MARTIN county

Request for Proposals

to

Lease, Sell or Convey

Martin General Hospital

February 13, 2025

EXECUTIVE SUMMARY

The Martin County Board of Commissioners ("the County")[1] seeks proposals from qualified healthcare organizations to restore essential healthcare services through operation of a Rural Emergency Hospital ("REH")[2] in Williamston, North Carolina. While the August 2023 closure of Martin General Hospital created significant challenges for the community, it also presents an opportunity to implement an innovative healthcare model designed specifically for rural markets. The REH model allows for focused investment in emergency and outpatient services that match documented community demand, while ensuring access to higher levels of care through regional partnerships.

The County owns a facility[3] that can readily accommodate an REH with minimal capital investment, as the County is completing necessary updates to support immediate reopening. The emergency department, expanded in 2001, along with imaging and laboratory areas provide an excellent foundation for REH services. Looking ahead, the opportunity exists to develop a new, right-sized facility optimized for REH and outpatient operations.

Based on extensive analysis, the County has determined that an REH represents the most sustainable approach to providing healthcare services for Martin County's residents. While the County will review proposals for alternative models, Respondents[4] proposing alternatives must demonstrate compelling advantages over the REH model and show clear clinical and financial viability.

The County will evaluate proposals based on four primary criteria:

Quality and Reputation. Demonstrated excellence in clinical quality and operational performance.

Breadth and Commitment to Services. A focus on emergency services with planned expansion of outpatient care.

System Integration. Ability to coordinate seamless care delivery with facilities providing higher levels of care, preferably through established regional health system relationships.

Timing and Facility Commitment. Expeditious reopening and long-term facility planning.

The County anticipates working collaboratively with the selected Respondent to ensure successful implementation and long-term sustainability of healthcare services in Martin County.

Proposals must be submitted no later than Friday, March 28, 2025, 5 PM ET. Questions about the RFP and requests for facility site visits should be directed to Dawn Carter at Ascendient Healthcare Advisors (dawncarter@ascendient.com). Site visits will be arranged upon request.

To provide potential Respondents with comprehensive information about this opportunity and the County's requirements, this Request for Proposals (RFP) details the background, analysis, and evaluation criteria that will guide the selection process.

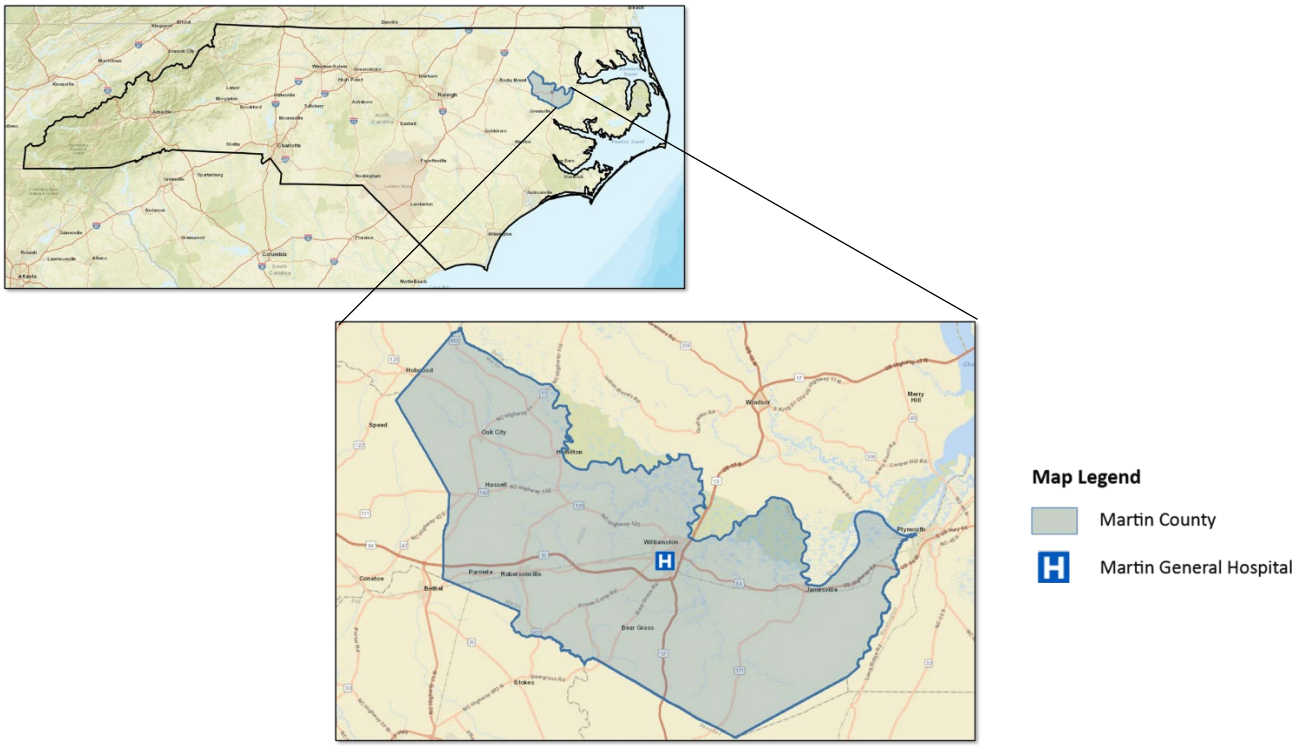
[1] Throughout this document, "the County" refers to the Martin County Board of Commissioners.
[2] Rural Emergency Hospital (REH) is a Medicare designation established by CMS to ensure continued access to emergency hospital services for rural residents.
[3] "The facility" refers to the physical hospital building and associated property owned by Martin County.
[4] "Respondent" refers to any organization submitting a proposal in response to this RFP.

TABLE OF CONTENTS

1.0 INTRODUCTION

In recognition of both the critical need for local emergency and outpatient healthcare services and the opportunity to implement an innovative healthcare delivery model in Martin County, North Carolina, the County is seeking proposals from qualified healthcare organizations to operate a Rural Emergency Hospital. While the loss of the community's only hospital creates challenges, the REH model offers a sustainable path forward by focusing resources on services with demonstrated community demand by the 22,000 residents.

Martin County, North Carolina



Based on thorough market analysis and evaluation of sustainable healthcare models, the County has determined that operation as a Rural Emergency Hospital represents the optimal model for providing essential healthcare services to the community. This conclusion considers both market realities - including utilization patterns and payor mix - and the advantages of the REH's focused scope of services and streamlined operational requirements. While alternative models will be considered, proposals must present compelling evidence of both clinical and financial viability that equals or exceeds the advantages of the REH model.

The existing facility provides a solid foundation for REH services, particularly in key areas. The emergency department, expanded in 2001, along with recently updated imaging and laboratory areas, can readily accommodate REH operations. The County is completing limited renovations needed for reopening, requiring minimal, if any, capital investment from the selected Respondent. While the facility's age presents long-term challenges, the opportunity exists to develop a new, purpose-built facility optimized for REH and outpatient services within the next several years.

The County is distributing this RFP to solicit Respondents interested in either leasing or purchasing the facility. Given future facility needs, the County seeks a Respondent prepared to address both immediate operations and long-term development of a new facility. Under either scenario - lease or purchase - the selected Respondent must demonstrate the following minimum qualifications:

Minimum qualifications for Respondents include:

- Current operation of an acute care hospital(s) and/or Rural Emergency Hospital(s)
- Medicare/Medicaid certification and current accreditation by The Joint Commission or DNV at existing facilities, with commitment to obtain same for the Martin County facility within six months of opening
- Demonstrated understanding of CMS Conditions of Participation for Rural Emergency Hospitals
- Capability to establish and maintain required transfer agreement(s) with Level I or II trauma center(s)
- Financial stability with documented funds sufficient to successfully reopen and operate the facility

See Section 6.1 Respondent Qualifications for detailed documentation requirements for each of these qualifications.

Martin County is the owner of the facility. The evaluation and selection process for this opportunity will include multiple steps, beginning with this Request for Proposals and culminating in a public hearing prior to a final decision. N.C. Gen. Stat. § 131E-13(d) sets forth the procedural requirements the County must follow to sell, lease or otherwise convey the facility; such procedural requirements were promulgated to ensure that all interested parties, including members of the general public, have the opportunity to comment about a potential conveyance of a hospital facility or part thereof. A copy of N.C. Gen. Stat. § 131E-13(d) is included as Attachment A for your reference.

This Request for Proposal seeks to garner information to better understand Respondent's organization and responses to specific questions so that the County may adequately evaluate proposals. ***Please be responsive to the specific requests; Respondents may provide more information than requested; at a minimum, however, please provide the information requested.*** Please submit the response in a narrative form, restate each question included in the RFP, followed by a response.

To facilitate this process, the County has engaged the services of Ascendient Healthcare Advisors, among other advisors. Please submit proposals no later than Friday, March 28, 2025, 5 PM ET. Electronic submission is acceptable and preferred. Please submit to:

Martin County Hospital RFP
c/o Dawn Carter
Senior Partner
Ascendient Healthcare Advisors
1335 Environ Way
Chapel Hill, NC 27517
dawncarter@ascendient.com

Please address any questions about the RFP, process, or information needs to Dawn Carter. Please do not contact any County official or County Commissioner about the RFP, the process, or your proposal.

To help Respondents understand both the challenges and opportunities presented by this RFP, the following sections provide relevant background and analytical support.

2.0 BACKGROUND

Martin General Hospital has served the healthcare needs of Martin County residents for more than 50 years. Prior to 1998, Martin County operated Martin General Hospital as a county-owned facility. In November 1998, Martin County executed a 30-year lease of the hospital property to Williamston Hospital Corporation, which was controlled by Quorum Health Corporation at the time of closure.

On August 3, 2023, Williamston Hospital Corporation filed for Chapter 7 bankruptcy in the Delaware Bankruptcy Court and suspended hospital operations at Martin General Hospital on August 4, 2023. On September 20, 2023, the bankruptcy trustee filed a motion with the Delaware Bankruptcy Court to reject Williamston Hospital Corporation's lease with Martin County. At that time, the County took control of the hospital facility with consent of the trustee.

Prior to its closure, Martin General Hospital operated as the only provider of acute care services in Martin County. The hospital's most active services were its emergency department and outpatient programs.

Statistic (Rounded)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Average IP Acute Daily Census	10	12	12	12	10
Emergency Visits	13,900	13,900	11,200	10,600	11,000
Outpatient Visits	29,800	28,700	21,200	26,000	26,400
ED Admits	800	760	790	730	580
Surgical Cases	0	0	0	750	480
GI Endoscopy Cases	230	290	240	200	92

Source: HLRA for data years ending September 30.

In addition to services offered on the main hospital campus, several clinics operated through Williamston Clinic Corporation over time, representing specialties including orthopedics, nephrology, pulmonology, and general surgery. These clinics closed along with the hospital.

Understanding this historical utilization data helped inform the County's analysis of sustainable healthcare delivery models for the community. The following section details how this analysis supports the REH model as an innovative solution for maintaining essential services in Martin County.

3.0 REH Analysis and Viability

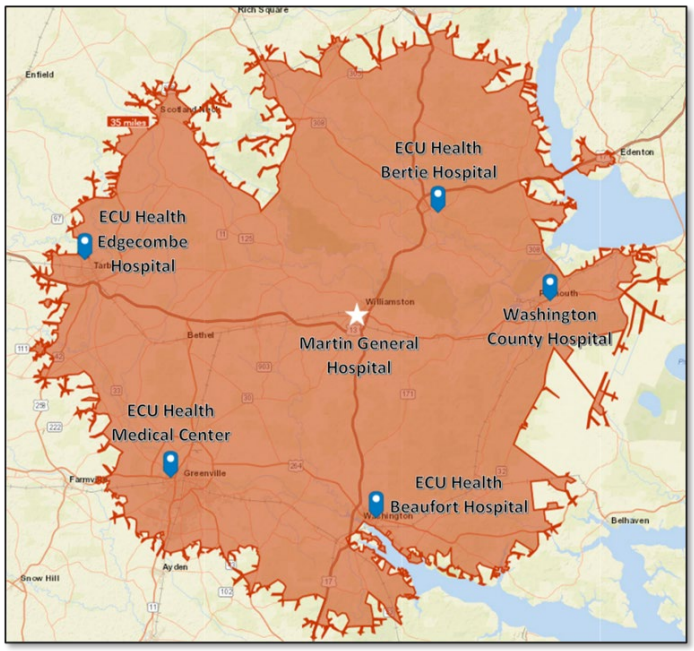
Following extensive analysis of healthcare delivery options for Martin County, the County has concluded that a Rural Emergency Hospital represents the most sustainable model for providing essential healthcare services to the community. This determination emerged from careful evaluation of several critical factors, beginning with the opportunities this model presents for the market.

Market Opportunity. The REH model presents several compelling advantages for Martin County. This innovative approach allows for concentrated investment in services with demonstrated local demand, particularly emergency and outpatient care, while eliminating the burden of maintaining low-volume inpatient services. The model's enhanced reimbursement structure, including dedicated facility payments and increased Medicare rates, provides a more sustainable financial foundation. Its streamlined operational requirements reduce overhead costs while maintaining flexibility to develop innovative outpatient programs that meet community needs. The REH model also creates opportunities for integration with regional health systems while preserving local healthcare services. Furthermore, it offers the potential to develop a new, purpose-built facility specifically designed for modern healthcare delivery, allowing for optimal efficiency in both patient care and operations.

Market Dynamics and Service Sustainability. The proximity of Martin County to larger healthcare systems, particularly academic medical centers with comprehensive subspecialty services, creates both challenges and opportunities for healthcare delivery. Historical utilization patterns show strong community demand for emergency and outpatient services, while specialty and inpatient care are often sought at regional facilities. The REH model aligns with these established patterns by focusing resources on services with demonstrated local need. While aggregate inpatient volumes might appear sufficient to support a community hospital, detailed analysis reveals that individual specialty volumes cannot sustainably support the full complement of specialists required for inpatient care. The REH model addresses this reality by concentrating resources on emergency and outpatient services while ensuring smooth transitions to higher levels of care when needed.

Regulatory Framework. The facility's location relative to other hospitals makes it ineligible for Critical Access Hospital designation and most other supplemental payment programs designed to support rural hospitals. However, as a rural hospital with fewer than 50 beds that was operational on December 27, 2020, the facility does qualify for REH designation. The County's advisors have confirmed directly with CMS the hospital's eligibility for REH designation, as long as the REH opens in the existing facility. This designation provides access to enhanced reimbursement specifically designed to support this innovative model of rural healthcare delivery.

35-Mile Drive Distance from Martin General Hospital



Source: Esri Business Analyst 2022

Facility Considerations and Implementation. The existing facility provides an efficient path to restoring essential services through the REH model. The emergency department, expanded in 2001, along with imaging and laboratory areas, requires minimal updates to meet REH requirements. The County is completing these limited renovations, allowing the selected Respondent to focus on service implementation rather than facility improvements. Furthermore, the opportunity to develop a new, purpose-built facility within the next several years will enable optimization of space and operations specifically for REH and outpatient services.

Workforce Requirements. The REH model addresses one of the key challenges facing rural healthcare facilities - recruitment and retention of healthcare professionals. By focusing on emergency and outpatient services, the model provides greater flexibility in staffing patterns while maintaining appropriate coverage. This focused scope of services allows for more efficient staff utilization and reduces the burden of maintaining specialty coverage, making workforce management more sustainable.

Financial Sustainability. The REH model offers several financial advantages that support long-term viability:

- Annual facility payments of approximately $3.2 million
- Enhanced Medicare outpatient service payments at 105% of standard rates
- Reduced operational costs through focused service offerings
- Alignment of resources with services having demonstrated community demand

This analysis supports the County's conclusion that the REH model best positions the facility to provide sustainable healthcare services to Martin County residents. The following section outlines key considerations for implementing this model successfully.

4.0 KEY CONSIDERATIONS

The successful implementation of healthcare services in Martin County presents several opportunities that will require close collaboration between the selected Respondent and the County. Understanding and addressing these considerations will support both immediate reopening and long-term sustainability.

Medicaid REH Payment Structure. The County is actively monitoring ongoing discussions regarding the Medicaid payment methodology for Rural Emergency Hospitals. This includes engaging with hospital associations and other stakeholders working to address payment policy issues. The County will continue its advocacy efforts and welcomes the selected Respondent's participation in these initiatives.

Legacy Medical Facility Requirements. Martin General Hospital qualifies as a Legacy Medical Care Facility under North Carolina General Statutes, which provides certain advantages including exemption from Certificate of Need review. To maintain this status, notice must be provided to the North Carolina Department of Health and Human Services (NC DHHS) prior to August 3, 2025, indicating intention to operate within the same county and service area. The facility must then become operational within 36 months of this notice. Attachment B includes excerpts from the statute related to a Legacy Medical Care Facility.

Existing Facility Design. The County is preparing key areas of the facility for REH operations, including the emergency department, imaging, and laboratory services. A floor plan showing the designated REH space is included as Attachment C. The County's renovation work will address requirements for reopening, minimizing the selected Respondent's initial capital needs. The County is working closely with NC DHHS on final approval of the proposed plan for reopening as an REH.

Future Facility Development. While the existing facility can support immediate REH operations, the opportunity exists to develop a new, purpose-built facility within the next ten years. This presents a chance to optimize design and operations for the REH model. The County may explore grant funding or other sources to support a potential contribution toward the new facility's development. Respondents should clearly outline any expectations regarding County participation in funding the new facility.

These considerations inform the County's criteria for evaluating Respondents' proposals, as detailed in the following section.

5.0 EVALUATION CRITERIA

The closure of Martin General Hospital in August 2023 has created a vacuum of healthcare services for Martin County residents. While the preceding analysis demonstrates the viability of the REH model, successful implementation requires selecting an operator with the right capabilities, commitment, and regional presence. The County's primary objective is to restore essential healthcare services as expeditiously as possible while ensuring long-term sustainability. After careful consideration of the

community's needs and healthcare delivery trends, the County has established the four key criteria for evaluating Respondents:

Quality and Reputation. The County seeks a Respondent with demonstrated excellence in clinical quality, patient safety, and operational performance. The selected Respondent must have a proven track record of maintaining high standards across their facilities and the ability to recruit and retain qualified healthcare professionals. This criterion reflects the County's commitment to ensuring Martin County residents have access to high-quality care locally.

Breadth and Commitment to Services. While immediate restoration of emergency services is the priority, the County seeks a Respondent committed to providing the broadest scope of sustainable healthcare services to the community. The selected Respondent should be prepared to establish a Rural Emergency Hospital with 24/7 emergency services while developing additional outpatient services, on the campus and/or at other locations in the community, as soon as reasonably feasible. The Respondent must demonstrate a long-term commitment to growing services as community needs and facility capabilities evolve, maintaining flexibility to adapt service offerings based on community needs and operational sustainability.

System Integration. The County places high value on proposals from Respondents who can demonstrate their ability to provide seamless, coordinated care across all levels of service. Respondents should demonstrate their capability and experience in integrating medical staff across facilities, implementing common clinical protocols, maintaining unified medical records systems, and managing efficient patient transfers. Of particular importance is the Respondent's ability to ensure Martin County patients have straightforward access to higher levels of care when needed. Respondents with established healthcare operations in the region, particularly those operating facilities that provide higher levels of care, will be best positioned to demonstrate these capabilities. Respondents should clearly outline their approach to eliminating barriers between care locations and providing comprehensive care navigation support for patients and families.

Timing and Facility Commitment. The County seeks a Respondent prepared to reopen emergency services as quickly as possible. Additionally, the selected Respondent must be willing and able to develop and execute plans for transitioning services to a new facility, demonstrating a clear commitment to maintaining services for the long term.

These criteria will be used to evaluate all proposals, regardless of the specific operating model proposed. While the County believes a Rural Emergency Hospital represents the most sustainable model for Martin County, we will consider alternative approaches that meet these core criteria and demonstrate compelling advantages and viability.

The sections that follow outline the specific information Respondents must provide to demonstrate their qualifications and capabilities relative to these criteria.

6.0 PROPOSAL SECTIONS

The following sections specify the information and documentation Respondents must provide to demonstrate their qualifications, capabilities, and commitment to restoring sustainable healthcare services in Martin County. Each section aligns with the evaluation criteria and seeks evidence of the Respondent's ability to address both immediate needs and long-term objectives.

6.1 RESPONDENT QUALIFICATIONS

To ensure proposals come from organizations capable of successfully implementing and sustaining healthcare services in Martin County, Respondents must demonstrate they meet the following minimum qualifications:

1. Current Operation Experience. To demonstrate capability and track record in healthcare operations, please provide:
    a. Number, type and location of facilities in operation
    b. Length of time operating each facility
    c. Regulatory compliance history

2. Quality and Accreditation Status. To verify commitment to quality care and regulatory compliance, please provide:
    a. Current certification/accreditation status at all facilities
    b. Recent survey results or corrective actions
    c. Timeline and process for obtaining certification/accreditation for Martin County facility

3. REH Operational Knowledge. To confirm understanding of REH requirements and operations, please demonstrate:
    a. Experience operating under REH or similar regulatory frameworks
    b. Knowledge of specific REH requirements and how they will be met

4. Transfer Capability. To ensure appropriate access to higher levels of care, please demonstrate:
    a. Existing transfer relationships
    b. Proposed transfer partners for Martin County
    c. Process for establishing and maintaining agreements

5. Financial Capability. To verify ability to fund and sustain operations, please provide:
    a. Recent audited financial statements
    b. Current bond ratings, if applicable
    c. Evidence of access to capital
    d. Documentation of funds available for startup and operations

6. Implementation Timeline. To demonstrate ability to meet reopening targets, please provide:
    a. Detailed timeline for reopening
    b. Resource allocation plan
    c. Major milestones and dependencies

These qualifications serve as the foundation for the more detailed information requested in subsequent sections. Please address how your organization meets each qualification, providing specific examples and documentation where applicable.

6.2 RESPONDENT BACKGROUND

This section seeks to understand the Respondent's strategic fit with Martin County's healthcare needs and your rationale for pursuing this opportunity. Please provide comprehensive responses to the following.

1. Strategic Vision and Regional Presence. Describe Respondent's vision/strategy regarding:
    a. Current size and scope of operations
    b. Geographic service area and regional presence
    c. Strategic goals for rural healthcare delivery
    d. How Martin County fits within this framework

2. Interest and Organizational Alignment. Please explain:
    a. Why Respondent has chosen to pursue this opportunity
    b. Specific benefits a Martin County facility would bring to Respondent's organization
    c. How the facility would be integrated into Respondent's operational structure
    d. Respondent's experience with similar facilities or markets

3. Operational and Quality Performance. In accordance with N.C.G.S. 131E-13(d)(4), provide detailed metrics for all owned, leased or managed facilities, including:
    a. Financial performance indicators
    b. Quality metrics and outcomes
    c. Service volumes and scope
    d. Charges
    e. Indigent care policies and amounts

This information will help establish Respondent's qualifications and compatibility with Martin County's healthcare needs. The following sections address the proposed transaction terms and the Respondent's ability to meet the County's evaluation criteria.

6.3 PROPOSED TERMS

The County seeks proposals for either: 1) lease of the existing facility with provisions for eventual ownership and development of a new facility, or 2) immediate purchase of the existing facility with commitment to develop a new facility. (See Section 4.0 Key Considerations for specific facility requirements.) Under either scenario, development of a new facility is expected within 10 years. While the County believes a Rural Emergency Hospital represents the most sustainable model of care for Martin

County, we will consider alternative care delivery models that demonstrate compelling advantages and viability. Regardless of the proposed care delivery model, Respondents must address the following:

1. Transaction Structure. Provide specific proposed terms for either lease or purchase of the facility, including:
   a. Proposed financial terms
   b. Timeline for closing
   c. Key conditions and contingencies
   d. Basic parameters for new facility development rights/obligations
   e. Expected County participation in funding

2. Care Access Commitments. In accordance with N.C.G.S. 131E-13(a)(2), (3), and (4), please describe Respondent's commitment to:
   a. Ensuring availability to the indigent population
   b. Preserving or enhancing historical levels of charity and indigent care
   c. Maintaining admission policies that do not restrict essential medical treatment based on immediate ability to pay
   d. Providing access to Medicare and Medicaid beneficiaries without discrimination

3. Implementation Approach. To ensure efficient execution of the proposed transaction, please detail:
   a. Due diligence requirements and timeline
   b. Key milestones to closing
   c. Desired closing date(s)

4. Risk Assessment. To demonstrate understanding of potential challenges, please identify:
   a. Potential obstacles to completing the transaction
   b. Mitigation strategies for identified risks
   c. Required County actions or support

These terms will provide the framework for the proposed transaction. The following sections should detail how Respondent will meet the County's key evaluation criteria, beginning with documentation of quality and performance track record.

6.4 QUALITY AND REPUTATION

These requirements expand upon the quality-related minimum qualifications outlined earlier and seek to establish Respondent's commitment to excellence in healthcare delivery. Please provide detailed responses to the following:

1. Quality Performance Metrics. To demonstrate excellence in clinical care, please provide three years of data for all facilities operated by Respondent, including:
   a. CMS star ratings
   b. Core quality measures and outcomes
   c. Patient satisfaction scores
   d. Other relevant quality indicators

2. Regulatory Compliance. To verify commitment to maintaining high standards, please detail:
    a. Results of recent CMS surveys
    b. State survey results
    c. Accreditation survey findings
    d. Resolution of any corrective action plans

3. Quality Management. To illustrate your systematic approach to quality, please describe:
    a. Quality management structure and reporting
    b. Performance improvement methodology
    c. Successful quality initiatives and outcomes
    d. Approach to quality oversight across facilities

4. Workforce Development. To demonstrate ability to maintain qualified staff, please detail:
    a. Physician and clinical staff recruitment strategies
    b. Retention rates and programs
    c. Experience with such in rural markets similar to Martin County

Respondent's quality record provides context for evaluating your proposed approach to service delivery. The following section addresses how you would implement and expand healthcare services in Martin County.

6.5 BREADTH/COMMITMENT TO SERVICES

This section seeks detailed information about Respondent's planned service implementation and growth strategy. The REH model presents opportunities to align services with community needs while ensuring sustainability. Responses should demonstrate both immediate capability to restore essential services and vision for expanding outpatient care to meet evolving community needs.

1. Service Implementation Plan. To outline your approach to service restoration and development, please describe in detail:
    a. Initial services upon reopening
    b. Service additions within the first three years
    c. Long-term service vision in new facility

2. REH Operations Experience. To demonstrate capability in emergency and outpatient care delivery:
    a. Describe experience operating REHs or similar facilities
    b. Provide examples of service growth in similar markets

3. Community Needs Assessment. To show understanding of local healthcare needs, please:
    a. Describe your analysis of community needs
    b. Outline approach to ongoing needs assessment

Respondent's service delivery plan will require seamless coordination with other facilities and providers. The following section addresses how you will integrate these services to ensure comprehensive care for Martin County residents.

6.6 System Integration

This section focuses on Respondent's ability to create and maintain an integrated system of care that optimizes healthcare delivery for Martin County residents. Strong regional relationships can enhance both quality of care and operational efficiency. Particular emphasis is placed on coordination with facilities providing higher levels of care to ensure seamless patient transitions.

1. Care Coordination Infrastructure. To demonstrate your ability to provide seamless care delivery, please describe:
    a. Transfer protocols and agreements
    b. Medical staff integration across facilities
    c. Information technology integration
    d. Care navigation support for patients

2. Regional Network. To illustrate your capability to provide seamless care delivery across facilities, please:
    a. Detail your existing healthcare operations in the region
    b. Describe established relationships with tertiary care centers and specialists
    c. Explain how Martin County services would integrate with your regional network
    d. Outline your approach to coordinating patient care across facilities
    e. Describe successful examples of care integration in similar markets

3. Operational Integration. To show how Martin County services will connect to your broader system, please describe:
    a. Emergency medical transport arrangements
    b. Specialty consultation arrangements access
    c. Communication protocols between facilities

Respondent's approach to system integration provides context for the implementation timeline. The following section addresses how you will execute both immediate reopening and long-term facility development plans.

6.7 Timing and Facility Commitment

This section focuses on Respondent's ability to restore services quickly while planning for long-term facility needs. Your responses should demonstrate both immediate implementation capability and sustained commitment to facility development.

1. Implementation Timeline. To document your approach to reopening services, please provide:
    a. Detailed reopening timeline with key milestones
    b. Certifications/Accreditations timeline
    c. Service implementation sequence/timeline

2. Facility Development. To demonstrate your commitment to long-term facility needs, please provide:
    a. Timeline for new facility planning and development
    b. Financing strategy and capabilities
    c. Site selection considerations

3. Project Experience. To validate your capability in facility development, please provide:
    a. Examples of similar facility projects
    b. Construction management approach
    c. Evidence of successful project completion

6.8 ADDITIONAL CONSIDERATIONS

The County recognizes that innovative healthcare models may present opportunities not fully captured in previous sections. Respondents should use this section to highlight any additional capabilities, approaches, or considerations that demonstrate their ability to provide sustainable healthcare services in Martin County.

The information provided in the preceding sections will be evaluated through a structured process to ensure thorough and fair consideration of all proposals. The following section outlines this evaluation approach.

7.0 EVALUATION PROCESS

The County will evaluate proposals through a multi-step process designed to identify the Respondent best qualified to restore and maintain healthcare services in Martin County. Each proposal will be assessed based on both minimum qualifications and the four primary evaluation criteria. To ensure thorough consideration of all proposals while maintaining momentum toward service restoration, the County has established the following process timeline and requirements.

Initial Review

- Verification of minimum qualifications
- Completeness of submission
- Financial viability assessment

Detailed Evaluation

- Quality and performance history
- Service implementation capability
- Integration and coordination approach
- Timeline feasibility
- Facility development capacity

Throughout the evaluation process, the County through its advisors may:

- Request additional information or clarification
- Conduct site visits to Respondent facilities
- Interview key personnel
- Contact references
- Seek third-party verification of submitted information

Those Respondents who meet the minimum qualifications will be invited to make presentations to the County.

To ensure an efficient evaluation process, Respondents should carefully note the following timeline and submission requirements.

8.0 NEXT STEPS

Please do not contact any County official or County Commissioner about the RFP, the process, or your proposal. As noted previously, please address any and all questions about the RFP, process, or information needs to Dawn Carter at dawncarter@ascendient.com or 919.226.1701.

Proposal Requirements

- Electronic submission (PDF format preferred)
- Complete responses to all sections
- Supporting documentation as specified
- Clear labeling of all attachments

Facility Site Visits

Respondents interested in conducting a site visit of the facility should direct requests to Dawn Carter at dawncarter@ascendient.com or 919.226.1701. Site visits will be arranged for interested parties upon request.

Timeline

- Submission deadline (electronic submission preferred): Friday, March 28, 2025, 5 PM ET
- Public notice of hearing: Minimum 10 days in advance
- Public hearing: In accordance with N.C. Gen. Stat. § 131E-13(d)

ATTACHMENT A

Copy of N.C. Gen. Stat. § 131E-13

§ 131E-13. Lease or sale of hospital facilities to or from for-profit or nonprofit corporations or other business entities by municipalities and hospital authorities.

(a) A municipality or hospital authority as defined in G.S. 131E-16(14), may lease, sell, or convey any hospital facility, or part of a hospital facility, to a corporation, foreign or domestic, authorized to do business in North Carolina, subject to these conditions, which shall be included in the lease, agreement of sale, or agreement of conveyance:

(1) The corporation shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the lease, sale, or conveyance. These services may be terminated only as prescribed by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable, by review procedure designed to guarantee public participation pursuant to rules adopted by the Secretary of the Department of Health and Human Services.

(2) The corporation shall ensure that indigent care is available to the population of the municipality or area served by the hospital authority at levels related to need, as previously demonstrated and determined mutually by the municipality or hospital authority and the corporation.

(3) The corporation shall not enact financial admission policies that have the effect of denying essential medical services or treatment solely because of a patient's immediate inability to pay for the services or treatment.

(4) The corporation shall ensure that admission to and services of the facility are available to beneficiaries of governmental reimbursement programs (Medicaid/Medicare) without discrimination or preference because they are beneficiaries of those programs.

(5) The corporation shall prepare an annual report that shows compliance with the requirements of the lease, sale, or conveyance.

The corporation shall further agree that if it fails to substantially comply with these conditions, or if it fails to operate the facility as a community general hospital open to the general public and free of discrimination based on race, creed, color, sex, or national origin unless relieved of this responsibility by operation of law, or if the corporation dissolves without a successor corporation to carry out the terms and conditions of the lease, agreement of sale, or agreement of conveyance, all ownership or other rights in the hospital facility, including the building, land and equipment associated with the hospital, shall revert to the municipality or hospital authority or successor entity originally conveying the hospital; provided that any building, land, or equipment associated with the hospital facility that the corporation has constructed or acquired since the sale may revert only upon payment to the corporation of a sum equal to the cost less depreciation of the building, land, or equipment.

This section shall not apply to (i) leases in which the same tenant has continuously held possession of a hospital facility, or part of a hospital facility, since at least June 30, 1984, or (ii) leases, sales, or conveyances of nonmedical services or commercial activities, including the gift shop, cafeteria, the flower shop, or to surplus hospital property that is not required in the delivery of necessary hospital services at the time of the lease, sale, or conveyance.

(b) In the case of a sale or conveyance, if either general obligation bonds or revenue bonds issued for the benefit of the hospital to be conveyed are outstanding at the time of sale or conveyance, then the corporation shall agree to the following:

By the effective date of sale or conveyance, the corporation shall place into an escrow fund money or direct obligations of, or obligations the principal of and interest on which, are unconditionally guaranteed by the United States of America (as approved by the Local

Government Commission), the principal of and interest on which, when due and payable, will provide sufficient money to pay the principal of and the interest and redemption premium, if any, on all bonds then outstanding to the maturity date or dates of such bonds or to the date or dates specified for the redemption thereof. The corporation shall furnish to the Local Government Commission such evidence as the Commission may require that the securities purchased will satisfy the requirements of this section. A hospital which has placed funds in escrow to retire outstanding general obligation or revenue bonds, as provided in this section, shall not be considered a public hospital, and G.S. 159-39(a)(3) shall be inapplicable to such hospitals.

No bonds, notes or other evidences of indebtedness shall be issued by a municipality or hospital authority to finance equipment for or the acquisition, extension, construction, reconstruction, improvement, enlargement, or betterment of any hospital facility if the facility has been sold or conveyed to a corporation, foreign or domestic, authorized to do business in North Carolina.

(c) In the case of a lease, the municipality or hospital authority shall determine the length of the lease. No lease executed under this section shall be deemed to convey a freehold interest. Any sublease or assignment of the lease shall be subject to the conditions prescribed by this section. If the term of the lease is more than 10 years, and either general obligation bonds or revenue bonds issued for the benefit of the hospital to be leased are outstanding at the time of the lease, then the corporation shall agree to the following:

By the effective date of the lease, the corporation shall place into an escrow fund money or direct obligations of, or obligations the principal of and interest on which, are unconditionally guaranteed by the United States of America (as approved by the Local Government Commission), the principal of and interest on which, when due and payable, will provide sufficient money to pay the principal of and the interest and redemption premium, if any, on all bonds then outstanding to the maturity date or dates of such bonds or to the date or dates specified for the redemption thereof. The corporation shall furnish to the Local Government Commission such evidence as the Commission may require that the securities purchased will satisfy the requirements of this section.

No bonds, notes or other evidences of indebtedness shall be issued by a municipality or hospital authority to finance equipment for or the acquisition, extension, construction, reconstruction, improvement, enlargement, or betterment of any hospital facility when the facility is leased to a corporation, foreign or domestic, authorized to do business in North Carolina.

(d) The municipality or hospital authority shall comply with the following procedures before leasing, selling, or conveying a hospital facility, or part of a hospital facility:

(1) The municipality or hospital authority shall first adopt a resolution declaring its intent to sell, lease, or convey the hospital facility at a regular meeting on 10 days' public notice. Notice shall be given by publication in one or more papers of general circulation in the affected area describing the intent to lease, sell, or convey the hospital facility involved, known potential buyers or lessees, a solicitation of additional interested buyers or lessees and intent to negotiate the terms of the lease or sale. Specific notice, given by certified mail, shall be given to the local office of each state-supported program that has made a capital expenditure in the hospital facility, to the Department of Health and Human Services, and to the Office of State Budget and Management.

(2) At the meeting to adopt a resolution of intent, the municipality or hospital authority shall request proposals for lease or purchase by direct solicitation of at least five prospective lessees or buyers. The solicitation shall include a copy of G.S. 131E-13.

(3) The municipality or hospital authority shall conduct a public hearing on the resolution of intent not less than 15 days after its adoption. Notice of the public hearing shall be given by publication at least 15 days before the hearing. All interested persons shall be heard at the public hearing.

(4) Before considering any proposal to lease or purchase, the municipality or hospital authority shall require information on charges, services, and indigent care at similar facilities owned or operated by the proposed lessee or buyer.

(5) Not less than 45 days after adopting a resolution of intent and not less than 30 days after conducting a public hearing on the resolution of intent, the municipality or hospital authority shall conduct a public hearing on proposals for lease or purchase that have been made. Notice of the public hearings shall be given by publication at least 10 days before the hearing. The notice shall state that copies of proposals for lease or purchase are available to the public.

(6) The municipality or hospital authority shall make copies of the proposals to lease or purchase available to the public at least 10 days before the public hearing on the proposals.

(7) Not less than 60 days after adopting a resolution of intent, the municipality or hospital authority at a regular meeting shall approve any lease, sale, or conveyance by a resolution. The municipality or hospital authority shall adopt this resolution only upon a finding that the lease, sale, or conveyance is in the public interest after considering whether the proposed lease, sale, or conveyance will meet the health-related needs of medically underserved groups, such as low income persons, racial and ethnic minorities, and handicapped persons. Notice of the regular meeting shall be given at least 10 days before the meeting and shall state that copies of the lease, sale, or conveyance proposed for approval are available.

(8) At least 10 days before the regular meeting at which any lease, sale, or conveyance is approved, the municipality or hospital authority shall make copies of the proposed contract available to the public.

(d1) Subsection (d) of this section does not apply to subleases in which the same tenant, acting as a sublessor, has continuously held possession of a hospital facility, or part of a hospital facility, since at least June 30, 1984; provided, however, that upon notice by the tenant to a municipality or hospital authority that the tenant, acting as a sublessor, has approved a sublease of a hospital facility, or part of a hospital facility, the municipality or hospital authority shall comply with the provisions of subdivisions (h)(1) through (h)(4) of this section.

(e) Notwithstanding the provisions of subsections (c) and (d) of this section or G.S. 131E-23, a hospital authority as defined in G.S. 131E-16(14) or a municipality may lease or sublease hospital land to a corporation or other business entity, whether for profit or not for profit, and may participate as an owner, joint venturer, or other equity participant with a corporation or other business entity for the development, construction, and operation of medical office buildings and other health care or hospital facilities, so long as the municipality, hospital authority, or other entity continues to maintain its primary community general hospital facilities as required by subsection (a) of this section.

(f) A municipality or hospital authority may permit or consent to the pledge of hospital land or leasehold estates in hospital land to facilitate the development, construction, and operation of medical office buildings and other health care or hospital facilities. A municipality or hospital authority also may, as lessee, enter into master leases or agreements to fund for temporary vacancies relating to hospital land or hospital facilities for use in the provision of health care.

(g) Neither G.S. 153A-176 nor Article 12 of Chapter 160A of the General Statutes shall apply to leases, subleases, sales, or conveyances under this Chapter.

(h) A municipality or hospital authority that has complied with the requirements of subdivisions (1) through (6) of subsection (d) of this section but has not, following good-faith negotiations, approved any lease, sale, or conveyance as required by subdivisions (7) and (8) of subsection (d) of this section may, not less than 120 days following the public hearing required by subdivision (5) of subsection (d) of this section, solicit additional prospective lessees or buyers not previously solicited as required by subdivision (2) of subsection (d) of this section and may approve any lease, sale, or conveyance without the necessity to repeat compliance with the requirements of subdivisions (1) through (6) of subsection (d) of this section, except for the following:

(1) Before considering any proposal to lease or purchase the hospital facility or part of a hospital facility, the municipality or hospital authority shall require information on charges, services, and indigent care at similar facilities leased, owned, or operated by the proposed lessee or buyer.

(2) The municipality or hospital authority shall declare its intent to approve any lease or sale in the manner authorized by this subsection at a regular or special meeting held on 10 days' public notice. Such notice shall state that copies of the lease, sale, or conveyance proposed for approval will be available 10 days prior to the regular or special meeting required by subdivision (3) of this subsection and that the lease, sale, or conveyance shall be considered for approval at a regular or special meeting not less than 10 days following the regular or special meeting required by this subsection. Notice shall be given by publication in one or more papers of general circulation in the affected area describing the intent to lease, sell, or convey the hospital facility involved and the potential buyer or lessee.

(3) Not less than 10 days following the regular or special meeting required by subdivision (2) of this subsection, the municipality or hospital authority shall approve any lease, sale, or conveyance by a resolution at a regular or special meeting.

(4) At least 10 days before the regular or special meeting at which any lease, sale, or conveyance is approved, the municipality or hospital authority shall make copies of the proposed contract available to the public.

(i) This section does not apply to a transaction that is part of an agreement between a municipality or hospital authority and the University of North Carolina Health Care System for the lease, sale, or conveyance of a hospital facility, or part of a hospital facility, to the University of North Carolina Health Care System. (1983 (Reg. Sess., 1984), c. 1066, s. 1; 1997-233, s. 2; 1997-443, s. 11A.118(a); 2000-140, s. 93.1(a); 2001-424, s. 12.2(b); 2015-288, s. 3; 2023-134, s. 4.10(j); 2023-137, s. 53(a).)

ATTACHMENT B

Excerpts of Legacy Medical Facility Statute

§ 131E-176. Definitions.

The following definitions apply in this Article:

(1) Adult care home. – A facility with seven or more beds licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes or under this Chapter that provides residential care for aged individuals or individuals with disabilities whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.

(1a) Air ambulance. – Aircraft used to provide air transport of sick or injured persons between destinations within the State.

(1b) Ambulatory surgical facility. – A facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional, or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room or gastrointestinal endoscopy room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under Part 4 of Article 6 of this Chapter, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.

(1c) Ambulatory surgical program. – A formal program for providing on a same-day basis those surgical procedures which require local, regional, or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to surgery or gastrointestinal endoscopy, to be medically unnecessary.

(2) Bed capacity. – Space used exclusively for inpatient care, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(2a) Bone marrow transplantation services. – The process of infusing bone marrow into persons with diseases to stimulate the production of blood cells.

(2b) Burn intensive care services. – Services provided in a unit designed to care for patients who have been severely burned.

(2c) Campus. – The adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health service facility and related health care entities.

(2d) Capital expenditure. – An expenditure for a project, including but not limited to the cost of construction, engineering, and equipment which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair

market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase.

(2e) Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice offices December 31, 2005.

(2f) Cardiac catheterization equipment. – The equipment used to provide cardiac catheterization services.

(2g) Cardiac catheterization services. – Those procedures, excluding pulmonary angiography procedures, in which a catheter is introduced into a vein or artery and threaded through the circulatory system into the heart specifically to diagnose abnormalities in the motion, contraction, and blood flow of the moving heart or to perform surgical therapeutic interventions to restore, repair, or reconstruct the coronary blood vessels of the heart.

(3) Certificate of need. – A written order which affords the person so designated as the legal proponent of the proposed project the opportunity to proceed with the development of the project.

(4) Repealed by Session Laws 1993, c. 7, s. 2.

(5) Change in bed capacity. – Any of the following:

a. Any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another.

b. Any redistribution of health service facility bed capacity among the categories of health service facility bed.

c. Any increase in the number of health service facility beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(5a) Chemical dependency treatment facility. – A public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or a substance use disorder. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of individuals with chemical dependence or substance use disorders, and related services. The facility or unit may be any of the following:

a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5 of this Chapter.

b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of former Chapter 122 of the General Statutes or Article 2 of Chapter 122C of the General Statutes.

c. A freestanding facility specializing in treatment of individuals with chemical dependence or substance use disorders that is licensed under Article 1A of former Chapter 122 of the General Statutes or Article 2 of Chapter 122C of the General Statutes. The facility may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse treatment units," "residential chemical dependency, substance use disorder, alcoholism or drug abuse facilities," or by other names if the purpose is to provide treatment of individuals with chemical dependence or substance use disorders. The term, however, does not include social setting detoxification facilities, medical detoxification facilities, halfway houses, or recovery farms.

(5b) Chemical dependency treatment beds. – Beds that are licensed for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance use disorder are chemical dependency treatment beds. Chemical dependency treatment beds do not include beds licensed for detoxification.

(6) Department. – The North Carolina Department of Health and Human Services.

(7) Develop. – When used in connection with health services, means to undertake those activities which will result in the offering of institutional health service or the incurring of a financial obligation in relation to the offering of such a service.

(7a) **(Effective until November 21, 2026 – see note)** Diagnostic center. – A freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds three million dollars ($3,000,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than three million dollars ($3,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

(7a) **(Effective November 21, 2026 – see note)** Diagnostic center. – A freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds three million dollars ($3,000,000). No facility, program, or provider, including, but not limited to, physicians' offices, clinical laboratories, radiology centers, or mobile diagnostic programs, shall be deemed a diagnostic center solely by virtue of having a magnetic resonance imaging scanner in a county with a population of greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census. In determining whether the medical diagnostic equipment in a diagnostic center costs more than three million dollars ($3,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S.

Department of Labor for the 12–month period preceding the previous September 1.

(7b) Expedited review. – The status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:

a. The review is not competitive.
b. The proposed capital expenditure is less than five million dollars ($5,000,000).
c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.
d. The agency has not determined that a public hearing is in the public interest.

(7c) Gamma knife. – Equipment which emits photon beams from a stationary radioactive cobalt source to treat lesions deep within the brain and is one type of stereotactic radiosurgery.

(7d) Gastrointestinal endoscopy room. – A room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

(8), (9) Repealed by Session Laws 1987, c. 511, s. 1.

(9a) Health service. – An organized, interrelated activity that is medical, diagnostic, therapeutic, rehabilitative, or a combination thereof and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. "Health service" does not include administrative and other activities that are not integral to clinical management.

(9b) **(Effective until November 21, 2025 – see note)** Health service facility. – A hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9b) **(Effective November 21, 2025 – see note)** Health service facility. – A hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility. The term "health service facility" does not include a qualified urban ambulatory surgical facility.

(9c) Health service facility bed. – A bed licensed for use in a health service facility in the categories of (i) acute care beds; (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for individuals with intellectual disabilities; (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; (ix) adult care home beds; and (x) long-term care hospital beds.

(10) Health maintenance organization (HMO). – A public or private organization which has received its certificate of authority under Article 67 of Chapter 58 of the General Statutes and which either is a qualified health maintenance

organization under Section 1310(d) of the Public Health Service Act or satisfies all of the following:

a. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X ray, emergency and preventive services, and out-of-area coverage.

b. Is compensated, except for copayments, for the provision of the basic health care services listed in sub-subdivision a. of this subdivision to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided.

c. Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organizations, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(10a) Heart-lung bypass machine. – The equipment used to perform extra-corporeal circulation and oxygenation during surgical procedures.

(11) Repealed by Session Laws 1991, c. 692, s. 1.

(12) Home health agency. – A private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.

(12a) Home health services. – Items and services furnished to an individual by a home health agency, or by others under arrangements with such others made by the agency, on a visiting basis, and except for sub-subdivision e. of this subdivision, in a place of temporary or permanent residence used as the individual's home as follows:

a. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse.

b. Physical, occupational, or speech therapy.

c. Medical social services, home health aid services, and other therapeutic services.

d. Medical supplies, other than drugs and biologicals and the use of medical appliances.

e. Any of the items and services listed in this subdivision which are provided on an outpatient basis under arrangements made by the home health agency at a hospital or nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual at home, or which are furnished at the facility while the individual is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

(13) Hospital. – A public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term includes all facilities licensed pursuant to G.S. 131E-77, except long-term care hospitals.

(13a) Hospice. – Any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(13b) Hospice inpatient facility. – A freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in an inpatient setting. For purposes of this Article only, a hospital which has a contractual agreement with a licensed hospice to provide inpatient services to a hospice patient as defined in G.S. 131E-201(4) and provides those services in a licensed acute care bed is not a hospice inpatient facility and is not subject to the requirements in sub-subdivision (5)b. of this section for hospice inpatient beds.

(13c) Hospice residential care facility. – A freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting.

(14) Repealed by Session Laws 1987, c. 511, s. 1.

(14a) Intermediate care facility for individuals with intellectual disabilities. – Facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

(14b) Repealed by Session Laws 1991, c. 692, s. 1.

(14c) Reserved for future codification.

(14d) Repealed by Session Laws 2001-234, s. 2, effective January 1, 2002.

(14e) Kidney disease treatment center. – A facility that is certified as an end-stage renal disease facility by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 405.

(14f) "Legacy Medical Care Facility" means a facility that meets all of the following requirements:

a. Is not presently operating.

b. Has not continuously operated for at least the past six months.

c. Within the last 24 months:

1. Was operated by a person holding a license under G.S. 131E-77; and

2. Was primarily engaged in providing to inpatients or outpatients, by or under supervision of physicians, (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(14g) Linear accelerator. – A machine used to produce ionizing radiation in excess of 1,000,000 electron volts in the form of a beam of electrons or photons to treat cancer patients.

§ 131E-184. Exemptions from review.

(a) Except as provided in subsection (b) of this section, the Department shall exempt from certificate of need review a new institutional health service if it receives prior written notice from the entity proposing the new institutional health service, which notice includes an explanation of why the new institutional health service is required, for any of the following:

(1) To eliminate or prevent imminent safety hazards as defined in federal, State, or local fire, building, or life safety codes or regulations.

(1a) To comply with State licensure standards.

(1b) To comply with accreditation or certification standards which must be met to receive reimbursement under Title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under Title XIX of that act.

(2) Repealed by Session Laws 1987, c. 511, s. 1.

(3) To provide data processing equipment.

(4) To provide parking, heating or cooling systems, elevators, or other basic plant or mechanical improvements, unless these activities are integral portions of a project that involves the construction of a new health service facility or portion thereof and that is subject to certificate of need review.

(5) To replace or repair facilities destroyed or damaged by accident or natural disaster.

(6) To provide any nonhealth service facility or service.

(7) To provide replacement equipment.

(8) To acquire an existing health service facility, including equipment owned by the health service facility at the time of acquisition. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of this subdivision.

(9) To develop or acquire a physician office building regardless of cost, unless a new institutional health service other than defined in G.S. 131E-176(16)b. is offered or developed in the building.

(10) To allow a licensed home care agency, as defined in G.S. 131E-136, to provide Early and Periodic Screening, Diagnosis, and Treatment services to children up to 21 years of age, in compliance with federal Medicaid requirements under 42 U.S.C. § 1396d. This exemption applies to all home care agencies licensed under Article 6 of this Chapter, whether or not they are Medicare-certified.

(b) Those portions of a proposed project which are not proposed for one or more of the purposes under subsection (a) of this section are subject to certificate of need review, if these non-exempt portions of the project are new institutional health services under G.S. 131E-176(16).

(c) Repealed by Session Laws 2023-7, s. 3.1(b), effective March 27, 2023, and applicable to activities occurring on or after that date.

(d) Repealed by Session Laws 2023-7, s. 3.1(b), effective March 27, 2023, and applicable to activities occurring on or after that date.

(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would meet all of the following requirements:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding any of the following existing facilities:

1. Nursing home facility.
2. Adult care home facility.
3. Intermediate care facility for individuals with intellectual disabilities.

b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:

a. Conversion of semiprivate resident rooms to private rooms.

b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.

c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents.

(f) The Department shall exempt from certificate of need review the purchase of any replacement equipment that exceeds the monetary threshold set forth in G.S. 131E-176(22a) if all of the following conditions are met:

(1) The equipment being replaced is located on the main campus.

(2) The Department has previously issued a certificate of need for the equipment being replaced. This subdivision does not apply if a certificate of need was not required at the time the equipment being replaced was initially purchased by the licensed health service facility.

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

(g) The Department shall exempt from certificate of need review any capital expenditure that exceeds the monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

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

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

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

(h) The Department must exempt from certificate of need review the acquisition or reopening of a Legacy Medical Care Facility. The person seeking to operate a Legacy Medical Care Facility shall give the Department written notice of all of the following:

(1) Its intention to acquire or reopen a Legacy Medical Care Facility within the same county and the same service area as the facility that ceased continuous operations. If the Legacy Medical Care Facility will become operational in a new location within the same county and the same service area as the facility

that ceased continuous operations, then the person responsible for giving the written notice required by this section shall notify the Department, as soon as reasonably practicable and prior to becoming operational, of the new location of the Legacy Medical Care Facility. For purposes of this subdivision, "service area" means the service area identified in the North Carolina State Medical Facilities Plan in effect at the time the written notice required by this section is given to the Department.

(2) That the facility will be operational within 36 months of the notice.

The Department shall extend the time by which a facility must be operational in order to be exempt from certificate of need review under this subsection by one additional 36-month period if the person seeking to reopen or acquire the Legacy Medical Care Facility gives the Department written notice of extension within 36 months of the original notice of intent to acquire or reopen the Legacy Medical Care Facility. The written notice of extension must notify the Department (i) that the person has undertaken all reasonable efforts to make the facility operational within 36 months of the notice of intent, (ii) that, despite these reasonable efforts, the person does not anticipate the facility will be operational within that time, and (iii) of its intention that the facility will be operational within 36 months of the notice of extension.

A person seeking to operate a Legacy Medical Care Facility located in a development tier one or tier two area, as defined in G.S. 143B-437.08, may request an additional extension of time by which the facility must be operational in order to be exempt from certificate of need review under this subsection by providing an additional written notice of extension to the Department, delivered prior to the conclusion of the original 36-month extension period, affirming that the person has entered into a contract for the acquisition or reopening of the Legacy Medical Care Facility and that, pursuant to the terms of the contract, the facility will commence operations within 36 months of the conclusion of the original notice of extension. Upon receipt of this notice, the Department shall grant an extension of the time by which the facility must be operational that is sufficient to permit the acquisition or reopening of the Legacy Medical Care Facility as provided in the contract. (1983, c. 775, s. 1; 1987, c. 511, s. 1; 1991 (Reg. Sess., 1992), c. 1030, s. 37; 1993, c. 7, s. 7; 2001-424, s. 25.19(c); 2002-159, s. 41; 2009-145, s. 1; 2009-487, s. 3; 2011-145, s. 19.1(h); 2013-360, s. 12G.3(b); 2013-363, s. 4.6; 2014-100, s. 12G.1(a); 2015-288, s. 2; 2017-184, s. 7(a); 2017-186, s. 2(xxxxx); 2018-81, s. 3(b); 2018-145, s. 15; 2019-76, s. 20; 2021-180, ss. 9E.4, 19C.9(sss); 2023-7, s. 3.1(b).)

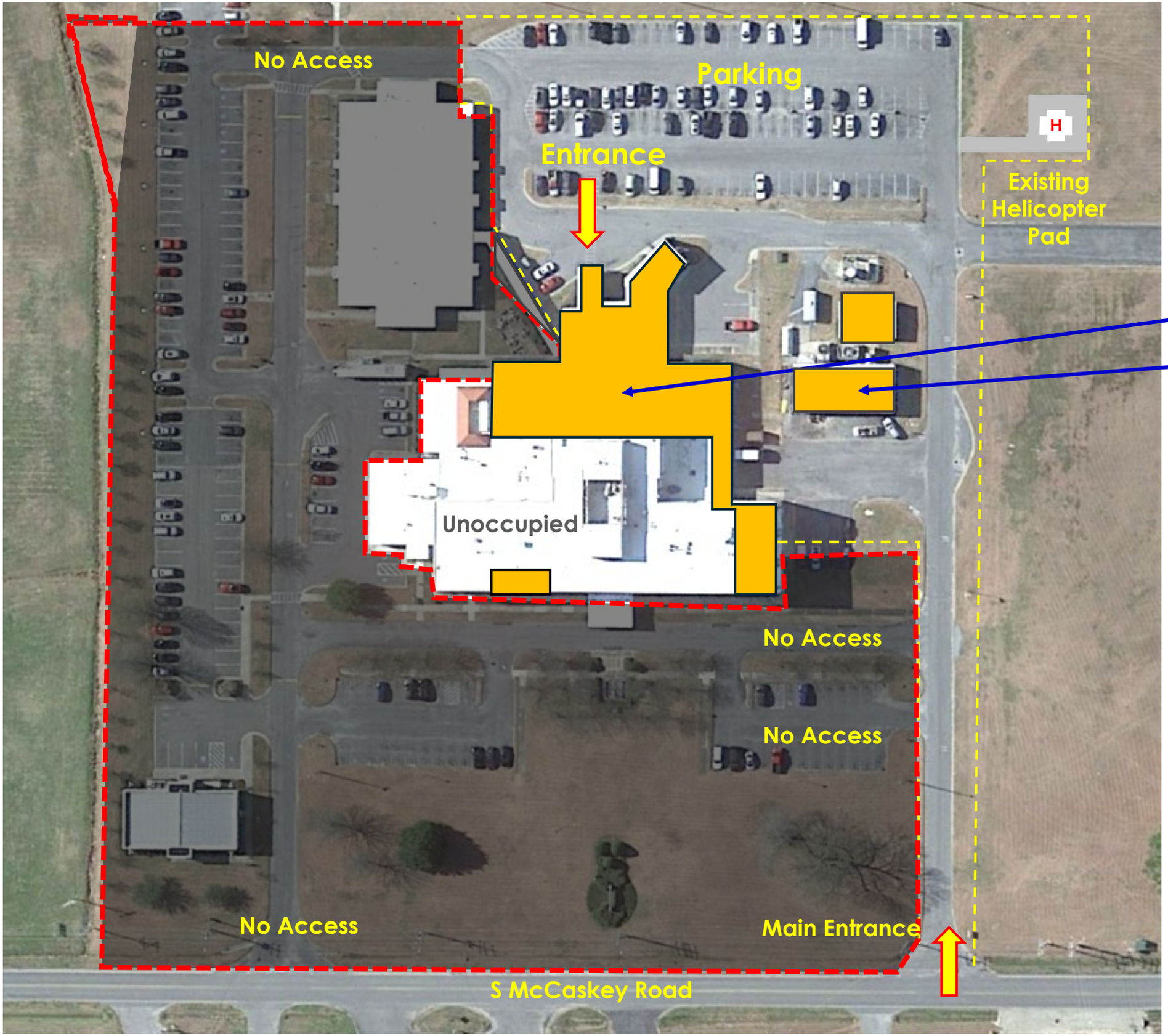
ATTACHMENT C

Site Plan & Floor Plan of Designated REH Area

Martin Rural Emergency Hospital – Site Plan

CriterionHealthcare

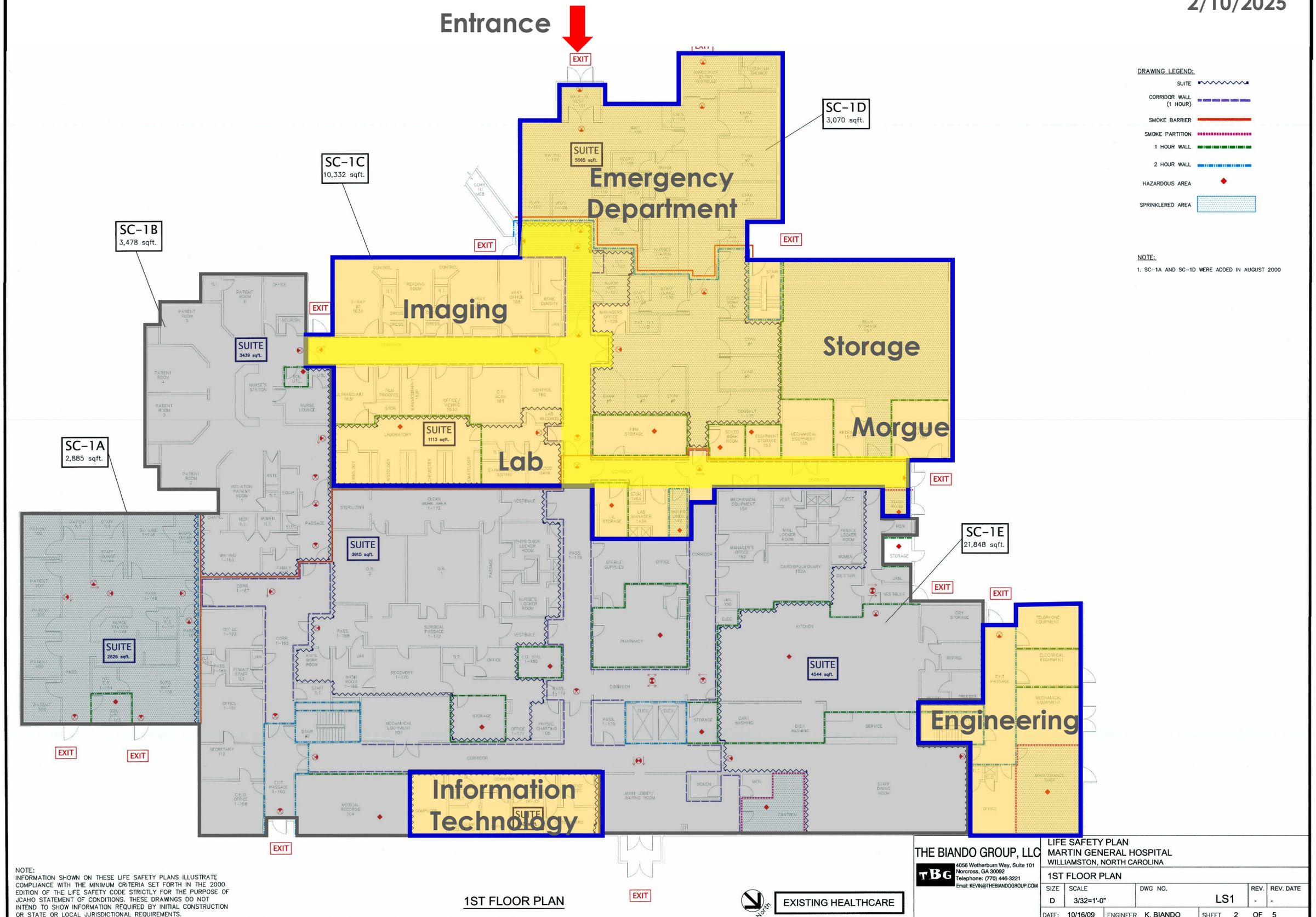
2/10/2025



Martin Rural Emergency Hospital Floor Plan

CriterionHealthcare

2/10/2025



NOTE:
INFORMATION SHOWN ON THESE LIFE SAFETY PLANS ILLUSTRATE COMPLIANCE WITH THE MINIMUM CRITERIA SET FORTH IN THE 2000 EDITION OF THE LIFE SAFETY CODE STRICTLY FOR THE PURPOSE OF JCAHO STATEMENT OF CONDITIONS. THESE DRAWINGS DO NOT INTEND TO SHOW INFORMATION REQUIRED BY INITIAL CONSTRUCTION OR STATE OR LOCAL JURISDICTIONAL REQUIREMENTS.

1ST FLOOR PLAN

North

EXISTING HEALTHCARE

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LIFE SAFETY PLAN
MARTIN GENERAL HOSPITAL
WILLIAMSTON, NORTH CAROLINA

1ST FLOOR PLAN

SIZE	SCALE	DWG NO.	REV.	REV. DATE
D	3/32=1'-0"	LS1	-	-

DATE: 10/16/09 | ENGINEER K. BIANDO | SHEET 2 OF 5