1.8% charity / indigent care
VA- 03765	Lee Regional Medical Center	B	Introduce Cardiac Catheterization Services	1.6% indigent / primary care
VA- 03768	Bon Secours St. Mary's Hospital and a To-Be-Established LLC	B	Establish an Outpatient Surgical Hospital	1.6% indigent / primary care
VA- 03778	Alleghany Regional Hospital	D	Replace Mobile MRI with a Fixed MRI Unit	1.6% indigent / primary care
VA- 03779	The Center for Advanced Imaging	D	Addition of 1 CT Scanner	1.6% indigent / primary care
VA- 03782	MRI of Reston, L.P.	D	Addition of a 4th MRI Scanner	1.9% indigent / primary care
VA- 03783	Inova Health System	D	Add a 4th MRI at Inova Fairfax Hospital MRI Cntr	1.9% indigent / primary care
VA- 03784	Virginia Oncology Associates	F	Establish a Cancer Care Center in Norfolk, Including a Linear Accelerator, a CT and Mobile PET	1.8% indigent / primary care
VA- 03785	Sentara Healthcare	F	Establish a Cancer Care Center Including a Linear Accelerator, a CT, PET, in VA Beach	1.8% indigent / primary care
VA- 03786	Riverside Regional Medical Center	F	Establish a Cancer Care Center Including 2 Linear Accelerator, a CT, in Newport News	1.8% indigent / primary care
VA- 03788	Chesapeake General Hospital	F	Addition of a Second Linear Accelerator	1.8% indigent / primary care
VA- 03789	Williamsburg Radiation Therapy Center, Inc.	F	Addition of a Second Linear Accelerator	1.8% indigent / primary care

VA-	03790	Sentara Leigh Hospital	D	Establish a Specialized Center for CT Imaging (Mobile Site)	1.8% indigent / primary care
VA-	03791	Bon Secours St. Mary's Hospital	B	Addition of a 4th Cardiac Catheterization Laboratory	1.6% indigent / primary care
VA-	03792	Henrico Doctors' Hospital-Forrest	B	Addition of a 4th Cardiac Catheterization Laboratory	1.6% indigent / primary care
VA-	03793	Northern Virginia Community Hospital, LLC	A	Establish a 164-Bed General Acute Care Hospital with New OB Service	1.37% indigent / primary care
VA-	03797	Mid-Rivers Cancer Center, L.L.C.	F	Establish a Specialized Center for Radiation Therapy Services	1.8% indigent / primary care
VA-	03798	Bon Secours Mary Immaculate Hospital	F	Introduce Lithotripsy Services	1.8% indigent / primary care
VA-	03799	Falls Church Lithotripsy, L.L.C.	F	Establish Multiple Mobile Orthopedic Lithotripter Sites	1.8% indigent / primary care
VA-	03800	Falls Church Lithotripsy, L.L.C.	F	Establish Multiple Mobile Orthopedic Lithotripter Sites	1.8% indigent / primary care
VA-	03801	Inova Health System	F	Introduce Lithotripsy Services at the Franconia-Springfield Healthplex	2.5% indigent / primary care
VA-	03805	Children's Hospital of The King's Daughters	B	Establish an Outpatient Surgical Hospital	charity care
VA-	03806	Sentara CarePlex	B	Relocation of an Outpatient Surgical Hospital	1.8% indigent / primary care
VA-	03807	Bon Secours Mary Immaculate Hospital	B	Establish an Outpatient Surgical Hospital	1.8% indigent / primary care
VA-	03808	Hampton Roads Orthopaedics & Sports Medicine	D	Establish a Specialized Center for MRI Imaging	3.6% indigent / primary care
VA-	03811	Loudoun Hospital Center	A	Add Intensive Care Beds at Lansdowne Campus	2.5% indigent / primary care
VA-	03815	R Joy LLC and R Joy II LLC (Eye Surgery Limited and/or Beach Surgicenter for Eyes)	B	Establish an Outpatient Surgical Hospital	2.0% indigent / primary care
VA-	03816	Chesapeake General Hospital	B	Establish an Outpatient Surgical Hospital	1.8% indigent / primary care
VA-	03820	Norton Community Hospital	B	Introduce Cardiac Catheterization Services, Mobile Site	1.8% indigent / primary care
VA-	03821	Winchester Medical Center	B	Addition of a Cardiac Catheterization Laboratory	3.8% indigent / primary care
VA-	03823	Virginia Eye Consultants, Inc.	B	Establish an Outpatient Surgical Hospital	2.2% indigent / primary care
VA-	03824	Rockingham Memorial Hospital	B	Addition of a Cardiac Catheterization Laboratory	2.7% indigent / primary care
VA-	03825	Memorial Hospital of Martinsville and Henry County	E	Convert up to 20 Med/Surg Beds to Medical Rehabilitation (15 beds approved)	2.0% indigent / primary care
VA-	03826	Medical Imaging of Fredericksburg, LLC	D	Introduce PET/CT Hybrid Services and Addition of MRI Equipment	1.1% indigent / primary care

VA-	03828	Commonwealth Radiology, P.C.	D	Establish a Specialized Center for CT and MRI Imaging	1.6% indigent / primary care
VA-	03829	Richmond West End Diagnostic Imaging, L.L.C.	D	Relocate and Add one MRI to an Existing Service	2.0% indigent / primary care
VA-	03830	Virginia Cancer Institute, Inc.	D	Introduce CT Services	1.6% indigent / primary care

Appendix I

Cummulative List of COPNs Issued With Indigent Care and/or Primary Care Conditions

Applicant/Project Location	Project	PD	COPN #	Decision Date	Conditions	Report on Condition?	Condition Met?
Lucy Corr Nursing Home	Replace Nursing Home & Add 30 N.H. Beds	15	VA- 03085	1/6/1993	Subsidize charity care	N/A	
The Retreat Hospital	Establish an Outpatient Surgical Hospital	15	VA- 03088	1/25/1993	2.0% charity care	N/A	
Urosurgical Center of Richmond	Establish an Outpatient Surgical Hospital	15	VA- 03090	2/22/1993	2.0% charity care	N/A	
Lewis-Gale Medical Center	Replacement of a CT Scanner	5	VA- 03184	8/18/1994	1.3% charity care	N/A	
Culpeper Hospital and Fauquier Hospital	Replacement MRI	9	VA- 03221	3/28/1995	1.8% charity care	N/A	
Lewis-Gale Hospital	Replace Radiation Therapy Equipment	5	VA- 03245	10/6/1995	charity care at the median, indigent policy, reporting	N/A	
Royal Medical Health Services	Replace MRI unit		VA- 03252	11/8/1995	1.22% charity care	N/A	
Columbia/HCA Retreat Hospital	Replacement of a CT Scanner	15	VA- 03272	4/16/1996	1.2% charity care	N/A	
UVA/HEALTHSOUTH L.L.C.	Establish 50-bed freestdg. med. rehab. hosp.	10	VA- 03277	5/17/1996	Care to all pts	N/A	
Johnston-Willis Hospital	Convert 20 med/surg beds to 10 med rehab beds	15	VA- 03279	5/24/1996	1 med rehab bed set aside for charity care	N/A	
McGuire Medical Group (now Virginia Physicians, Inc.)	Replacement CT	15	VA- 03283	6/3/1996	1.0% charity	N/A	
Comm. Mem. Healthcenter	Introduce eswl. services thru contract	13	VA- 03303	9/5/1996	3.0% charity care	N/A	
Russell County Medical Center	Provide lithotripsy services	2	VA- 03310	11/22/1996	1.8% charity care	N/A	
Martha Jefferson Hospital	Establish Cardiac Catheterization Service	10	VA- 03330	3/8/1997	charity care without regard for ability to pay	N/A	
Center for Heart and Vascular Studies	Establishment of a Medical Care Facility for Provision of SPECT	20	VA- 03331	3/21/1997	2.0% charity care	N/A	
Sentara Leigh Hospital	Replace MRI Equipment	20	VA- 03342	6/5/1997	2.0% charity care	N/A	
SMT Mobile X Corporation	Add Magnetic Resonance Imaging Equipment		VA- 03346	7/28/1997	Various % indigent care based on location	N/A	
Chesterfield Community Healthcare Center, Inc. d/b/a Ironbridge Medical Park ASC	Establish an Outpatient Surgical Hospital	15	VA- 03354	8/27/1997	2.3% charity care	N/A	
Dickenson County Med. Ctr.	Replace Computed Tomography (CT)	2	VA- 03358	9/18/1997	1.9% charity care	N/A	
MRI & CT Diagnostics	Replacement of MRI Equipment	20	VA- 03356	9/25/1997	2.0% charity care	N/A	
Columbia Henrico Doctors' Hosp.	Replacement of Computed Tomography (CT)	15	VA- 03360	9/30/1997	1.7% charity care	N/A	
Columbia Lewis-Gale Medical Center	Replace Cardiac Catheterization Equipment & Construction of New Cath Lab	5	VA- 03375	1/20/1998	1.93% charity care	N/A	
Sentara Leigh Hospital	Replacement of a cardiac catheterization laboratory	20	VA- 03378	2/18/1998	1.7% charity care	N/A	
Children's Hospital of the Kings Daughters	Introduce MRI Services	20	VA- 03389	4/8/1998	1.7% charity care	N/A	
Rockingham Memorial Hospital	Replacement of MRI Equipment	6	VA- 03400	6/30/1998	1.8% charity care	N/A	
						N/A	
SMT Mobile X Corporation	Addition of MRI Equipment at Memorial Hospital, Martinsville & Henry County	12	VA- 03408	9/14/1998	2.0% charity care,	N/A	

Columbia Retreat Hospital & John Randolph Medical Center	Replace mobile Cardiac Catheterization equipment	15/19	VA-	03422	1/6/1999	1.7% charity care @ 200% of poverty level	N/A	
Williamsburg Community Hospital	Replace CT Equipment	21	VA-	03421	1/8/1999	1.2% charity care	N/A	
Sentara Leigh Hospital	Add CT Equipment		VA-	03435	4/8/1999	1.3% charity care	N/A	
Covenant Woods/Richmond Home for Ladies	Establish a Nursing Home in Hanover County	15	VA-	03437	4/19/1999	Assistance subsidy of at least $230,000 annually	N/A	
Surgi Center of Central Virginia	Add OR	15	VA-	03454	7/23/1999	2.0% charity care from surgical services	N/A	
IMI of Arlington	Establish a Facility for MRI	8	VA-	03456	8/13/1999	1.9% indigent care	N/A	
Prince William Hospital	Add CT Equipment	8	VA-	03458	8/16/1999	1.9% charity care	N/A	
Guild Lithotripsy	Establish Mobile Lithotripsy Services	15	VA-	03473	11/2/1999	Contract clause for 21.1% charity care	N/A	
Williamsburg Community Hospital	Establish a Specialized Center for CT Services	21	VA-	03469	11/8/1999	1.2% charity care	N/A	
HCA Health Services of Virginia, Inc, d/b/a Reston Hospital Center	Capital Expenditure for Hospital Renovation & Expansion	8	VA-	03470	11/10/1999	indigent care	N/A	
Inova Franconia Springfield Medical Center	Introduce CT services	8	VA-	03497	2/3/2000	1.2% charity care	No	
Sentara Virginia Beach General Hospital	Establish a facility for nuclear medicine imaging	20	VA-	03488	2/4/2000	2.0% charity care	No	
Management Services d/b/a Positron Emission Tomography Institute of Hampton Roads, LLC	Establish a Facility for PET	20	VA-	03490	2/9/2000	1.4% charity care	No	
Bon Secours DePaul Medical Center	Establish a Facility for CT in Virginia Beach	20	VA-	03500	2/9/2000	1.4% charity care	No	
Augusta Medical Center	Introduce Positron Coincidence Detection Imaging, PCD	6	VA-	03502	2/9/2000	1.8% charity care	No	
Chesapeake General Hospital	Add CT	20	VA-	03504	2/9/2000	1.4% charity care	No	
Sentara Healthcare	Add mobile CT for use at Sentara Leigh Hospital	20	VA-	03507	2/9/2000	1.4% charity care	No	
Sentara Healthcare	Establish a Facility for CT in Newport News	21	VA-	03508	2/9/2000	1.4% charity care	No	
Chippenham & Johnston-Willis Hospitals, Inc	Add a 5th Cardiac Catheterization Lab	15	VA-	03524	6/8/2000	0.9% charity care rate for caths for 3 yrs	No	
Greensville Memorial Hospital	Replacement facility	19	VA-	03527	6/12/2000	2.1% charity care	No	
MRI of Reston	Add MRI Equipment	8	VA-	03536	8/8/2000	1.2% charity care	No	
Chippenham & Johnston-Willis Hospitals, Inc	Add CT Equipment at Johnston-Willis Hospital	15	VA-	03532	8/9/2000	0.9% charity care	No	
Johnston Willis Hospital	Add CT Equipment	15	VA-	03532	8/9/2000	0.9% indigent care	No	
Sentara Healthcare	Introduce MRI at Sentara Bayside Hospital	20	VA-	03534	8/9/2000	1.4% charity care	No	
Chippenham & Johnston-Willis Hospitals, Inc	Capital expenditure at Johnston-Willis Hospital	15	VA-	03545	11/30/2000	0.9% indigent care	No	
Chippenham & Johnston-Willis Hospitals, Inc	Capital expenditure for Chippenham Medical Center	15	VA-	03546	11/30/2000	0.9% indigent care	No	
Martha Jefferson Hospital	Establish an Outpatient Surgical Hospital	10	VA-	03549	1/8/2001	2.0% charity care	No	
Winchester Medical Center	Addition of a CT Scanner	7	VA-	03551	2/9/2001	2.0% charity care	No	
Riverside Regional Medical Center	Capital expenditure for trauma services facility	21	VA-	03559	3/12/2001	1.2% charity care	No	
Loudoun Hospital Center	Add CT Equipment at Lansdowne Campus	8	VA-	03564	3/27/2001	2.3% charity care	No	
Columbia Healthcare of Southwest Virginia	Introduce Mobile PET services at 5 hospitals	III	VA-	03576	5/11/2001	1.4% charity care	No	
Bon Secours Hampton Roads	Capital Expenditure in Excess of $5 million to Expand and Renovate Mary Immaculate Hospital	21	VA-	03570	5/15/2001	1.2% charity care	No	

Southampton Memorial Hospital	Capital Expenditure in Excess of $5 million to Expand and Renovate the Hospital	20	VA-	03571	5/15/2001	1.2% charity care	No	
Loudoun Hospital Center	Introduce MRI Services at the Lansdowne Campus	8	VA-	03583	6/25/2001	1.9% charity care	No	
Fairfax Radiology Centers	Add CT Equipment	8	VA-	03592	8/16/2001	1.9% charity care	No	
Martha Jefferson Hospital	Introduce Mobile PET	10	VA-	03593	8/16/2001	1.8% charity care	No	
Riverside Radiation Therapy Centers, LLC	Establish a Specialized Center for Radiation Therapy Services	18	VA-	03599	10/15/2001	1.2% charity care	No	
Augusta Medical Center	Establish a Radiation Therapy Service	6	VA-	03613	12/3/2001	1.6% charity care	No	
Norton Community Hospital	Capital Expenditure of $5M or More to for Renovation and Expansion	1	VA-	03607	12/6/2001	1.4% charity care	No	
Fairfax Surgery Center	On-site Replacement of a Medical Care Facility	8	VA-	03615	12/20/2001	Sliding scale charity care	No	
St. Mary's Hospital of Richmond, now Bon Secours St. Mary's Hospital	Addition of a Third Cardiac Catheterization Laboratory	15	VA-	03309	10/30/1996	1.7% charity care	Yes	No
St. Mary's Hospital of Richmond, now Bon Secours St. Mary's Hospital	Replace SPECT Equipment	15	VA-	03315	12/21/1996	1.7% charity care	Yes	No
HEALTHSOUTH Medical Center	Replacement of CT System	15	VA-	03335	4/17/1997	1.7% charity care	Yes	No
Community Memorial HealthCenter	Replacement of Computed Tomography Equipment	13	VA-	03349	8/29/1997	2.7% charity care	Yes	Yes
Bon Secours St. Mary's Hospital	Increase in Total Operationg Rooms	15	VA-	03424	2/3/1999	1.0% charity care	Yes	No
Hospital Authority of the City of Petersburg, Southside Regional Medical Center	Introduce MRI Services	19	VA-	03428	3/2/1999	1.7% charity care	Yes	No
Bathe County	Add CT Equipment	6	VA-	03461	8/25/1999	2.0% charity care	Yes	Yes
Richmond Medical Commons, LLC	Establish an Outpatient Surgical Hospital (Replace Richmond Eye & Ear Hospital)	15	VA-	03472	11/5/1999	2.3% charity care	Yes	No
The Surgery Center of Lynchburg	Establish an Outpatient Surgical Hospital w/3 ORs	11	VA-	03509	2/9/2000	3.0% charity care	Yes	Yes
Martha Jefferson Hospital	Add CT Equipment	10	VA-	03537	8/9/2000	2.0% charity care	Yes	Yes
Martha Jefferson Hospital	Add a MRI Unit	10	VA-	03598	10/15/2001	1.6%charity care	Yes	Yes
First Hospital Corporation of Virginia Beach	Add 10 Psychiatric Beds	20	VA-	03621	1/14/2002	1.2% charity care	No	
Central Virginia Hospital, LLC	Add Psychiatric Beds at Henrico Doctors Hospital	15	VA-	03622	1/11/2002	29 days/month free care	No	
Chippenham & Johnston-Willis Hospitals	Capital Expenditure of $5M or More to Construct a Specialized Center and Introduce Gamma Knife Services	15	VA-	03629	1/8/2002	0.8% outpatient services, 1.5% Gamma Knife	No	
Danville Regional Medical Center	Addition of 3 ORs	12	VA-	03632	1/30/2002	free or reduce to 200%	No	
First Meridian Medical Corporation t/a MRI and CT Diagnostics	Addition of Magnetic Resonance Imaging Equipment	20	VA-	03633	2/12/2002	1.3% charity care	No	
Sentara Healthcare	Addition of MRI Equipment at Sentara Leigh Hospital	20	VA-	03634	2/12/2002	1.3% charity care	No	
Rockingham Memorial Hospital	Addition of a 2nd MRI	6	VA-	03636	2/12/2002	1.3% charity care	No	
Centra Health	Addition of MRI Equipment at Lynchburg General Hospital	11	VA-	03637	2/12/2002	1.4% charity care	Yes	Yes
MRI of Reston LP	Add Magnetic Resonance Imaging Equipment	8	VA-	03639	2/12/2002	1.9% charity care	No	
Reston Hospital Center	Add Computed Tomography Equipment at Reston Hospital Center Campus	8	VA-	03640	2/12/2002	1.9% charity care	No	

Potomac Hospital Corporation of Prince William	Add CT Equipment at Potomac Hospital Campus	8	VA-	03641	2/12/2002	1.9% charity care	No	
Virginia Commonwealth University Health System Authority	Addition of 4 ORs	15	VA-	03644	2/7/2002	2.0% charity care	No	
Bon Secours Memorial Regional Medical Center & Memorial Ambulatory Surgical Center, LLC	Establish an Outpatient Surgical Hospital w/ 6 ORs	15	VA-	03645	2/7/2002	Provide care w/o regard to ability to pay	No	
Loudoun Hospital Center	Add 23 beds	8	VA-	03647	2/26/2002	Charity care - sliding scale 125%-250% FPL	No	
Loudoun Healthcare	Add 8 ORs	8	VA-	03648	2/26/2002	Charity care - sliding scale 125%-250% FPL	No	
Northern Virginia Surgery Center, LLC	Establish an Outpatient Surgical Hospital	8	VA-	03651	2/26/2002	Inova's charity care - sliding scale - 125%-250% FPL	No	
Surgical Care Affiliates, Inc., now Regional Surgical Services, LLC	Establish an Outpatient Surgical Hospital	2	VA-	03652	2/28/2002	3.0% charity care	No	
Lewis-Gale Medical Center	Addition of Radiation Therapy Equipment	5	VA-	03656	4/15/2002	1.36% charity care	No	
Inova Health System	Introduce Mobile Lithotripsy	8	VA-	03657	4/12/2002	Fair Oaks & vendor provide 1.4% charity care	No	
CDL Medical Technologies, Inc	Establish a Mobile Positron Emission Tomography Imaging Service	I	VA-	03660	4/12/2002	1.2% charity care	No	
Virginia Imaging, LLC	Establish a Specialized Center for Computed Tomography Imaging Services	15	VA-	03664	4/17/2002	2.0% charity care	No	
Pulaski Community Hospital	Capital Expenditure of More Than $5 Million	4	VA-	03667	5/24/2002	1.4% charity care	No	
Prince William Hospital	Capital Expenditure of More Than $5 Million	8	VA-	03670	6/10/2002	1.4% charity / primary care	No	
Williamsburg Community Hospital	Add 1 OR	21	VA-	03671	6/15/2002	1.7% charity / primary care	No	
Bon Secours St. Mary's Hospital	Add 6 ORs	15	VA-	03673	6/15/2002	2.1% charity / primary care	No	
Roanoke Ambulatory Surgery Center, LLC	Establish a 3 General OR Outpatient Surgical Hospital	5	VA-	03674	6/12/2002	1.5% charity / primary care	No	
Roanoke Cardiac Catheterization Center, LLC now Carilion Roanoke Memorial Hospital	Establish a Specialized Center for Cardiac Catheterization	5	VA-	03675	6/12/2002	1.5% charity / primary care	No	
Danville Regional Medical Center	Introduce Positron Emission Tomography Imaging Services Through a Mobile Provider	III	VA-	03680	8/15/2002	1.5% charity / primary care	No	
Medical Imaging of Fredericksburg, LLC	Addition of a second MRI Scanner	16	VA-	03681	8/15/2002	2.2% charity / primary care	No	
Mary Washington Hospital	Addition of 2 CT Scanners	16	VA-	03682	8/15/2002	2.2% charity / primary care	No	
Pratt Medical Center	Addition of a MRI Scanner and a CT Scanner at an Outpatient Diagnostic Center	16	VA-	03683	8/15/2002	2.2% charity / primary care	No	
Inova Health System	Addition of an MRI Scanner	8	VA-	03684	8/13/2002	1.4% charity / primary care	No	
Virginia Hospital Center Arlington Health System	Addition of a 2nd MRI	8	VA-	03685	8/13/2002	1.4% charity / primary care	No	
Loudoun Hospital Center	Addition of a CT Scanner	8	VA-	03686	8/13/2002	1.4% charity / primary care	No	
Winchester Radiologists, PC, Winchester Open MRI, LLC	Addition of Computed Tomography Imaging Equipment	7	VA-	03688	8/14/2002	2.0% charity / primary care	No	

University of Virginia Health System	Establish a Specialized Center for MRI (2 MRI Scanners) and CT (2 CT Scanners) Services	10	VA-	03689	8/16/2002	8.3% charity / primary care	Yes	No
Falls Church Lithotripsy	Addition of Mobile Lithotripsy Equipment	8	VA-	03695	10/15/2002	Indigent / primary care - diff % in each HPR	No	
Prince William Hospital and Fauquier Hospital	Establish a Specialized Center for Radiation Therapy Services	8	VA-	03697	10/18/2002	1.4% indigent / primary care	No	
Loudoun Hospital Center	Introduction of Radiation Therapy into an Existing Medical Care Facility	8	VA-	03698	10/18/2002	1.4% indigent / primary care	No	
Bon Secours Virginia HealthSource, Inc.	Establish a Specialized Center for Radiation Therapy Services	15	VA-	03699	10/28/2002	1.7% indigent / primary care	No	
Lewis-Gale Medical Center, LLC	Addition of a second MRI Scanner	5	VA-	03700	10/8/2002	1.5% indigent care	No	
Southwest Virginia Regional Open MRI Center	Establish a Specialized Center for MRI Services	5	VA-	03701	10/8/2002	2.0% indigent care	No	
Lewis-Gale Medical Center	Capital Expenditure of More Than $5 Million	5	VA-	03704	11/8/2002	1.4% charity / primary care	No	
Williamsburg Community Hospital	Establish a General Hospital	21	VA-	03706	11/15/2002	1.8% charity / primary care	No	
Potomac Hospital	Add 30 Acute Care Beds	8	VA-	03708	11/14/2002	1.4%charity / primary care	No	
The Urosurgical Center of Richmond	Establish an Outpatient Surgical Hospital	15	VA-	03709	12/18/2002	1.7% charity / primary care	No	
Bon Secours Richmond Health System	Add 4 ORs at St. Francis Medical Center	15	VA-	03710	12/18/2002	1.7% charity / primary care	No	
Bon Secours Richmond Health System, Bon Secours St. Francis Medical Center	Establish a 130 bed acute care hospital, replace Bon Secours Sturat Circle Hosptial	15	VA-	03713	1/28/2003	3.0% charity care	No	
Warren Memorial Hospital	Introduce Mobile MRI Services	7	VA-	03715	2/14/2003	1.9% charity / indigent care	No	
Halifax Regional Hospital, Inc.	Introduce Mobile PET Services	IV	VA-	03716	2/15/2003	1.6% charity / indigent care	Yes	Yes
Community Radiology of Virginia, Inc.	Introduce Positron Emission Tomography Imaging Services Through a Mobile Provider	III	VA-	03717	2/11/2003	5.0% charity / indigent care	No	
Sentara Bayside Hospital	Addition of a Second CT Scanner	20	VA-	03718	2/11/2003	1.8% charity / indigent care	No	
Chesapeake General Hospital	Addition of Second Cardiac Catheterization Lab	20	VA-	03724	3/19/2003	1.8% charity / primary care	No	
Culpeper Regional Hospital	Introduce Mobile Lithotripsy Services (renal)	9	VA-	03725	4/15/2003	1.9% indigent / primary care	No	
Sentara Healthcare	Establish Mobile Lithotripsy Services (renal)	V	VA-	03726	4/16/2003	1.8% charity / primary care	No	
Memorial Hospital of Martinsville and Henry County	Establish a 4-OR Outpatient Surgical Hospital	12	VA-	03727	4/9/2003	1.7% charity / primary care	No	
Winchester Medical Center	Capital Expenditure of More Than $5 Million	7	VA-	03730	5/15/2003	1.9% charity / primary care	No	
Henrico Doctors' Hospital-Parham	Capital Expenditure of More Than $5 Million	15	VA-	03731	5/20/2003	1.6% charity / primary care	No	
Sentara Healthcare (VA Beach Gen.)	Capital Expenditure of More Than $5 Million	20	VA-	03732	5/19/2003	1.8% charity / primary care	No	
Riverside Regional Medical Center	Establish Fixed CT Services and Introduce Mobile MRI Services at an Existing Medical Care Facility	21	VA-	03733	5/27/2003	1.8% indigent / primary care	No	
Williamsburg Community Hospital	Introduce MRI Services into an Existing Medical Care Facility	21	VA-	03734	5/27/2003	1.8% indigent / primary care	No	
Williamsburg Community Hospital	Introduce CT Services into an Existing Medical Care Facility	21	VA-	03735	5/27/2003	1.8% indigent / primary care	No	
Lewis-Gale Medical Center	Addition of Cardiac Catheterization Equipment	5	VA-	03736	6/15/2003	1.6% charity / primary care	No	
Roanoke Valley Center for Sight, L.L.C.	Addition of 1 General Operating Room	5	VA-	03737	6/15/2003	1.6% charity / indigent care	No	

Bon Secours Memorial Regional Medical Center	Addition of 3rd Cardiac Catheterization Laboratory	15	VA-	03738	6/16/2003	1.6% charity / indigent care	No	
Riverside Behavioral Center dba Peninsula Behavioral Center	Transfer 60 Psychiatric Beds from Riverside Regional Medical Center	21	VA-	03741	7/21/2003	1.8% charity care	No	
Loudoun Hospital Center	Addition of Psychiatric Beds	8	VA-	03744	7/18/2003	1.4% charity / primary care	No	
Buford Road Imaging, L.L.C.	Introduce CT Services into an Existing Medical Care Facility	15	VA-	03748	8/15/2003	1.6% indigent / primary care	No	
Urosurgical Center of Richmond - South	Establish a Specialized Center for CT Services	15	VA-	03749	8/15/2003	1.7% indigent / primary care	No	
Fairfax Radiology Consultants, P.C.	Introduce CT Services into an Existing Medical Care Facility	8	VA-	03751	8/15/2003	1.9% indigent / primary care	No	
Riverside Regional Medical Center	Capital Expenditure of More Than $5 Million	21	VA-	03754	8/8/2003	1.8% charity / primary care	No	
Carilion New River Valley Medical Center	Establsih an OSH with 3 ORs & 1 Minor Procedure Rm	4	VA-	03757	8/28/2003	1.9% charity / primary care	No	
Falls Church Lithotripsy, L.L.C.	Add 3 Sites (podiatric) for Mobile Lithotripter (ortho)	V	VA-	03759	10/15/2003	1.8% charity / indigent care	No	
Lee Regional Medical Center	Introduce Cardiac Catheterization Services	1	VA-	03765	12/15/2003	1.6% indigent / primary care	No	
Bon Secours St. Mary's Hospital and a To-Be-Established LLC	Establish an Outpatient Surgical Hospital	15	VA-	03768	1/15/2004	1.6% indigent / primary care	No	
Alleghany Regional Hospital	Replace Mobile MRI with a Fixed MRI Unit	5	VA-	03778	2/15/2004	1.6% Indigent / primary care	No	
The Center for Advanced Imaging	Addition of 1 CT Scanner	5	VA-	03779	2/15/2004	1.6% Indigent / primary care	No	
MRI of Reston, L.P.	Addition of a 4th MRI Scanner	8	VA-	03782	2/10/2004	1.9% Indigent / primary care	No	
Inova Health System	Add a 4th MRI at Inova Fairfax Hospital MRI Cntr	8	VA-	03783	2/10/2004	1.9% Indigent / primary care	No	
Virginia Oncology Associates	Establish a Cancer Care Center in Norfolk, Including a Linear Accelerator, a CT and Mobile PET	V	VA-	03784	2/4/2004	1.8% Indigent / primary care	No	
Sentara Healthcare	Establish a Cancer Care Center Including a Linear Accelerator, a CT, PET, in VA Beach	V	VA-	03785	2/4/2004	1.8% Indigent / primary care	No	
Riverside Regional Medical Center	Establish a Cancer Care Center Including 2 Linear Accelerator, a CT, in Newport News	V	VA-	03786	2/4/2004	1.8% Indigent / primary care	No	
Chesapeake General Hospital	Addition of a Second Linear Accelerator	V	VA-	03788	2/4/2004	1.8% Indigent / primary care	No	
Williamsburg Radiation Therapy Center, Inc.	Addition of a Second Linear Accelerator	V	VA-	03789	2/4/2004	1.8% Indigent / primary care	No	
Sentara Leigh Hospital	Establish a Specialized Center for CT Imaging (Mobile Site)	20	VA-	03790	2/16/2004	1.8% Indigent / primary care	No	
Bon Secours St. Mary's Hospital	Addition of a 4th Cardiac Catheterization Laboratory	15	VA-	03791	2/27/2004	1.6% indigent / primary care	No	
Henrico Doctors' Hospital-Forrest	Addition of a 4th Cardiac Catheterization Laboratory	15	VA-	03792	2/27/2004	1.6% indigent / primary care	No	
Northern Virginia Community Hospital, LLC	Establish a 164-Bed General Acute Care Hospital with New OB Service	8	VA-	03793	3/10/2004	1.37% Indigent / primary care	No	
Mid-Rivers Cancer Center, L.L.C.	Establish a Specialized Center for Radiation Therapy Services	17/V	VA-	03797	4/15/2004	1.8% Indigent / Primary Care	No	
Bon Secours Mary Immaculate Hospital	Introduce Lithotripsy Services	21	VA-	03798	4/15/2004	1.8% Indigent / Primary Care	No	
Falls Church Lithotripsy, L.L.C.	Establish Multiple Mobile Orthopedic Lithotripter Sites	IV	VA-	03799	4/15/2004	1.8% Indigent / Primary Care	No	
Falls Church Lithotripsy, L.L.C.	Establish Multiple Mobile Orthopedic Lithotripter Sites	V	VA-	03800	4/15/2004	1.8% Indigent / Primary Care	No	

Inova Health System	Introduce Lithotripsy Services at the Franconia-Springfield Healthplex	8	VA-	03801	4/15/2004	2.5% Indigent / primary care	No	
Children's Hospital of The King's Daughters	Establish an Outpatient Surgical Hospital	21	VA-	03805	4/26/2004	charity care	No	
Sentara CarePlex	Relocation of an Outpatient Surgical Hospital	21	VA-	03806	4/26/2004	1.8% Indigent / primary care	No	
Bon Secours Mary Immaculate Hospital	Establish an Outpatient Surgical Hospital	21	VA-	03807	4/26/2004	1.8% Indigent / primary care	No	
Hampton Roads Orthopaedics & Sports Medicine	Establish a Specialized Center for MRI Imaging	21	VA-	03808	4/27/2004	3.6% indigent / primary care	No	
Loudoun Hospital Center	Add Intensive Care Beds at Lansdowne Campus	8	VA-	03811	5/15/2004	2.5% Indigent / primary care	No	
R Joy LLC and R Joy II LLC (Eye Surgery Limited and/or Beach Surgicenter for Eyes)	Establish an Outpatient Surgical Hospital	20	VA-	03815	5/17/2004	2.0% indigent / primary care	No	
Chesapeak General Hospital	Establish an Outpatient Surgical Hospital	20	VA-	03816	5/17/2004	1.8% Indigent / primary care	No	
Norton Community Hospital	Introduce Cardiac Catheterization Services, Mobile Site	1	VA-	03820	6/15/2004	1.8% Indigent / Primary Care	No	
Winchester Medical Center	Addition of a Cardiac Catheterization Laboratory	7	VA-	03821	6/21/2004	3.8% Indigent / primary care	No	
Virginia Eye Consultants, Inc.	Establish an Outpatient Surgical Hospital	20	VA-	03823	6/14/2004	2.2% Indigent / primary care	No	
Rockingham Memorial Hospital	Addition of a Cardiac Catheterization Laboratory	6	VA-	03824	6/21/2004	2.7% Indigent / primary care	No	
Memorial Hospital of Martinsville and Henry County	Convert up to 20 Med/Surg Beds to Medical Rehabilitation (15 beds approved)	12	VA-	03825	6/2/2004	2.0% indigent / primary care	No	
Medical Imaging of Fredericksburg, LLC	Introduce PET/CT Hybrid Services and Addition of MRI Equipment	I 16	VA-	03826	6/9/2004	1.1% indigent / primary care	No	
Commonwealth Radiology, P.C.	Establish a Specialized Center for CT and MRI Imaging	15	VA-	03828	6/23/2004	1.6% indigent / primary care	No	
Richmond West End Diagnostic Imaging, L.L.C.	Relocate and Add one MRI to an Existing Service	15	VA-	03829	6/23/2004	2.0% indigent / primary care	No	
Virginia Cancer Institute, Inc.	Introduce CT Services	15	VA-	03830	6/23/2004	1.6% indigent / primary care	No	

Source: DCOPN