SunCrest
Healthcare

www.suncresthealth.com

Corporate Office
510 Hospital Drive
Suite 100
Madison, TN 37115
615-627-9267
Fax: 615-577-0081

June 1, 2010

Craig Smith, Chief
Certificate of Need Section
Division of Health Service Regulation
N.C. Dept. of Health and Human Services
701 Barbour Drive - Council Building
Raleigh, NC 27603

By Hand Delivery

RE: Certificate of Need Applications by- Assisted Care Home Health: J-8506-10; ARC Therapy Services d/b/a Innovative Senior Care: J-8507-10: Home Health and Hospice Care: J-8509-10: Community Home Health of North Carolina: J-8510-10; United Home Care of Wake County: J-8511-10; Continuum II Home Care and Hospice: J-8512-10. Comments by SunCrest (CON application J-8508-10)

Dear Mr. Smith:

Please accept this letter, together with its attachments, as written comments regarding the above-referenced certificate of need ("CON") applications submitted by applicants seeking approval to offer home health services in Wake County as identified in the 2010 State Medical Facilities Plan. These comments are submitted pursuant to N.C. Gen. Stat. §131E-185(al)(1).

We are submitting these comments on behalf of SunCrest, which, as the applicant in the certificate of need application assigned Project I.D. No. J-8508-10, is an "affected person" with respect to these above identified applications pursuant to N.C. Gen. Stat. §131E-188(c). For the reasons set forth in this letter and its attachments, the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Certificate of Need Section (the "Agency") should approve SunCrest's application and none of the above listed competing applications for which these comments are submitted. None of these comments are intended to amend and should not be treated as amending SunCrest's application.

We appreciate your consideration.

Gary Rasmussen
Chief Financial Officer

Project # J-8508-10
SunCrest Comments on Competing CON Applications for Wake County, NC

The competing applicants in this CON batching cycle are identified in the table below and are associated with a shortened name that will be used throughout these comments of opposition:

Project #	Legal Name	Short Name
J-8506-10	AssistedCare Home Health, Inc.	AssistedCare
J-8507-10	ARC Therapy Services, LLC d/b/a Innovative Senior Care Home Health	ARC
J-8508-10	SunCrest Home Health of North Carolina, Inc.	SunCrest
J-8509-10	Home Health and Hospice Care, Inc.	3HC
J-8510-10	Community Home Health of North Carolina, Inc.	Community
J-8511-10	United Home Care, Inc.	United
J-8512-10	Continuum II Home Care and Hospice, Inc.	Continuum

SECTION II: SCOPE OF SERVICES/QUALITY OF CARE

The approved services offered by home health agencies are determined by CMS. However, the manner in which services are delivered and the ways in which quality of care are managed can vary significantly between agencies. In this section, SunCrest compares some of the means that are used by the applicants to manage and improve quality of care. SunCrest has deliberately not included a discussion of Quality Improvement Programs, Quality Assurance, licensure or accreditation since these differ little between applicants. Their existence is assumed.

Use of Disease Management Protocols/Clinical Pathways

A key method of assuring that the care provided to clients, apart from licensure, accreditation and quality rating organizations, is to provide the process management and organization tools that support quality. One of these is the use of disease state management protocols, or clinical pathways, by clinical providers.

Use of Disease Management Protocols/Clinical Pathways						
SunCrest	**3HC**	**ARC**	**Community**	**Continuum**	**AssistedCare**	**United**
Clinical Pathway & Patient Education	No	Future	Patient Education Only	Patient Education Only	Patient Education Only	Future

SunCrest

As part of the services skilled nursing provides to patients SunCrest includes "disease management" (see page 9 of the CON). However, this goes beyond the usual patient education provided by clinicians in home health settings.

The 9-page "Clinical Pathway for Diagnosis: Heart Failure" is an example of how SunCrest establishes a program of treatment using both regular visits by Skilled Nursing, Daily Telehealth monitoring, and OT treatment as needed. The events programmed for each of 10 scheduled visits

are described and include physical assessment, review of trends from telehealth records, and patient instruction/education. While the Clinical Pathway describes a specific set of steps, it is a guide to be modified, *"Based on the acuity of the patient, specific requests by physician or the individualized treatment planÖî* In addition, a "Patient Teaching Guide: Understanding Heart Failure" is provided to the patient. This 15-page guide describes the nature of Heart Failure, ways to control health and environmental problems that affect Heart Failure, medication awareness, self-care procedures, food recommendations, symptom awareness, vital sign monitoring forms, and a description of events that may require medication management.

3HC
Not discussed in the application.

ARC
Disease Management is shown as a function of "other social services" (p.9, CON Application).

Disease management is mentioned under HIV/AIDS Care, but no means of implementing is provided other than "social work-nurse disease management teams." There appears to be a confounding with "case management", a related but different approach to care (p. 13, CON application). A similar discussion on p.14 refers to self-management of the disease and to "nurse disease managers".

ARC provides a discussion of "disease management" on p.19, which seems to describe Disease Management as a future activity, not as an existing program. ARC states: "The definition of a Disease Management Program to be utilized (underlining added by SunCrest) by the applicant is as follows: *"A comprehensive and coordinated system of care that manages a disease state, rather than an acute episode, with an integrated approach designed to maximize outcomes and reduce overall cost." [Notes: italics in original]*

In a similar vein ARC says "The applicant has proposed a comprehensive scope of clinical services (please refer to the *"Scope of Services"* section) which includes a detailed disease management program. The disease management model essentially uses a nursing/social work team to work with the patient and the patient's family caregivers to get the health care and other community services they need, when they need them, and for the best value (p.21 CON application)." ARC further states this same process again emphasizing that their approach is a "social work-nurse disease management team (p.47, CON application)." This is a useful approach to coordinating care and involving the patient in self-care using nursing management, *but it is not the same as a disease management protocol* for specific disease states, which can then be modified upon clinician experience.

No evidence of the existence of a current disease management protocol or of patient disease educational materials is provided.

Community
In its preamble to its application, p. vii, Community says "CHHNC will provide disease specific educational materials that target the diseases highly associated with home care services (heart disease, diabetes, respiratory disease, etc.) to churches, pharmacies, community health fairs, senior centers, and civic groups." Community refers to its disease specific educational materials in other places (p.42, CON application).

Other than disease educational materials, there is no mention of disease management protocols.

Continuum
The sole discussion by Continuum of "disease management" is found at p.13, CON application. "A Registered Nurse will be responsible for providing nursing services such as client/caregiver education in disease and disease management (ex. Cardiac, Wound Care, Diabetes, HIV/AIDS), treatments (ex. wound care, venipunctures, ostomy care), and assessment of client/caregiver understanding and compliance and effectiveness of Plan of Care." (p.13, CON application)

Assisted Care
"AssistedCare incorporates the use of best practices for disease management for: Oncology, Neurology, Cardiology, Orthopedics, Endocrinology, Respiratory / Pulmonary, Psychiatry, Wound Care (p.12, CON application)." Of these, seven are medical specialties each treating a broad array of diseases. Only one, wound care, is a specific problem which must be managed.

Disease management is described as a part of the nursing staff's "Teaching, supervising, and counseling the patient and family members about providing care for the patient at home, including disease management, safety, medication administration/ side effects, and nutritional guidance (p.18, CON application)." All of this is a part of patient and caregiver education and not specifically a protocol for managing the course of curative care for a specific disease state.

Disease management is again mentioned in these words: "The model created by CCNC includes a medical home that links providers with patients needing care. This alliance provides care coordination, disease management and quality improvement for residents in its Medicaid program (p. 29, CON application, also on pages 36, & 58)." Disease management appears to be an incidental issue to AssistedCare, important to the extent that a payor is involved, and not as a means of managing the curative course of disease treatment. The CCNC concept that AssistedCare discusses is focused only on its Medicaid patients. In Wake County, AssistedCare is seeking to serve a much broader population and likely an older population than it experiences with CCNC. For this reason the medical home context and the disease management as case management/education approach that they refer to do not address the more rigorous disease management protocol approach that tracks vital signs and other indicators as a means of allowing clinicians to adjust the course of a disease specific treatment protocol.

United
United lists one of its services as: "Diabetes and chronic disease management services- provided under the guidance of a diabetes educators" (p. 17, CON Application).

Subsequently they propose (but do not definitively offer) disease management: "In addition, United will develop carefully tailored programs to cater to clients with special needs. United *proposes to offer the following enriched* (emphasis added) service programs through its own staff or by written agreement or referral consultative arrangements: Palliative Care, Wound Care Management, Pain Management, IV and Infusion Therapy, Diabetes and Chronic Disease Management, Heart Failure Care, Oncology Care, Chronic Obstructive Pulmonary Disease (COPD) Management, Joint Replacement Care, Pediatric Care, HIV / AIDS Care, Tele-monitoring (p. 32, CON Application)."

"When care is needed for clients with diabetes or other chronic diseases, [United] will evaluate the client and initiate an appropriate care plan with the Client's physician. Diabetic treatments may include physical therapy and exercise regiments, dietary programs, and medication. *A significant portion of the treatment process for diabetic clients will consist of monitoring and documenting* [emphasis added] the client's progress (p. 50, CON application)."

Assessment:
Only SunCrest fully uses a Disease Management Protocol/Clinical Pathway system as a means of reducing the variance in treatment and outcomes for a specific disease state. This tool is in the hands of the clinician for critical judgment. While patient education for self-care is important, patient education is not, in itself, a disease management protocol. The patient under treatment requires more active assessment and intervention by clinicians of their progress in recovery from the event or disease that precipitated treatment. Clinical Pathways/Disease Management Protocols achieve this end. Patient education helps but by itself does not markedly affect the course of treatment of home health care.

Telehealth and Tele-monitoring

Telehealth and tele-monitoring are often used synonymously to refer to the use of devices left in the home that record vital signs such as temperature, blood pressure, weight, patient movement within the home and other information. This information can be transmitted back to a central location for monitoring and some devices have algorithms that test the data and issue prompts or warnings to either the patient or the clinical staff.

Telehealth and Tele-monitoring						
SunCrest	**3HC**	**ARC**	**Community**	**Continuum**	**AssistedCare**	**United**
Yes	Yes	Future	No	No	Yes	Future

SunCrest

As seen in the Clinical Pathway for Congestive Heart Failure in its application, SunCrest integrates the use of Telehealth and Tele-monitoring into its patient care plans. Special note of this is made for hypertensive diseases as part of the disease management and specialty programs for patients discussed in the CON (p.10). There is also an extended discussion of telehealth at the bottom half of page 12. SunCrest uses a reliable Philips system for telehealth at no cost to patient. Information on this Philips tele-monitoring system is located in the SunCrest appendix (at about page 110 in Tab 2). Further description of the use of this system for heart failure telehealth monitoring is provided at about page 114, Tab 2, Appendices).

Additional information, in a press release from Philips, is provided (about p.149, Tab 2, appendices). Further, SunCrest has designated a corporate officer, Kari Byrne, VP Clinical Support, to oversee the Telehealth program (about page 162, Tab 2, Appendices). SunCrest includes telehealth as part of its required Professional Staff Orientation (about page 372 of Appendices), uses tele-monitoring along with laptops in the field and provides access to experts at the SunCrest corporate office (CON p.48 response to item 7(b), paragraph 2). SunCrest acts upon this commitment by including tele-monitoring equipment rentals costs in its pro forma (page 73).

In summary, as SunCrest says on page 48, it uses "Tele-management devices and techniques to better manage the care of its patients and to provide yet another vital communication link between the patient and his/her caregiver."

3HC

"From 2004-2009, 3HC continued to use new technologies to enhance the quality of care offered to patients. For example, McKesson Health Buddy telehealth and monitoring, VitalStim, and PT/INR allow early intervention to health-threatening conditions. Anodyne Therapy, or infrared therapy, is 3HCs latest offering to the communities it serves (p.10 CON)."

"The McKesson Health Buddy Monitoring System is a simple-to-use health monitor that collects patient's clinical vital signs every day. Using voice prompts and visual cues the monitor will guide the patient through the vital signs process measuring weight, blood pressure, blood oxygen saturation, and pulse. To get a more comprehensive input on patient's health, the monitor will also ask up to ten health-related questions. Therefore the questions are tailored to the patient's specific diagnosis. The patient's data is immediately transmitted to our agency for a clinical review and included in the patient's medical record. If the data collected indicates a need for intervention or if the user fails to collect their vital signs when they are prompted to, appropriate action is taken and members of the care team may be contacted for intervention (p.20, CON application).

But, no capital costs are associated with this project for these devices (p.96, CON application). Nor are any operating costs associated with these services or devices (pro forma assumptions unnumbered page 134 of 135, CON Application). For this reason we cannot be assured that this applicant actually plans to use the devices which they describe.

ARC

ARC describes this as ìA potential additional service in the near future is Telehealth (systems for monitoring patients' conditions in their homes through advanced technology)î on p.24 of CON application.

ARC refers to home cardiac monitoring as an industry trend (p 26, CON), but does not otherwise mention this service in their application. ARC also refers to "community diagnostic monitoring" for oncology, but does not specify how this is to be done by the applicant (p.46, CON).

While ARC occasionally addresses "monitoring" monitoring is apparently limited to things such as patient satisfaction (page 28) and Quality Improvement (see pp. 55-56 of CON, among others).

Community

No mention is made of either telehealth or telemonitoring.

Continuum

No mention is made of either telehealth or telemonitoring.

Assisted Care

AssistedCare uses the Viterion TeleHealth Monitoring System. Allows customized alert ranges for each patient for more accurate monitoring of patients and early detection for proactive management of outcomes (p.20, CON application). AssistedCare currently uses this system in its Brunswick County, North Carolina agency office (p.20, CON).

United
United lists telemonitoring as a service it provides (p.17, CON) then much later in the CON it talks specifically about telemonitoring: "[United] will offer tele-monitoring services to facilitate regular and efficient communication between its clients and its home health professionals.... [United] has established a relationship with Honeywell to provide tele-monitoring equipment and services. Honeywell will install and program the tele-monitoring devices in clients' homes and instruct clients, caregivers, and [United] staff members on how to use the devices.... Telemonitoring services will initially be offered exclusively to clients with the highest risk of heart failure (e.g., clients with late-stage CHF, COPD, etc.). As client volumes grow and technology improves, [United] plans to offer these services to a broader group of clients (p. 55, CON)."

United provides other comments about telemonitoring on pages 86 & 108 which are essentially similar. United does include Honeywell tele-monitoring system at $5,200 for 2 units in its CON Assumption Exhibit (p. 234, CON). Note, however, that United does not indicate that it has prior experience in using telemonitoring devices and it discusses telemonitoring as a limited service to be offered to a few patients.

Assessment:
Telemonitoring is not offered by Community or Continuum. It is proposed as a future service by ARC, and is proposed as a limited service by United. It is incorporated in the operational plans of SunCrest, 3HC and AssistedCare.

Laptop, Wireless, Physician Portal, Point of Care
While we have discussed the importance of computers in the modern home health agency, there is a specific use that deserves separate attention. Use of laptops by clinical field staff is an important means of accurate timely recording of data and when these are appropriately supplemented with specialized software, immediate contact with physicians can be obtained.

Laptop, Wireless & Point of Care						
SunCrest	**3HC**	**ARC**	**Community**	**Continuum**	**AssistedCare**	**United**
Yes	Yes	No	No	No mention	Yes	Yes

SunCrest
Laptop Yes
Wireless Yes
Point of Care Yes

The importance of the field laptop computer is best described in this section from the CON application: "At SunCrest the multi-disciplinary team comprised of nurses and ancillary health workers will utilize computer "laptops" that allow for superior communication between the office and field staff. SunCrest-Parent has a proven track record of success in using these "point of care" devices to create an electronic medical record. SunCrest has invested in Allscripts software for this purpose because it is one of the highest rated Home Care software products and is located in Wake County. This comprehensive, user friendly software provides SunCrest clinicians ease of learning and is effective in use in the field. Clinicians will have immediate access to patient records from anywhere there is wireless Internet connectivity. This ability to access and update the medical

record between the field clinician and the office staff is a far superior type of clinical management, thus improving the delivery of quality care. Additionally, all full-time field staff are required to carry a cell phone in order to ensure prompt voice communications with the Agency office, as well as the physician office, if necessary" (p.12, CON application).

Laptop computers improve communication across the multidisciplinary team, and allow clinicians to manage care in the home (Section II.2; p.14, CON). SunCrest specifically provides field laptops to its clinical staff (Section II.2.; p.14, CON). The reason SunCrest makes such substantial investment "... in technology (laptop computers for all professional caregivers) ... [is that it] enhances the clinicians' ability to manage the patients' care in the home and improves communications across the multidisciplinary team, resulting in enhanced clinical outcomes and continuity of care (Section V.7.b, p.49, CON)."

3HC
Laptops for clinicians are mentioned as part of a discussion of wound care and the "Automated Wound Care Management Program in Point of Service Product" (p.17, CON Application).

Wireless: no mention.
Point of Care: no direct mention.

ARC
Laptop no mention
Wireless no mention
Point of Care: no mention

Community
Laptop no mention
Wireless no mention
Point of Care: no mention

Continuum
Laptop no mention
Wireless no mention

Point of Care: "Continuum proposes to use state of the art point of care software and Clinical Pathways (p.101, CON application)." However, beyond this single mention there is no evidence that Continuum has actually used any point of care software or Clinical Pathways or that any of its management has experience with such use.

Assisted Care
Laptop no mention
Wireless no mention

Point of Care: AssistedCare does not propose a POC product. AssistedCare only identifies the "...use of a web-based software program CareAnyware, and electronic medical record" (page 27, CON application).

United
Laptop no mention
Wireless no mention

Point of Care. "Through a "smart-link" connection, all client data is uploaded to Centers for Medicaid and Medicare Services (CMS), on a daily basis. This allows timely payment verification and automatically extracts [United] agency information to be utilized by Home Health Compare and CASPER, national quality benchmarking programs." Additionally, all client data are uploaded to a benchmarking service OCS. At the second to last paragraph of this section on information systems: "[United] also plans to implement a point-of-care IS that [United] has been running as a pilot program for the past year. This system will allow home care professionals to view patient history, drug-on-drug interactions and other customized patient information in real time at the patient's point of care (p. 35, CON)." Finally United says, "The Director of Specialty Programs will also assist [United] with its point of care management systems (p. 58, CON)."

Assessment:
ARC, Community and ARC fail to incorporate any mention of Laptop, Wireless, or point of care services in their discussions. 3HC has a very limited discussion of laptop use and physician portals, all in the context of a wound care program. There is no evidence of a wider use of these technologies. There is no evidence that United is actually proposing to deliver a comprehensive system that allows data entry at the patient site as well as the ability for the clinician to interact. The United approach is focused on CMS communication and benchmarking services. They do propose a future system with available patient data at the patient home. AssistedCare proposed web-based software program and some electronic medical record support. Only SunCrest demonstrates working familiarity and use with point of care software.

Electronic Medical Record/EMR
As part of the long build up to health care reform there has been substantial discussion of the use of electronic medical records and the importance of the EMR in improving the quality of care and in preventing medication errors and in facilitating the most appropriate treatment. Only one applicant, SunCrest, specifically mentions the use of an EMR system as a part of their clinical treatment in the patient's home.

Electronic Medical Record/EMR						
SunCrest	**3HC**	**ARC**	**Community**	**Continuum**	**AssistedCare**	**United**
Yes	No	No	No	No	No	No

SunCrest
"SunCrest-Parent has a proven track record of success in using these "point of care" devices to create an electronic medical record. SunCrest has invested in Allscripts software for this purpose because it is one of the highest rated Home Care software products and is located in Wake County. This comprehensive user friendly software provides SunCrest clinicians ease of learning and effective use in the field. Clinicians will have immediate access to patient records from anywhere there is wireless internet connectivity. This ability to access and update the medical record between

the field clinician and the office staff is a far superior type of clinical management, thus improving the delivery of quality care" (Section II.1.c. page 12 CON application).

3HC - Not mentioned.

ARC - Not mentioned.

Community - Not mentioned.

Continuum - Not mentioned.

Assisted Care
Mentioned on page 27 of the CON but no discussion of the product used is provided.

United
United talks about the electronic medical record being administered by business services: "These staff will be responsible for revenue cycle management, accounts payable, financial reporting, and also assurance of coding and completeness of all electronic medical records prior to submission for payment" (p. 61, CON application). An EMR is not mentioned as such.

Assessment
Only SunCrest (and perhaps Assisted Care) has experience in using and creating an EMR with point of care wireless laptop equipment.

Quality Related Issues Summary
The aggregate chart below illustrates the ability of the various competitors to provide a modern level of home health services with appropriate disease management protocols, computer and software based tools to maximize cost effectiveness, timely information sharing, and improved patient outcomes based on targeted adjustments to disease treatments.

	SunCrest	3HC	ARC	Community	Continuum	AssistedCare	United
Clinical Pathway	Y	N	Future	N	N	N	Future
Tele-health	Y	Y	Future	N	N	Y	Future
Computers	Y	Y	Y	N	Y	Y	Y
Laptops	Y	Y	N	N	N	N	N
Wireless	Y	N	N	N	N	N	N
Point of Care	Y	?	N	N	Y	Y	N
EMR	Y	Y	N	N	N	Y?	N
Definite Yes	7	4	1	0	2	4	1

Briefly, only SunCrest already has experience in using high technology to deliver timely, cost effective and appropriate curative care to patients. A review of 6 important quality related issues shows that SunCrest has a greater commitment to the use of high technology and clinical process improvement to improve the delivery of home health care than does any other applicant.

SECTION III: NEED/DEMAND

One of the important aspects of this section is to demonstrate the expected impact of this agency in delivering the care identified as being needed. Only three applicants and SunCrest are discussed in this section: Home Health & Hospice Care, Inc. (3HC), ARC Therapy Services, LLC (ARC), and United Home Care, Inc. (United). Comments are provided for three applicants where a problematic treatment of need or demand in their applications was identified.

Demonstrates Quantitative Need						
SunCrest	**3HC**	**ARC**	**Community**	**Continuum**	**AssistedCare**	**United**
Yes	No	No	Not evaluated	Not evaluated	Not evaluated	No

3HC

This applicant is part of the problem. It is a major provider in counties for which there is unmet need. 3HC notes on page 12 that it serves 422 patients in Wake County and states that "Upon completion of the proposed Wake County project, 3HC's Johnston County agency will no longer serve residents from Wake County (as they will be served by the Wake County agency)." Further, on page 29 of the application 3HC notes that it has served 322 patients from Wake County in 2007 and 300 patients in 2008. Clearly 3HC is a significant contributor to home health care for residents of Wake County. Further, 3HC shows that it served 858 Johnston County residents in 2007, 955 in 2008 and 889 in 2009. But in the 2010 SMFP an unmet need is shown for both Johnston County (42 persons) and for Wake County (444) persons. Thus 3HC has been unsuccessful in fully addressing the home health needs of its home county, Johnston County, based upon the 2008 data from the most current SMFP.

3HC asserts on page 30 that

> "... the proposed Medicare-certified home health agency in Wake County will not have a negative impact on 3HC's existing agencies, including its Johnston County agency. Rather 3HC anticipates that the number of Johnston County home health patients it serves via the Smithfield agency will increase based on several factors, including but not limited to: aging and projected population growth in Johnston County, overall projected home health patients in Johnston County, 3HCs long standing relationships referral sources in Johnston County and the ability to focus on Johnston County residents without need to provide service to Wake County residents (via the Smithfield office)."

The proposed project largely cannibalizes patients served from its existing office in Johnston County. Of the 1,465 patients the Johnston County office served in FY 2009 (from 2010 Home Health Data Supplement in Exhibit 17 of the 3HC appendices), there were 422 from Wake County. If these 422 persons are no longer served by 3HC of Johnston and are instead served by 3HC of Wake, how will the existing 3HC of Johnston County recapture this lost number of patients? They will in fact be cannibalizing their Johnson County office to establish the new Wake County office. They say that they will grow the Johnston County office by increases in patients that will derive from Johnson County. Presumably they mean they will grow serving the SMFP projected unmet need.

Yet, as they point out in their table on page 30 of their CON application, the expected unmet need in 2011 for Johnston County will be 42 persons. If they captured all of this unmet need they would still need to find an additional 380 persons from Johnson County to serve in order to remain at their present volume level. Where would these additional patients come from if there are only 42 unserved persons in Johnston County? They would have to come from increased volumes from either surrounding counties or from patients now being served by other home health agencies in Johnston County. Since the other counties being served by 3HC show a surplus of patients being served it is unlikely that there is a pool of unserved patients in Durham, Greene, Harnett, Jones. Nash, Orange, Pitt, Sampson, Wayne or Wilson Counties (all served by 3HC/Johnson in FY2009) who could be captured by 3HC without an adverse impact upon existing providers.

3HC provides a table on page 31 of their CON application, which projects the Johnston County utilization of the agency. This shows a consistent growth in anticipated Johnston County patients served. This also shows that over the period that 3HC projects they will only add 137 Johnston County patients. Yet they have cannibalized 422 patients from that agency leaving a net loss of 285 patients in the 3HC/Johnston agency. The effects of this loss upon their own agency have not been calculated in their discussion. As we see in the table below, while 3HC anticipates increasing the number of patients they serve in Johnston County, the increase of 137 patients, by 2014, does not come close to recovering the number of patients that they will transfer to their proposed Wake County office.

	Actual	Projected				
	2009	2010	2011	2012	2013	2014
Johnston Co HH Pts	889	915	941	969	997	1026
Incremental		26	26	28	28	29
Cumulative		26	52	80	108	137

Moving 422 patients (FY2009) from 3HC/Johnston to 3HC/Wake would likely have serious adverse consequences either for 3HC/Johnston or for other providers in counties served by 3HC/Johnston.

Since existing patients served by the applicant are part of the proposed project, this project does not fully serve the unmet need in Wake County. But how does this transfer of patients from one 3HC office to another operate to reduce the expected deficit of 444 persons served in Wake County in 2011? In fact, the proposal as presented would only serve 22 of the unserved persons identified in the 2010 SMFP, leaving 422 Wake County residents still in need of a source of home health care. Finally, 3HC does not provide any proof that the Wake County residents it currently serves out of its Johnston County office will benefit from a 3HC office located in Wake County.

In summary, the model for serving the unmet need in Wake County of 444 persons is flawed. It will in fact only serve 22 additional persons, leaving 422 persons without access to any greater level of home health care than is currently available within Wake County.

ARC

The projections of patients to be served by ARC include patients already being referred by ARC and therefore don't include all of the unserved patients in need. In the ARC Executive Summary on

p8 of 133, they state: "During 2009, [ARC] referred approximately 200 Wake County community residents to home health services." Then in a discussion on page 41 of 133, "Unduplicated Patient Caseload; Assumptions" they say that their Year 1 (2011) patients will be primarily based upon the ARC 2009 referrals to home health (201 patients). Then, using a 7% compound average growth rate, they expect that the 201 referrals in 2009 will become became 230 patients in their Year 1 pro forma (2011) out of the 275 total patients anticipated to be served. Therefore, the projections do not address all of the unmet need of 444 patients in Year 2 since they incorporate the Wake County patients already being referred by ARC. For this reason only about half of the patients will be from the unserved patient pool. Further they appear to intend to steer residents of their Wake County facilities to their own HHA (see the ARC application page 35).

The applicant describes their approach to calculating the number of patients they expect to serve in their application in the excerpt (page 33 of the ARC CON) described as follows.

> 1) Existing referrals from ARC to other HHAs are a part of the 444 pts served/unmet need;
> 2) They project 230 referrals in Yr 2 based upon their prior history of referrals from their senior facilities to home health care;
> 3) The 444 persons they propose to serve includes the 230 they already refer out and therefore does not meet total unmet need.

These calculations, as described above, depend upon the applicant serving all of the patients that were referred to home health care from their Wake based facilities. They assume that these persons in need would increase from the year of their data, 2009, to the projected years of 2010 and 2011 by 7% annually. This 7% increase is based upon a five-year compound annual growth rate for the period 2004 to 2009 for Wake County home health patients. Implicit in their assumption is that the number of referrals from ARC facilities will grow at the same rate as the overall past experience of Wake County. They could also have looked at their internal data for the same period to observe whether their referral rate did in fact parallel the increase in countywide utilization for the same period. This test would have validated the reasonableness of this assumption.

However, if this assumption that the increase in referrals at ARC facilities parallels the county-wide increase in numbers of patients actually seen, there are still several problems to be addressed. Countywide population for Wake County was increasing during the base period that they used, 2004-2009. This increase in population was 4.24% over the period (2004 and 2009 Wake County). Population estimates of 725,334 and 892,607 are from http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/demog/countygrowth_2004.html and the CAGR was calculated using a web based compound annual growth rate calculator. However, it is unknown whether these ARC facilities demonstrated an increase in their ADC, or in the total numbers of unduplicated persons served over that same period. If there was no increase in either the ADC or the number of unduplicated persons served, then use of this more general Wake County growth rate is not validated. Based upon the rate of population increase of 4.2% the 7% annual increase used by the applicant is problematic.

But beyond the question of whether the general growth rate for Wake County is the appropriate factor to use in estimating the growth in the number of referrals to home health from the ISC facilities in Wake County is a more troublesome question.

The 201 referrals made from ARC facilities in 2009 to home health care were, of course residents of Wake County. However, these referrals represent a portion of the persons who actually received home health care. They do not represent some pool of persons unserved by home health care. *They represent a part of the persons who actually did receive home health care in 2009 in Wake County.* On the other hand, the need of 444 persons identified in the 2010 SMFP represent the pool of persons estimated by the State to be unserved (after factoring out a 275 person placeholder for the operation of the approved Bayada application in 2007). The attribution of an already served population to the pool of persons that ARC anticipates serving in 2011 actually double counts this already served population. In fact, of the 230 persons that ARC anticipates serving in 2011 all are already included in the 14,769 persons estimated by the state to be served by home health care in that year. None of the 230 persons ARC plans to serve in 2011 are a part of the pool of 444 unserved persons estimated by the State to be in need of home health care.

As a result, this application will only increase access to home health care in Wake County to about 214 of the 444 who are unserved. It will seek to take those 230 patients already being served by existing agencies that serve Wake County residents.

There are other troubling questions about the approach taken by this applicant. Based upon the assumptions in the application it is evident that the applicant intends to actively steer residents of its centers to its own home health agency. If it does not do so then its Year 1 unduplicated patient volume of 230 persons will have to be achieved by a means not discussed in the application. To what extent is the implied steering of patients appropriate? Older persons in ALFs or NHs may be susceptible to overt or implicit guidance in the selection of providers (5/19/2010 communication with Mary Ball, Research Director, Gerontology Center, Georgia State University, Atlanta, Georgia).

United

Curiously, United is proposing to compete in counties beyond the one for which a need for an additional home health agency is indicated in Table 12D of the 2010 SMFP. Several of these counties show excess utilization. For example, Durham is "overserved" by 163 persons and Sampson is "overserved" by 40 persons. But none of the counties proposed to be served, other than Wake, show a need for an additional home health agency (p. 123). However, some show a slight unmet need in 2011, which does not rise to the level of need for an additional home health agency. Here are the additional counties that United proposes to serve (page 123) of the United CON application), which are not listed as being in need of a new home health agency: Durham, Harnett, Franklin, Nash, Wilson, Granville, and Sampson.

SunCrest

SunCrest accepted the 2010 SMFP defined unmet need of 444 persons in Wake County for 2011, but undertook additional examination of the data:

1) Examined the population growth from the estimate for 2008 to the forecast for 2013 and observed consistent growth.
2) Examined home health use rates for four age groups over the same period and the forecast for 2011 in the SMFP.
3) Calculated the 2008-2011 change for the four age groups and determined that an additional 3,306 persons were expected to be in need of home health services by 2011.

4) Forecasted the expected home health demand for 2012 and 2013.
5) From our prior experience in other markets, SunCrest determined its likely initial market share in Wake County at a very conservative 2.92% level.
6) Existing Wake County-based home health agencies would retain their current market share.
7) Agencies based outside of Wake County would lose modest market share, but still show a slight increase in patients served due to growth in the size of the market.

Therefore, SunCrest expects to serve all of the unmet need in 2011, see growth in 2012 and 2013, introduce a new competitor into the market place and that existing providers will also continue to grow as the size of the market increases.

SECTION IV: UTILIZATION

A side-by-side comparison of the competing applicants for Table IV.2 follows. The annual statistics of patient visits by service discipline are for Year 2 of the proposed projects.

Service Discipline Visits by Applicant for Year 2 – with Unduplicated Patients Shown

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J-8512-10
Name	SunCrest	AssistedC	ARC	3HC	Community	United	Continuum
Undup Pts	484	474	444	497	410	588	480
Discipline:							
Nursing	3,482	3,768	2,594	4,476	3,568	5,555	3,712
Phys Th	2,399	2,582	2,461	1,900	2,496	5,077	3,094
Speech Th	220	68	436	104	71	146	177
Occup Th	611	476	439	446	250	1,611	707
Med Soc Wk	149	98	121	113	35	135	88
HH Aide	750	559	654	1,390	714	1,186	1,061
TOTAL	7,611	7,550	*6,705*	8,782	7,134	**14,109**	8,839
Visits/Patient	15.7	15.9	*15.1*	17.7	17.4	**24.0**	18.4

Distribution of Visits by Service Discipline by Applicant (Year 2)

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J-8512-10
Name	SunCrest	AssistedC	ARC	3HC	Community	United	Continuum
Undup Pts	484	474	444	497	410	588	480
Discipline:							
Nursing	45.7%	49.9%	*38.7%*	**53.1%**	50.0%	40.5%	42.0%
Phys Th	31.5%	34.2%	36.7%	*22.5%*	35.0%	**37.0%**	35.0%
Speech Th	2.9%	0.9%	**6.5%**	1.2%	1.0%	1.1%	2.0%
Occup Th	8.0%	6.3%	6.5%	5.3%	*3.5%*	**11.8%**	8.0%
Med Soc Wk	2.0%	1.3%	1.8%	1.3%	0.5%	1.0%	1.0%
HH Aide	9.9%	*7.4%*	9.8%	**16.5%**	10.0%	8.7%	12.0%

Source: CON applications for Wake County, 2010.
Bold denotes Highest Value; *Italic denotes lowest value.*

How an Applicant distributes its visits can infer the nature of its services and the target population toward which this Applicant is geared. There is substantial variation between the highest and lowest values (percentages) for each service discipline, except for Medical Social Work where this variation is only 1.5%. Notable observations are arranged by Applicant (following).

UNITED:
This Applicant proposes to serve the most unduplicated patients and proposes the highest number of visits. Its average number of visits per patient is 24.0, far above what is proposed by any other Applicant. Its distribution of visits by service discipline is highest for the rehabilitation-related disciplines of Physical Therapy and Occupational Therapy. Its percentages for Nursing and Home Health Aides are among the lowest. This Applicant seems to focus on a certain segment of clinical care and to provide a very high number of visits to these patients, even extraordinarily high.

3HC:
Conversely, this Applicant has the highest values in Nursing and Home Health Aide visits. It appears to be geared to patients with medical conditions and less towards the rehabilitation-related disciplines of Physical Therapy (lowest value), Occupational Therapy and Speech Therapy (values among the lowest). Consequently, only a segment of the unmet need is focused upon.

ARC:
This company proposes the lowest share of skilled Nursing visits of all Applicants. Skilled nursing care is the cornerstone of home health services. Instead, this Applicant has the highest proportion of Speech Therapy visits, and nearly the highest proportion of Physical Therapy visits (only 0.3% below the highest value). Coupled with this lowest proportion of skilled nursing care is the fact that it proposes the lowest number of visits per patient at 15.1. It is conceivable that insufficient nursing care is being proposed, or that it will not serve those patients with intensive medical conditions requiring more Nursing visits.

The high utilization of therapy ties to ARC's focus on providing services to their own patient population, which tend to need more therapy services. Given its assisted living facility roots, providing full nursing services would be duplicative of the assisted living services.

SUNCREST HOME HEALTH:
We propose to serve the full spectrum of care and utilize all service disciplines appropriately as directed by its clinically-proven Disease Management Protocols, as discussed previously. With the exception of Medical Social Work, SunCrest is neither High nor Low in any of its service discipline visit proportions. A slightly higher proportion of medical social work visits reflects SunCrest's commitment to addressing the social service and welfare aspects of a patient's home health care needs, as well. Overall, SunCrest does not base its visits on a Statewide average, but on its expected service mix in the Wake County area, as well as its prior operating experience. Given these facts as shown on the preceding tables, SunCrest is the superior applicant for this Section.

SECTION VII: STAFFING

A side-by-side comparison of the competing applicants for Table VII.2 follows. The annual statistics of FTEs by category are for Year 2 of the proposed projects.

Staffing Profile by Applicant for Year 2 – with Unduplicated Patients & Visits

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J--8512-10
Name	SunCrest	AssistedC	ARC	3HC	Community	United	Continuum
Undup Pts	484	474	444	497	410	588	480
Visits	7,611	7,550	6,705	8,782	7,134	14,109	8,839
FTEs:							
Nursing	3.1	3.4	0.9	3.5	2.6	5.0	3.5
Phys Th	Contr+0.9	1.0	0.8	1.6	1.8	Contract	2.6
Speech Th	Contract	0.1	0.2	0.1	0.1	Contract	0.2
Occup Th	Contract	0.5	< 0.1	0.4	0.2	Contract	0.7
Med Soc Wk	Contract	0.2	0.1	0.1	< 0.1	Contract	0.2
HH Aide	0.8	0.5	0.2	1.1	0.5	1.0	0.9
Other Admin	6.0	2.0	3.0	2.8	3.0	7.0	5.5
TOTAL	10.8	9.1	5.2	9.6	8.2 *	13.0	13.6

Source: Table VII.2, CON applications; employed staff only. * FTEs actually calculated to 0.001.
Statistics subject to rounding error of 0.1.

In general, it is difficult to critique minor differences in the allocation of FTEs among the service disciplines among the providers. It may be beneficial to compare FTEs by service discipline to the projected number of visits. Applicants who have a mismatch between service loads and FTEs should be questioned. However, SunCrest does not take that approach; rather, we take a larger view of FTEs by Applicant and critique where notable.

COMMUNITY:
This Applicant calculates FTEs to 0.001 precision, and proposes that 100% of staff will be employed. Labor costs are a large component of costs. This degree of precision evaporates in reality. Labor is purchased in larger chunks and typically is larger than what is proposed, especially when these therapists are employed staff. Contracted staff are most able to be hired incrementally, but this Applicant chooses to hire all of its staff – even at the 0.1 FTE level. Such a commitment must be documented fully and clearly, otherwise the annual operations will not meet the required level of Net Income to make this project feasible. Consequently, the staffing estimate (and, therefore, labor costs) is highly questionable.

ARC:
This Applicant proposes only 2.2 FTEs of clinical care to service 6,705 visits. Clearly, this project as proposed by this Staffing Plan is not feasible and should be rejected. We note that the staffing model uses a 260 day/8 hour day expectation. However, inevitably an individual person will not always be present and arrangements must account for the need to allow travel, training, and illness in the staffing model.

UNITED:
This Applicant has large numbers of FTEs at first glance. However, SunCrest understands that staffing a new home health agency is dependent upon visit estimates, and this apparently drives the high nursing FTEs. Adequate numbers of Administrative personnel are required for training,

quality of care, and especially business development. Addressing the unmet need requires an active approach and adequate staff. The question for United is the large number of visits. Its 24.0 visits per patient are far above any other Applicant. SunCrest questions this proposed project on these grounds, as discussed in a previous section.

SUNCREST:
SunCrest adequately staffs this proposed project to fully serve its proposed complement of patients and includes the proper complement of administrative staff to manage clinical care, for business management and logistics roles, and for community outreach and marketing to attract those patients who otherwise have an "unmet need", those who require clinical care but are not getting it at present. The SunCrest staffing model is based upon a 48 week FTE calculation (page 55, CON application) which means that additional staffing expenses for travel, training, and illness are accounted for in the SunCreast model. SunCrest has a staffing complement that reflects a superior choice for the CON award.

SECTION VIII: CAPITAL COSTS AND FINANCING

A side-by-side comparison of the competing applicants for Item 1.A in Section VIII follows. The annual statistics of FTEs by category are for Year 2 of the proposed projects.

***Capital Costs of the Proposed Projects** – with Unduplicated Patients, Year 2*

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J-8512-10
Name	SunCrest	AssistedC	ARC	3HC	Community	United	Continuum
Undup Pts	484	474	444	497	410	588	480
Capital Cost Categories							
Deposits/Lease/Utilities	3,500	0	0	0	0	0	0
Other:							
Computer/Telecom Equip	36,000	38,900	4,352		18,000	15,800	37,000
Office/Medical Equip	8,500	3,000	5,700		13,000	7,500	6,500
Furniture	7,500	3,000	6,331		4,000	18,000	4,500
Consultant/Attorney/Travel	39,400		32,000	40,000	100,000	45,000	750
Miscellaneous:							
Filing fee	5,000						
HHA Software							40,000
Start-Up Cost Amort.			46,832				
Contingency						12,945	
Miscellaneous Subtotal	96,400	44,900	95,215	40,000	135,000	99,245	88,750
TOTAL CAPITAL COSTS	99,900	44,900	95,215	40,000	135,000	99,245	88,750

Source: CON applications.

A proper accounting of capital costs can shed light on the thoughtfulness and sophistication of a CON application. Ultimately, the prospects for financial feasibility of the project and of the Applicant can be judged. Following are critiques for each Applicant where notable observations can be made.

ASSISTED CARE:
In North Carolina it is prudent to employ consultants and attorneys to guide an Applicant through the CON process. This Applicant apparently will not pay either Consultants or Attorneys through this CON review process – either that, or the Applicant did not account for it. The CON reviewer should be cognizant of this point to see if this Applicant has properly accounted for its costs.

ARC:
This Applicant mistakenly included Start-Up Cost Amortization in this page. These costs are to be shown in Section IX. Excluding this amount reduces the Capital Costs to $48,383, of which $32,000 is devoted to Consultants/Attorneys. This leaves $16,383 to fund the acquisition of computer and telecommunication infrastructure, office and medical equipment, and office furnishings. We believe that $4,352 for computer and telecommunications infrastructure is in no way sufficient to properly care for patients utilizing home health services. This CON application is deficient in properly accounting for capital costs.

3HC:
This Applicant has devoted no capital costs for the proposed project beyond consultant and attorney costs. The Applicant has not shown in its CON application that all such assets are already in existence and ready to be used for home health care. Therefore, this CON application should be rejected.

CONTINUUM:
In North Carolina it is prudent to employ consultants and attorneys to guide an Applicant through the CON process. This Applicant apparently will not pay either Consultants or Attorneys through this CON review process – either that, or the Applicant did not account for it. The CON reviewer should be cognizant of this point to see if this Applicant has properly accounted for its costs.

COMMUNITY:
This applicant apparently believes that the majority of costs associated with the start up of a new home health agency are in its consultants and attorneys.

SUNCREST:
SunCrest has properly and fully accounted the costs in setting up a full-service, fully-functioning home health agency. Sufficient resources have been devoted to establish the computer and telecommunication infrastructure that is the backbone of home health care delivery and management. It has set aside sufficient funds for Office and Medical Equipment and for office furnishings. It pays its consultants and attorneys and has tried to properly account for advance deposits and filing fee costs. This demonstrates that SunCrest is the superior choice for award of the CON for Wake County.

SECTION IX: START-UP AND INITIAL OPERATING EXPENSES/ FINANCING

Below is a side-by-side comparison of the competing applicants for Section IX, Items 1-4. The following profiles show the three components of business operations that require cash: capital costs, Start-Up Expenses, and Initial Operating Period – which shows the maximum amount of working capital (cash) required during the period where cash outflows are greater than cash inflows.

***Profile of Cost Components by Applicant** – with Unduplicated Patients, Year 2*

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J--8512-10
Name	SunCrest	AssistedC	ARC	3HC	Community	United	Continuum
Undup Pts	484	474	444	497	410	588	480
Component:							
Capital Costs	$99,900	$44,900	$95,215	$40,000	$135,000	$99,245	$88,750
Start-Up Exp	45,057	66,323	78,832	75,000	20,880	144,594	94,520
Initial Operat.	189,086	128,542	524,360	100,000	253,094	314,580	230,770
TOTAL	334,043	239,765	698.407	215,000	408,974	558,419	414,040
Available Funds Shown	$450,000	$194,866	$603,192	$100,000	$700,000	$459,174	$230,770

Source: CON applications. No applicant is proposing debt to fund capital costs. Therefore, capital costs are included here. For this exercise, we recognize that there is a small degree of double-counting the capital cost depreciation during the Initial Operating Period.

All Applicants propose to fund the proposed project through cash reserves or through a line of operating credit. In no instance is debt used to fund capital cost. Therefore, for this exercise Capital Costs, Start-Up Expenses and Initial Operating Expenses should all be viewed as using cash for which Available Funds should be shown. SunCrest understands that the State of North Carolina intends that each of these areas is distinct and discrete for the purposes of CON application review.

General observations, where notable, are listed below.

1) Only SunCrest and Community have available funds in excess of the TOTAL of these three areas of cash usage. This is an important factor for project financial feasibility.

2) "Lowest" is not the "Best". The total cash requirements to set-up, start and operate a home health agency is substantial. The "funds available" amounts projected by AssistedCare, 3HC, and Continuum are too low to make the proposed projects financially feasible.

3) For its proposed patient and visits volumes, ARC has the largest cash requirements at nearly $700,000.

4) SunCrest has prudently counted the necessary costs and is prepared to support these expenditures with sufficient funds. It remains the superior choice for the CON award for Wake County.

SECTION X: COST INFORMATION & PRO FORMA-RELATED

A side-by-side comparison of the competing applicants for Table X.1 follows. The annual statistics of Cost per Unit of Service are for Year 2 in order to compare agencies after they have established their client bases.

Cost per Unit of Care by Applicant by Discipline for Year 2 – with Unduplicated Patients

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J-8512-10
Name	SunCrest	AssistedC	ARC Ther	3HC	Community	United	Continuum
Undup Pts	484	474	444	497	410	588	480
Discipline:							
Nursing	$156.01	$117.49	$123.20	*$74.37*	$140.98	**$159.42**	$146.38
Phys Th	**188.49**	149.72	133.90	*119.13*	126.79	127.32	159.63
Speech Th	197.88	**215.20**	149.77	*76.07*	134.27	137.62	138.86
Occup Th	171.73	**193.63**	129.37	*79.51*	127.54	137.62	132.59
Med Soc Wk	117.67	179.22	173.06	*72.26*	119.04	122.17	**197.21**
HH Aide	**92.07**	84.55	53.04	*20.56*	80.07	89.18	49.46

Source: Table X.1, CON applications. **Bold denotes Highest Value**; *Italic denotes lowest value.*

This table above shows that in all instances, the lowest average Cost [per Visit] statistics belong to 3HC (Home Health & Hospice Care). However, as discussed previously, the cost structure, staffing and proposed capital costs – along with the anticipated cash needs – are too low as to make the proposed project not feasible. Secondly, the table shows that the highest Cost per Visit statistics are distributed among SunCrest, AssistedCare, United, and Continuum.

There are various factors that affect Costs per Visit: 1) mix of service discipline visits; 2) total number of visits to which costs are allocated; and, 3) Applicant cost-structure. But have these statistics been properly calculated? The following table was earlier presented in Section IV comments of opposition to Service Discipline visits allocation by the Applicants.

Distribution of Visits by Service Discipline by Applicant (Year 2), with Total Visits

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J-8512-10
Name	SunCrest	AssistedC	ARC Ther	3HC	Community	United	Continuum
Total Visits	7,611	7,550	6,705	8,782	7,134	14,109	8,839
Discipline:							
Nursing	45.7%	49.9%	*38.7%*	**53.1%**	50.0%	40.5%	42.0%
Phys Th	31.5%	34.2%	36.7%	*22.5%*	35.0%	**37.0%**	35.0%
Speech Th	2.9%	*0.9%*	**6.5%**	1.2%	1.0%	1.1%	2.0%
Occup Th	8.0%	6.3%	6.5%	5.3%	*3.5%*	**11.8%**	8.0%
Med Soc Wk	2.0%	1.3%	1.8%	1.3%	0.5%	1.0%	1.0%
HH Aide	9.9%	*7.4%*	9.8%	**16.5%**	10.0%	8.7%	12.0%

Source: from Table IV.2, CON applications; SunCrest calculations, as shown in this document under Section IV comments. **Bold denotes Highest Value**; *Italic denotes lowest value.*

This table showed that SunCrest was near the middle of the group of seven applicants in terms of the number of total visits proposed for Year 2. United was the highest at 14,109 visits, followed by Continuum and 3HC at 8,839 and 8,782 visits, respectively.

If Total Costs are properly accounted, an Applicant's sum of the weighted average of each Service Discipline Total Cost per Unit of Care should equal its Total Cost per Unit of Care (Total Expenses divided by Total Visits).

To say it another way, does:

> (% Nursing visits * Nursing Total Cost per Visit) + (% PT visits * PT Total Cost per Visit) + (% ST visits * ST Total Cost per Visit) + (% OT visits * OT Total Cost per Visit) + (% MSW visits * MSW Total Cost per Visit) + (% HHA visits * HHA Total Cost per Visit) = (Total Expenses / Total Visits)?

Are these two measures of Cost per Visit consistent by Applicant? The table below shows each of these calculations by Applicant.

Total Cost per Visit (Unit of Care) Calculations, Year 2

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J-8512-10
Name	SunCrest	AssistedC	ARC	3HC	Community	United	Continuum
Total Visits	7,611	7,550	6,705	8,782	7,134	14,109	8,839
Weighted Average (above visits distributions)	**$ 161.67**	$ 132.55	$ 123.32	*$ 75.85*	$ 129.27	$ 138.30	$ 138.64
Total Expenses/ Total Visits	$ 162.68	$ 132.56	$ 122.82	*$ 113.15*	**$ 172.01**	$ 134.39	$ 138.83

Source: CON applications; "Total Expenses" from Section X, Form B. **Bold denotes Highest Value**; *Italic denotes lowest value.*

The table shows that 3HC and Community had very disparate cost of care values by these two calculations. 3HC remains the (abnormally) low cost-per-visit applicant – as discussed in earlier sections, while Community is actually the High-Cost provider.

SunCrest has consistently shown its costs fully and in a reasonable manner. On the surface, SunCrest remains as a higher-cost provider, but this is a function of fully recognizing its costs in a prudent manner and through its relatively low Visits per Patient ratios. It would be short-sighted to determine from the basis of this one table that the lower-cost providers are preferred. Rather, the reviewer should consider the entire pattern of accurately and consistently showing costs which reflect the capability to forecast and manage the financial aspects of the proposed project. SunCrest has demonstrated this throughout its CON application and remains the superior choice.

Next, our discussion turns toward larger pro forma-related items. The following table shows selected items of comparison from each Applicant's pro forma. Notable observations and comments will be arranged by Applicant following the table.

Selected Pro Forma Items for Year 2 – with Unduplicated Patients & Visits

Project#	J-8508-10	J-8506-10	J-8507-10	J-8509-10	J-8510-10	J-8511-10	J-8512-10
Name	SunCrest	AssistedC	ARC	3HC	Community	United	Continuum
Undup Pts	484	474	444	497	410	588	480
Visits	7,611	7,550	6,705	8,782	7,134	14,109	8,839
Income Stmt:							
Gross Rev	$1.54 mm	$1.23 mm	$1.02 mm	$1.14 mm	$1.07 mm	$1.84 mm	$1.31 mm
Net Rev	$1.34 mm	$1.09 mm	$0.92 mm	$1.02 mm	$0.94 mm	$1.94 mm	$1.45 mm
Direct Exp	$0.53 mm	$0.64 mm	$0.37 mm	$0.67 mm	$0.58 mm	$1.07 mm	$0.90 mm
Admin Exp	$0.71 mm	$0.36 mm	$0.45 mm	$0.37 mm	$0.34 mm	$0.83 mm	$0.33 mm
Total Exp	$1.24 mm	$1.00 mm	$0.82 mm	$0.99 mm	$0.92 mm	$1.90 mm	$1.23 mm
Net Income	$104,659	$92,574	$101,205	$29,217	$14,939	$44,629	$221,306

Source: Section X, Form B.

ASSISTED CARE:
The Applicant has an existing Medicare-certified home health agency in Leland, NC. The pro forma, Balance Sheet, and Cash Flow projections are to be for the proposed project, as specified in the CON application instructions. This Applicant has provided on page 130 a Balance Sheet that incorporates the existing business(es) of the Applicant instead of only the proposed project. The title "Wake County Home Health Agency" is incorrect. This claim is inferred because the Cash Flows generated from the proposed project, the assets and liabilities do not correspond to the proposed project; and on the Section I, Item 1 footnote, there is an explanation of the various entities of the Applicant. Consequently, a true picture of the proposed project is not shown.

When looking at the Administrative Expenses detail on page 133, certain items are materially under-estimated.
1) The Telephone/Communications line is stated at $658. A typical four-line telephone system typically costs $400 per month, or $4,800 per year.
2) The Legal/Accounting line is stated at $171. Accountancy work to generate a Medicare Cost Report at a minimum is $2000.
3) In general, the Management Services fee is a bit hazy in terms of what it covers. The concept is fine, but are they inclusive and at fair market value? Sometimes a related-entity can absorb losses or below-market pricing to support another company in question.

ARC:
This Applicant has been fully discussed in other sections, where certain items have revealed deep flaws in its application as to determine it unqualified for CON award. No additional time or space is devoted here to its pro forma.

3HC:
This Applicant has been fully discussed in other sections, where certain items have revealed deep flaws in its application as to determine it unqualified for CON award. No additional time or space is devoted here to its pro forma.

COMMUNITY:
First, this Applicant is the only entity to propose not meeting the entire unmet need in Year 2. Additionally, the schedule or timeline of project development is quite long when compared to everyone else. Second, in its pro forma there is a large item called Central Office Overhead. The Application does not define what is included and how it is calculated – at least in our examination of the CON application. Third, there is such a small Net Income of $14,939 on a basis of 410 patients in Year 2. Any mistake in the projections of costs quickly makes this project financially unfeasible.

UNITED:
The overall observation is that this is a large proposed project. To reach 14,109 visits in Year 2 is quite an undertaking; and its proposed 24.0 visits per patient is considerably higher than what is proposed by everyone else.

We noted the contracted costs for therapy visits are based on rates quoted by a sister company. The rates seemed below the market average and are not arms-length. Also, we could not find the actual

contracts for these therapists in the CON application. Consequently, there was no way to verify what was entered into the pro forma and costs per unit of care comparisons were correct.

In order to make this proposed project financially work, we noted some aggressive assumptions made in Accounts Receivable (A/R). For Year 1 there was $1,179,169 in Revenue, and only $129,380 in A/R (see Balance Sheet). For Year 2 there was $1,940,687 in Revenue, and only $180,710 in A/R. These ratios are about 10% and roughly translate to 35 A/R days.

This assumed level of A/R days is truly optimistic. In its Revenue assumptions (p.224), United states that for Medicare, half of the revenue is received upon admission and the other half at the end of the episode (60 days), for an average A/R day figure of 30 (SunCrest calculations). If United would bill Medicare on the day of admission (which does not normally occur), United would not receive that money until at least 7 days later because it is Medicare's policy to hold an initial RAP claim for at least 7 days. For the final billing, if United would bill within 14 days of the end of episode (industry standard) – and typically this billing is towards the end of the 14 days – then Medicare would hold the final claim again for 14 days, to yield the final payment received somewhere between 80 and 90 days from admission. The A/R figure should be realistically around 49 days (Day 14 + Day 84 divided by 2). 49 A/R days is 63% higher than 30 A/R days. Consequently, the level in Accounts Receivable should be 63% higher than stated. In Year 2, the A/R figure should be $294,557, or a difference of $113,847.

Such a difference impacts cash flow projections. And the preceding calculations are only for Medicare. For such a large proposed project, the initial operating period would be significantly longer than projected. United assumes short A/R periods for Medicaid, Commercial and Private Pay. Consequently, the entire Cash Flow projections are suspect.

Lastly, the proposed Net Income of $44,629 is small when considering 14,109 visits and Gross Revenues of $1,840,000. Any miscalculation on the revenue or on the cost side can quickly turn this project to be financially unfeasible. On pages 224 and 225, Commercial payers are assumed to reimburse at 88% of billed charges. If only that were true; we all would love it. However, the actual rates are much lower. And it is shown that rent at the proposed site of the Mayview Convalescent Center is at $1,000 per month. Normally, $30,000 is a fair market rate. It would appear that the optimistic commercial reimbursement rates and the savings from a sweetheart deal at Mayview comprise the bottom line of the proposed project.

When we examined the floor plan of Mayview, we saw that there was no designation where the home health offices would be placed. Consequently, this project is subject to a razor-thin margin if an alternative site is required.

CONTINUUM:
When looking more closely at this Applicant's pro forma, there are no contractual allowances made for Commercial payers. 100% of billed charges are assumed. Only Medicaid contractuals of $40,816 are shown.

For Medicare revenue (pg 112-113), no adjustments were made for LUPA (lower utilization, lower payment patients). All patients are assumed to be at full HHRG, which is a large assumption. Secondly, the 2007 Medicare data as reference for certain assumptions serves as a rather old basis.

Upon review of the Management Services line item, there are no Accounting and Payroll services listed. By omitting these services, the Net Income line is considerably larger than if these services would be fully represented. Consequently, after considering all of the preceding, the stated Net Income of $221,306 in Year 2 is not realistic.

SUNCREST:
SunCrest has attempted to fully and realistically account the total costs of this proposed project. The basis for a financially feasible project is sound. SunCrest would be a superior choice for award of the CON for Wake County.

SUMMARY OF SUNCREST COMMENTS AND APPLICANT EVALUATION

	CON APPLICATION SECTIONS						
APPLICANTS	II	III	IV	VII	VIII	IX	X
ARC/Innovative Senior Care	-	-	-	-	-		-
AssistedCare	-				-	-	-
Community	-			-			-
Continuum II	-				-	-	-
Home Health & Hospice		-	-		-	-	-
United	-	-	-	-			-
SunCrest	+	+	+	+	+	+	+

This table highlights where SunCrest has made comments in opposition to the competing applicants by CON Section. Certain Applicants were singled out for having notable deficiencies, miscalculations or data analysis that raised serious questions about the CON application. Below a summary of the arguments are repeated as a Summary.

Section II (Quality): Suncrest is the only applicant to consistently use Disease State Management (Clinical Pathways) and with actual experience in Telehealth systems to manage outcomes. The other noted Applicants are deficient in their commitment to these measures of quality.

Section III (Need): SunCrest uses a documented, step by step methodology to validate the persons expected to be served in Year 1, 2, and 3. Several applicants do not fully address the unmet need of Wake County in their proposed projects or propose to serve counties which have no need for additional home health service.

Section IV (Utilization): SunCrest utilization data is based upon its actual experience with its 15 existing agencies and does not depend upon modeling the average behavior of agencies in NC or Wake County. Its utilization of disciplines is balanced to serve the continuum of home health patients. Other applicants are skewed toward certain disciplines.

Section V (Coordination): SunCrest is the only applicant not currently with a business presence in NC, yet SunCrest has diligently contacted a broad array of providers in Wake County and has sought to establish relationships with them.

Section VII (Staffing): The SunCrest staffing model is in the mid-range of those proposed. The model is driven by SunCrest's experience with using telehealth. The other Applicants are

noted for having too few proposed staff or assuming that employed staff can be hired in increments of 0.01 FTE or 0.001 FTE – thereby under-estimating labor costs considerably.

Section VIII (Capital): 3HC fails to fully account for capital costs while other Applicants seriously underestimate the required resources to fully implement the proposed project.

Section IX (Start-up): SunCrest has funds available in excess of the costs of start-up. Community is the only other applicant in this position.

Section X (Costs of services): 3HC and Community have high disconnects in their weighted average costs compared to total expenses per visit. The remaining applicants are generally similar. SunCrest and AssistedCare are the most consistent in their allocated costs. SunCrest reflects costs per visit that reflect the higher allocation of treatment resources (staff, equipment, clinical pathway driven care, etc).

Section X (Proforma-related): Numerous and varied factors impinge upon the reasonableness test of the pro forma and overall project financial feasibility. Each Applicant utilized certain assumptions that seemed aggressive and permitted a positive Net Income in Year 2. In some instances, the Net Income was very small, or "skinny" – where any miscalculation of the pro forma would render the proposed project as financially unfeasible. SunCrest, however, used prudent cost and revenue assumptions behind its projections and remains as the superior choice for award of the CON for Wake County.