I. Call to Order & Introductions

Chairperson Falahee called the meeting to order @ 9:04 a.m.

A. Members Present:

   James B. Falahee, Jr., JD, Chairperson
   Bradley Cory
   Kathleen Cowling, DO
   Charles Gayney arrived @ 9:18 a.m.
   Robert Hughes arrived @ 9:06 a.m.
   Marc Keshishian, MD
   Brian Klott arrived @ 9:07 a.m.
   Gay L. Landstrom, RN
   Suresh Mukherji, MD
   Michael A. Sandler, MD

B. Members Absent:

   Edward B. Goldman, Vice-Chairperson

C. Department of Attorney General Staff:

   Joe Potchen

C. Michigan Department of Community Health Staff Present:

   Melanie Brim
   Jessica Austin
   Scott Blakeney
   Natalie Kellogg
   Tania Rodriguez
II. **Review of Agenda**

Motion by Commissioner Landstrom and seconded by Commissioner Mukherji to accept the agenda as presented. Motion Carried.

III. **Declaration of Conflicts of Interest**

No conflicts declared.

IV. **Review of Minutes**

Motion by Commissioner Mukherji and seconded by Commissioner Hughes to accept the minutes as presented from the September 22, 2011 meeting, with the exception to review the vote count on the final failed motion for Cardiac Catheterization. Motion Carried.

V. **Hospital Beds Standard Advisory Committee (HBSAC) Report**

Mr. Casalou and Mr. Shortridge gave an overview of the HBSAC recommendations submitted to the Commission for proposed action (see attachments A).

A. **Review of Proposed Language:**

Ms. Rogers gave a brief overview of the proposed language (see Attachment B).

B. **Public Comment:**

Keith Proll, Oaklawn Hospital  
Penny Crissman, Doctors Hospital of MI (see Attachment C)  
Brie Hanlon, BCBS of Michigan (see Attachment D)  
Greg Dobis, McLaren Health  
Dennis McCafferty, Economic Alliance for Michigan (EAM)  
Robert Casalou, St. Joseph Hospital/Trinity Health

C. **Commission Discussion**

Discussion followed.
D. Commission Final Action

Motion by Mr. Hughes and seconded by Commissioner Mukherji to approve the proposed language and move it forward for public hearing and JLC review. Motion Carried in a vote of 10- Yes, 0- No, 0- Abstained.

VI. Cardiac Catheterization Services- Public hearing Comments

Ms. Rogers gave a brief summary of the CC language submitted to the Commission for final action (see attachments E).

A. Public Comment

Rick McNamara, Spectrum health

B. Commission Discussion

Commissioner Keshishian inquired upon the trans-catheter aortic valve replacement procedure and the impact it may have upon the CC Standards.

Discussion followed.

C. Commission Final Action

Motion by Commissioner Sandler and seconded by Commissioner Mukherji to approve the proposed language and move it forward to the JLC and Governor for the 45-day review period. Motion Carried in a vote of 10- Yes, 0- No, and 0- Abstained.

VII. Computed Tomography (CT) Scanner Services - Public Hearing Comments

Ms. Rogers gave a brief summary of the proposed language submitted to the Commission for final action (see attachment F).

A. Public Comment

Michael Ketslark, National Diagnostic Services

B. Commission Discussion

Discussion followed.

C. Commission Final Action
Motion by Commissioner Keshishian and seconded by Commissioner Gayney to accept the proposed language and amendment to Section 12(3) and move it forward to the JLC and Governor for the 45-day review period. Motion Carried in a vote of 7- Yes, 3- No, 0- Abstained.

Dr. Sandler recommended taking the CT Standards and the issue of mobile CT scanners out of the review cycle.

Break @ 10:50 a.m. - 11:08 a.m.

VIII. Surgical Services - Public Hearing Comments

Ms. Rogers gave a brief summary of the proposed language submitted to the Commission for final action (see attachment G).

A. Public Comment

Andrew Krass, Lifeline Vascular Access

B. Commission Discussion

Discussion followed.

C. Commission Proposed Action

Motion by Commissioner Keshishian and seconded by Commissioner Landstrom to accept the proposed language and move it forward to the JLC. Motion Carried in a vote of 10-Yes, 0- No, and 0- Abstained.

Public Comment:

Robert Meeker, Spectrum Health

IX. Positron Emission Tomography (PET)/ Magnetic Resonance Imaging (MRI) - Update

Commissioner Keshishian gave a brief update on the PET/MR hybrid. Discussion followed.

Motion by Commissioner Keshishian and seconded by Commissioner Sandler to form a workgroup with Commissioner Keshishian chairing, to further explore the PET/MR hybrid and draft language within the
PET standards for the Commission to review at the January Commission meeting. Motion Carried in a vote of 10-Yes, 0- No, and 0- Abstained.

X. MRI/Angiography- Update

Commissioner Keshishian gave a brief overview of the MR/Angio hybrid technology.

Discussion followed.

Motion by Commissioner Keshishian and seconded by Commissioner Mukherji to delegate the Department and a panel of experts to develop language specific to the MR/Angio hybrid for the Commission to review at either the January or March meeting. Motion carried in a vote of 10-Yes, 0- No, and 0- Abstained.

XI. Open Heart Surgery Services Charge for SAC

A. Review of Charge

B. Commission Discussion

Commissioner Keshishian expressed concern regarding requirements for facilities performing trans catheter aortic valve replacements.

C. Commission Action

Motion by Commissioner Sandler and seconded by Commissioner Klott to accept the charge and delegate the finalization to Chairperson Falahee. Motion carried in a vote of 10- Yes, 0- No, and 0- Abstained.

XII. Standing New Medical Technology Advisory Committee (NEWTAC)

Commissioner Keshishian advised there were no new updates.

XIII. Legislative Report

None.

XIV. Administrative Update

A. Health Policy Section Update
Ms. Brim gave a brief staffing update.

B. CON Evaluation Section Update

2. Quarterly Performance Measures (Written Report – Attachment I).

XV. Legal Activity Report

Mr. Potchen gave a brief update of legal activity (see Attachment J).

XVI. Future Meeting Dates

A. January 31, 2012 (Special Commission Meeting)
C. March 29, 2012
D. June 14, 2012
E. September 27, 2012
F. December 13, 2012

XVII. Public Comment

None.

XVIII. Review of Commission Work Plan

Ms. Rogers gave a brief summary of the work plan (see Attachment K).

A. Commission Discussion

B. Commission Action

Motion by Commissioner Hughes and seconded by Commissioner Mukherji to approve the work plan as amended at the meeting.
Motion Carried in a vote of 10- Yes, 0- No, and 0- Abstained.

XIX. Adjournment

Motion by Commissioner Sandler and seconded by Commissioner Gayney to adjourn the meeting @ 12:33 p.m. Motion Carried.
FINAL REPORT AND SUMMARY OF RECOMMENDATIONS

HOSPITAL BED STANDARDS
STANDARDS ADVISORY COMMITTEE (SAC)

Presented to the
STATE OF MICHIGAN
CERTIFICATE OF NEED COMMISSION
DECEMBER 15, 2011
AGENDA

- HBSAC Membership
- Overview of HBSAC Charge
- Organization of Work
- Recommendations For Charges 2-5
- Recommendations for Bed Need Methodology (Charge 1)
- Recommendations for Unused Beds (Charge 6)
- Alternative Proposal For Future Consideration
Hospital Beds Standard
Advisory Committee Members

• Robert Casalou, St. Joseph Mercy Hospitals/Trinity Health, Chair
• Jane Schelberg, Henry Ford Health System, Vice Chair
• James Ball, Michigan Manufacturer’s Association
• Ron Bieber, United Auto Workers
• Heidi Gustine, Munson Healthcare
• David Jahn, War Memorial Hospital
• Patrick Lamberti, POH Regional Medical Center/McLaren
• Nancy List, Covenant Healthcare
• Conrad Mallett, Sinai Grace Hospital/Detroit Medical Center
• Robert Milewski, BCBSM
• Doug Rich, St. John Providence Health System/Ascension Health
• Kevin Splaine, Spectrum Health
HOSPITAL BEDS
STANDARD ADVISORY COMMITTEE CHARGE
(Approved by the CON Commission on January 26, 2011)

The Hospital Bed Standards SAC should review and recommend any necessary changes to the Hospital Bed Standards with consideration of the following:

1. Review and update, if necessary, the subarea methodology to determine current health care markets and needs including relevant demographic data. If needed, revise methodologies based on defined geographical areas for determining stable projection need.

2. Review project delivery requirements to assure quality, measurability, and affordability for both the provider and consumer.
3. Review and update, if necessary, size requirement for replacement hospitals.

4. Review possible elimination of existing Addendum for HIV Infected Individuals.

5. Consider language similar to that in the nursing home standards requiring all outstanding debt obligations to the State of Michigan for Quality Assurance Assessment Program (QAAP) or Civil Monetary Penalties (CMP) be paid prior to receiving or replacing hospital beds.
HOSPITAL BEDS
STANDARD ADVISORY COMMITTEE CHARGE
(Approved by the CON Commission on January 26, 2011)

6. Consider the proper number of beds for Michigan’s population given demographic (aging and health of the population) concerns and consider concepts that link occupancy to inventory thereby allowing for reduction of “excess” beds. Example: Determine the “appropriate” occupancy, and if over a defined period of time bed capacity remains below that figure, unused beds must be released.

7. Consider any necessary technical or other changes e.g. updates or modifications consistent with other CON review standards and the Public Health Code.
HBSAC RECOMMENDATIONS OF CHARGES 2 - 5

2. Review project delivery requirements to assure quality, measurability, and affordability for both the provider and consumer.

*There were no substantive changes recommended by HBSAC for the project delivery requirements. The committee accepted language changes provided by MDCH staff to be consistent with other standards.*
HBSAC RECOMMENDATIONS FOR CHARGES 2 – 5
(continued)

3. Review and update, if necessary, size requirement for replacement hospitals.

There were no substantive changes recommended by the HBSAC for the size requirement of replacement hospitals. The committee did accept language changes to incorporate “Hospital Group” name changes consistent with the proposed replacement for the subarea methodology to be discussed later in this presentation.
HBSAC RECOMMENDATIONS FOR CHARGES 2 – 5 (continued)

4. Review possible elimination of existing Addendum for HIV Infected Individuals.

The HBSAC unanimously approved a recommendation to eliminate the existing Addendum for HIV Infected Individuals from the standards.
5. Consider language similar to that in the nursing home standards requiring all outstanding debt obligations to the State of Michigan for Quality Assurance Assessment Program (QAAP) or Civil Monetary Penalties (CMP) be paid prior to receiving or replacing hospital beds.

*The HBSAC accepted QAAP/CMP language drafted by MDCH staff.*
Hospital Subarea Methodology
Charge #1
Subarea Methodology Objectives

• Objective
• Replicable
• Sustainable
Subarea Methodology Process

Use most recent 3 year MIDB data to cluster hospitals based on patient days and location.

Consider potential subarea results with peak incremental “fit” scores.

Select final number of subareas based on:

- Cap the maximum number of hospitals in a subarea to 20 or less
- Of remaining options, select the one with the fewest single-hospital subareas
- If multiple options exist with the fewest single-hospital subareas, select the option with the largest number of subareas
Subarea Methodology Decisions

All hospitals reporting in MIDB will be included, regardless of whether they have 3 full years of data.

- Rationale: Persons running the methodology in the future will not have the benefit of a workgroup to advise them of hospital changes (new, closed, expanded, downsized) that occurred during the three-year period. The impacts are anticipated to be minimal.

Hospitals not reporting in MIDB will not be assigned to a subarea.

- Rationale: If their beds are not being counted in the bed need, they should not be included in the allocation of beds; hence they do not need to be included in a subarea.
- Note: There are very few of these cases. If one of these hospitals wished to file a CON, they would have to participate in the MIDB, as required under the existing project delivery requirements.
Subarea Methodology Decisions (continued)

If feasible, MSU Geography and MDCH will work together to create a methodology which will allow an applicant to see which hospital group the facility will likely fall into. A proposed new hospital will be grouped using only the location component of the grouping methodology. The method will use minimum average road distance to each hospital in the nearest hospital groups to make such a determination. To determine their hospital group assignment, an applicant can request that the methodology be run.

–Rationale: In other standards, an applicant can determine in advance whether or not their project meets the CON Review Standards. Running the location component of the methodology would allow an applicant to see where their hospital would be placed and whether a need exists in that subarea.
Subarea Recommendations

Rename “hospital subareas” as “hospital groups” and number 1-35 based on the sum of licensed beds in each group.

- Rationale: Since the hospital clusters are not geography-based, and since many cross Health Service Area (HSA) boundaries, they are no longer "subareas" within the HSAs.

Re-run methodology at least every 5 years, or sooner at the request of the CON Commission, following the availability of new MIDB data.
Hospital Group Impacts

For illustrative purposes, we applied the proposed methodology to the current MIDB data.

- Would reduce the number of Hospital Groups from 64 to 35
- Would reduce single-Hospital Groups from 32 to 1

Using 2009 final MIDB data, the following three slides illustrate the potential changes should the Commission adopt this methodology. If accepted, it will be calculated using the 2010 final MIDB data.
64 Current Subareas
### 35 Hospital Groups

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<td>Edward W Sparrow Hospital</td>
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<td>Mary Free Bed Rehabilitation Hospital</td>
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Bed Need Methodology
Charge #1
Bed Need Methodology Objectives

• Objective
• Replicable
• Sustainable
• Easy to run (re-run every two years)
Bed Need Methodology:
Projecting Demand

Projection of demand will be on a county-wide vs. zip code level.

- Rationale: Counties provide more robust rates and less volatility.

Projection of demand will model patient days per county directly using a 5-year regression model based on monthly data. If the regression model is not significant, a 3-year bed day average will be used.

- Rationale: This model eliminates the need for population projections, which added an additional margin for projection error. It is not advisable to use a trend model for prediction if there is no trend - the prediction is not meaningful and likely farther from the actual value than the 3-year average would be.
Bed Need Methodology: Projecting Demand (continued)

Modeling is done at the aggregate level, not by age brackets and bed type.

- Rationale: Modeling at the aggregate level produces statistically identical bed need projections as the projections done by age and type. Additionally, beds are no longer licensed separately as Med/Surg, OB, or Peds. For ease of running the model, the work group recommends eliminating this step.
Bed Need Methodology: Allocating Demand

The predicted patient days are then allocated to Hospital Groups and bed need is calculated.

- Use utilization rates from base year (most recent year of available MIDB data)
- Convert to average daily census
- Adjust using occupancy rate table

The existing occupancy adjustment tables were merged into one table, and the range was modified from 60%-85% to 60%-80%.

- Rationale: Merging the tables was appropriate since bed need projections would be made at the aggregate level, not at the bed-type level. The upper end of the range was adjusted so that bed need planning was consistent with the high-occupancy standard.
Bed Need Methodology: Allocating Demand (continued)

Hospitals that do not report in MIDB are not included in the allocation of bed need.

– Rationale: If their days are not reported in MIDB, they are not included in the bed need calculation, hence they cannot be included in the allocation of bed need.

VA and Psych Hospitals are no longer included.

– Rationale: These facilities are not subject to the CON Hospital Bed Need process so their inclusion would distort projections.

In-state residents visiting out-of-state hospitals will not be included in the methodology, however out-of-state residents visiting in-state hospitals are included.

– Rationale: This will ensure that future bed need predictions match the actual use of Michigan’s hospitals.
Bed Need Recommendations

Re-run methodology every two years, following the availability of new MIDB data.
Bed Need Impact

• The proposed methodology was applied to current MIDB data.

• No bed need identified in the State of Michigan

• In fact, there are more excess beds than previously identified with old methodology.
Illustrative Bed Need Output

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In Summary

• When applied to current MIDB data, the proposed Hospital Group and Bed Need Methodologies do not project any areas of need within the state.

• The methodologies proposed are more replicable and are simplified, when compared to the current methodologies.

• The use of patient day projections at a county level will ensure that bed need will be responsive to the hospital needs of Michigan’s population.
Hospital Bed Workgroup
Charge #6
Recommendation

The HBSAC recommends (by a 9 to 3 super majority vote) that the CON standards be amended to incorporate a “low occupancy” standard by which “excess licensed beds” could potentially be reduced upon a CON request for the replacement, relocation or acquisition of hospital beds.
RATIONALE

• Excess Beds present a potential cost to the health care system and employers at the time they are replaced, relocated or put into use after an acquisition.

• A process is needed to begin reducing the number of excess beds in the State of Michigan.
RATIONALE

• The Low Occupancy Standard is enabled by the current availability of the High Occupancy Rule that provides a mechanism for hospitals to obtain additional beds if volumes grow.

• Reduces concern that hospital beds become a “commodity” that can be bought or sold regardless of whether they are in use.
Workgroup Process

- A workgroup chaired by HBSAC Vice-Chair, Jane Schelberg, met several times with input from a wide range of HBSAC and non-HBSAC members.

- The workgroup and HBSAC considered various proposals presented by the Economic Alliance of Michigan (EAM).
Definitions

**Replacement beds in a hospital**" means hospital beds that meet all of the following conditions; (i) an equal or greater number of hospital beds are currently licensed to the applicant at the licensed site at which the proposed replacement beds are currently licensed; (ii) the hospital beds are proposed for replacement in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.); and (iii) the hospital beds to be replaced will be located in the replacement zone.

**Acquiring a hospital**" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a licensed and operating hospital and which does not involve a change in bed capacity unless otherwise provided in these Standards.

**Relocate existing licensed hospital beds"** for purposes of sections 6(3) and 8 of these standards, means a change in the location of existing hospital beds from the existing licensed hospital site to a different existing licensed hospital site within the same hospital subarea or HSA. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards.
Recommendations

Replacement

In order to obtain CON approval for replacement of acute care hospital beds, a hospital with average adjusted occupancy of below 40% during the most recent three (3) years, must de-license sufficient beds to raise its adjusted occupancy to 60%.
Recommendations

Acquisition

In order to obtain CON approval for acquisition of an acute care hospital with average adjusted occupancy of below 40% during the most recent three (3) years, an applicant (the new owner) must agree to de-license sufficient beds to raise its adjusted occupancy to 60%, if it fails to achieve at least 40% average adjusted occupancy in the third year after acquisition.
Recommendations

Relocation

In order to obtain CON approval for relocation of acute care hospital beds from a hospital with average adjusted occupancy of below 40% during the most recent three (3) years, the hospital (source hospital) must de-license the number of beds required for the source hospital to be at 60% adjusted occupancy after the relocations. A receiving hospital may not, after the relocations, have an adjusted occupancy below 40%. The source hospital may file multiple CONS at one time for relocations to more than one hospital.
RATIONALE FOR THRESHOLDS
(Replacement, Acquisition, Relocation)

• New standard will have some uncertainty so threshold set to initially minimize risk.

• The approach is sustainable with different thresholds over time if deemed appropriate by the CON Commission.

• Proposal supported by EAM as “a starting point” for this type of standard.
EXCLUSIONS/LIMITATION
(Replacement, Acquisition, Relocation)

EXCLUSIONS
• critical access hospitals
• rural county hospitals
• micropolitan county hospitals
• long term acute care hospitals (LTACH)
• hospitals with less than 25 beds
• Sole Community Hospital as designated by CMS

ADDITIONAL LIMITATION
• Standard would not allow bed reduction/right sizing to below 25 beds
ALTERNATIVE FOR FUTURE CONSIDERATION

• Proposal submitted to HBSAC by member Patrick Lamberti on behalf of McLaren Health Care as HBSAC proceedings were concluding at final meeting.

• Proposal was to simplify the Hospital Bed Standards and provide new criteria for relocating existing hospital beds.
McLaren Health Care Proposal

• Reduce restrictions on CON for relocating hospital beds to a new site. If a hospital elects to relocate beds to a new site it must demonstrate:
  • Financial viability with regards to the entire project
  • Conclusive positive community need assessment for both the proposed hospital site that is receiving beds and the hospital giving up beds:
    • Significant community benefit with a financially viable plan for reuse of the existing facility.
    • Existing facilities cannot close to move to a new facility.
McLaren Proposal (continued)

• No additional beds in Michigan
• Maintain existing payer contracts for at least five years.
• Delicense at least 10% of existing facility’s beds
• Proposed new hospital site may not be approved within five miles of existing acute care hospitals, nor within the same county as single community providers.
McLaren Proposal Discussion

• Although the method and timing of this proposal was questionable, the HBSAC did take it under consideration and discussion.

• The following comments were put on the record during the discussion:
  • The proposal has elements that could be very useful as criteria in the CON standards.
  • Taken in isolation, this proposal would open up the potential for unchecked and unwarranted construction of new hospitals and excess capacity.
McLaren Proposal Discussion (cont)

• A proposed modification to this proposal was made to include the following:
  • That the criteria would be used in the event that a Bed Need was identified in a hospital grouping that triggered the ability for a new market entrant.
  • That if a bed need was identified that all applications for the new hospital site would be subject to comparative review. The “McLaren criteria” could be incorporated into the comparative review standards.
  • That the “five mile” from a new hospital site standard be replaced with the established “30-minute drive time” standard.
McLaren Proposal Discussion (cont)

• Member Lamberti did not accept any of these proposed modifications. The proposal was defeated by super-majority vote of the HBSAC.

• Please note that member Patrick Lamberti, representing McLaren, cast a roll call “yes” vote in favor of the new bed need and hospital grouping methodologies at the October 19, 2011 HBSAC meeting.
Questions & Answers

Thank you
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR HOSPITAL BEDS


Section 1. Applicability

Sec. 1. (1) These standards are requirements for approval of delivery of services for all projects approved and certificates of need issued under Part 222 of the Code that involve (a) beginning operation of a new hospital, (b) increasing licensed beds in a hospital licensed under Part 215 or (b) replacing beds in a hospital, or physically relocating hospital beds from one licensed site to another geographic location or (c) increasing licensed beds in a hospital licensed under Part 215 replacing beds in a hospital or (d) acquiring a hospital or (e) beginning operation of a new hospital PURSUANT TO PART 222 OF THE CODE.

(2) A hospital licensed under Part 215 is a covered health facility for purposes of Part 222 of the Code. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

(3) An increase in licensed hospital beds is a change in bed capacity for purposes of Part 222 of the Code.

(4) The physical relocation of hospital beds from a licensed site to another geographic location is a change in bed capacity for purposes of Part 222 of the Code.

(5) An increase in hospital beds certified for long-term care is a change in bed capacity for purposes of Part 222 of the Code and shall be subject to and reviewed under the CON Review Standards for Long-Term-Care Services.

(6) The Department shall use sections 3, 4, 5, 6, 7, 8, 10, and 16 of these standards and Section 2 of the Addendum for Projects for HIV Infected Individuals, as applicable, in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws.

(7) The Department shall use Section 9 of these standards and Section 3 of the Addendum for Projects for HIV Infected Individuals, as applicable, in applying Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

Section 2. Definitions

Sec. 2. (1) As used in these standards:

(a) "Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a licensed and operating hospital and which does not involve a change in bed capacity.

(b) "ADJUSTED PATIENT DAYS" MEANS THE NUMBER OF PATIENT DAYS WHEN CALCULATED AS FOLLOWS:

(I) COMBINE ALL PEDIATRIC PATIENT DAYS OF CARE AND OBSTETRICS PATIENT DAYS OF CARE PROVIDED DURING THE PERIOD OF TIME UNDER CONSIDERATION AND MULTIPLY THAT NUMBER BY 1.1.

(II) ADD THE NUMBER OF NON-PEDIATRIC AND NON-OBSTETRIC PATIENT DAYS OF CARE PROVIDED DURING THE SAME PERIOD OF TIME TO THE PRODUCT OBTAINED IN (I) ABOVE. THIS IS THE NUMBER OF ADJUSTED PATIENT DAYS FOR THE APPLICABLE PERIOD.
"Alcohol and substance abuse hospital" means a licensed hospital within a long-term (acute) care (LTAC) hospital that exclusively provides inpatient medical detoxification and medical stabilization and related outpatient services for persons who have a primary diagnosis of substance dependence covered by DRGs 433 - 437.

"Base year" means the most recent year that final MIDB data is available to the Department unless a different year is determined to be more appropriate by the Commission.

"Certificate of Need Commission" or "Commission" means the Commission created pursuant to Section 22211 of the code, being Section 333.22211 of the Michigan Compiled Laws.

"Close a hospital" means an applicant will demonstrate to the satisfaction of the Department that a hospital licensed under Part 215, and whose licensed capacity for the most recent 24 months prior to submission of the application was at least 80 percent for acute care beds, will close and surrender its acute care hospital license upon completion of the proposed project.

"Disproportionate share hospital payments" means the most recent payments to hospitals in the special pool for non-state government-owned or operated hospitals to assure funding for costs incurred by public facilities providing inpatient hospital services which serve a disproportionate number of low-income patients with special needs as calculated by the Medical Services Administration within the Department.

"Gross hospital revenues" means the hospital’s revenues as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

"Health service area" OR "HSA" means the groups of counties listed in Section 18 APPENDIX A.

"Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital.

"Hospital" means a hospital as defined in Section 20106(5) of the Code being Section 333.20106(5) of the Michigan Compiled Laws and licensed under Part 215 of the Code. The term does not include a hospital or hospital unit licensed or operated by the Department of Mental Health.
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110 (s) “HOSPITAL GROUP” MEANS A CLUSTER OR GROUPING OF HOSPITALS BASED ON GEOGRAPHIC PROXIMITY AND HOSPITAL UTILIZATION PATTERNS. THE LIST OF HOSPITAL GROUPS AND THE HOSPITALS ASSIGNED TO EACH HOSPITAL GROUP WILL BE POSTED ON THE STATE OF MICHIGAN CON WEB SITE AND WILL BE UPDATED PURSUANT TO SECTION 3.

114 (T) “Hospital long-term-care unit” or “HLTCU” means a nursing care unit, owned or operated by and as part of a hospital, licensed by the Department, and providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

117 (s) “Hospital subarea” or “subarea” means a cluster or grouping of hospitals and the relevant portion of the state’s population served by that cluster or grouping of hospitals. For purposes of these standards, hospital subareas and the hospitals assigned to each subarea are set forth in Appendix A.

120 (T) “Host hospital” means a licensed and operating hospital, which delicensces hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow a new hospital to begin operation.

123 (w) “Licensed site” means the location of the facility authorized by license and listed on that licensee’s certificate of licensure.

125 (y) “Limited access area” means those geographic-UNDERSERVED areas containing a population of 50,000 or more based on the planning year and not within 30 minutes drive time of an existing licensed acute care hospital with 24 hour/7 days a week emergency services utilizing the slowest route available as defined by the Michigan Department of Transportation (MDOT)-WITH A PATIENT DAY DEMAND THAT MEETS OR EXCEEDS THE STATE-WIDE AVERAGE OF PATIENT DAYS USED PER 50,000 RESIDENTS IN THE BASE YEAR and as identified in Appendix E. Limited access areas shall be redetermined when a new hospital has been approved or an existing hospital closes.

128 (x) “Market forecast factors” (%N) means a mathematical computation where the numerator is the number of total inpatient discharges indicated by the market survey forecasts and the denominator is the base year MIDB discharges.

131 (y) “Medicaid” means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and TO 1396v-6 and TO 1396U.

134 (z) “Medicaid volume” means the number of Medicaid recipients served at the hospital as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

137 (aa) “Metropolitan statistical area county” means a county located in a metropolitan statistical area as that term is defined under the “standards for defining metropolitan and micropolitan statistical areas” by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

140 (bb) “Michigan Inpatient Data Base” or “MIDB” means the data base compiled by the Michigan Health and Hospital Association or successor organization. The data base consists of inpatient discharge records from all Michigan hospitals and Michigan residents discharged from hospitals in border states for a specific calendar year.

143 (cc) “Micropolitan statistical area county” means a county located in a micropolitan statistical area as that term is defined under the “standards for defining metropolitan and micropolitan statistical areas” by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

146 (dd) “New beds in a hospital” means hospital beds that meet at least one of the following: (i) are not currently licensed as hospital beds, (ii) are currently licensed hospital beds at a licensed site in one subarea HOSPITAL GROUP which are proposed for relocation in a different subarea HOSPITAL GROUP as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed hospital beds at a licensed site in one subarea HOSPITAL GROUP which are proposed for relocation to another geographic site which is in the same subarea HOSPITAL GROUP as determined by the Department, but which are not in the replacement zone, or (iv) are currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with Section 6(2) of these standards.

150 (ee) “New hospital” means one of the following: (i) the establishment of a new facility that shall be issued a new hospital license, (ii) for currently licensed beds, the establishment of a new licensed site...
that is not in the same hospital subareaGROUP as the currently licensed beds, (iii) currently licensed hospital beds at a licensed site in one subareaHOSPITAL GROUP which are proposed for relocation to another geographic site which is in the same subareaHOSPITAL GROUP as determined by the Department, but which are not in the replacement zone, or (iv) currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with section 6(2) of these standards.

(ii) "Obstetrics patient days of care" means inpatient days of care for patients in the applicant’s Michigan Inpatient Data Base data ages 15 through 44 with drgs 370 through 375 (obstetrical discharges).

(iii) "Overbedded subareaHOSPITAL GROUP" means a hospital subareaGROUP in which the total number of existing hospital beds in that subareaHOSPITAL GROUP exceeds the subareaHOSPITAL GROUP needed hospital bed supply as set forth in Appendix C.

(iv) "Pediatric patient days of care" means inpatient days of care for patients in the applicant’s Michigan Inpatient Data Base data ages 0 through 14 excluding normal newborns.

(v) "Planning year" means five years beyond the base year, established by the CON Commission, for which hospital bed need is developed, unless a different year is determined to be more appropriate by the Commission.

(vi) "Qualifying project" means each application in a comparative group which has been reviewed individually and has been determined by the Department to have satisfied all of the requirements of Section 22225 of the code, being section 333.22225 of the Michigan Compiled Laws and all other applicable requirements for approval in the Code or these Standards.

(vii) "Relocate existing licensed hospital beds" for purposes of sections 6(3) and 8 of these standards, means a change in the location of existing hospital beds from the existing licensed hospital site to a different existing licensed hospital site within the same hospital subareaGROUP or HSA. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards.

(viii) "Remaining patient days of care" means total inpatient days of care in the applicant’s Michigan Inpatient Data Base data minus obstetrics patient days of care and pediatric patient days of care.

(ix) "Replacement beds in a hospital" means hospital beds that meet all of the following conditions; (i) an equal or greater number of hospital beds are currently licensed to the applicant at the licensed site at which the proposed replacement beds are currently licensed; (ii) the hospital beds are proposed for replacement in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.); and (iii) the hospital beds to be replaced will be located in the replacement zone.

(x) "Replacement zone" means a proposed licensed site that is (i) in the same subareaHOSPITAL GROUP as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.

(xi) "Rural county" means a county not located in a metropolitan statistical area or micropolitan statistical area as those terms are defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information regulatory affairs of the United States office of management and budget, 65 F.R., p. 82238 (December 27, 2000) and as shown in Appendix B.

(xii) "Uncompensated care volume" means the hospital’s uncompensated care volume as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

(xiii) "UNDERSERVED AREA" MEANS THOSE GEOGRAPHIC AREAS NOT WITHIN 30 MINUTES DRIVE TIME OF AN EXISTING LICENSED ACUTE CARE HOSPITAL WITH 24 HOUR/7 DAYS A WEEK
EMERGENCY SERVICES UTILIZING THE MOST DIRECT ROUTE USING THE LOWEST SPEED LIMITS POSTED AS DEFINED BY THE MICHIGAN DEPARTMENT OF TRANSPORTATION (MDOT).

(oo) “Utilization rate” or “use rate” means the number of days of inpatient care per 1,000 population during a one-year period.

(ss) “Zip code population” means the latest population estimates for the base year and projections for the planning year, by zip code.

(2) The definitions in Part 222 shall apply to these standards.

Section 3. Hospital subarea GROUPS

Sec. 3. (1)(a) Each existing hospital is assigned to a hospital subarea GROUP as set forth in Appendix A B which is incorporated as part of these standards, until Appendix A B is revised pursuant to this subsection (1).

(1) These hospital subarea GROUPs, and the assignments of hospitals to subarea HOSPITAL GROUPs, shall be updated BY THE DEPARTMENT EVERY FIVE YEARS OR, at the direction of the Commission, starting in May 2003, to be completed no later than November 2003. Thereafter, at the direction of the Commission, the updates shall occur no later than two years after the official date of the federal decennial census, provided that: THE METHODOLOGY DESCRIBED IN "A METHODOLOGY FOR DEFINING HOSPITAL GROUPS" BY PAUL L. DELAMATER, ASHTON M. SHORTRIDGE, AND JOSEPH P. MESSINA, 2011 SHALL BE USED AS FOLLOWS:

(AA) Population data at the federal zip code level, derived from the federal decennial census, are available, and final MIDB data are available to the Department for that same census year. FOR EACH HOSPITAL, CALCULATE THE PATIENT DAY COMMITMENT INDEX (%C – A MATHEMATICAL COMPUTATION WHERE THE Numerator IS THE NUMBER OF INPATIENT HOSPITAL DAYS FROM A SPECIFIC GEOGRAPHIC AREA PROVIDED BY A SPECIFIED HOSPITAL AND THE Denominator IS THE TOTAL NUMBER OF PATIENT DAYS PROVIDED BY THE SPECIFIED HOSPITAL USING MIDB DATA) FOR ALL MICHIGAN ZIP CODES USING THE SUMMED PATIENT DAYS FROM THE MOST RECENT THREE YEARS OF MIDB DATA. INCLUDE ONLY THOSE ZIP CODES FOUND IN EACH YEAR OF THE MOST RECENT THREE YEARS OF MIDB DATA. ARRANGE OBSERVATIONS IN AN ORIGIN-DESTINATION TABLE SUCH THAT EACH HOSPITAL IS AN ORIGIN (ROW) AND EACH ZIP CODE IS A DESTINATION (COLUMN) AND INCLUDE ONLY HOSPITALS WITH INPATIENT RECORDS IN THE MIDB.

(b) For an application involving a proposed new licensed site for a hospital (whether new or replacement), the proposed new licensed site shall be assigned to an existing hospital subarea utilizing a market survey conducted by the applicant and submitted with the application. The market survey shall provide, at a minimum, forecasts of the number of inpatient discharges for each zip code that the proposed new licensed site shall provide service. The forecasted numbers must be for the same year as the base year MIDB data. The market survey shall be completed by the applicant using accepted standard statistical methods. The market survey must be submitted on a computer media and in a format specified by the Department. The market survey, if determined by the Department to be reasonable pursuant to Section 15, shall be used by the Department to assign the proposed new site to an existing subarea based on the methodology described by: "The Specification of Hospital Service Communities in a Large Metropolitan Area" by J. William Thomas, Ph.D., John R. Griffith, and Paul Durance, April 1979 as follows: FOR EACH HOSPITAL, CALCULATE THE ROAD DISTANCE TO ALL OTHER HOSPITALS. ARRANGE OBSERVATIONS IN AN ORIGIN-DESTINATION TABLE SUCH THAT EACH HOSPITAL IS AN ORIGIN (ROW) AND EACH HOSPITAL IS ALSO A DESTINATION (COLUMN).

(c) For the proposed new site, a discharge relevance factor for each of the zip codes identified in the application will be computed. Zip codes with a market forecast factor of less than .05 will be deleted from consideration. RESCALE THE ROAD DISTANCE ORIGIN-DESTINATION TABLE BY DIVIDING EVERY ENTRY IN THE ROAD DISTANCE ORIGIN-DESTINATION TABLE BY THE MAXIMUM DISTANCE BETWEEN ANY TWO HOSPITALS.

(d) The base year MIDB data will be used to compute discharge relevance factors (%R) for each hospital subarea for each of the zip codes identified in step (i) above. Hospital subareas with a %R of less than 0.10 for all zip codes identified in step (i) will be deleted from the computation.
ROAD DISTANCE ORIGIN-DESTINATION TABLE TO THE ORIGIN-DESTINATION TABLE (BY HOSPITAL) TO CREATE THE INPUT DATA MATRIX FOR THE CLUSTERING ALGORITHM.

(iiiE) The third step in the methodology is to calculate a population-weighted average discharge relevance factor $R_j$, for the proposed hospital and existing subareas. Letting:

- $P_i$ = Population of zip code $i$.
- $d_{ij}$ = Number of patients from zip code $i$ treated at hospital $j$.
- $D_i = \sum_j d_{ij}$ = Total patients from zip code $i$.
- $I_j = \{i | (d_{ij}/D_i) \geq \alpha\}$, set of zip codes for which the individual relevance factor $\%R$ from (i) and (ii) above) values $(d_{ij}/D_i)$ of hospital $j$ exceeds or equals $\alpha$, where $\alpha$ is specified $0 \leq \alpha \leq 1$.

Then $R_j = \sum_{i \in I_j} P_i (d_{ij}/D_i)$

CLUSTERING ALGORITHM WITH INITIAL CLUSTER CENTERS PROVIDED BY A WARDS HIERARCHICAL CLUSTERING METHOD. ITERATE OVER ALL CLUSTER SOLUTIONS FROM 2 TO THE NUMBER OF HOSPITALS ($n$) MINUS 1.

(iv) After $R_j$ is calculated for the applicant(s) and the included existing subareas, the hospital/subarea with the smallest $R_j$ is grouped with the hospital/subarea having the greatest individual discharge relevance factor $\%R$ from the applicant's home zip code. $S_j$'s home zip code is defined as the zip code from $S_j$ with the greatest discharge relevance factor. FOR EACH CLUSTER SOLUTION, RECORD THE GROUP MEMBERSHIP OF EACH HOSPITAL, THE CLUSTER CENTER LOCATION FOR EACH OF THE CLUSTERS, THE $r^2$ VALUE FOR THE OVERALL CLUSTER SOLUTION, THE NUMBER OF SINGLE HOSPITAL CLUSTERS, AND THE MAXIMUM NUMBER OF HOSPITALS IN ANY CLUSTER.

(iii) "K-MEANS CLUSTERING ALGORITHM" MEANS A METHOD FOR PARTITIONING OBSERVATIONS INTO A USER-SPECIFIED NUMBER OF GROUPS. IT IS A STANDARD ALGORITHM WITH A LONG HISTORY OF USE IN ACADEMIC AND APPLIED RESEARCH. THE APPROACH IDENTIFIES GROUPS OF OBSERVATIONS SUCH THAT THE SUM OF SQUARES FROM POINTS TO THE ASSIGNED CLUSTER CENTERS IS MINIMIZED, I.E., OBSERVATIONS IN A CLUSTER ARE MORE SIMILAR TO ONE ANOTHER THAN THEY ARE TO OTHER CLUSTERS. SEVERAL K-MEANS IMPLEMENTATIONS HAVE BEEN PROPOSED, THE BED NEED METHODOLOGY USES THE WIDELY-ADOPTED HARTIGAN-WONG ALGORITHM. ANY CLUSTERING OR DATA MINING TEXT WILL DISCUSS K-MEANS; ONE EXAMPLE IS B.S. EVERITT, S. LANDAU, M. LEESE, & D. STAHL (2011) CLUSTER ANALYSIS, 5TH EDITION. WILEY, 346 P.

(iii) "WARDS HIERARCHICAL CLUSTERING METHOD" MEANS A METHOD FOR CLUSTERING OBSERVATIONS INTO GROUPS. THIS METHOD USES A BINARY TREE STRUCTURE TO SEQUENTIALLY GROUP DATA OBSERVATIONS INTO CLUSTERS, SEEKING TO MINIMIZE OVERALL WITHIN-GROUP VARIANCE. IN THE BED NEED METHODOLOGY, THIS METHOD IS USED TO IDENTIFY THE STARTING CLUSTER LOCATIONS FOR K-MEANS. ANY CLUSTERING TEXT WILL DISCUSS HIERARCHICAL CLUSTER ANALYSIS, INCLUDING WARDS'S METHOD; ONE EXAMPLE IS: G. GAN, C. MA, & J. WU (2007) DATA CLUSTERING: THEORY, ALGORITHMS, AND APPLICATIONS (ASA-SIAM SERIES ON STATISTICS AND APPLIED PROBABILITY). SOCIETY FOR INDUSTRIAL AND APPLIED MATHEMATICS (SIAM), 466 P.

(vF) If there is only a single applicant, then the assignment procedure is complete. If there are additional applicants, then steps (iii), and (iv) must be repeated until all applicants have been assigned to an existing subarea. CALCULATE THE INCREMENTAL F SCORE ($F_{inc}$) FOR EACH CLUSTER SOLUTION (i) BETWEEN 3 AND $n-1$ LETTING:

- $r_i = r^2$ of solution $i$
- $r_{i-1}^2 = r^2$ of solution $i-1$
- $k_i = \text{number of clusters in solution} i$
- $k_{i-1} = \text{number of clusters in solution} i-1$
- $n = \text{total number of hospitals}$
WHERE:  \[ F_{inc,i} = \frac{\left( r_i^2 - r_{i-1}^2 \right)}{k_i - k_{i-1}} \]

**G**. SELECT CANDIDATE SOLUTIONS BY FINDING THOSE WITH PEAK VALUES IN \( F_{inc} \).

**H**. REMOVE ALL CANDIDATE SOLUTIONS IN WHICH THE LARGEST SINGLE CLUSTER CONTAINS MORE THAN 20 HOSPITALS.

**I**. IDENTIFY THE MINIMUM NUMBER OF SINGLE HOSPITAL CLUSTERS FROM THE REMAINING CANDIDATE SOLUTIONS. REMOVE ALL CANDIDATE SOLUTIONS CONTAINING A GREATER NUMBER OF SINGLE HOSPITAL CLUSTERS THAN THE IDENTIFIED MINIMUM.

**J**. FROM THE REMAINING CANDIDATE SOLUTIONS, CHOOSE THE SOLUTION WITH THE LARGEST NUMBER OF CLUSTERS (\( k \)). THIS SOLUTION (\( k \) CLUSTERS) IS THE RESULTING NUMBER AND CONFIGURATION OF THE HOSPITAL GROUPS.

**K**. RENAME HOSPITAL GROUPS AS FOLLOWS:

**I**. FOR EACH HOSPITAL GROUP, IDENTIFY THE HSA IN WHICH THE MAXIMUM NUMBER OF HOSPITALS ARE LOCATED. IN CASE OF A TIE, USE THE HSA NUMBER THAT IS LOWER.

**II**. FOR EACH HOSPITAL GROUP, SUM THE NUMBER OF CURRENT LICENSED HOSPITAL BEDS FOR ALL HOSPITALS.

**III**. ORDER THE GROUPS FROM 1 TO \( k \) BY FIRST SORTING BY HSA NUMBER, THEN SORTING WITHIN EACH HSA BY THE SUM OF BEDS IN EACH HOSPITAL GROUP. THE HOSPITAL GROUP NAME IS THEN CREATED BY APPENDING NUMBER IN WHICH IT IS ORDERED TO "HG" (E.G., HG1, HG2, ..., HGk).

**IV**. HOSPITALS THAT DO NOT HAVE PATIENT RECORDS IN THE MIDB - IDENTIFIED IN SUBSECTION (1)(A) - ARE DESIGNATED AS "NG" FOR NON-GROUPABLE HOSPITALS.

**2**. FOR AN APPLICATION INVOLVING A PROPOSED NEW LICENSED SITE FOR A HOSPITAL (WHETHER NEW OR REPLACEMENT), THE PROPOSED NEW LICENSED SITE SHALL BE ASSIGNED TO AN EXISTING HOSPITAL GROUP UTILIZING THE METHODOLOGY DESCRIBED IN "A METHODOLOGY FOR DEFINING HOSPITAL GROUPS" BY PAUL L. DELAMATER, ASHTON M. SHORTRIDGE, AND JOSEPH P. MESSINA, 2011 AS FOLLOWS:

**A**. CALCULATE THE ROAD DISTANCE FROM PROPOSED NEW SITE (\( s \)) TO ALL EXISTING HOSPITALS, RESULTING IN A LIST OF \( n \) OBSERVATIONS (\( s_n \)).

**B**. RESCALE \( s_n \) BY DIVIDING EACH OBSERVATION BY THE MAXIMUM ROAD DISTANCE BETWEEN ANY TWO HOSPITALS IDENTIFIED IN SUBSECTION (1)(C).

**C**. FOR EACH HOSPITAL GROUP, SUBSET THE CLUSTER CENTER LOCATION IDENTIFIED IN SUBSECTION (1)(E)(I) TO ONLY THE ENTRIES CORRESPONDING TO THE ROAD DISTANCE BETWEEN HOSPITALS. FOR EACH HOSPITAL GROUP, THE RESULT IS A LIST OF \( n \) OBSERVATIONS THAT DEFINE EACH HOSPITAL GROUP'S CENTRAL LOCATION IN RELATIVE ROAD DISTANCE.

**D**. CALCULATE THE DISTANCE (\( d_{k,s} \)) BETWEEN THE PROPOSED NEW SITE AND EACH EXISTING HOSPITAL GROUP

\[ d_{k,s} = \sqrt{\left(HG_{k1} - s_1\right)^2 + \left(HG_{k2} - s_2\right)^2 + \left(HG_{k3} - s_3\right)^2 + \ldots + \left(HG_{kn} - s_n\right)^2} \]

**E**. ASSIGN THE PROPOSED NEW SITE TO THE CLOSEST HOSPITAL GROUP (HGk) BY SELECTING THE MINIMUM VALUE OF \( d_{k,s} \).

**F**. IF THERE IS ONLY A SINGLE APPLICANT, THEN THE ASSIGNMENT PROCEDURE IS COMPLETE. IF THERE ARE ADDITIONAL APPLICANTS, THEN STEPS (A-E) MUST BE REPEATED UNTIL ALL APPLICANTS HAVE BEEN ASSIGNED TO AN EXISTING HOSPITAL GROUP.
The Commission DEPARTMENT shall amend Appendix A THE HOSPITAL GROUPS to reflect:
(a) approved new licensed site(s) assigned to a specific hospital subareaGROUP; (b) hospital closures; and (c) licensure action(s) as appropriate.

As directed by the Commission, new subareaHOSPITAL GROUP assignments established according to subsection (1)(a)(i) shall supersede Appendix A THE PREVIOUS SUBAREA/HOSPITAL GROUP ASSIGNMENTS and shall be included as an amended appendix to these standards POSTED ON THE STATE OF MICHIGAN CON WEB SITE effective on the date determined by the Commission.

Section 4. Determination of the needed hospital bed supply

Sec. 4. (1) The determination of the needed hospital bed supply for a limited access area and a hospital subareaGROUP for a planning year shall be made using the MIDB and population estimates and projections by zip code in the following methodology DETAILED IN "A METHODOLOGY FOR DETERMINING NEEDED HOSPITAL BED SUPPLY" BY PAUL L. DELAMATER, ASHTON M. SHORTRIDGE, AND JOSEPH P. MESSINA, 2011 AS FOLLOWS:
(a) All hospital discharges for normal newborns (DRG 391 PRIOR TO 2008, DRG 795 THEREAFTER) and psychiatric patients (ICD-9-CM codes 290 through 319 as a principal diagnosis) will be excluded.
(b) For each discharge from the selected zip codes for a limited access area or each hospital subarea discharge, as applicable, calculate the number of patient days (take the patient days for each discharge and accumulate it within the respective age group) for the following age groups: ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 through 375 obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older. Data from non-Michigan residents are to be included for each specific age group. For limited access areas, proceed to section 4(1)(e) FOR EACH COUNTY, COMPILe THE MONTHLY PATIENT DAYS USED BY COUNTY RESIDENTS FOR THE PREVIOUS FIVE YEARS (BASE YEAR PLUS PREVIOUS FOUR YEARS). COMPILe THE MONTHLY PATIENT DAYS USED BY NON-MICHIGAN RESIDENTS IN MICHIGAN HOSPITALS FOR THE PREVIOUS FIVE YEARS AS AN "OUT-OF-STATE" UNIT. THE OUT-OF-STATE PATIENT DAYS UNIT IS CONSIDERED AN ADDITIONAL COUNTY THEREAFTER. PATIENT DAYS ARE TO BE ASSIGNED TO THE MONTH IN WHICH THE PATIENT WAS DISCHARGED. FOR PATIENT RECORDS WITH AN UNKNOWN COUNTY OF RESIDENCE, ASSIGN PATIENT DAYS TO THE COUNTY OF THE HOSPITAL WHERE THE PATIENT RECEIVED SERVICE.
(c) For each hospital subarea, calculate the relevance index (%Z) for each zip code and for each of the following age groups: ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 THROUGH 375 obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older. FOR EACH COUNTY, CALCULATE THE MONTHLY PATIENT DAYS FOR ALL MONTHS IN THE PLANNING YEAR. FOR EACH COUNTY, CONSTRUCT AN ORDINARY LEAST SQUARES LINEAR REGRESSION MODEL USING MONTHLY PATIENT DAYS AS THE DEPENDENT VARIABLE AND MONTHS (1-60) AS THE INDEPENDENT VARIABLE. IF THE LINEAR REGRESSION MODEL IS SIGNIFICANT AT A 90% CONFIDENCE LEVEL (F-SCORE, TWO TAILED p VALUE < 0.1), PREDICT PATIENT DAYS FOR MONTHS 109-120 USING THE MODEL COEFFICIENTS. IF THE LINEAR REGRESSION MODEL IS NOT SIGNIFICANT AT A 90% CONFIDENCE LEVEL (F-SCORE, TWO TAILED p VALUE > 0.1), CALCULATE THE PREDICTED MONTHLY PATIENT DAY DEMAND IN THE PLANNING YEAR BY FINDING THE MONTHLY AVERAGE OF THE THREE PREVIOUS YEARS (MONTHS 25-60).
(d) For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective base year zip code and age group specific year population. The result will be the zip code allocations by age group for each subarea FOR EACH COUNTY, CALCULATE THE PREDICTED YEARLY PATIENT DAY DEMAND IN THE PLANNING YEAR. FOR COUNTIES WITH A SIGNIFICANT REGRESSION MODEL, SUM THE MONTHLY PREDICTED PATIENT DAYS FOR THE PLANNING YEAR. FOR COUNTIES WITH A NON-SIGNIFICANT REGRESSION MODEL, MULTIPLY THE THREE YEAR MONTHLY AVERAGE BY 12.
(e) For each limited access area or hospital subarea, as applicable, calculate the subarea base year population by age group by adding together all zip code population allocations calculated in (d) for each specific age group in that subarea. For a limited access area, add together the age groups identified for the limited access area. The result will be six population age groups for each limited access area or subarea, as applicable. FOR EACH COUNTY, CALCULATE THE BASE YEAR PATIENT DAY COMMITMENT INDEX (%C) TO EACH HOSPITAL GROUP. SPECIFICALLY, DIVIDE THE BASE YEAR PATIENT DAYS FROM EACH COUNTY TO EACH HOSPITAL GROUP BY THE TOTAL NUMBER OF BASE YEAR PATIENT DAYS FROM EACH COUNTY.

(f) For each limited access area or hospital subarea, as applicable, calculate the patient day use rates for ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 through 375 — obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older by dividing the results of (e) by the results of (f) FOR EACH COUNTY.

ALLOCATE THE PLANNING YEAR PATIENT DAYS TO THE HOSPITAL GROUPS BY MULTIPLYING THE PLANNING YEAR PATIENT DAYS BY THE %C TO EACH HOSPITAL GROUP FROM SUBSECTION (E).

(g) For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective planning year zip code and age group specific year population. The results will be the projected zip code allocations by age group for each subarea. For a limited access area, multiply the population projection for the plan year by the proportion of the zip code that is contained within the limited access area for each zip code age group. The results will be the projected zip code allocations by age group for each zip code within the limited access area FOR EACH HOSPITAL GROUP, SUM THE PLANNING YEAR PATIENT DAYS ALLOCATED FROM EACH COUNTY.

(h) For each hospital subarea, calculate the subarea projected year population by age group by adding together all projected zip code population allocations calculated in (g) for each specific age group. For a limited access area, add together the zip code allocations calculated in (g) by age group identified for the limited access area. The result will be six population age groups for each limited access area or subarea, as applicable FOR EACH HOSPITAL GROUP, CALCULATE THE AVERAGE DAILY CENSUS (ADC) FOR THE PLANNING YEAR BY DIVIDING THE PLANNING YEAR PATIENT DAYS BY 365.
ROUND EACH ADC VALUE UP TO THE NEAREST WHOLE NUMBER.

(i) For each limited access area or hospital subarea, as applicable, calculate the limited access area or hospital subarea, as applicable, projected patient days for each age group by multiplying the six projected populations by age group calculated in step (h) by the age specific use rates identified in step (f) FOR EACH HOSPITAL GROUP. SELECT THE APPROPRIATE OCCUPANCY RATE FROM THE OCCUPANCY TABLE IN APPENDIX C.

(j) For each limited access area or hospital subarea, as applicable, calculate the adult medical/surgical limited access area or hospital subarea, as applicable, projected patient days by adding together the following age group specific projected patient days calculated in (i): ages 15 through 44, ages 45 through 64, ages 65 through 74, and ages 75 and older. The 0 (excluding normal newborns) through 14 (pediatric) and female ages 15 through 44 (DRGs 370 through 375 — obstetrical discharges) age groups remain unchanged as calculated in (i) FOR EACH HOSPITAL GROUP, CALCULATE THE PLANNING YEAR BED NEED BY DIVIDING THE PLANNING YEAR ADC BY THE APPROPRIATE OCCUPANCY RATE. ROUND EACH BED NEED VALUE UP TO THE NEAREST WHOLE NUMBER.

(k) For each limited access area or hospital subarea, as applicable, calculate the limited access area or hospital subarea, as applicable, projected average daily census (ADC) for three age groups: Ages 0 (excluding normal newborns) through 14 (pediatric), female ages 15 through 44 (DRGs 370 through 375 — obstetrical discharges), and adult medical surgical by dividing the results calculated in (j) by 365 (or 366 if the planning year is a leap year). Round each ADC to a whole number. This will give three ADC computations per limited access area or subarea, as applicable.

(l) For each limited access area or hospital subarea, as applicable, and age group, select the appropriate occupancy rate from the occupancy rate table in Appendix D.

(m) For each limited access area or hospital subarea, as applicable, and age group, calculate the limited access area or subarea, as applicable, projected bed need number of hospital beds for the limited access area or subarea, as applicable, by age group by dividing the ADC calculated in (k) by the appropriate occupancy rate determined in (l). To obtain the total limited access area or hospital, as
applicable, bed need, add the three age group bed projections together. Round any part of a bed up to a whole bed.

(2) THE DETERMINATION OF THE NEEDED HOSPITAL BED SUPPLY FOR A LIMITED ACCESS AREA SHALL BE MADE USING THE MIDB AND THE METHODOLOGY DETAILED IN "A METHODOLOGY FOR DETERMINING NEEDED HOSPITAL BED SUPPLY" BY PAUL L. DELAMATER, ASHTON M. SHORTRIDGE, AND JOESP H. P. MESSINA, 2011 AS FOLLOWS:

(A) ALL HOSPITAL DISCHARGES FOR NORMAL NEWBORNS (DRG 391 PRIOR TO 2008, DRG 795 THEREAFTER) AND PSYCHIATRIC PATIENTS (ICD-9-CM CODES 290 THROUGH 319 AS A PRINCIPAL DIAGNOSIS) WILL BE EXCLUDED.

(B) CALCULATE THE AVERAGE PATIENT DAY USE RATE OF MICHIGAN RESIDENTS. SUM TOTAL PATIENT DAYS OF MICHIGAN RESIDENTS IN THE BASE YEAR AND DIVIDE BY ESTIMATED BASE YEAR POPULATION FOR THE STATE (POPULATION DATA AVAILABLE FROM US CENSUS BUREAU).

(C) CALCULATE THE MINIMUM NUMBER OF PATIENT DAYS FOR DESIGNATION OF A LIMITED ACCESS AREA BY MULTIPLYING THE AVERAGE PATIENT DAY USE RATE BY 50,000. ROUND UP TO THE NEAREST WHOLE NUMBER.

(D) FOLLOW STEPS OUTLINED IN SECTION 4(1)(B) – (D) TO PREDICT PLANNING YEAR PATIENT DAYS FOR EACH UNDERSERVED AREA. ROUND UP TO THE NEAREST WHOLE NUMBER. THE PATIENT DAYS FOR EACH UNDERSERVED AREA ARE DEFINED AS THE SUM OF THE ZIP CODES CORRESPONDING TO EACH UNDERSERVED AREA.

(E) FOR EACH UNDERSERVED AREA, COMPAR E THE PLANNING YEAR PATIENT DAYS TO THE MINIMUM NUMBER OF PATIENT DAYS FOR DESIGNATION OF A LIMITED ACCESS AREA CALCULATED IN (C). ANY UNDERSERVED AREA WITH A PLANNING YEAR PATIENT DAY DEMAND GREATER THAN OR EQUAL TO THE MINIMUM IS DESIGNATED AS A LIMITED ACCESS AREA.

(F) FOR EACH LIMITED ACCESS AREA, CALCULATE THE PLANNING YEAR BED NEED USING THE STEPS OUTLINED IN SECTION 4(1)(H) – (J). FOR THESE STEPS, USE THE PLANNING YEAR PATIENT DAYS FOR EACH LIMITED ACCESS AREA.

Section 5. Bed Need

Sec. 5. (1) The bed-need numbers incorporated as part of these standards as Appendix C shall apply to projects subject to review under these standards, except where a specific CON review standard states otherwise.

(2) The Commission shall direct the Department, effective November 2004 and SHALL re-calculate the acute care bed need methodology in Section 4, every two years, thereafter OR AS DIRECTED BY THE COMMISSION, to re-calculate the acute care bed need methodology in Section 4, within a specified time frame.

(3) The Commission shall designate the base year and the future planning year which shall be utilized in applying the methodology pursuant to subsection (2).

(4) When the Department is directed by the Commission to apply the methodology pursuant to subsection (2), the effective date of the bed-need numbers shall be established by the Commission.

(5) As directed by the Commission, new bed-need numbers established by subsections (2) and (3) shall supersede the PREVIOUS bed-need numbers shown in Appendix C and shall be included as an amended appendix to these standards POSTED ON THE STATE OF MICHIGAN CON WEB SITE AS PART OF THE HOSPITAL BED INVENTORY.

(6) MODIFICATIONS MADE BY THE COMMISSION PURSUANT TO THIS SECTION SHALL NOT REQUIRE STANDARD ADVISORY COMMITTEE ACTION, A PUBLIC HEARING, OR SUBMITTAL OF
Section 6. Requirements for approval -- new beds in a hospital

Sec. 6. (1) An applicant proposing new beds in a hospital, except an applicant meeting the requirements of subsection 2, 3, 4, or 5 shall demonstrate that it meets all of the following:

(a) The new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.

(b) The total number of existing hospital beds in the subareaHOSPITAL GROUP to which the new beds will be assigned does not currently exceed the needed hospital bed supply as set forth in Appendix C. The Department shall determine the subareaHOSPITAL GROUP to which the beds will be assigned in accord with Section 3 of these standards.

(c) Approval of the proposed new beds in a hospital shall not result in the total number of existing hospital beds, in the subareaHOSPITAL GROUP to which the new beds will be assigned, exceeding the needed hospital bed supply as set forth in Appendix C. The Department shall determine the subareaHOSPITAL GROUP to which the beds will be assigned in accord with Section 3 of these standards.

(2) An applicant proposing to begin operation as a new long-term (acute) careLTAC hospital or alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it meets all of the requirements of this subsection:

(a) If the long-term (acute) careLTAC hospital applicant described in this subsection does not meet the Title XVIII requirements of the Social Security Act for exemption from PPS as a long-term (acute) careLTAC hospital within 12 months after beginning operation, then it may apply for a six-month extension in accordance with R325.9403 of the CON rules. If the applicant fails to meet the Title XVIII requirements for PPS exemption as a long-term (acute) careLTAC hospital within the 12 or 18-month period, then the CON granted pursuant to this section shall expire automatically.

(b) The patient care space and other space to establish the new hospital is being obtained through a lease arrangement and renewal of a lease between the applicant and the host hospital. The initial, renewed, or any subsequent lease shall specify at least all of the following:

(i) That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital or any subsequent application to add additional beds.

(ii) That the proposed new beds shall be for use in space currently licensed as part of the host hospital.

(iii) That upon non-renewal and/or termination of the lease, upon termination of the license issued under Part 215 of the act to the applicant for the new hospital, or upon noncompliance with the project delivery requirements or any other applicable requirements of these standards, the beds licensed as part of the new hospital must be disposed of by one of the following means:

(A) Relicensure of the beds to the host hospital. The host hospital must obtain a CON to acquire the long-term (acute) careLTAC hospital. In the event that the host hospital applies for a CON to acquire the long-term (acute) careLTAC hospital [including the beds leased by the host hospital to the long-term (acute) careLTAC hospital] within six months following the termination of the lease with the long-term (acute) careLTAC hospital, it shall not be required to be in compliance with the hospital bed supply set forth in Appendix C if the host hospital proposes to add the beds of the long-term (acute) careLTAC hospital to the host hospital's medical/surgical licensed capacity and the application meets all other applicable project delivery requirements. The beds must be used for general medical/surgical purposes. Such an application shall not be subject to comparative review and shall be processed under the procedures for non-substantive review (as this will not be considered an increase in the number of beds originally licensed to the applicant at the host hospital);

(B) Delicensure of the hospital beds; or

(C) Acquisition by another entity that obtains a CON to acquire the new hospital in its entirety and that entity must meet and shall stipulate to the requirements specified in Section 6(2).
(c) The applicant or the current licensee of the new hospital shall not apply, initially or subsequently, for CON approval to initiate any other CON covered clinical services; provided, however, that this section is not intended, and shall not be construed in a manner which would prevent the licensee from contracting and/or billing for medically necessary covered clinical services required by its patients under arrangements with its host hospital or any other CON approved provider of covered clinical services.

(d) The new licensed hospital shall remain within the host hospital.

(e) The new hospital shall be assigned to the same HOSPITAL GROUP as the host hospital.

(f) The proposed project to begin operation of a new hospital, under this subsection, shall constitute a change in bed capacity under Section 1(32) of these standards.

(g) The lease will not result in an increase in the number of licensed hospital beds in the HOSPITAL GROUP.

(h) Applications proposing a new hospital under this subsection shall not be subject to comparative review.

(3) An applicant proposing to add new hospital beds, as the receiving licensed hospital under Section 8, shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

(a) The approval of the proposed new hospital beds shall not result in an increase in the number of licensed hospital beds as follows:

(i) In the HOSPITAL GROUP PURSUANT TO SECTION 8(2)(A), or

(ii) in the HSA pursuant to Section 8(2)(b).

(A) The receiving hospital shall meet the requirements of section 6(4)(b) of these standards.

(b) AN APPLICANT PROPOSING TO ADD NEW LICENSED BEDS AS THE RECEIVING HOSPITAL WHERE THE SOURCE HOSPITAL WAS SUBJECT TO SECTION 8(3)(B) SHALL MEET THE FOLLOWING REQUIREMENTS:

(I) THE NUMBER OF BEDS TO BE ADDED SHALL BE NO MORE THAN THE NUMBER, WHICH, WHEN ADDED TO THE NUMBER OF LICENSED BEDS PRIOR TO THE ADDITION, WOULD RESULT IN THE ADJUSTED OCCUPANCY RATE FOR THE RECEIVING HOSPITAL TO BE AT LEAST 40 PERCENT;

(II) FOR THE PURPOSES OF SUBSECTION (I) ABOVE, THE REVISED NUMBER OF LICENSED BEDS AT THE RECEIVING HOSPITAL SHALL BE CALCULATED AS FOLLOWS:

(A) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

(B) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN SUBSECTION (A) ABOVE BY .40 TO DETERMINE LICENSED BED DAYS AT 40 PERCENT OCCUPANCY.

(C) DIVIDE THE RESULT OF SUBSECTION (B) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP YEAR) AND ROUND THE QUOTIENT UP TO THE NEXT WHOLE NUMBER. THIS IS THE MAXIMUM NUMBER OF BEDS THAT CAN BE LICENSED AT THE RECEIVING HOSPITAL AFTER THE ACCEPTANCE OF THE NEW BEDS, OR 25 WHICHEVER IS LARGER.

(C) SUBSECTION (3)(B) SHALL NOT APPLY TO EXCLUDED HOSPITALS.

(D) The proposed project to add new hospital beds, under this subsection, shall constitute a change in bed capacity under Section 1(32) of these standards.

(E) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.

(4) An applicant may apply for the addition of new beds if all of the following subsections are met. Further, an applicant proposing new beds at an existing licensed hospital site shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

(a) The beds are being added at the existing licensed hospital site.
(b) The hospital at the existing licensed hospital site has operated at an adjusted occupancy rate of 80 percent or above for the previous, consecutive 24 months based on its licensed and approved hospital bed capacity. The adjusted occupancy rate shall be calculated as follows:

(i) Combine all pediatric patient days of care and obstetric patient days of care provided during the most recent, consecutive 24-month period for which verifiable data are available to the Department and multiply that number by 1.1.

(ii) Add remaining patient days of care provided during the most recent, consecutive 24-month period for which verifiable data are available to the Department to the number calculated in (i) above. This is the adjusted patient days. CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 24-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

(iii) Divide the number calculated in (ii) above by the total possible patient days [licensed and approved hospital beds multiplied by 730 (or 731 if including a leap year)]. This is the adjusted occupancy rate.

(c) The number of beds that may be approved pursuant to this subsection shall be the number of beds necessary to reduce the adjusted occupancy rate for the hospital to 75 percent. The number of beds shall be calculated as follows:

(i) Divide the number of adjusted patient days calculated in subsection (b)(ii) by .75 to determine licensed bed days at 75 percent occupancy.

(ii) Divide the result of step (i) by 730 (or 731 if including a leap year) and round the result up to the next whole number.

(iii) Subtract the number of licensed and approved hospital beds as documented on the "Department Inventory of Beds" from the result of step (ii) and round the result up to the next whole number to determine the maximum number of beds that may be approved pursuant to this subsection.

(d) A licensed acute care hospital that has relocated its beds, after the effective date of these standards, shall not be approved for hospital beds under this subsection for five years from the effective date of the relocation of beds.

(e) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.

(f) Applicants proposing to add new hospital beds under this subsection shall demonstrate to the Department that they have pursued a good faith effort to relocate acute care beds from other licensed acute care hospitals within the HSA. At the time an application is submitted to the Department, the applicant shall demonstrate that contact was made by one certified mail return receipt for each organization contacted.

(5) An applicant proposing a new hospital in a limited access area shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards, agrees and assures to comply with all applicable project delivery requirements, and all of the following subsections are met.

(a) The proposed new hospital, unless a critical access hospital, shall have 24 hour/7 days a week emergency services, obstetrical services, surgical services, and licensed acute care beds.

(b) The Department shall assign the proposed new hospital to an existing subarea HOSPITAL GROUP based on the current market use patterns of existing subarea HOSPITAL GROUPs.

(c) Approval of the proposed new beds in a hospital in a limited access area shall not exceed the bed need for the limited access area as determined by the bed need methodology in Section 4 and as set forth in Appendix ED.

(d) The new beds in a hospital in a limited access area shall result in a hospital of at least 100 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. If the bed need for a limited access area, as shown in Appendix ED, is less, then that will be the minimum number of beds for a new hospital under this provision. If an applicant for new beds in a hospital under this provision simultaneously applies for status as a critical access hospital, the minimum hospital size shall be that number allowed under state/federal critical access hospital designation.

(e) Applicants proposing to create a new hospital under this subsection shall not be approved, for a period of five years after beginning operation of the facility, of the following covered clinical services: (i) open heart surgery, (ii) therapeutic cardiac catheterization, (iii) fixed positron emission tomography (PET)
services, (iv) all transplant services, (v) neonatal intensive care services/beds, and (vi) fixed urinary extracorporeal shock wave lithotripsy (UESWL) services.

(f) Applicants proposing to add new hospital beds under this subsection shall be prohibited from relocating the new hospital beds for a period of 10 years after beginning operation of the facility.

(g) An applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital as follows:

(i) In a metropolitan statistical area county, an applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital within the limited access area and serve a population of 50,000 or more inside the limited access area and within 30 minutes drive time from the proposed new hospital.

(ii) In a rural or micropolitan statistical area county, an applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital within the limited access area and serve a population of 50,000 or more inside the limited access area and within 60 minutes drive time from the proposed new hospital.

Section 7. Requirements for approval -- replacement beds in a hospital in a replacement zone

Sec. 7. (1) If the application involves the development of a new licensed site, an applicant proposing replacement beds in a hospital in the replacement zone shall demonstrate that the new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.

(2) In order to be approved, the applicant SHALL DEMONSTRATE THAT THE new licensed site is in the replacement zone.

(3) IN ORDER TO BE APPROVED, THE APPLICANT SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS, AS APPLICABLE:

(A) THE APPLICANT shall propose to (i) replace an equal or lesser number of beds currently licensed to the applicant at the licensed site at which the proposed replacement beds are located, and (ii) that the proposed new licensed site is in the replacement zone. IF THE HOSPITAL AT THE EXISTING LICENSED HOSPITAL SITE HAS OPERATED AT AN AVERAGE ADJUSTED OCCUPANCY RATE OF 40 PERCENT OR ABOVE FOR THE PREVIOUS, CONSECUTIVE 36 MONTHS, BASED ON ITS LICENSED AND APPROVED HOSPITAL BED CAPACITY, THE AVERAGE ADJUSTED OCCUPANCY RATE SHALL BE CALCULATED AS FOLLOWS:

(I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

(II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP YEAR).

(B) IF THE HOSPITAL AT THE EXISTING LICENSED HOSPITAL SITE HAS OPERATED AT AN AVERAGE ADJUSTED OCCUPANCY RATE LESS THAN 40 PERCENT FOR THE PREVIOUS CONSECUTIVE 36 MONTHS, IN ORDER TO BE APPROVED, THE REVISED NUMBER OF BEDS AT THE LICENSED SITE SHALL BE NO MORE THAN THE NUMBER OF BEDS WHICH WOULD RESULT IN AN ADJUSTED OCCUPANCY RATE FOR THE HOSPITAL OF 60 PERCENT. THE REVISED NUMBER OF LICENSED BEDS AT THE HOSPITAL SHALL BE CALCULATED AS FOLLOWS:

(I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

(II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY 60 TO DETERMINE LICENSED BED DAYS AT 60 PERCENT OCCUPANCY.

(III) DIVIDE THE RESULT OF SUBSECTION (II) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP YEAR) AND ROUND THE RESULT UP TO THE NEXT WHOLE NUMBER. THIS IS THE MAXIMUM
NUMBER OF BEDS THAT CAN BE LICENSED AT THE EXISTING LICENSED HOSPITAL SITE AFTER THE REPLACEMENT, OR 25 WHICHEVER IS LARGER.

(C) SUBSECTION (3)(B) SHALL NOT APPLY TO EXCLUDED HOSPITALS.

(34) An applicant proposing replacement beds in the replacement zone shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

Section 8. Requirements for approval of an applicant proposing to relocate existing licensed hospital beds

Sec 8. (1) The proposed project to relocate beds, under this section, shall constitute a change in bed capacity under Section 1(43) of these standards.

(2) Any existing licensed acute care hospital may relocate all or a portion of its beds to another existing licensed acute hospital as follows:

(a) The licensed acute care hospitals are located within the same subarea HOSPITAL GROUP, or
(b) the licensed acute care hospitals are located within the same HSA if the receiving hospital meets the requirements of Section 6(4)(b) of these standards.

(3) IN ORDER TO BE APPROVED, THE APPLICANT SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS, AS APPLICABLE:

(A) ANY EXISTING LICENSED ACUTE CARE HOSPITAL MAY RELOCATE ALL OR A PORTION OF ITS BEDS TO ANOTHER EXISTING LICENSED ACUTE CARE HOSPITAL(S) IF THE EXISTING LICENSED HOSPITAL HAS OPERATED AT AN AVERAGE ADJUSTED OCCUPANCY RATE OF 40 PERCENT OR ABOVE FOR THE PREVIOUS, CONSECUTIVE 36 MONTHS, BASED ON ITS LICENSED AND APPROVED HOSPITAL BED CAPACITY. THE AVERAGE ADJUSTED OCCUPANCY RATE SHALL BE CALCULATED AS FOLLOWS:

(I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

(II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP YEAR).

(B) IF THE EXISTING LICENSED HOSPITAL SITE HAS OPERATED AT AN AVERAGE ADJUSTED OCCUPANCY RATE OF LESS THAN 40 PERCENT FOR THE PREVIOUS, CONSECUTIVE 36 MONTHS, IN ORDER TO BE APPROVED, THE FOLLOWING REQUIREMENTS MUST BE MET:

(I) UPON COMPLETION OF THE RELOCATION(S), THE REVISED NUMBER OF BEDS AT THE EXISTING LICENSED HOSPITAL (“SOURCE HOSPITAL”) SHALL BE NO MORE THAN THE NUMBER OF BEDS WHICH WOULD RESULT IN AN ADJUSTED OCCUPANCY RATE FOR THE SOURCE HOSPITAL OF 60 PERCENT.

(II) MULTIPLE RELOCATIONS CAN BE REQUESTED AT THE SAME TIME AND CAN BE COMBINED TO MEET THE CRITERIA OF (I) ABOVE. A SEPARATE CON MUST BE SUBMITTED FOR EACH RELOCATION AND MULTIPLE APPLICATIONS FILED ON THE SAME APPLICATION DATE SHALL BE CONSIDERED TOGETHER TO MEET THIS CRITERION.

(C) FOR THE PURPOSES OF SUBSECTION (3)(B)(I), THE REVISED NUMBER OF LICENSED BEDS AT THE SOURCE HOSPITAL SHALL BE CALCULATED AS FOLLOWS:

(I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

(II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY 60 TO DETERMINE LICENSED BED DAYS AT 60 PERCENT OCCUPANCY.

(III) DIVIDE THE RESULT OF SUBSECTION (II) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP YEAR) AND ROUND THE RESULT UP TO THE NEXT WHOLE NUMBER. THIS IS THE MAXIMUM
NUMBER OF BEDS THAT CAN BE LICENSED AT THE EXISTING LICENSED HOSPITAL SITE AFTER THE RELOCATION, OR 25 WHICHEVER IS LARGER.

(D) SUBSECTION (3)(B) SHALL NOT APPLY TO EXCLUDED HOSPITALS.

(4) The hospital from which the beds are being relocated, and the hospital receiving the beds, shall not require any ownership relationship.

(45) The relocated beds shall be licensed to the receiving hospital and will be counted in the inventory for the applicable subarea HOSPITAL GROUP.

(56) The relocation of beds under this section shall not be subject to a mileage limitation.

Section 9. Project delivery requirements -- terms of approval for all applicants

Sec. 9. (1) An applicant shall agree that, if approved, the project shall be delivered in compliance with the following terms of CON approval:

(a1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(A) The applicant shall assure compliance with Section 20201 of the Code, being Section 333.20201 of the Michigan Compiled Laws.

(3) COMPLIANCE WITH THE FOLLOWING ACCESS TO CARE REQUIREMENTS:

(A) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.

(i) Not deny services to any individual based on ability to pay or source of payment.

(ii) Maintain information by source of payment to indicate the volume of care from each payor and non-payor source provided annually.

(iii) Provide services to any individual based on clinical indications of need for the services.

(4) COMPLIANCE WITH THE FOLLOWING MONITORING AND REPORTING REQUIREMENTS:

(A) An applicant approved pursuant to Section 6(4) must achieve a minimum occupancy of 75 percent over the last 12-month period in the three years after the new beds are put into operation, and for each subsequent calendar year, or the number of new licensed beds shall be reduced to achieve a minimum of 75 percent average annual occupancy for the revised licensed bed complement.

(B) The applicant must submit documentation acceptable and reasonable to the Department, within 30 days after the completion of the 3-year period, to substantiate the occupancy rate for the last 12-month period after the new beds are put into operation and for each subsequent calendar year, within 30 days after the end of the year.

(D) The applicant shall participate in a data collection SYSTEM established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information, OPERATING SCHEDULES, THROUGH-PUT SCHEDULES, and demographic, morbidity, and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on a separate basis for each licensed site, in a format established by the Department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(E) The applicant shall participate and submit data to the Michigan Inpatient Data Base (MIDB). The data shall be submitted to the Department or its designee.

(F) The applicant shall provide the Department with a notice stating the date the hospital beds are placed in operation and such TIMELY notice shall be submitted to the Department OF THE PROPOSED PROJECT IMPLEMENTATION consistent with applicable statute and promulgated rules.

(b) Compliance with applicable operating standards.
An applicant approved pursuant to Section 6(4) must achieve a minimum occupancy of 75 percent over the last 12-month period in the three years after the new beds are put into operation, and for each subsequent calendar year, or the number of new licensed beds shall be reduced to achieve a minimum of 75 percent average annual occupancy for the revised licensed bed complement.

The applicant must submit documentation acceptable and reasonable to the Department, within 30 days after the completion of the 3-year period, to substantiate the occupancy rate for the last 12-month period after the new beds are put into operation and for each subsequent calendar year, within 30 days after the end of the year.

Compliance with the following quality assurance standards:

(i) The applicant shall provide the Department with a notice stating the date the hospital beds are placed in operation and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

(ii) The applicant shall assure compliance with Section 20201 of the Code, being Section 333.20201 of the Michigan Compiled Laws.

(iii) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information and demographic, diagnostic, morbidity, and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on a separate basis for each licensed site, in a format established by the Department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(A) The applicant shall participate and submit data to the Michigan Inpatient Data Base (MIDB). The data shall be submitted to the Department or its designee.

(iv) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.

(d) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:

(i) Not deny services to any individual based on ability to pay or source of payment.

(ii) Maintain information by source of payment to indicate the volume of care from each payor and non-payor source provided annually.

(iii) Provide services to any individual based on clinical indications of need for the services.

The agreements and assurances required by this section shall be in the form of a certification agreed to by the applicant or its authorized agent.

Section 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties

Sec. 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties, for purposes of these standards, are incorporated as part of these standards as Appendix B. The Department may amend Appendix B as appropriate to reflect changes by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget.

Section 11. Department inventory of beds

Sec. 11. The Department shall maintain and provide on request a listing of the Department inventory of beds for each subarea HOSPITAL GROUP.

Section 12. Effect on prior planning policies; comparative reviews

Sec. 12. (1) These CON review standards supersede and replace the CON standards for hospital beds approved by the CON Commission on December 12, 2006, and effective March 8, 2007.

(2) Projects reviewed under these standards shall be subject to comparative review except those projects meeting the requirements of Section 7 involving the replacement of beds in a hospital within the
replacement zone and projects involving acquisition (including purchase, lease, donation or comparable arrangements) of a hospital.

Section 13. Additional requirements for applications included in comparative reviews

Sec. 13. (1) Except for those applications for limited access areas, any application for hospital beds, that is subject to comparative review under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

(2) Each application in a comparative review group shall be individually reviewed to determine whether the application is a qualifying project. If the Department determines that two or more competing applications are qualifying projects, it shall conduct a comparative review. The Department shall approve those qualifying projects which, when taken together, do not exceed the need, as defined in Section 22225(1) of the Code, and which have the highest number of points when the results of subsection (3) are totaled. If two or more qualifying projects are determined to have an identical number of points, then the Department shall approve those qualifying projects that, when taken together, do not exceed the need in the order in which the applications were received by the Department based on the date and time stamp placed on the applications by the department in accordance with rule 325.9123.

(3)(a) A qualifying project will be awarded points based on the percentile ranking of the applicant’s uncompensated care volume and as measured by percentage of gross hospital revenues as set forth in the following table. The applicant’s uncompensated care volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant that are located in the same health service area as the proposed hospital beds. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero. The source document for the calculation shall be the most recent Cost Report filed with the Department for purposes of calculating disproportionate share hospital payments.

<table>
<thead>
<tr>
<th>Percentile Ranking</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.0 – 100</td>
<td>25 pts</td>
</tr>
<tr>
<td>80.0 – 89.9</td>
<td>20 pts</td>
</tr>
<tr>
<td>70.0 – 79.9</td>
<td>15 pts</td>
</tr>
<tr>
<td>60.0 – 69.9</td>
<td>10 pts</td>
</tr>
<tr>
<td>50.0 – 59.9</td>
<td>5 pts</td>
</tr>
</tbody>
</table>

Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to be closed shall be excluded from this calculation.

(b) A qualifying project will be awarded points based on the health service area percentile rank of the applicant’s Medicaid volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant’s Medicaid volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant that are located in the same health service area as the proposed hospital beds. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero. The source document for the calculation shall be the most recent Cost Report filed with the department for purposes of calculating disproportionate share hospital payments.

<table>
<thead>
<tr>
<th>Percentile Rank</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>87.5 – 100</td>
<td>20 pts</td>
</tr>
<tr>
<td>75.0 – 87.4</td>
<td>15 pts</td>
</tr>
<tr>
<td>62.5 – 74.9</td>
<td>10 pts</td>
</tr>
<tr>
<td>50.0 – 61.9</td>
<td>5 pts</td>
</tr>
</tbody>
</table>
Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to be closed shall be excluded from this calculation.

(c) A qualifying project shall be awarded points as set forth in the following table in accordance with its impact on inpatient capacity. If an applicant proposes to close a hospital(s), points shall only be awarded if (i) closure of that hospital(s) does not create a bed need in any subarea as a result of its closing; (ii) the applicant stipulates that the hospital beds to be closed shall not be transferred to another location or facility; and (iii) the utilization (as defined by the average daily census over the previous 24-month period prior to the date that the application is submitted) of the hospital to be closed is at least equal to 50 percent of the size of the proposed hospital (as defined by the number of proposed new licensed beds).

<table>
<thead>
<tr>
<th>Impact on Capacity</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closure of hospital(s)</td>
<td>25 pts</td>
</tr>
<tr>
<td>Closure of hospital(s) which creates a bed need</td>
<td>-15 pts</td>
</tr>
</tbody>
</table>

(d) A qualifying project will be awarded points based on the percentage of the applicant’s historical market share of inpatient discharges of the population in an area which will be defined as that area circumscribed by the proposed hospital locations defined by all of the applicants in the comparative review process under consideration. This area will include any zip code completely within the area as well as any zip code which touches, or is touched by, the lines that define the area included within the figure that is defined by the geometric area resulting from connecting the proposed locations. In the case of two locations or one location or if the exercise in geometric definition does not include at least ten zip codes, the market area will be defined by the zip codes within the county (or counties) that includes the proposed site (or sites). Market share used for the calculation shall be the cumulative market share of the population residing in the set of above-defined zip codes of all currently licensed Michigan hospitals under common ownership or control with the applicant, which are in the same health service area.

<table>
<thead>
<tr>
<th>Percent</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of market share</td>
<td>% of market share served x 30 (total pts. awarded)</td>
</tr>
</tbody>
</table>

The source for calculations under this criterion is the MIDB.

Section 14. Review standards for comparative review of a limited access area

Sec. 14. (1) Any application subject to comparative review, under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards, shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

(2) Each application in a comparative group shall be individually reviewed to determine whether the application has satisfied all the requirements of Section 22225 of the Code, being Section 333.22225 of the Michigan Compiled Laws and all other applicable requirements for approval in the Code and these standards. If the Department determines that two or more competing applications satisfy all of the requirements for approval, these projects shall be considered qualifying projects. The Department shall approve those qualifying projects which, when taken together, do not exceed the need, as defined in Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws, and which have the highest number of points when the results of subsection (3) are totaled. If two or more qualifying projects are determined to have an identical number of points, then the Department shall approve those qualifying projects, when taken together, that do not exceed the need, as defined in...
Section 22225(1) in the order in which the applications were received by the Department based on the
date and time stamp placed on the application by the Department when the application is filed.

(3)(a) A qualifying project will be awarded points based on the percentile ranking of the applicant’s uncompensated care volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant’s uncompensated care will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant. The source document for the calculation shall be the most recent Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

<table>
<thead>
<tr>
<th>Percentile Ranking</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.0 – 100</td>
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</tr>
<tr>
<td>80.0 – 89.9</td>
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<tr>
<td>70.0 – 79.9</td>
<td>15 pts</td>
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<tr>
<td>60.0 – 69.9</td>
<td>10 pts</td>
</tr>
<tr>
<td>50.0 – 59.9</td>
<td>5 pts</td>
</tr>
</tbody>
</table>

Where an applicant proposes to close a hospital as part of its application, data from the closed hospital shall be excluded from this calculation.

(b) A qualifying project will be awarded points based on the statewide percentile rank of the applicant’s Medicaid volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant’s Medicaid volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant. The source documents for the calculation shall be the Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

<table>
<thead>
<tr>
<th>Percentile Rank</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>87.5 – 100</td>
<td>20 pts</td>
</tr>
<tr>
<td>75.0 – 87.4</td>
<td>15 pts</td>
</tr>
<tr>
<td>62.5 – 74.9</td>
<td>10 pts</td>
</tr>
<tr>
<td>50.0 – 61.9</td>
<td>5 pts</td>
</tr>
<tr>
<td>Less than 50.0</td>
<td>0 pts</td>
</tr>
</tbody>
</table>

Where an applicant proposes to close a hospital as part of its application, data from the closed hospital shall be excluded from this calculation.

(c) A qualifying project shall be awarded points as set forth in the following table in accordance with its impact on inpatient capacity in the health service area of the proposed hospital site.

<table>
<thead>
<tr>
<th>Impact on Capacity</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closure of hospital(s)</td>
<td>15 pts</td>
</tr>
<tr>
<td>Move beds</td>
<td>0 pts</td>
</tr>
<tr>
<td>Adds beds (net)</td>
<td>-15 pts</td>
</tr>
<tr>
<td>or</td>
<td></td>
</tr>
<tr>
<td>Closure of hospital(s)</td>
<td></td>
</tr>
<tr>
<td>or delicensure of beds</td>
<td></td>
</tr>
<tr>
<td>which creates a bed need</td>
<td></td>
</tr>
<tr>
<td>or</td>
<td></td>
</tr>
<tr>
<td>Closure of a hospital</td>
<td></td>
</tr>
<tr>
<td>which creates a new Limited Access Area</td>
<td></td>
</tr>
</tbody>
</table>
(d) A qualifying project will be awarded points based on the percentage of the applicant’s market share of inpatient discharges of the population in the limited access area as set forth in the following table. Market share used for the calculation shall be the cumulative market share of Michigan hospitals under common ownership or control with the applicant.

<table>
<thead>
<tr>
<th>Percent</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of market share</td>
<td>% of market share served x 15</td>
</tr>
<tr>
<td>(total pts awarded)</td>
<td></td>
</tr>
</tbody>
</table>

The source for calculations under this criterion is the MIDB.

(e) A qualifying project will be awarded points based on the percentage of the limited access area’s population within a 30 minute travel time of the proposed hospital site if in a metropolitan statistical area county, or within 60 minutes travel time if in a rural or micropolitan statistical area county as set forth in the following table.

<table>
<thead>
<tr>
<th>Percent</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of population within</td>
<td>% of population</td>
</tr>
<tr>
<td>30 (or 60) minute travel</td>
<td>covered x 15 (total pts awarded)</td>
</tr>
<tr>
<td>time of proposed site</td>
<td></td>
</tr>
</tbody>
</table>

(f) All applicants will be ranked in order according to their total project costs as stated in the CON application divided by its proposed number of beds in accordance with the following table.

<table>
<thead>
<tr>
<th>Cost Per Bed</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest cost</td>
<td>10 pts</td>
</tr>
<tr>
<td>2nd Lowest cost</td>
<td>5 pts</td>
</tr>
<tr>
<td>All other applicants</td>
<td>0 pts</td>
</tr>
</tbody>
</table>

Section 15. Documentation of market survey

Sec. 15. An applicant required to conduct a market survey under Section 3 shall specify how the market survey was developed. This specification shall include a description of the data source(s) used, assessments of the accuracy of these data, and the statistical method(s) used. Based on this documentation, the Department shall determine if the market survey is reasonable.

Section 4615. Requirements for approval -- acquisition of a hospital

Sec. 4615. (1) An applicant proposing to acquire a hospital shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C for the subarea HOSPITAL GROUP in which the hospital subject to the proposed acquisition is assigned if the applicant demonstrates that all of the following are met:
(a) the acquisition will not result in a change in bed capacity,
(b) the licensed site does not change as a result of the acquisition,
(c) the project is limited solely to the acquisition of a hospital with a valid license, and
(d) if the application is to acquire a hospital, which was proposed in a prior application to be established as an long-term (acute) care LTAC hospital (LTAC) and which received CON approval, the applicant also must meet the requirements of Section 6(2). Those hospitals that received such prior approval are so identified in Appendix AB ON THE DEPARTMENT INVENTORY OF BEDS.

(2) IN ORDER TO BE APPROVED, THE APPLICANT SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS, AS APPLICABLE:
(A) THE EXISTING LICENSED HOSPITAL HAS OPERATED AT AN AVERAGE ADJUSTED OCCUPANCY RATE OF AT LEAST 40 PERCENT FOR THE PREVIOUS CONSECUTIVE 36 MONTHS BASED ON ITS LICENSED AND APPROVED HOSPITAL BED CAPACITY. AVERAGE ADJUSTED OCCUPANCY SHALL BE CALCULATED AS FOLLOWS.

CON Review Standards for Hospital Beds
For CON Commission Proposed Action December 15, 2011
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(I) Calculate the number of adjusted patient days during the most recent, consecutive 36-month period for which verifiable data are available to the department.

(II) Divide the number of adjusted patient days calculated in (I) above by 1095 (or 1096 if including a leap year).

(B) If the existing licensed hospital has operated at an average adjusted occupancy rate of less than 40 percent for the previous consecutive 36 months, as calculated in (A) above, in order to be approved, the applicant shall agree to all of the following:

(I) The hospital to be acquired will achieve an adjusted annual occupancy of at least 40% during any consecutive 12-month period by the end of the third year of operation after completion of the acquisition. Average adjusted occupancy shall be calculated as follows:

(A) Calculate the number of adjusted patient days during the most recent, consecutive 12-month period for which verifiable data are available to the department.

(B) Divide the number of adjusted patient days calculated in (A) above by 365 (or 366 if a leap year).

(II) If the hospital to be acquired does not achieve an adjusted annual occupancy of at least 40 percent, as calculated in (B) above, during any consecutive 12-month period by the end of the third year of operation after completion of the acquisition, the applicant shall relinquish sufficient beds at the existing hospital to raise its adjusted occupancy to 60 percent. The revised number of licensed beds at the hospital shall be calculated as follows:

(I) Calculate the number of adjusted patient days during the most recent, consecutive 12-month period for which verifiable data are available to the department.

(II) Divide the number of adjusted patient days calculated in subsection (I) above by .60 to determine licensed bed days at 60 percent occupancy.

(III) Divide the result of step subsection (II) above by 365 (or 366 if a leap year) and round the result up to the next whole number. This is the maximum number of licensed beds at the hospital. The number of licensed beds permitted for the licensed hospital shall be the maximum number of licensed beds, or 25, whichever is larger.

(C) Subsection (2) shall not apply to excluded hospitals.

Section 4716. Requirements for approval – all applicants

Sec. 4716. (1) An applicant shall provide verification of Medicaid participation. An applicant that is a new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved.

(2) The applicant certifies all outstanding debt obligations owed to the State of Michigan for Quality Assurance Assessment Program (QAAP) or civil monetary penalties (CMP) have been paid in full.

(3) The applicant certifies that the health facility for the proposed project has not been cited for a state or federal code deficiency within the 12 months prior to the submission of the application. If a state code deficiency has been issued, the applicant shall certify that a plan of correction for cited state deficiencies at the health facility has been submitted and approved by the Bureau of Health Systems within the Department of Licensing and Regulatory Affairs. If a federal code deficiency has been issued, the applicant shall certify that a plan of correction for cited federal deficiencies at the health
FACILITY HAS BEEN SUBMITTED AND APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES. IF CODE DEFICIENCIES INCLUDE ANY UNRESOLVED DEFICIENCIES STILL OUTSTANDING WITH THE DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THAT ARE THE BASIS FOR THE DENIAL, SUSPENSION, OR REVOCATION OF AN APPLICANT'S HEALTH FACILITY LICENSE, POSES AN IMMEDIATE JEOPARDY TO THE HEALTH AND SAFETY OF PATIENTS, OR MEETS A FEDERAL CONDITIONAL DEFICIENCY LEVEL, THE PROPOSED PROJECT CANNOT BE APPROVED WITHOUT APPROVAL FROM THE BUREAU OF HEALTH SYSTEMS OR, IF APPLICABLE, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.
### Section 18. Health-service areas

Sec. 18. Counties assigned to each of the health service areas are as follows:

<table>
<thead>
<tr>
<th>HSA</th>
<th>COUNTIES</th>
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</thead>
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<td>Macomb, Oakland, Washtenaw</td>
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<td>2 - Mid-Southern</td>
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<td>Barry, Calhoun, St. Joseph</td>
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<td>Berrien, Cass, Van Buren</td>
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*This is a hospital that must meet the requirement(s) of Section 16(1)(d) – LTAC.*
## APPENDIX A (continued)

### 1 – Southeast (continued)

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<td>Mount Clemens Regional Medical Center (Fac #50-0090)</td>
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<td>St. John River District Hospital (Fac #74-0030)</td>
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<td>Mercy Memorial Hospital System (Fac #58-0030)</td>
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### 2 – Mid-Southern

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<tr>
<th>Area</th>
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<th>Hospital Name</th>
<th>City</th>
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<td>2A</td>
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<td>Eaton Rapids Medical Center (Fac #35-0010)</td>
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<td>Hayes Green Beach Memorial Hosp (Fac #23-0020)</td>
<td>Charlotte</td>
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<td>Ingham Regional Orthopedic Hospital (Fac #23-0010)</td>
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<td>Edward W. Sparrow Hospital (Fac #35-0090)</td>
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<td>Carelink of Jackson (LTAC Fac #18-0010)*</td>
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<td>2B</td>
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<td>Allegiance Health (Fac #28-0010)</td>
<td>Jackson</td>
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*This is a hospital that must meet the requirement(s) of Section 16(1)(d) – LTAC.*
### Health Service Sub Area
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<th>Area</th>
<th>Hospital Name</th>
<th>City</th>
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<tbody>
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<td>2</td>
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<td>Emma L. Bixby Medical Center</td>
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<td>Herrick Memorial Hospital</td>
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<td>3</td>
<td>Borgess Medical Center</td>
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<td>Bronson Methodist Hospital</td>
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*This is a hospital that must meet the requirement(s) of Section 16(1)(d) – LTAC.

(A) This is a hospital that has state/federal critical access hospital designation.
### Health Service Sub

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*This is a hospital that must meet the requirement(s) of Section 16(d)—LTAC.

(A) This is a hospital that has state/federal critical access hospital designation.
### Appendix A (continued)

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*This is a hospital that must meet the requirement(s) of Section 16(1)(d) – LTAC. (A) This is a hospital that has state/federal critical access hospital designation.
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(A) This is a hospital that has state/federal critical access hospital designation.
Rural Michigan counties are as follows:

- Alcona
- Hillsdale
- Ogemaw
- Alger
- Huron
- Onetonagon
- Antrim
- Iosco
- Osceola
- Arenac
- Iron
- Oscoda
- Baraga
- Lake
- Otsego
- Charlevoix
- Luce
- Presque Isle
- Cheboygan
- Mackinac
- Roscommon
- Clare
- Manistee
- Sanilac
- Crawford
- Mason
- Schoolcraft
- Emmet
- Montcalm
- Tuscola
- Gladwin
- Montmorency
- Gogebic
- Oceana

Micropolitan statistical area Michigan counties are as follows:

- Allegan
- Gratiot
- Mecosta
- Alpena
- Houghton
- Menominee
- Benzie
- Isabella
- Midland
- Branch
- Kalkaska
- Missaukee
- Chippewa
- Keweenaw
- St. Joseph
- Delta
- Leelanau
- Shiawassee
- Dickinson
- Lenawee
- Wexford
- Grand Traverse
- Marquette

Metropolitan statistical area Michigan counties are as follows:

- Barry
- Ionia
- Newaygo
- Bay
- Jackson
- Oakland
- Berrien
- Kalamazoo
- Ottawa
- Calhoun
- Kent
- Saginaw
- Cass
- Lapeer
- St. Clair
- Clinton
- Livingston
- Van Buren
- Eaton
- Macomb
- Washtenaw
- Genesee
- Monroe
- Wayne
- Ingham
- Muskegon

Source:

- 65 F.R., p. 82238 (December 27, 2000)
- Statistical Policy Office
- Office of Information and Regulatory Affairs
- United States Office of Management and Budget
The hospital bed need for purposes of these standards, effective March 2, 2009, and until otherwise changed by the Commission are as follows:

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<tr>
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</tbody>
</table>
LIMITED ACCESS AREAS

Limited access areas and the hospital bed need, effective March 2, 2009 (INSERT EFFECTIVE DATE), for each of those areas are identified below. The hospital bed need for limited access areas shall be changed by the department in accordance with section 2(1)(vW) of these standards, and this appendix shall be updated accordingly.

<table>
<thead>
<tr>
<th>HEALTH SERVICE</th>
<th>LIMITED ACCESS AREA</th>
<th>BED NEED</th>
<th>POPULATION FOR PLANNING YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Alpena/Plus 0808</td>
<td>358</td>
<td>66,946</td>
</tr>
<tr>
<td>8</td>
<td>Upper Peninsula 0808</td>
<td>415</td>
<td>135,215</td>
</tr>
</tbody>
</table>

(NEEDS TO BE UPDATED WHEN BED NEED IS RUN.)

Sources:

1) Michigan State University  
   Department of Geography  
   Hospital Site Selection Final Report  
   November 3, 2004, as amended

2) Section 4 of these standards

3) Michigan State University  
   Department of Geography  
   2011 Planning Year Hospital Bed Need Calculations  
   August 28, 2008

(SOURCES MAY NEED UPDATING)
Section 1.—Applicability; definitions

Sec. 1. (1) This addendum supplements the CON Review Standards for Hospital Beds and may be used for determining the need for projects established to meet the needs of HIV infected individuals.

(2) Except as provided by sections 2 and 3 below, these standards supplement and do not supersede the requirements and terms of approval required by the CON Review Standards for Hospital Beds.

(3) The definitions that apply to the CON Review Standards for Hospital Beds apply to these standards.

(4) “HIV infected” means that term as defined in Section 5101 of the Code.

(5) Planning area for projects for HIV infected individuals means the State of Michigan.

Section 2.—Requirements for approval; change in bed capacity

Sec. 2. (1) A project which, if approved, will increase the number of licensed hospital beds in an overbedded subarea or will result in the total number of existing hospital beds in a subarea exceeding the needed hospital bed supply as determined under the CON Review Standards for Hospital Beds may, nevertheless, be approved pursuant to subsection (3) of this addendum.

(2) Hospital beds approved as a result of this addendum shall be included in the Department inventory of existing beds in the subarea in which the hospital beds will be located. Increases in hospital beds approved under this addendum shall cause subareas currently showing a current surplus of beds to have that surplus increased.

(3) In order to be approved under this addendum, an applicant shall demonstrate all of the following:

(a) The Director of the Department has determined that action is necessary and appropriate to meet the needs of HIV infected individuals for quality, accessible and efficient health care.

(b) The hospital will provide services only to HIV infected individuals.

(c) The applicant has obtained an obligation, enforceable by the Department, from existing licensed hospital(s) in any subarea of this state to voluntarily delicense a number of hospital beds equal to the number proposed in the application. The effective date of the delicensure action will be the date the beds approved pursuant to this addendum are licensed. The beds delicensed shall not be beds already subject to delicensure under a bed reduction plan.

(d) The application does not result in more than 20 beds approved under this addendum in the State.

(4) In making determinations under Section 22225(2)(a) of the Code, for projects under this addendum, the Department shall consider the total cost and quality outcomes for overall community health systems for services in a dedicated portion of an existing facility compared to a separate aids facility and has determined that there exists a special need, and the justification of any cost increases in terms of important quality/access improvements or the likelihood of future cost reductions, or both.

Section 3.—Project delivery requirements—additional terms of approval for projects involving HIV infected individuals approved under this addendum.
Sec. 3.  (1) An applicant shall agree that, if approved, the services provided by the beds for HIV infected individuals shall be delivered in compliance with the following terms of CON approval:

(a) The license to operate the hospital will be limited to serving the needs of patients with the clinical spectrum of HIV infection and any other limitations established by the Department to meet the purposes of this addendum.

(b) The hospital shall be subject to the general license requirements of Part 215 of the Code except as waived by the Department to meet the purposes of this addendum.

(c) The applicant agrees that the Department shall revoke the license of the hospital if the hospital provides services to inpatients other than HIV infected individuals.

Section 4. Comparative reviews

Sec. 4.  (1) Projects proposed under Section 3 shall be subject to comparative review.
December 15, 2011

Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Certificate of Need Commission:

I am writing this letter to strongly oppose the Bed Need Standard Advisory Committee’s (HBSAC) recommendation on a bed reduction methodology. Doctors’ Hospital of Michigan is a privately owned hospital facility where dedicated physicians are working diligently to provide for the medical and health care needs of the residents of the Pontiac area.

Doctors’ Hospital was created when a group of physicians purchased the 321 bed hospital and other assets of North Oakland Medical Center in November of 2008. Our physicians are determined to keep the hospital operational and growing. We have been in a recovery mode following the bankruptcy by the previous owners. There has been a complete change in leadership and a new plan of action for growth and community service is in place.

As Doctors Hospital recovers and grows, it will be necessary to seek CON approval under the Bed Need Standards for renovations and updates. The proposal before you will drastically diminish our ability to fully utilize the hospital facility that we have purchased. Under the 40% occupancy trigger with only the ability to utilize 60 percent of beds above the previous 3 year occupancy level will leave us with only a 61 bed hospital and a nearly empty building. The formula does not have any scientific basis and is arbitrary.

The few beds that could incrementally be added back to the hospital under the high occupancy standard are not sufficient for our expected future needs. It would require countless CON applications at a cost that is prohibitive.

Doctors Hospital is a purchased asset and under the recommendations of the HBSAC, you would be taking that asset away from us without due process and without due compensation. As a for profit hospital, we pay property taxes to the City of Pontiac. Under the proposal, Doctors’ Hospital would be paying property taxes on a building and land that could not be utilized to its full potential. You would also be limiting our ability to hire additional staff during a time when every job is vital to the economic recovery of Michigan.
Empty hospital beds are not a cost to healthcare. They are not a liability to the state, to purchasers of health insurance or providers. There is really no economic need for this bed reduction proposal. As a result, I strongly urge the Certificate of Need Commission to vote down the bed reduction proposal. In the alternative, I urge you to exclude for-profit-hospitals as there is a value to the purchased beds.

Your consideration of my request will be greatly appreciated.

Sincerely,

Sam R. Gizzi
President and Chief Executive Officer
Testimony
Blue Cross Blue Shield of Michigan/Blue Care Network
CON Commission Meeting: Proposed Hospital Bed Standards
December 15, 2011

Thank you for the opportunity to provide testimony on behalf of Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN). BCBSM/BCN supports the proposed hospital bed standards which have been submitted for Commission consideration by the Hospital Bed SAC. The proposed standards reflect months of deliberative discussions and ensure that the needs and realities of the health care marketplace in Michigan are the central tenet of the standards.

Hospital Group and Bed Need Methodology
The proposed methodologies developed by the workgroup and approved by the SAC were developed over a period of five months with the participation of multiple stakeholders and the assistance of the MSU Department of Geography. The workgroup focused on the goal of developing objective, replicable, and sustainable standards which could be utilized now and into the future.

The standards developed through the workgroup process accomplish these goals in the following manner:

- The proposed hospital group methodology groups hospitals based on location and utilization patterns. This methodology will more logically group hospitals than the groupings provided by the existing methodology.
- The demand for bed need will be based on modeling of trends based on the previous five years of county-wide patient day data. The previous methodology relied on zip-code level data and often inaccurate population projections. The proposed methodology will capture trends in bed day rates more effectively than the current methodology, will avoid the errors that are encountered when using small data sets, and will require the collection of dramatically less data.
- According to MSU Geography, which has been contracted to run this data for the Department in previous years, the methodologies “can be executed within a short time frame, using open-source code, and produces replicable results.”

When considering the tenets of cost, quality, and access, the proposed methodologies show that the current number of hospitals and hospital beds in the state are more than adequately serving the demands of Michigan’s population. When run illustratively for the workgroup using 2009 MIDB data, the proposed methodologies found no areas of hospital bed need in the state and an overall excess of 6,747 hospital beds state-wide. Should patient population and utilization trends change in the future, the methodologies are equipped to reflect such changes.

Hospital Bed Reduction
BCBSM supports the proposals that emerged from the hospital bed reduction work group as a valuable first step in addressing the excess bed capacity in Michigan’s hospitals. The proposals
adopted by the SAC will limit the financial incentive for hospitals to use large amounts of excess beds as a bargaining tool for their purchase. Additionally, the proposals will promote the development of capital projects that will be more reflective of a hospital's average occupancy, which could provide cost savings in the future. While BCBSM believes that the proposal is a step in the right direction, continued efforts must address excess hospital capacity on a larger scale in order to truly make a more significant impact on excess costs within the health care system.

Conclusion
BCBSM/BCN supports the Hospital Bed Standards recommended by the Hospital Bed SAC to the CON Commission. The thorough review of these standards over the past six months has resulted in significant improvements to the standards that will ensure appropriate hospital access and reflect the health care needs of the state's population for years to come.

12/15/11
Michigan Department of Community Health (MDCH or Department)
MEMORANDUM
Lansing, MI

Date:       November 10, 2011
TO:         Brenda Rogers
FROM:       Natalie Kellogg
RE:         Summary of Public Hearing Comments on Cardiac Catheterization (CC) Services Standards and MDCH Policy Staff Analysis

Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission “...shall conduct a public hearing on its proposed action.” The Commission took proposed action on the CC Standards at its September 22, 2011 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed CC Standards on November 3, 2011. Written testimony was accepted for an additional 7 days after the hearing via an electronic link on the Commission’s website. Testimony was received from six organizations and is summarized as follows:

Steven Szelag, University of Michigan Health System (UMHS)

UMHS strongly supports the proposed revisions of the CC services standards but, would like to provide additional information pertaining to the necessity of a 0.5 inventory adjustment factor for an Operating Room (OR) and CC Lab used in a hybrid configuration. Data shows that the progressive trend for therapy for Cardiovascular Disease (CVD) is using percutaneous endovascular therapy with or without combined open repair. Those cases without combined open repair will require surgical backup and therefore all cases will necessitate a hybrid OR/CCL. UMHS indicates that the estimated case distribution in a typical hybrid OR/CCL is 60% catheter-based, 30% open surgery and 10% true hybrid (2010 Vascular and Hybrid Suite Benchmarking Survey. It is based on this finding that UMHS is proposing 0.5 inventory adjustment for both the OR and CCL used in a hybrid configuration.

Robert Meeker, Spectrum Health

Spectrum supports the proposed revisions of the CC services standards, particularly the continued requirement that elective angiography procedures can only be performed at hospitals with open-heart surgery back-up. Maintenance of
requirements that restrict the addition of unneeded angioplasty programs in Michigan is good public policy. There are two provisions of the proposed standards which merit further consideration, specifically 1) requirements for replacement of cardiac catheterization units, and 2) requirements of primary angioplasty programs.

In regards to requirements for replacement, Spectrum contends need for the equipment to be replaced should be demonstrated, and such a requirement could be less than the volume required for initiation, perhaps 50% but substantially greater than zero.

Concerning the requirements for primary angioplasty, the SAC recommended reductions in the initiation requirements for primary angioplasty, both the minimum volume of diagnostic cardiac catheterization procedures actually performed and the volume of primary angioplasty projected at the proposed new site. Spectrum Health recommends adjusting the diagnostic CC requirement to 600 procedure equivalents (which would retain the current requirement of 400 procedures) and maintaining the projected volume of 48 emergency PCI procedures. Another issue the Commission may wish to discuss is the “75% rule,” specifically the program section sanctions for providers which perform below 75% of the minimum volume requirements.

Daniel Witt, Metro Health

Metro Health asks that the definition of diagnostic cardiac catheterization procedures be modified to incorporate the right side ablation procedures because the procedure was discussed by the SAC and it was determined that they are safely performed in the Cath Lab setting. The right sided catheter ablation procedures were omitted from the definition when the elective PCI language was removed at the prior Commission meeting.

Patrick O’Donovan, Beaumont Health System

Beaumont supports the CC Standards that were approved for public comment by the Commission at the September 22, 2011 meeting. While Beaumont supports the SAC recommendation to allow (under certain conditions) elective PCI without on-site open heart surgery availability, they do not wish to delay the remaining recommendations. Furthermore Beaumont supports an expedited review of this issue by the Commission at whatever point the ACC guidelines change.

Dennis McCafferty, the Economic Alliance for Michigan (EAM)

EAM, for the most part, supports the proposed changes to the CC standards. EAM feels that the existing 33 sites that are able to perform elective PCI are well distributed across the state, and by concentrating the declining elective PCI volume in fewer sites helps assure higher quality and lower probability that
marginally necessary procedures are being performed. This means lower costs by avoiding capital and staff expense of establishing more elective PCI programs to treat the same population of patients.

EAM did have concerns related specifically to the decrease of annual volume from 48 to 36. The MDCH CON staff does not take corrective action until a provider has dropped below 75% of the CON standards minimum annual volume. The enforceable minimum is now 27, far below the national standards for patient safety. EAM recommends that the Commission consider revisiting this decision, and increase the annual minimum volume for emergency PCI back to 48.

_Sallie Flanders, CON Evaluation Section, MDCH_

The Standards do not provide clear guidance on how to calculate procedure equivalents when several types of procedures are performed within one session, e.g. diagnostic procedure followed by a therapeutic procedure. Should the provider apply the higher weight (2.7 for adult therapeutic) or does one combine the weights (1.5 for adult diagnostic or 2.7 for adult therapeutic)?

_Bart Buxton, Lapeer Regional_

Mr. Buxton is concerned that the Commission chose to ignore the CCSACs recommendation and is even more concerned that the Commission chose to pay no heed to the CON process. He states that as an expert appointed to the SAC, the Committee members and the Department spent countless hours putting together industry information on allowing elective PCI without on-site surgical back-up and the impact it would have upon health care communities in Michigan. The Committee deliberated and ultimately recommended that the Commission adopt language providing for elective PCI without open heart back up under clearly articulated safety guidelines outlined and included as an attachment (American College of Cardiology Guidelines for Percutaneous Coronary Intervention published November 9, 2011). Mr. Buxton further states that he plans to raise concerns with the Joint Legislative Review Committee in addition to local legislators.

_Karen Kippen, Henry Ford Health System (HFHS)_

HFHS supports the CON Standards for CC Services that received initial approval from the Commission on September 22, 2011. HFHS continues to believe that there are additional cost savings and patient care improvements for Michigan that can be achieved by de-linking the angioplasty (PCI) from open heart surgery, but recognize that the discussion will be more productive once guidelines from the American College of Cardiology have been publicly released. Lastly, HFHS fully supports the Commission’s decision to reduce the number of procedures required to obtain and maintain primary PCI.
Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission “...shall conduct a public hearing on its proposed action.” The Commission took proposed action on the SS Standards at its September 22, 2011 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed SS Standards on November 3, 2011. Written testimony was accepted for an additional 7 days after the hearing via an electronic link on the Commission’s website. Testimony was received from three organizations and is summarized as follows:

Steven Szelag, University of Michigan Health System (UMHS)

UMHS strongly supports the proposed revisions of the Surgical Services Standards but would like to provide additional information pertaining to the necessity of a 0.5 inventory adjustment factor for an Operating Room (OR) and Cardiac Catheterization Lab (CCL) used in a hybrid configuration. Data shows that the progressive trend for therapy for Cardiovascular Disease (CVD) is using percutaneous endovascular therapy with or without combined open repair. Those cases without combined open repair will require surgical backup and therefore all cases will necessitate a hybrid OR/CCL. UMHS indicates that the estimated case distribution in a typical hybrid OR/CCL is 60% catheter-based, 30% open surgery and 10% true hybrid (2010 Vascular and Hybrid Suite Benchmarking Survey.) It is based on this finding that UMHS is proposing 0.5 inventory adjustment for both the OR and CCL used in a hybrid configuration.

Dennis McCafferty, Economic Alliance for Michigan (EAM)

EAM supports the proposed changes to the Surgical Services Standards, including the exemption for emergency room (ER) for trauma care and the new definition for hybrid operating room/cardiac cath labs. EAM also noted with
interest the issues raised by the Vascular Access Centers to be re-classified as ambulatory surgical centers, specifically so they are able to bill an additional facility fee to Medicare, thereby reversing the reduction in Medicare reimbursement. EAM is concerned that the procedures performed within the Vascular Access centers are not considered to be surgical procedures, nor the treatment rooms to be considered operating rooms. EAM is further concerned that if a CON were granted, this would allow an exemption for a non-surgical service. The precedent of using CON standards to address reimbursement reductions by Medicare for a specific type of provider could have far-reaching and unanticipated consequences, and recommends excluding this change in the proposed standards.

Robert Meeker, Spectrum Health

Spectrum Health is supportive of the proposed changes to the Surgical Services standards, particularly the revisions allowing dedicated trauma room and defining hybrid OR/CCLs.

The modification for trauma rooms would allow a trauma center to operate a dedicated trauma OR, without counting either the room or the surgical cases performed therein, in the OR need calculation. Providing the option for a busy trauma center to operate a truly dedicated trauma room acknowledges this loss of capacity and allows for a fully-equipped OR ready for trauma patients at all times.

The proposed revisions for hybrid OR/CCLs provides regulatory acknowledgement of the increasing complexity of contemporary surgical procedures. Procedures and cases previously requiring open surgery are able to be performed using approaches previously employed in cardiac catheterization labs and special radiologic procedure rooms. The proposed changes specify requirements for CON approval for the hybrid room(s) and allows the hospital to count each hybrid OR/CCL as either a surgical procedure or a cath lab procedure, as long as they are not counted more than once. They will also allow major referral centers in Michigan to upgrade their cardiac cath and surgical capabilities with the latest equipment. Furthermore, the proposed provisions will insure that hybrid OR/CCLs are only approved at established centers with CON compliant cardiac cath and open-heart surgery programs.
CERTIFICATE OF NEED

4th Quarter Compliance Report to the CON Commission
October 1, 2010 through September 30, 2011 (FY 2011)

This report is to update the Commission on Department activities to monitor compliance of all Certificates of Need recipients as required by Section 22247 of the Public Health Code.

MCL 333.22247

(1) The department shall monitor compliance with all certificates of need issued under this part and shall investigate allegations of noncompliance with a certificate of need or this part.

(2) If the department determines that the recipient of a certificate of need under this part is not in compliance with the terms of the certificate of need or that a person is in violation of this part or the rules promulgated under this part, the department shall do 1 or more of the following:
   (a) Revoke or suspend the certificate of need.
   (b) Impose a civil fine of not more than the amount of the billings for the services provided in violation of this part.
   (c) Take any action authorized under this article for a violation of this article or a rule promulgated under this article, including, but not limited to, issuance of a compliance order under section 20162(5), whether or not the person is licensed under this article.
   (d) Request enforcement action under section 22253.
   (e) Take any other enforcement action authorized by this code.
   (f) Publicize or report the violation or enforcement action, or both, to any person.
   (g) Take any other action as determined appropriate by the department.

(3) A person shall not charge to, or collect from, another person or otherwise recover costs for services provided or for equipment or facilities that are acquired in violation of this part. If a person has violated this subsection, in addition to the sanctions provided under subsection (2), the person shall, upon request of the person from whom the charges were collected, refund those charges, either directly or through a credit on a subsequent bill.

Activity Report

Follow Up: In accordance with Administrative Rules 325.9403 and 325.9417, the Department tracks approved Certificates of Need to determine if proposed projects have been implemented in accordance with Part 222. By rule, applicants are required to either implement a project within one year of approval or execute an enforceable contract to purchase the covered equipment or start construction, as applicable. In addition, an applicant must install the equipment or start construction within two years of approval.

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
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</thead>
<tbody>
<tr>
<td>Approved projects requiring 1-year follow up</td>
<td>90</td>
<td>341</td>
</tr>
<tr>
<td>Approved projects contacted on or before anniversary date</td>
<td>61</td>
<td>229</td>
</tr>
<tr>
<td>Approved projects completed on or before 1-year follow up</td>
<td>68%</td>
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</tr>
<tr>
<td>CON approvals expired due to noncompliance with Part 222</td>
<td>14</td>
<td>80</td>
</tr>
<tr>
<td>Total follow up correspondence sent</td>
<td>136</td>
<td>726</td>
</tr>
<tr>
<td>Total approved projects still ongoing</td>
<td>364</td>
<td></td>
</tr>
</tbody>
</table>

Compliance: The Evaluation Section continues to conduct statewide compliance checks based on 2010 annual survey data.
CERTIFICATE OF NEED
4th Quarter Program Activity Report to the CON Commission
October 1, 2010 through September 30, 2011 (FY 2011)

This quarterly report is designed to assist the CON Commission in monitoring and assessing the operations and effectiveness of the CON Program Section in accordance with Section 22215(1)(e) of the Public Health Code, 1978 PA 368.

Measures

Administrative Rule R325.9201 requires the Department to process a Letter of Intent within 15 days upon receipt of a Letter of Intent.

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percent</td>
</tr>
<tr>
<td>Letters of Intent Received</td>
<td>94</td>
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<tr>
<td>Letters of Intent Processed within 15 days</td>
<td>92</td>
<td>98%</td>
</tr>
<tr>
<td>Letters of Intent Processed Online</td>
<td>94</td>
<td>100%</td>
</tr>
</tbody>
</table>

Administrative Rule R325.9201 requires the Department to request additional information from an applicant within 15 days upon receipt of an application, if additional information is needed.

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percent</td>
</tr>
<tr>
<td>Applications Received</td>
<td>54</td>
<td>N/A</td>
</tr>
<tr>
<td>Applications Processed within 15 Days</td>
<td>52</td>
<td>96%</td>
</tr>
<tr>
<td>Applications Incomplete/More Information Needed</td>
<td>26</td>
<td>48%</td>
</tr>
<tr>
<td>Applications Filed Online*</td>
<td>54</td>
<td>100%</td>
</tr>
<tr>
<td>Application Fees Received Online*</td>
<td>15</td>
<td>28%</td>
</tr>
</tbody>
</table>

* Number/percent is for only those applications eligible to be filed online, potential comparative and comparative applications are not eligible to be filed online, and emergency applications have no fee.

Administrative rules R325.9206 and R325.9207 require the Department to issue a proposed decision for completed applications within 45 days for nonsubstantive, 120 days for substantive, and 150 days for comparative reviews.

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Issued on Time</td>
<td>Percent</td>
</tr>
<tr>
<td>Nonsubstantive Applications</td>
<td>36</td>
<td>100%</td>
</tr>
<tr>
<td>Substantive Applications</td>
<td>50</td>
<td>100%</td>
</tr>
<tr>
<td>Comparative Applications</td>
<td>23</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: Data in this table may not total/correlate with application received table because receive and processed dates may carry over into next month/next quarter.
Measures – continued

Administrative Rule R325.9227 requires the Department to determine if an emergency application will be reviewed pursuant to Section 22235 of the Public Health Code within 10 working days upon receipt of the emergency application request.

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Issued on Time</td>
<td>Percent</td>
</tr>
<tr>
<td>Emergency Applications Received</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Decisions Issued within 10 workings Days</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

Administrative Rule R325.9413 requires the Department to process amendment requests within the same review period as the original application.

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Issued on Time</td>
<td>Percent</td>
</tr>
<tr>
<td>Amendments</td>
<td>18</td>
<td>100%</td>
</tr>
</tbody>
</table>

Section 22231(10) of the Public Health Code requires the Department to issue a refund of the application fee, upon written request, if the Director exceeds the time set forth in this section for a final decision for other than good cause as determined by the Commission.

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percent</td>
</tr>
<tr>
<td>Refunds Issued Pursuant to Section 22231</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Other Measures

<table>
<thead>
<tr>
<th>Activity</th>
<th>4th Quarter</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percent</td>
</tr>
<tr>
<td>FOIA Requests Received</td>
<td>45</td>
<td>N/A</td>
</tr>
<tr>
<td>FOIA Requests Processed on Time</td>
<td>45</td>
<td>100%</td>
</tr>
<tr>
<td>Number of Applications Viewed Onsite</td>
<td>2</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Certificate of Need Evaluation Section, Michigan Department of Community Health.
<table>
<thead>
<tr>
<th>Case Name</th>
<th>Date Opened</th>
<th>Case Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medilodge of Howell v MDCH and Trilogy—Howell Health Campus</td>
<td>04/22/11</td>
<td>Application for Leave to Appeal relating to DCH's decision to remand a comparative review involving nursing home beds.</td>
<td>After the Circuit Court granted DCH’s motion to dismiss, Medilodge filed an application for leave to appeal with the Michigan Court of Appeals. The COA has not ruled on the application.</td>
</tr>
<tr>
<td>Livingston County Circuit Court No: 11-25961-AV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro Health Hospital – CON Application: 10-1026 MAHS</td>
<td>01/07/11</td>
<td>Metro Health requested a hearing relating to DCH’s 11/20/10 proposed decision to deny Metro Health’s application for open heart surgery services and cardiac and catheterization services.</td>
<td>DCH’s Motion for Summary Disposition filed and Metro Health’s Response is due by December 15, 2011.</td>
</tr>
<tr>
<td>Monroe County – Compare Group #95-0216 Includes: Mercy Memorial – CON App # 11-0039 Fountain View – CON App # 11-0018 Medilodge of Monroe – CON App # 11-0030</td>
<td>11/14/11</td>
<td>Monroe County – Comparative Review of nursing home beds – Administrative Appeal The three applicants are: (1) Mercy Memorial (denied applicant); (2) Fountain View (denied applicant); (3) Medilodge of Monroe (approved applicant)</td>
<td>Pre-hearing conference held on 11/23/11. Dates for discovery and motions set.</td>
</tr>
<tr>
<td>Case Name</td>
<td>Date Opened</td>
<td>Case Description</td>
<td>Status</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Oakland County – Compare Group #95-0217</td>
<td>11/1/11</td>
<td>Oakland County – Comparative Review of nursing home beds – Administrative Appeal</td>
<td>Pre-hearing conference held on 12/1/11. Dates for discovery and motions set.</td>
</tr>
<tr>
<td>Includes: Medilodge of Oxford – CON App # 11-0045</td>
<td></td>
<td>The eight applicants are: (1) Medilodge of Oxford (denied applicant); (2) Medilodge of Clarkston (denied applicant); (3) Medilodge of Square Lake (denied applicant); (4) Regency on the Lake (denied applicant); (5) Manor of Farmington Hills (approved applicant); (6) Bloomfield Orchard Villa (approved applicant); (7) Senior Community Of Auburn Hills (approved applicant); (8) Senior Community of Providence Park (approved applicant)</td>
<td></td>
</tr>
<tr>
<td>Medilodge of Clarkston – CON App # 11-0043</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medilodge of Square Lk – CON App # 11-0041</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regency on the Lk – CON App # 11-0033</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manor of Farm. Hills – CON App # 11-0024</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloomfield Orchard – CON App # 11-0028</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Livingston County – Compare Group #95-0214</td>
<td>11/1/11</td>
<td>Livingston County – Comparative Review of nursing home beds – Administrative Appeal</td>
<td>Pre-hearing conference held on 12/6/11. Dates for discovery and motions set.</td>
</tr>
<tr>
<td>Includes: Medilodge of Livingston – CON App # 11-0044</td>
<td></td>
<td>The two applicants are: (1) Medilodge of Livingston (denied applicant); (2) Livingston Care Center (approved applicant)</td>
<td></td>
</tr>
<tr>
<td>Livingston Care Center – CON App # 11-0021</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Clair County – Compare Group #95-0219</td>
<td>11/1/11</td>
<td>St. Clair County – Comparative Review of nursing home beds – Administrative Appeal</td>
<td>Pre-hearing conference held on 12/13/11. Dates for discovery and motions set.</td>
</tr>
<tr>
<td>Includes: Medilodge of St. Clair – CON App # 11-0032</td>
<td></td>
<td>The two applicants are: (1) Medilodge of St. Clair (denied applicant); (2) Regency on the Lake-Fort Gratiot (approved applicant)</td>
<td></td>
</tr>
<tr>
<td>Regency on Lk- Ft. Gratiot – CON App # 11-0034</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## CERTIFICATE OF NEED LEGAL ACTION
### (12.15.11)

<table>
<thead>
<tr>
<th>Case Name</th>
<th>Date Opened</th>
<th>Case Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ausable Valley Continuing Care – CON App # 11-0017</td>
<td>11/19/11</td>
<td>Oscoda County – Administrative Appeal relating to denial of CON application seeking 13 nursing home beds.</td>
<td>Pre-hearing conference is scheduled for 12/20/11.</td>
</tr>
<tr>
<td>Medilodge of Pickney – CON App # 11-0189</td>
<td>11/19/11</td>
<td>Livingston County – Administrative Appeal relating to denial of CON application seeking 56 nursing home beds.</td>
<td>Pre-hearing conference held on 1/12/12. Dates for discovery and motions set.</td>
</tr>
</tbody>
</table>

CON Leg Action; report 12.15.11
Note: New or revised standards may include the provision that make the standard applicable, as of its effective date, to all CON applications for which a final decision has not been issued.

| Service Description                                                                 | 2011 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Bone Marrow Transplantation Services                                               |      |   |   |   |   | PH |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Cardiac Catheterization Services                                                   |      |   |   |   |   |   |   |   |   |   |   |   |   |   | R  |   |   |   |   |   |   |
| Computed Tomography (CT) Scanner Services                                          |      |   |   |   |   |   |   |   |   |   |   |   |   | R  |   |   |   |   |   |   |
| Heart/Lung and Liver Transplantation Services                                      |      |   |   |   |   | PH |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Hospital Beds and Addendum for HIV Infected Individuals                             |      |   |   |   |   | R  | S  | S  |   |   |   |   |   |   |   |   |   |   |   |   |
| Magnetic Resonance Imaging (MRI) Services                                           |      |   |   |   |   |   |   |   |   |   |   |   |   | R  | F  |   |   |   |   |   |
| Open Heart Surgery Services                                                        |      |   |   |   |   | R  |   |   |   |   |   |   |   |   |   |   | D  |   |   |   |
| Pancreas Transplantation Services                                                  |      | PH|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Psychiatric Beds and Services                                                      |      | PH|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Surgical Services                                                                  |      |   |   |   |   |   |   |   |   |   |   |   |   |   |   | M |   |   |   |   |
| Renewal of “Guiding Principles for Determining Whether a Clinical Service should Require Certificate of Need (CON) Review” |      | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M |

**Commission & Department Responsibilities**

| 2011 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| M    | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M |

**CON Annual Activity Report FY 2011**

| 2011 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| M    | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M | M |

**KEY**

- - Receipt of proposed standards/documents, proposed Commission action
  A - Commission Action
  C - Consider proposed action to delete service from list of covered clinical services requiring CON approval
  D - Discussion
  F - Final Commission action, Transmittal to Governor/Legislature for 45-day review period
  M - Monitor service or new technology for changes
  PH - Staff work/Informal Workgroup/Commission Liaison Work/Standing Committee Work
  P - Commission public hearing/Legislative comment period
  PH - Public Hearing for initial comments on review standards
  R - Receipt of report
  S - Solicit nominations for standard advisory committee or standing committee membership

For Approval December 15, 2011

The CON Commission may revise this work plan at each meeting. For information about the CON Commission work plan or how to be notified of CON Commission meetings, contact the Michigan Department of Community Health, Health Policy & Regulation Administration, CON Policy Section, 7th Floor Capitol View Bldg., 201 Townsend St., Lansing, MI 48913, 517-335-6708, www.michigan.gov/con.
## SCHEDULE FOR UPDATING CERTIFICATE OF NEED (CON) STANDARDS EVERY THREE YEARS*

<table>
<thead>
<tr>
<th>Standards</th>
<th>Effective Date</th>
<th>Next Scheduled Update**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air Ambulance Services</td>
<td>August 12, 2010</td>
<td>2013</td>
</tr>
<tr>
<td>Bone Marrow Transplantation Services</td>
<td>December 3, 2010</td>
<td>2012</td>
</tr>
<tr>
<td>Cardiac Catheterization Services</td>
<td>February 25, 2008</td>
<td>2014</td>
</tr>
<tr>
<td>Computed Tomography (CT) Scanner Services</td>
<td>June 20, 2008</td>
<td>2013</td>
</tr>
<tr>
<td>Heart/Lung and Liver Transplantation Services</td>
<td>May 28, 2010</td>
<td>2012</td>
</tr>
<tr>
<td>Hospital Beds and Addendum for HIV Infected Individuals</td>
<td>March 2, 2009</td>
<td>2014</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI) Services</td>
<td>November 21, 2011</td>
<td>2012</td>
</tr>
<tr>
<td>Megavoltage Radiation Therapy (MRT) Services/Units</td>
<td>November 21, 2011</td>
<td>2014</td>
</tr>
<tr>
<td>Neonatal Intensive Care Services/Beds (NICU)</td>
<td>August 12, 2010</td>
<td>2013</td>
</tr>
<tr>
<td>Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups</td>
<td>March 11, 2011</td>
<td>2013</td>
</tr>
<tr>
<td>Open Heart Surgery Services</td>
<td>February 25, 2008</td>
<td>2014</td>
</tr>
<tr>
<td>Pancreas Transplantation Services</td>
<td>November 5, 2009</td>
<td>2012</td>
</tr>
<tr>
<td>Positron Emission Tomography (PET) Scanner Services</td>
<td>November 21, 2011</td>
<td>2014</td>
</tr>
<tr>
<td>Psychiatric Beds and Services</td>
<td>November 5, 2009</td>
<td>2012</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>June 20, 2008</td>
<td>2014</td>
</tr>
<tr>
<td>Urinary Extracorporeal Shock Wave Lithotripsy Services/Units</td>
<td>February 25, 2008</td>
<td>2013</td>
</tr>
</tbody>
</table>

*Pursuant to MCL 333.22215 (1)(m): "In addition to subdivision (b), review and, if necessary, revise each set of certificate of need review standards at least every 3 years."

**A Public Hearing will be held in October prior to the review year to determine what, if any, changes need to be made for each standard scheduled for review. If it is determined that changes are necessary, then the standards can be deferred to a standard advisory committee (SAC), workgroup, or the Department for further review and recommendation to the CON Commission. If no changes are determined, then the standards are scheduled for review in another three years.