Granville-Vance District Health Department

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HAND DELIVERED

September 30, 2013

Mr. Craig Smith, Section Chief
Jane Rhoe-Jones, Project Analyst
Certificate of Need Section
Division of Health Service Regulation
NC Department of Health and Human Services
809 Ruggles Drive
Raleigh, North Carolina 27603

Re: Comments on Competing Applications for a Certificate of Need for a new Medicare Certified Hospice Home Care agency in Granville County, Health Service Area IV; CON Project ID Numbers:

K-10172-13 Gentiva Hospice
K-10174-13 Continuum Home Care and Hospice

Dear Ms. Rhoe-Jones and Mr. Smith:

On behalf of Granville-Vance Health Department (GVDHD), Project ID K-010173-13, thank you for the opportunity to comment on the above referenced applications for development of a new Medicare-Certified Hospice Home Care agency in Granville County.

We understand that you must review the application in light of the Statutory Review Criteria in G.S.-131 E Article 10. We ask that you pay particular attention to:

- The capacity of the applicants to deliver hospice home care services to people in their homes in this very rural area;
- The applicants' experience and demonstrated commitment to work with the health care delivery system in this very rural area,
- The capacity of applicants to offer both palliative and terminal care;
- The extent to which applicants have demonstrated ability to develop a volunteer network to deliver hospice care in the service area.

Hospice formally originated in the US, in 1974 as a volunteer service. In 1982, Congress included a hospice benefit in Medicare on a pilot basis, and did not make it permanent until 1993. The significant role of hospice in end of life care only became prominent nationally after 2005. Throughout hospice history, the volunteer has been a critical member of the hospice care delivery team. Medicare statute requires that a minimum of five percent of visits be provided by volunteers.[1] The Medicare benefit was designed to supplement resources provided by the local community, not to cover the total cost of providing a full and complete hospice program In addition to visits for social support, respite for family members, assistance with household support like shopping, child care and bereavement support, hospice volunteers play an important role in fund raising and administrative support.

To ensure that all volunteers are equipped for the challenge of working with people who are dying, volunteers must complete extensive orientation and training sessions, as well as submit to a routine background check. This means a substantial personal commitment for the volunteer. It is important that volunteers understand the history of hospice and are aware of the specific ways their local hospices work to serve the community. Depending on area of service, volunteers may require additional training. Understanding this, GVDHD engaged one of the top hospice providers in the state to assist with volunteer development.

Volunteer hours do not appear in the financial statistics in a CON application, because they are not paid. But, they can be measured.

Table 1 - Comparison of Volunteer Services Proposed

Volunteer Activity	GVDHD	Continuum	Gentiva
Number of Visits Proposed Year 02	996	775	0
Other Proposed Services	Administration, newspaper exposure, legal services, chaplaincy, companionship. Plus unspecified additional support	Clergy p 34 Tim Henderson; no letter of commitment. Policy in Appendix R Education program page37 non-specific	None
Commitment	87 volunteers, see Exhibit 45	None	None
Hours of Time Committed	1,794 specified volunteer hours. Plus additional unspecified hours	None	None

Applications from Gentiva and Continuum indicate that they were disadvantaged in obtaining community support because GVDHD is an applicant. Please be aware that the letters and support commitments presented in the GVDHD application represent hundreds of hours of work on the part of staff and volunteers working in communities in each county in the GVDHD service area. Letters were thoughtfully written and / or signed after the signators listened to and weighed the GVDHD proposal; and they provided feedback on what it would take to make hospice succeed in the service area.

[1] SEC. 418.78 CONDITION OF PARTICIPATION: VOLUNTEERS

As noted by the Hospice Foundation of America[2], All dying experiences are unique and influenced by many factors, such as the particular illness and the types of medications being taken, but there are some physical changes that are fairly common. For some, this process may take weeks; for others, only a few days or hours..." For persons with chronic diseases like cancer, individuals may need palliative care for a long time before they truly qualify for end of life care. GVDHD is unique among the applicants in having a home health agency that offers palliative are in the service area. This will enable GVDHD to provide continuous support for individuals who go into remission and may go for an extended period during which they will not qualify for hospice. For these people, a team that can provide continuity of care regardless of payor benefit designation is critical both to sustained personal comfort and satisfaction and to minimizing costs of care. The role of changing providers in cost of care has been well documented.[3]

Continuum listed obstacles to acceptance of hospice care. Among the applicants, GVDHD has and demonstrated the best capacity to address these obstacles:

[2]Hospice Foundation of America http://www.hospicefoundation.org/dyingsigns accessed September 26, 2013
[3] Improving Care Transitions, Robert Wood Johnson Foundatoinhttp://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/improving-care-transitions.html, September 13, 2012

Table 2 - Response to Obstacles

	Response		
	GVDHD	**Continuum**	**Gentiva**
Service Area	Granville, Vance, Franklin, Warren, Person	Granville Vance	Granville ,Vance, Franklin, Person
Obstacle			
Continuous Community Education	In place system of community education; existing staff zones; promises of 672 referrals from physicians per year (Exhibit 25)	"Physician interaction" but only one physician letter	No physicians, no volunteers, no letters
Loss of physician continuity	Letters of support from 27 primary care physicians (Exhibit 44)	States, "do not preclude primary physician"; but no letters from primary care physicians	Does not address
Lack of expertise in symptom management	Start with trained home health staff who are already managing end of life patients; start with experienced hospice staff	"Hire only competent staff familiar with hospice" – but no evidence of available staff for the proposed agency;	No evidence of capacity to hire staff in the four-county service area; propose to recruit from the 9.8 percent who are unemployed
Abandonment of surviving family	Evidence of support from churches in the service area Bereavement program, Letters from 12 established community groups	Bereavement and history with teenage support group	Bereavement program
Lack of education regarding Medicare hospice benefit	Organized, in-place delivery system for community education, see application page 50	Medicare eligibility – No delivery system for education	Does not address
Lack of education for nursing home residents	Letters of support from 5 nursing homes in the service area	Letters from two nursing homes agreeing, Exhibit D	Policy in Ex. 15, but no letters
Lack of financial coverage-reflected in Charity Care as Percent of Gross Revenue	4% charity	1% charity	1% charity
African American hospice awareness	Attachment I to these comments contains letters and a partition signed by 39 people representing 12 predominantly African American churches that work as an interfaith council in the service area	"will reach out" p 5	will reach out

Granville County has sufficient population to generate a need in the SMFP for one hospice home care agency. Communities in adjacent service areas, particularly Warren, are also underserved, particularly in the rural parts, but the population is too small to generate a need. Only one applicant, GVDHD proposes to and provides a means by which it will reach communities in Warren County.

GVDHD is also the most cost effective of the applicants with a Year 02 cost per routine visit of $96.24 compared to Gentiva at $132 and Continuum at $125.78. This is important because routine visits are the most frequent of the hospice home care services.

We recognize that the state's Certificate of Need (CON) award for the proposed hospice home care agency will be based upon CON health planning objectives, as outlined in G.S. 131E Article 10. Specifically, we request that the CON Section give careful consideration to the extent to which each applicant:

- Has resources and invested capacity to change a culture that is unaccustomed to using hospice services in this service area;
- Demonstrates evidence of coordination with and promised referrals from the health care delivery system throughout its proposed service area; and
- Demonstrates an overwhelming level of support from residents of the proposed service area, who specifically explain why they prefer the applicant.

All said we appreciate the responsibility and dedication you invest in these decisions and hope you will find these and other compelling reasons to decide in favor of Granville Vance District Health Department.

Sincerely,

Lisa M. Harrison

Lisa M. Harrison, MPH
Health Director
Granville-Vance District Health Department

Attachment(s)

ATTACHMENTS

Attachment A

COMPETITIVE REVIEW OF
CONTINUUM II HOME CARE & HOSPICE, INC,
PROJECT ID# K-10174-13

OVERVIEW

Continuum II Home Care and Hospice, Inc. proposes to open a new hospice home care agency in Granville County to serve Granville and Vance Counties.

Technical issues throughout the application, make the seriousness of the application questionable. The first occurs in the summary in Section I:

> *Continuum II Home Care & Hospice, Inc. proposes to develop a new hospice home care agency in Granville County that will provide standard and enhanced hospice and palliative care to a* ***projected ????? patients (??? deaths)*** *in its first year of operation* ***and????? patients (??? deaths)*** *in the second year of operation. [****Emphasis*** *added,"??" not added]*

The technical issues, and the fact that the applicant has held a hospice home care license in Vance County since 2005, but has not yet served any patients in Vance County, raises serious questions about the likelihood that this applicant would develop the proposed agency at all, let alone to the level of service forecast in the application.

As discussed in the following paragraphs, this applicant is non-conforming to Criteria (1), (3), (3a), (4), (5), (6),(7), (8), (13), (18a), and (20); and Criteria and Standards 10A NCAC 14C .1503.

CON REVIEW CRITERIA

(a) Applications must be consistent with the following statutory review criteria.

1. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ambulatory surgery operating rooms, or home health offices that may be approved.

Although the applicant requests no more agencies than are identified in the 2013 State Medical Facilities Plan, conformance with Policy GEN-3 is questionable.

Overview

Policy GEN-3 requires that the applicant:

> *A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area.*

As noted in the following discussions, internal contradictions in this application suggest that this applicant will favor residents of nursing homes over other residents of the service area. This is supported by its proposed referrals, its lack of evidence of contact with area communities, its history with an existing license in Vance County and its proposed payment rate for inpatient care, among other things.

Quality

Funding for proposed quality measurement from Deyta referenced on page 82 is not identified in the proformas. In response to questions about third party accreditation in Section VI, this applicant identifies none.

Access

The policy requires the applicant to *demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access... shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services.*

The application's statements about non-responsiveness of the population to its approaches (p 50) seem disingenuous, and out of touch with one of this application's comments about the applicant's deep understanding of and ability to overcome these barriers (page 15). It also calls into question the applicant's ability to change Vance County average length of stay from an average of 53.9 to the proposed 75 days in year 2 (page 97) or from below to the state average in 12 months, by employing the early placement referenced on page 39.

On page 100, the application indicates that the proposed agency will provide 320 volunteer visits in Year 01 and 746 in Year 02. However, the application provides no letters from persons interested in volunteering. Appendix, D, contains no letter from the proposed Rev. Henderson. Moreover, the application proposes no hours of volunteer clergy on page 106. The proposed level of volunteer visits represents a significant commitment for an applicant that found "lukewarm" community reception to its overtures (see page 40), especially one that has not been able to activate its hospice home care license in one of the two proposed service area counties.

Value

As noted in Continuum Appendix A and highlighted in Attachment C to these comments, Continuum holds a license for a hospice home care in Vance County and the office is located only six miles from the Granville County line. Starting a new agency will be far more costly than serving Vance and Granville Counties from the existing established licensed office. Continuum is non-conforming with this part of policy GEN-3.

Page 51 appears to challenge the cost-effectiveness of hospice care, indicating that cost effectiveness is not the sole purpose of hospice care, suggesting that hospice care could be more expensive through early enrollment and symptom management.

For these reasons, the application is non-conforming with this criterion.

3 **The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.**

The application lists its service area as Granville and Vance Counties.

On page 60, Continuum observes that there is only one licensed hospice home care office in Vance County. As demonstrated in Attachment C, this is incorrect. The 2013 SMFP Table 13A does not list Continuum Vance County because Continuum served no patients from this licensed agency office. The Continuum office is counted in Table 13B.

On page 87, the applicant explains its Admission to Death ratio. The ratio that Continuum uses (1.3) is too high and is not based on a sound formula. Continuum uses an average of the following averages: 2012 county ratio, 2012 Continuum ratio, and 2012 state ratio. Because of the volatility and small sample size at the county level and at the provider level, the applicant should have used a weighted average to compute the admission to death ratio. The higher ratio results in an over-projection of admissions, and an overstatement of need.

For these reasons, the application is non-conforming to this criterion.

3a. **In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.**

On page 22, the application notes: "neither Continuum, nor its parent company, provides or operates a licensed health service in the proposed service area." On page 49, the application lists the service area as Granville and Vance counties. In Appendix A (Attachment C), the application lists a licensed hospice agency (HOS 3314) in Vance County. The application notes, but does not explain why the applicant does not operate this agency.

For these reasons, the application is non-conforming to this criterion.

4. **Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.**

Continuum could serve Vance and Granville Counties from an office in Hendersonville, in Vance County. Continuum has not acknowledged or proposed the least costly alternative means for it to offer hospice home health services in its proposed service area.

The application suggests it will offer six percent of its days in nursing homes, noting that 94 percent of days will be provided in patient homes. This is inconsistent with the history of its other hospice offices as demonstrated on its Medicare Cost reports, and far in excess of the North Carolina average.: Like other Continuum locations, the Parent Company, Principal owns a nursing home in Vance County, Kerr Lake Nursing and Rehab. Table 1 shows Continuum's 2012 nursing home history.

Table 1 - History of Continuum Hospice in Nursing Homes

Location	Percent of Days for Residents in Nursing Homes 2012	Continuum Parent (Principal) Owned Nursing Home in the County
Lenoir	50	x
Onslow	34	x
Halifax	54	x
State Average *(per Hospice Trends 2012 report)*	18.7[1]	

[1] 2012 Fiscal Year Hospice Data & Trends, The Carolinas Center for Hospice and End of Life Care, Cary North Carolina, 9/5/13

The Office of the Inspector General has raised concerns about excessive hospice days in nursing homes.[2] The applicant's history and experience, and relationships contained in this application suggest that the actual pattern of service will represent a much higher proportion of care in nursing home days than presented in the application. The application contains no documentation of other relationships that would offset Continuum's history. The application referenced letters sent to other providers. They include three nursing homes (p 42); however, Continuum received letters from only two. Attachment d to these comments contains a copy of the Executive Summary from the 2011 OIG report on hospice care in nursing homes.

Although the application lists a wide range of services in addition to Core services, on page 43, the application suggests that the timeframe for implementation of these special programs and services in Granville County and Vance County will depend on evaluation of specific community needs. This leads one to question the extent to which the applicant evaluated needs of the population to be served.

The application discussed alternatives. However, for the reasons cited, the fact that only one CON can be awarded, and, with better choices available, the application is non-conforming to this criterion.

5. **Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs, as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.**

The application fails to demonstrate the availability of funds for capital and operating needs. With 65 licensed, but not active, licensed home health and hospice offices in the state, the applicant has a burden to demonstrate that it can operationalize these, or explain why it will not, before it requests approval for more. The application contains no such discussion. Hence, the reviewer must assume that the applicant will need sufficient funds to operationalize these offices and funding is not demonstrated. If each required just the working capital that the applicant claims in Section IX of the application, ($231,791), the applicant would need $15,066,415 in start-up funds (65 x $231,791 = $15,066,415). Audited financials in Appendix O indicate that neither the applicant, nor the parent company has such cash resources.

Proforma expenses are understated. In the pro forma statement of expenses in Section X, Continuum understates the cost of the medical director. The proforma builds a cost per visit that includes only one hour per physician visit. This disagrees with the total projected hours in the Year 02 staffing table for physicians on page 130, which indicates 568 hours required, and the number of hours per physician visit on page 129 (2.67 hours). Based on the medical director salary and hourly rate, the total physician cost in the pro forma is understated by approximately $60,000 in Year 02 and $25,756 in Year 01. The understatement in Year 01 will require additional working capital, which the applicant has not demonstrated is available. In Year 02, the impact is a reduction in net income after expenses.

Moreover, the letter from a physician in Vance County indicates willingness to negotiate terms to be medical director. The letter contains no indication of experience with hospice (page 187) Exhibit D

[2] Levinson, Daniel, Office of the Inspector General, DHHS, Medicare Hospices that Focus on Nursing Facility Residents, OEI-02-10-00070, July 2011

The application is often non-specific about how it will offer services in Granville County. On page 138, the application indicates that the proposed agency will have no management contract fees. Yet, the application throughout refers to the experience of the applicant with hospice services. In fact, page 43 indicates that services will be provided by corporate consultants (Section II.6). With no contract fees to pay for sharing corporate experience, it is not clear how the applicant will have access to this expertise.

In the cash flow on page 141, receipts are constant in each of the last three quarters. It is not clear how this ties to the monthly admissions pattern on page 96, which shows graduated admissions for these quarters.

On page 142, the proposed cost per day for General Inpatient Care seems low. A number of providers that contract with their local hospitals are paying a contract rate equal to the Medicare hospice inpatient payment per day, which would be over $600/day (Continuum reports a charge to patients of $628.26 in Section X). This application provides no information to the contrary. In fact, in 2012, per the Medicare cost reports for each of the three Continuum home care facilities in North Carolina Continuum inpatient costs were high:

- The Roanoke Rapids site (Halifax County) had no General Inpatient days or cost;
- The Kinston site(Lenoir County) had 9 days and a direct cost per day of $3,628 with total cost per day of $4,358;
- The Jacksonville site (Onslow County) had 32 days and a direct cost per day of $681 with total cost per day of $928[3]

Although the Continuum application discusses plans to work with local hospitals for inpatient stays (page 71), proformas in this application suggest that all inpatient stays will be in nursing homes. (See cost per day of $369.61 on page 142)

Page 146, Question X.5, Continuum notes that the proposed agency will have no "per visit" charge rate for the disciplines listed in the table. However, in order to complete Medicare claims for some of the services, a hospice agency must have a per visit charge rate.

Page 152, Form A is a Balance Sheet. It seemed odd that they would have under "Current Assets" a credit balance in the Patient Receivables and was not sure what Deferred Charges represented under "Property, Plant, and Equipment". No assumptions support these figures. See page 149.

Page 152, is a little confusing with the negative balance in the "intercompany balance" in Year 02 of the Stockholders Equity.

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[3] Referenced Medicare Cost Report Data can be obtained from the Statistical data in Worksheet S-1 found in the each Medicare Provider's report.
The 9/30/11 and 9/30/12 fiscal year Medicare Cost Reports for the following Providers were extracted into a database of Medicare Cost information:
Continuum II H/C & Hospice – Halifax... provider #34-1595
Continuum II H/C & Hospice of Lenoir... provider #34-1594
Continuum II Home Care & Hospice... provider #34-7228 (Home Health Based Program)... Hospice #34-1582

Utilization projections for the first year (page 97) use a very high ALOS. Continuum draws on experience of established agencies to forecast start-up years for what it acknowledges is a new hospice in a reluctant service area (page 40). Moreover, supporting material referenced on page 44 refers to a non-existent Appendix V.

Revenue is dependent on projected admissions. It is not clear why the proposed agency would have approximately $433,000 in revenue from Vance County (40/169 patients times $1,830,446 see pages 87 and 153). The application notes that the applicant has an existing agency office in Vance County. If those admissions and related revenue were attributed to the Vance County office, the project would have negative earnings in Year 02.

The application is non-conforming to this criterion.

6. **The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.**

In Appendix A, Continuum lists 40 hospice offices that are non-operational. One is in Vance and one is in Franklin County. Continuum application does not explain why the proposed new agency is not a duplication of an agency located in the same rural county as its own existing non-operational licensed agency office. The application fails to distinguish why a branch office of its existing agency is not an adequate provider.

The application is non-conforming to this criterion.

7. **The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.**

With so many licensed, but not active offices in the state, the applicant has a burden to demonstrate that it can operationalize these before it requests approval for more.

Moreover, as noted on page 21 and page 436 in Appendix O, the applicant has limited resources. According to the letter from the parent company, the parent will fund $266,041 startup cost from parent cash flow as shown in the financial statements in the appendix. According to the audited financial statements and cash flow analysis, the parent company has $792,000 available cash, and no evidence of other cash flow not used by operations. On page 21 the applicant states that the parent has also committed to funding $382,661 (home health CON) in Brunswick County and $613,123 (SNF CON) in Wake County. The combined commitment by the parent company is $1,261,825. Commitments to these two alone exceed cash available from the parent.

Cash flow projections, page 140, show a huge jump in revenue and increase in net cash in the 4th quarter of Year 1. Projections for admissions and days of care in the 4th quarter, compared to the first 3 quarters, show no assumptions or data that support such an increase in the 4th quarter. With a 60-day period in A/R, Continuum projects to collect revenue on 1,312 days of care in Year 1 Q3 and collect on 1,569 days of care in Year 1Q4. This should translate into a 19.6 percent increase in revenue collections. The increase in revenue collections in the table on page 140 shows an increase from $220,074 to $437,015, a 99 percent increase. This over-projection means that working capital requirements are understated and the application has not demonstrated sufficient working capital to fund the project.

The application is non-conforming to this criterion.

8. **The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.**

Although Appendix D contains letters from providers of ancillary services the applicant proposes to acquire, the application is deficient in arrangements with the essential referral base of individuals and primary care physicians that the applicant acknowledges are also essential to the proposed agency's success. . All but three support letters are from proposed vendors.

The application contains limited evidence of proposed referrals, with seven respondents proposing to make 55 Granville referrals and 35 Vance referrals. Of the proposed referrals, 40 of 55, or 73 percent of Granville and 20 of 35 or 57 percent of Vance are from nursing homes. (See surveys)

Table 2. Source of Proposed Referrals Continuum Surveys

Person/ Provider	# Referrals		Familiar w/ existing hospices?	
	Granville	Vance	Yes	No
Marvaretta Stevenson, MD				
Specialty Clinics (cancer)	15	0	1	
Christie Nicholson				
Nutrition Plus			1	
Diane Cox				
Kerr-Tar AAA ombudsman)			1	
Heidi Mallett		15		
RehabCare			1	
Charles Sharpe				
Universal Healthcare/Oxford	20		1	
Nancy Hughes				
Kerr Lake Nursing & Rehab	20	20	1	
Jesse Currin				
North Central Medical Transport				1
Total	***55***	***35***	***6***	***1***
Percent from Nursing Homes	***73%***	***67%***		

Source: Continuum Application, Section III.1(b), page 80

This will make the aggressive start-up and commitment to 94 percent of visits in patient homes difficult to achieve.

The application fails to demonstrate that its coordination will be consistent with the proposed services and is non-conforming to this criterion

13. **The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:**

(a) **The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;**

As noted, the applicant has an existing license for a hospice home care office in the service area and has had the license since 2005. In seven years, the applicant has not served any patients.

The application is non-conforming to this criterion.

(b) **Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;**

On pages 88 and 89, the application references slow start up of new hospice agencies. This is consistent with the very low performance of Continuum's hospices in counties where it has located.

Table 3a – Continuum Hospice Agency Admission History 2011

Office	Years in Operation	Admissions from Home County in 2011	2011Market Share Percent	Total Continuum Agency Unduplicated Admissions 2011
	a	b	c	d
Halifax	3	22	12%	29
Lenoir	5	30	21%	48
Craven	6	24	11%	44
Onslow	14	128	39%	137

Notes:

a) 2012 License Renewal Application, page 4
b) 2012 License Renewal Application, page 10
c) d/Total County Admission from 2011 Hospice Data & Trends Report
d) 2012 License Renewal Application, page 4

Table 3b – Continuum Hospice Agency Admission History 2012

Office	Years in Operation	Admissions from Home County in 2012	2012 Market Share Percent	Total Continuum Agency Unduplicated Admissions 2012
	a	b	c	d
Halifax	4	24	19%	40
Lenoir	6	26	26%	48
Craven	7	25	6%	25
Onslow	15	136	38%	136

Notes:

a) 2013 License Renewal Application, page 4
b) 2013 License Renewal Application, page 10
c) d/Total County Admission from 2012 Hospice Data & Trends Report
d) 2012 License Renewal Application, page 4 DHSR state database

This history and the lack of support from few outside its proposed vendors suggest that this applicant will not reach its proposed 169 patients in Year 02. Poor performance outside Onslow, where it acquired an existing agency, undermines the applicant's claims that it can increase the hospice penetration rate in counties it serves. It also demonstrates poor results from the community outreach and education efforts described with great fanfare in Section I. In fact, the majority of admissions are patients in nursing homes, conceivably, those owned by the parent company

The application notes on page 128 that its agencies have a history of no charity care and shows that, by contrast, others do have a history of charity care.

The application is non-conforming to this criterion.

(c) **That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and**

The application over-projects days and admissions. Consequently, any projections of service to underserved groups are also over-projected. The application's data cannot be used dependably in evaluation of this criterion.

18a. **The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for the service for which competition will not have a favorable impact.**

Competition

The application will not enhance competition. It will add a second license for the same provider in a two-county service area that will have only three distinct in-county providers.

Quality

Performance of the parent company can be an indicator of performance by the subsidiary. Attachments E and F to these comments contain copies of Level G deficiencies in the nursing homes owned by the parent company in Lenoir and Halifax Counties in the past 18 months. A Level G nursing home deficiency is considered one that puts patients in immediate jeopardy. Attachment G contains change of ownership/ name documentation from the CON Section that ties the names of the nursing homes to the parent company, Principal.

Cost Effectiveness

Because projections in the application are both over and under-stated, the application fails to demonstrate the cost-effectiveness of this application.

Access

The applicant's history with regard to initiating services where it has offices suggests that this project will have a very slow start up, with primary access provided to residents of nursing homes owned by the parent company. This would not have a positive effect on competition for, or competitively improve services provided in resident homes.

The application is non-conforming to this criterion.

20. An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

With the applicant's history of emphasis to service to persons in nursing homes, the parent company history of closing a nursing home license following numerous licensure citations in Orange County and recent Level G deficiencies in nursing homes in Halifax and Lenoir counties should be considered, especially in light of the fact that there are competitive alternatives in this application cycle.

(b) Applications must also conform to Special Rules adopted by the Department for Hospices. The following discusses rules to which the Gentiva application should be found non-conforming.

10A NCAC 14C .1503: Performance Standards

An applicant proposing to develop a hospice shall demonstrate that no less than 80 percent of the total combined number of days of hospice care furnished to Medicaid and Medicare patients will be provided in the patients' residences in accordance with 42 CFR 418.302(f)(2).

Although the application indicates that 94 percent of days will be provided in patients' residences, the applicant's information from proposed referrals and other experience from the applicant's cost reports, referenced in Table 1 indicate that the statement is supported by documentation and is likely incorrect.

History Note: *Authority G.S. 131E-177(1);*
Eff. July 1, 1994;
Temporary Amendment Eff. January 1, 1999;
Temporary Eff. January 1, 1999 Expired on October 12, 1999;
Temporary Amendment Eff. January 1, 2000;
Temporary Amendment effective January 1, 2000 amends and replaces a permanent rulemaking originally proposed to be effective August 2000;
Amended Eff. April 1, 2001;
Temporary Amendment Eff. January 1, 2003;
Amended Eff. August 1, 2004;
Temporary Amendment Eff. February 1, 2006;
Amended Eff. November 1, 2006.

Attachment B

COMPETITIVE REVIEW OF –
GENTIVA HOSPICE, GRANVILLE COUNTY,
PROJ ID# K-10172-13

OVERVIEW

Wiregrass Hospice of South Carolina, LLC, d/b/a Gentiva Hospice, referred to as "Gentiva" proposes to open a new hospice home care agency in Granville County to serve Granville, Franklin, Person and Vance Counties.

Technical problems in the application make it non-conforming with statutory criteria: (1), (3), (4), (5), (6), (7), (8), (13a), (14), and (18a); and with Special Rules 10A NCAC 14C .1505.

Moreover, issues in calculation of need and financial proformas suggest that this applicant has a limited understanding of the hospice benefit.

CON REVIEW CRITERIA

(a) Applications must be consistent with the following statutory review criteria.

1. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ambulatory surgery operating rooms, or home health offices that may be approved.

Overview

Policy GEN-3 requires that the applicant

> *A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area.*

As noted in the discussion of Criterion 3, this application proposes service arrangements that will not be convenient to residents of the proposed four-county service area. The application's projected volumes are inconsistent and fail to recognize the geography of the service area.

Value

Based on information supplied in the application, including the list of providers contacted in Exhibit 20, documents Gentiva intends to transfer Granville, Vance, Franklin and Person County residents to Wake County for inpatient care and respite care. None of the Wake County providers listed is a hospice inpatient facility that offers specialized services, which would justify the distance. All are hospitals and nursing homes. With hospitals and nursing homes located in the service area, the proposed long distance transfer of patients from the primary service area to Wake County will create an unnecessary hardship for the patient and family. Gentiva's arrangements will unnecessarily increase the cost of care. The applicant has failed to demonstrate that the applicant can provide quality cost effective inpatient or respite care to the residents of Granville, Vance, Franklin and Person counties.

3 **The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.**

Need Overestimated

Summary

Gentiva identifies the population to be served, but uses inflated metrics to forecast the need of the population for the services proposed. The result an overstated need by approximately 30 patients; and the results render other calculations in the application suspect. Moreover, inconsistent methodologies, and lack of information about the proposed service area make this application confusing and more generic to hospice home care than specific to this proposed service area.

Overestimated Admissions

Gentiva utilizes a highly variable and unreliable data point as the basis for its methodology for projecting Gentiva admissions and unduplicated patients in Year 01 and 02 of operation, 2015 and 2016. This flawed statistical method and projection of unduplicated patients leads to an unreasonable projection of patient days and an unsubstantiated forecast of patient revenue. Specifics are detailed in the following excerpts and related discussions.

The applicant states in Step 6 of its methodology for projecting Hospice Eligible Patients

> For information purposes, projected hospice eligible deaths are not equivalent to projected hospice eligible patients. Not all patients served by hospice die in the year of admission to a hospice agency, and some are discharged from care. The following table provides FY2012 hospice admission and death data for the counties in Gentiva's primary and secondary service area.

Hospice Admissions & Deaths, FY2012

County	Admissions	Deaths	Admission: Death Ratio
Granville	124	88	1.41
Franklin	131	112	1.17
Person	158	127	1.24
Vance	124	110	1.13

Source: Proposed 2014 SMFP

The application further states in Step 11 of the methodology for projecting Gentiva Hospice Patients (Admissions):

> As described previously, hospice deaths are not equivalent to hospice patients, as not all patients served by hospice die in the year of admission to a hospice agency, and some are discharged from care. Thus, to project the number of hospice patients served by the proposed hospice home care office, Gentiva applied the respective FY2012 Hospice Admission: Death Ratio (identified in Step 6) to the number of projected hospice deaths served (Step 10).

Projected Gentiva Hospice Patient Admissions, FY2015-FY2016

	2015	2016
Granville	82	126
Franklin	5	17
Person	2	7
Vance	3	13
Total	**92**	**163**

Totals may not foot due to rounding.

> For information purposes, Gentiva assumes the projected hospice patient admissions represent unduplicated hospice patients.

Because a reliable and reasonable admission to death ratio is critical for projecting unduplicated patients, great care must be used in analyzing and selecting the proper basis for the ratio for this calculation. Individual counties can experience wide variation in the admission to death ratios from year to year, particularly counties with fewer than 200 admissions and deaths and only a few hospice providers in the county. In the latter cases, a single provider in the county can be an outlier and skew the ratio for the entire county. Because of wide variation at the micro level, use of the statewide ratio is more reliable as a basis for projections. The statewide ratio smoothes-out the effect of outliers.

Table 1 provides an analysis of service area and state admission to death ratios for the past five years. The variation in county ratios year over year is evident; however, the statewide ratio remains constant at or around 1.20.

Table 1 - Analysis of Admission to Death Ratio
NC State Medical Facilities Plan Data
Outliers circled

County	2008 Data	2009 Data	2010 Data	2011 Data	2012 Data	5 Year Total
Granville Admissions	114	120	133	137	124	628
Granville Deaths	93	96	89	108	88	474
Granville Admission Death Ratio	1.23	1.25	**1.49**	1.27	**1.41**	1.32
Franklin Admissions	126	149	136	164	131	706
Franklin Deaths	88	117	114	106	112	537
Franklin Admission Death Ratio	**1.43**	1.27	1.19	**1.55**	1.17	1.31
Person Admissions	122	134	150	187	158	751
Person Deaths	98	114	130	143	127	612
Person Admission Death Ratio	1.24	1.18	1.15	1.31	1.24	1.23
Vance Admissions	102	97	122	895	124	1340
Vance Deaths	78	90	95	123	110	496
Vance Admission Death Ratio	1.31	1.08	1.28	**7.28**	1.13	2.70
CON Service Area Admissions	464	500	541	1383	537	3425
CON Service Area Deaths	357	417	428	480	437	2119
CON Service Area Admission Death Ratio	**1.30**	**1.20**	**1.26**	**2.88**	**1.23**	**1.62**
State Admissions	32509	33460	35403	38743	39214	179329
State Deaths	26353	27533	30075	31841	33060	148862
State Admission Death Ratio	**1.23**	**1.22**	**1.18**	**1.22**	**1.19**	**1.20**

Source: Hospice Trends Reports

Admissions to death ratios circled in Table 1 are outliers, with one time ratios of 1.4 and higher. Individual providers can have an outlier year that affects the ratio for the entire county in a single year, but those rates do not sustain.

Table 2 below shows individual provider outlier data that contributed to the ratios highlighted above.

Table 2 - Admission to Death Ratio
NC State Medical Facilities Plan Data
Analysis of Data Outliers

Facility Name	County	Data Year	Admissions	Deaths	Admission Death Ratio
Community Home Care and Hospice	Franklin	2008	50	34	**1.47**
Duke Hospice	Granville	2010	46	20	**2.30**
Amedisys	Franklin	2011	69	38	**1.82**
Community Home Care and Hospice	Vance	2011	810	64	**12.66**
Amedisys	Granville	2012	35	17	**2.06**

Outlier provider data points in Table 2 skewed the county admission to death ratio in the respective year, but did not alter the state ratio, which remained relatively constant. Even the widely variant Community Home Care and Hospice ratio in Vance County in 2011, an obvious reporting error, did not significantly impact the state ratio in 2011. It is clear that using the state ratio is a more reliable indicator.

Table 3 below shows Projected Gentiva Hospice Admissions, FY2015 – FY2016 using the 5-year statewide admission to death ratio of 1.20. The corrected methodology results in 12 fewer unduplicated Gentiva admissions in Year 01 and 18 fewer unduplicated Gentiva admissions in Year 02.

Table 3 -Revised Projected Gentiva Hospice Patient Admissions, FY2015 – FY2016
Based on Five-Year Statewide Admission to Death Ratio of 1.20

County	2015	2016
Granville	70	108
Franklin	5	18
Person	2	6
Vance	4	13
Total	**80**	**145**

In summary, Gentiva inappropriately used one-year county-level ratios that are highly variable year over year as the basis for its projected admissions. Using a volatile ratio to forecast the admission to death ratios three and four years into the future is unreasonable and unreliable.

Overestimated Unduplicated Patient Days and Visits

Summary

As noted, Gentiva's projected unduplicated patients (admissions) in 2015 and 2016 on page 67 are unreasonable and unsupported. Consequently Gentiva's projections of patient days and patient visits, which are based on unduplicated patients (admissions), are also unreasonable and unsupported.

Gentiva uses an unrealistic and unsupported assumption for its forecast Granville County hospice market share of unserved deaths in FY 2016, Year 02 of operation. Gentiva's application fails to demonstrate that it has the support of the African American community or the support of referral sources in Granville and Vance counties. Gentiva home health offices had a 10.9 percent home health market share in Granville County in 2012, but Gentiva fails to document which home health referral sources in Granville County support its hospice home care application. In addition, Gentiva proposes to provide inpatient and respite care in Wake County hospitals and nursing homes. This will force residents in Granville, Vance, Franklin and Person counties to drive great distances for services that could be available closer to home. This inconvenience will likely have a negative impact on this applicant's referrals and market share.

In Step 9 of its methodology for projecting hospice patients and deaths, Gentiva states that its market share of unserved deaths in Granville County in 2016 will be 95 percent. This is ambitious for an applicant that demonstrates no evidence of support from Granville County. The applicant states that its primary focus will be on serving residents of Granville County:

> To project the number of hospice deaths for the proposed project, Gentiva estimates that it will achieve the following market share by county during the first two project years. Please note the projected market share is applicable to the projected unserved hospice deaths (Step 8) only, not all projected hospice deaths (Step 5).

Gentiva Projected Market Share of Unserved Hospice Deaths
Proposed Granville County Hospice Home Care Office
FY2015-FY2016

	2015	2016
Granville	65.0%	95.0%
Franklin	5.0%	15.0%
Person	5.0%	15.0%
Vance	5.0%	20.0%

Gentiva's market share estimates are reasonable and conservative. Gentiva proposes to target the unserved hospice deaths in Granville County. Currently, there is only one licensed hospice home care office located in Granville County (Hospice of Wake County, HOS3133), and that agency only served one hospice patient during FY2012. Gentiva's proposed hospice home care agency will be located in Oxford and will have a primary focus on serving Granville County residents.

As further justification for their Granville County market share assumption, the applicant states that it will reach out to African American churches and civic groups and will leverage their existing home health market and referral sources in Granville County:

> As described previously, Gentiva recognizes the need for increased awareness and, more importantly, increased education regarding hospice services, including by African Americans and minority populations. Gentiva is committed to and will extend outreach to minority populations in Granville County. Gentiva intends to develop relationships with access points in the African American community, for example churches and civic organizations. Additionally, Gentiva's parent company currently provides home health services to residents of Granville, Franklin, Person and Vance counties via its Medicare-Certified home health agencies in Durham and Franklin counties. During FY2012, Gentiva served 87 home health patients in Granville County and 641 home health patients in the secondary service area. Therefore, Gentiva currently has strong, established relationships with local physicians and other providers in the proposed service area. The proposed hospice agency will leverage these existing relationships upon completion of the proposed project with the intent of serving hospice patients.

However, the application has no documentation of contact with or letters of support from Granville County residents or the Granville County African American community, churches or civic groups.

In FY2012, Gentiva Health Services served 87 home health patients in Granville County, and based on this, Gentiva claims that it has strong established relationships with local physicians and other providers in the proposed service area. However, the application contains no evidence that this referral base supports the proposed hospice agency. Table 4 demonstrates that GVDHD has a much stronger market share of home health agency patients in Granville County.

Because Gentiva claims a presence in Granville County, one must ask why none of its existing referral sources provided letters of support.

Table 4 - Granville County Home Health Patient Origin from Proposed 2014 SMFP

Lic. #	Name	Facility County	Resident County	<18	18-40	41-49	60-64	65-74	75-84	85 and >	Total
HC0501	Granville – Vance Home Health Agency	Vance	Granville	3	14	45	27	75	111	68	343
HC0360	Duke Home Health	Durham	Granville	2	12	40	13	37	37	15	156
HC0339	Intrepid USA Healthcare Services	Wake	Granville	0	0	13	7	12	30	25	87
HC0215	Gentiva Health Services	Franklin	Granville	0	1	9	6	17	12	9	54
HC2111	Gentiva Health Services	Durham	Granville	0	1	6	3	10	8	5	33
HC2112	Medi Home Health Agency	Wake	Granville	0	1	3	3	10	8	7	32
HC1176	Liberty Home Care	Durham	Granville	0	1	12	1	6	8	4	32
HC0823	Maria Parham Regional Home Health	Vance	Granville	0	3	5	2	4	7	2	23
HC0918	Heartland Home Health Care	Wake	Granville	0	0	3	1	5	6	1	16
HC0354	BAYADA Home Health Care, Inc.	Person	Granville	2	0	4	1	2	2	0	11
HC0074	Well Care Home Health, Inc.	Wake	Granville	1	1	3	0	1	1	0	7
HC0500	Franklin County Home Health Agency	Franklin	Granville	0	0	2	0	0	0	0	2
HC1293	WakeMed Home Health	Wake	Granville	0	0	0	0	0	1	0	1
	Granville Totals			**8**	**34**	**145**	**64**	**179**	**231**	**136**	**797**

Source: Table 12A Home Health Data by County of Patient Origin – 2012 Data – Proposed 2014 SMFP

In fact, Gentiva submitted no letters of support from providers in three of the proposed four service area counties, and none from Granville County. Gentiva failed to document any contacts with referral sources or letters of support in Granville County. All letters of support in Exhibit 20 are from providers in Wake or Franklin Counties. Gentiva does have a higher home health market share in Franklin County. According to the Proposed 2014 SMFP, Gentiva Health Services served 491 home health patients in Franklin County in FY2012. Yet, as noted in the Gentiva excerpt on page 6 of these comments, Gentiva proposes a much lower market share of unserved deaths in Franklin County.

Note that page 80 of the Gentiva application contains erroneous home health data for Granville County and Franklin Counties. The applicant reversed the total Gentiva home health patients served in Granville and Franklin Counties, showing in the table on page 80 that Gentiva Health Services served 491 total patients in Granville County and 87 total patients in Franklin County. In reality, as documented in the Proposed 2014 SMFP Home Health Chapter 12, Gentiva Health Services served 87 patients in Granville County and 491 patients in Franklin County.

Gentiva compounds the error by reporting 83 home health patients in Franklin County in FY2013 and 409 home health patients in Granville County in FY2013. The tables below were taken from page 80 of the Gentiva application. The FY2012 data for Granville County and Franklin County are not factual and are misleading, creating the impression that Gentiva Health Services has a higher market presence and higher market share in Granville County.

Gentiva Health Services
Unduplicated Home Health Patients, FY2012

Franklin County Home Health Patients, FY2012										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC0215	Gentiva Health Services	Franklin	0	1	9	6	17	12	9	54
HC2111	Gentiva Health Services	Durham	0	1	6	3	10	8	5	33
Granville County Home Health Patients, FY2012										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC0215	Gentiva Health Services	Franklin	0	9	87	40	147	123	85	491
Person County Home Health Patients, FY2012										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC2111	Gentiva Health Services	Durham	0	1	6	3	9	2	4	25
Vance County Home Health Patients, FY2012										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC0215	Gentiva Health Services	Franklin	0	2	32	9	33	37	12	125

Source: Gentiva Internal Data

Gentiva Health Services
Unduplicated Home Health Patients, FY2013

Franklin County Home Health Patients, FY2013 (Oct-July)										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC0215	Gentiva Health Services	Franklin	0	1	8	5	14	10	8	45
HC2111	Gentiva Health Services	Durham	0	1	5	3	8	7	4	28
Granville County Home Health Patients, FY2013 (Oct-July)										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC0215	Gentiva Health Services	Franklin	0	8	73	33	123	103	71	409
Person County Home Health Patients, FY2013 (Oct-July)										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC2111	Gentiva Health Services	Durham	0	1	5	3	8	2	3	21
Vance County Home Health Patients, FY2013 (Oct-July)										
		Facility Co.	<18	18-40	41-59	60-64	65-74	75-84	85+	Total
HC0215	Gentiva Health Services	Franklin	0	2	27	8	28	31	10	104

Source: Gentiva Internal Data

In summary, Gentiva's methodology assumption of 95 percent market share of unserved deaths in Granville County in 2016 is overstated and unsupported for five reasons: 1) Granville County had only 88 hospice deaths in 2012. Gentiva proposes to reach 90 deaths in 2016 (126/1.4 admissions per death). This would represent a total market share of approximately 51 percent. (90/ (88+ 90) = 50, or56 percent) 2) Gentiva provided no documented contacts or letters of support from the African American community; 3) Gentiva has no documented referral contacts or intent to refer from Granville County providers; 4) Gentiva Health Services operates offices in Durham and Franklin Counties and has limited home health market presence in Granville County; and 5) Gentiva has no documented contacts with, or referral letters from, Granville County hospitals or nursing homes for hospice inpatient and respite care.

Gentiva uses an unrealistic and unsupported assumption for its Granville County market share of unserved deaths in FY 2016, Year 02 of operation. Gentiva's application fails to demonstrate that it has the support of the African American community or the support of referral sources in Granville and Vance counties. With only 10.9 percent home health market share in Granville County in 2012, Gentiva would need a stronger referral base to reach the populations in need. It also fails to document which home health referral sources in Granville County support its application. The proposed inconveniences of inpatient care, lack of African American outreach and absence of support from the applicant's home health agency referral base all serve to weaken the market share assumptions.

4. Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Gentiva pursued few alternative solutions: status quo, joint venture with Granville Health System and a different office location. It did not consider the alternative of a different provider that is locally based, has access to hospice expertise and has support from a broad cross section of the referral community.

5. Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs, as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Utilization Projections Unsupported

Average Daily Census Inconsistent with Tables

Forecasts of patients to be served are overstated as noted in discussion of Criterion 3 and special rule 10 NCAC.1502. As a result, financial and operational projections for the project are not reasonable.

In response to instructions in Section IV.5(a) and (b), the applicant failed to provide the number of hospice patients to be served in each month. Instead, the applicant lists the unduplicated number of hospice patients admitted each of the first 24 months.

In the corresponding methodology explained in sub-section (b) the applicant uses conflicting, unsupported and confusing methodologies, assumptions and formulas to project patient census by month.

Please see additional discussion of Special Rule 10 NCAC 1502(b)(2) below.

The unduplicated admissions in a month and the average daily census (ADC) by level of care in a month (Exhibit 17) do not equate to the number of hospice patients (duplicated patients) served in the month. In addition the methodology used to project the ADC per month for routine home care (Exhibit 17) does not follow the methodology used in Section III.1 and does not follow the applicant's stated assumption for length of stay.

Average Length of Stay Inconsistent with ADC

The applicant states in sub-section (b) on page 83 and 84:

Please refer to Section III.1 for the specific assumptions and methodology used to project the number of unduplicated hospice patients in each of the initial two years following completion of the project. To project the corresponding hospice patient caseload by month, Gentiva assumes a gradual, conservative fill up based on the following assumptions:

> Routine Home Care Patients: Gentiva projects the proposed Granville County hospice home care agency will serve one routine home care patient during Month One (October 2014). Thereafter, Gentiva projects the average daily census (ADC) to increase by two patients each month during the first project year. Gentiva projects the ADC to increase by one patient each month during the second project year.

Gentiva projects the ALOS for routine days of care based on the FY2012 statewide median ALOS per admission (73.5) per the Proposed 2014 SMFP.

The applicant states on page 84 that its methodology for the number of unduplicated admissions and an average length of stay (ALOS) of 73.5 days are factors in determining the number of patients served in each month. However it does not use those variables in the calculations. Instead, the applicant uses an arbitrary scheme of increasing the ADC by two patients each month in Year 01. In Year 02, it increased the ADC by one patient each month. The projected ADC each month is arbitrary, because it is not based on the number of admissions or the stated length of stay assumption. The applicant does not provide supporting documentation in its methodology to show why the ADC would increase by two patients in each month in the first project year and only one patient each month in the second project year. It would seem more realistic in a start up agency to project monthly ADC would increase by one patient per month in Year 01 and two patients per month in Year 02.

The applicant does not state the supporting basis for its assumption that the ADC will increase by two patients each month in the first project year. On page 85 the applicant presents a formula used to project the patient census each month, but the formula makes no sense and the monthly patient census is not reported anywhere in the application. The applicant states:

> After projecting ADC by level of hospice care during each of the first 24 months of the proposed project, Gentiva's projected monthly patient census was calculated based on the following formula:
>
> Patient Census = Average Daily Census x Days in Month ÷ ALOS

If one uses this formula to project the monthly patient census, the product is much different from what is reported in Section IV.5.(a) or in Exhibit 17. For instance, according to the formula, the patient census in month 12 (September 2015) of the first project year should be 9.4. (9.4 = 23 ADC x 30 days in month divided by 73.5 ALOS). A patient census of 9.4 does not appear in the application in any monthly table and contradicts the number of unduplicated patients served in the same month (12 admissions in September 2015). Even if one adds the 0.3 patients for respite care, 0.3 patients for inpatient care, and 1 patient for continuous care as shown in Exhibit 17 in month 12, the total of 11 patients to be served in the month is less than the number of admissions in the month, an impossible result.

This patient census calculation contradicts the stated methodology and underscores the fact that that any monthly patient census projections in the application are unreasonable and unsupported.

Patient Census – Days and Visits Unsupported

Application Section IV.6 directs the applicant to "Provide projected number of visits by level of care…and, describe the methodology and assumptions used to make the projections in the previous tables…. (Pages 85 – 94)

The confusing, conflicting, and arbitrary shift in methodologies and formulas used in calculating number of patients to be served each month undermines the validity of the patient days projections and visit projections. In Year 01 of operation, patient days should be the product of patient admissions multiplied by the patient length of stay (LOS), and allowing for the fact that in the last two months of the year, patients will not reach their full LOS by year's end. Average daily census for a period of time is the result of dividing total patient days for the period by the number of days in the period (month or year). One must calculate the total patient days in a period before the ADC can be determined. Contrary to this accepted logical sequence of calculating patient days based on admissions and LOS, the applicant arbitrarily plugs in ADC assumptions each month and then calculates the patient days. On page 94 the applicant states:

To project the number of hospice visits by level of care during the first two project years, Gentiva began by projecting hospice days of care for each level of care. To project hospice days of care by month for each level of care, Gentiva utilized the following formula:

Hospice Days of Care per Month = ADC x Days in Month

Based on the projected unduplicated hospice admissions provided in Section IV.4 and IV.5 and the corresponding projected days of care (see IV.8), Gentiva projects the following overall ALOS.

Proposed Granville Hospice Home Care Office
Projected Unduplicated Hospice Patients and Days of Care

	FY2014	FY2015
Unduplicated Hospice Patients	92	163
Total Days of Care	4,486	10,542
ALOS	48.8	64.8

Please refer to Exhibit 17 for a summary of the methodology used to project hospice patients and days of care.

The excerpt above states that unduplicated hospice admissions are used in calculating the corresponding patient days, but in reality, as shown in the Gentiva formula above, patient days are the product of arbitrary and unsupported ADC projections. Exhibit 17 states that the ALOS for routine home care days (98 percent of the total days) in Year 01 and Year 02 is 73.5 days. If the applicant were to actually use its unduplicated admissions and the ALOS assumption of 73.5 routine days per admission, the routine days and corresponding total days of care would be much different than what is stated in the table above. For instance in the first project year routine days of care should be calculated as follows.

Table 5 - Revised Calculation of Gentiva Days of Care

Period	Admissions	x	Days	=	Days of Care
Month 1 through Month 10	68 unduplicated	x	73.5	=	4,998
Month 11	12	x	61 (2 months)	=	732
Month 12	12	x	30 (1 month)	=	360
Total Year 1	**92**				**6,090**

The average ALOS for the year would be 66.2 and not 73.5.

In contrast, the total days of care listed in the applicant's table on page 94 are significantly overstated and are completely contradictory with its stated methodology and the calculation does not conform to standard methods for projecting days of care based on unduplicated admissions and length of stay per admission.

The applicant fails to provide supported assumptions and methodology for projecting patient days of care in Year 01 and Year 02. This failure undermines the visit projections and the revenue projections in the application.

Estimates of Visits by Level of Care Flawed

The following discussion addresses in formation in Section IV.6, Visits by Discipline per Patient Day (pages 94 – 96).

In its application, Gentiva uses a flawed methodology for projecting visits by level of care and by discipline for each of the 24 months following completion of the project. Gentiva bases the number of visits provided in the period on the number of admissions in the period and not on the number of patient days provided in the period.

It is important to realize that in hospice home care, the number of visits that each hospice patient receives during the course of his/her care is determined by the number of projected visits ordered in the patient's plan of care on a weekly or monthly basis. A set number of visits per patient is not ordered upon admission. The actual number of visits a hospice patient receives during the course of care is a function of the number of days the person is in the hospice program. Because the length of stay in the program varies with each admission, the preferred methodology for projecting number of visits is based on average visits per patient per day for each discipline.

Step 1 in Gentiva's methodology for projecting visits is to project the number of patient days in Years 01 and 02. As stated earlier, Gentiva's method for projecting days of care is erroneous and unsupported by its assumptions. The contradictory methodology creates two different "overall ALOS" results in Years 01 and 02, despite the fact that the methodology documented in Exhibit 17 uses the same ALOS assumptions for Years 01 and 02.

The Gentiva deviations in "overall ALOS" from the stated ALOS assumptions create two fundamental problems in its methodology for projecting visits. First, Gentiva uses the wrong ALOS to convert the statewide average visits per admission to average visits per patient per day. Second, Gentiva provides a lower intensity of visits to patients admitted in the second year of operation. This results in patients admitted in the second year receiving fewer visits on a weekly basis, because their length of stay increased. Patients under hospice care should receive a consistent number of visits on a daily or weekly basis regardless of their length of time in the program.

In Step 2 for projecting visits, Gentiva reviews The Carolinas Center for Hospice and End of Life Care (TCC) statewide visit data within the *2011 Hospice Data and Trends report.* The table on page 95 shows the total statewide visits by discipline, percent of total visits by discipline and average number of visits per admission by discipline.

In Step 3 Gentiva divides TCC statewide average number of visits per admission by discipline by the Gentiva "overall ALOS" to calculate visits per patient per day in Years 01 and 02 of operation. There are two problems with this method. First, because Gentiva was using TCC statewide data to benchmark visits by discipline, it should have used the Carolinas Center ALOS (73.5 days) as the divisor to calculate the benchmark for average visit per day by discipline. Second, once the benchmark for average visits per patient per day has been calculated, the benchmark should be used consistently year over year. Although the total visits a hospice patient receives during the course of care will vary based on length of stay, average visits per patient per day do not significantly vary. At the statewide level, North Carolina average visits per patient per day have remained fairly constant year over year.

On page 95 of the application, Gentiva notes that the average number of visits per patient per day decreases in Year 02 because their length of stay increases in Year 02. The application states,

> *"Please note that the decrease in visits per day from Year 1 to Year 2 is merely a function of Gentiva's longer length of stay during Project Year 2."*

Gentiva fails to see the long-term deficiency in this logic. Why should a patient with a longer length of stay receive fewer visits per day or per week? On page 35 of the Gentiva 2012 Annual Report in Exhibit 13, Gentiva hospices nationally report ALOS of 89 days in 2011 and 96 days in 2012. If the proposed Gentiva hospice in Granville County achieves its corporate benchmark of 96 days ALOS, average nursing visits per patient per day would decrease from 0.40 nursing visits per day to 0.20 nursing visits per day.

In summary, Gentiva's methodology for projecting patient visits is inconsistent with its utilization of TCC visit data and TCC ALOS data. Gentiva uses a flawed methodology, basing visit projections on TCC statewide average visits per admission rather than TCC statewide average visits per patient per day. The Gentiva methodology is not patient-centered and not based on needs per patient per day. The Gentiva methodology is vulnerable to variations in length of stay; as seen in tables on page 95 and page 96, when LOS increases, hospice patients will receive fewer visits per day.

Proformas Incorrect

In addition to the errors in calculation of days and visits, inconsistent and incorrect information pervades the financial proformas.

1) Wages and Salaries Expense in Form B for Clinical Personnel are understated in the Year 02 column of Form B and do not agree with Projected Staffing table for the second year of operation on page 122. According to the Projected Staffing table, if one multiplies the Average Salary for one FTE (Column 4) times the FTE's (Column 3) and sums the total for clinical salaries (RN, RN on-call, Aides, Dietician, MSW, and Clergy), the total salaries in the second project year equal $431,725. In Form B, Year 02, the clinical salaries projected are $367,669. In Form B, clinical salaries and wages are understated by $64,056. In addition, Taxes/Benefits are understated by $17,936 (28 percent of salaries and wages).

2) The Building Lease expense in Form B is understated by $38,000 in Year 01 and $38,760 in Year 02. According to the table on page 129 of the application, office space lease in Granville County will be 2,000 square feet. However, in the supporting documentation from the real estate agent in Exhibit 11 each available site identified in the application is 4,000 square feet, not 2,000 square feet. Below is an excerpt from the letter.

   Available spaces are 4,000 SF. Lease rates range from $15.50-$19.00 per SF, with Common Area Maintenance expenses estimated to be $2.50 per SF for 2013.

   Current availability is as follows:
   107 McClanahan Ave, Oxford, NC : 4,000 SF
   911 Linden Avenue, NC 28462: 4,000 SF

   The actual lease expense on the two sites identified in the application will be $76,000 in Year 01 and $77,520 in Year 02.

3) The cost per day for inpatient care listed in Table X.1 on page 138 of the application is too low. Year 01 proposed cost per day for inpatient care is $396 per day; Year 02 is $315 per day. In Section X.2 of the application Gentiva fails to provide a detailed description of the methodology and assumptions used to make the projections in Table X.1. Gentiva refers the reader to Form B and the associated Assumptions, but does not show any inpatient cost detail in Form B or document how the inpatient costs per day were calculated. In addition, the Assumptions do not mention any inpatient cost assumptions.

   The only documentation that refers to projected inpatient costs is contained in sample contracts in Exhibit 15 for inpatient care in the hospital or in the nursing home. Within the sample hospital contract to provide hospice inpatient care in Exhibit 15 the rate Gentiva will pay the hospital is 100 percent of the Medicare and Medicaid hospice inpatient care daily rate. The daily Medicare and Medicaid rate for hospice inpatient care in 2013 is $617.62 in Granville County and $678.66 in Wake County (In 2014, these are $624.16 and $679.22). If Gentiva commits to paying the hospital 100 percent of the Medicare and Medicaid rate, its cost will have to increase to at least $617.62 or $678.66 per patient per day. For reference, see Attachment J, to these comments.

Gentiva may have the option to contract with a nursing home to provide hospice inpatient care, but that option is contingent on the nursing home being able to provide 24 hour hands-on nursing care from a Registered Nurse. In addition the sample nursing home contract in Exhibit 15 leaves the contract daily rate for inpatient care blank, and there is no way to verify Gentiva's claim that they can provide inpatient care for less than the hospital rate. The application provides no documentation of an available nursing home contract.

4) Gentiva's Medicare Revenue is grossly overstated in Form B. The Hospice Medicare rates listed on line one in the tables on pages 141 and 142 feed directly into Total Charges Billed and Total Medicare Revenue reported in Form B. Gentiva used higher CMS Hospice Medicare rates for all of its Medicare days and levels of care, not taking into account that the Hospice Medicare rates in Granville County and Vance County are significantly less than in Wake County. In Form B, Gentiva does not take a corresponding contractual adjustment to account for the difference. Consequently the Total Revenue in Form B is significantly overstated. See Attachment J to these comments.

5) The pro forma Assumptions and The Medicare Revenue in Form B do not account for sequestration. Without the sequestration factor, the Medicare Revenue is overstated above and beyond the incorrect rates.

6) In Form B, The Medical Supplies expense is too low. Gentiva does not explain in the Assumptions or in the pro forma what types of supplies are included in Medical Supplies. Because pharmacy and DME are not listed separately, one must assume that "Medical Supplies" includes patient supplies, pharmacy and DME. Gentiva's $10.06 per patient per day in Year 02 of operation is too low for supplies, pharmacy and DME cost per patient per day. The North Carolina benchmark for 2012 was $20.73, according to data from CMS cost reports. See Attachment H North Carolina Benchmark Report, with these comments.

With understated expenses and unsupported forecasts of services, the application is non-conforming to this criterion.

6. The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

The application does not discuss how Gentiva arrived at market share for other counties. Given its strong presence in Franklin County, the fact that all letters of support are from Franklin County, one must ask if the real intent is for this applicant to serve a much larger share of Franklin County and possibly duplicate the efforts of other providers.

7. **The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.**

A letter in Exhibit 20 indicates that a Gentiva home health agency in Atlanta, Georgia will provide physical, occupational, speech and respiratory therapy services under a contracted arrangement with the proposed office. The application does not explain how these resources will be made available in this rural service area.

The application provides no evidence of volunteer resources from the service area and no evidence of referrals from the service area. It contains only four support letters from the service area, all of which are from Franklin County. No support letters are included from Granville County.

Gentiva identified a medical director, but does not indicate where this person lives. In response to other staff recruitment issues, the application indicates that it will draw from the 9.8 percent unemployment pool in Granville County. It does not indicate how much of this labor pool would qualify to function as hospice staff.

On page 119, the application indicates that volunteers will make 3.0 visits per day and the only evidence of volunteer capacity is the notation on page 127 that the applicant will engage with local organizations and advertise. The application contains no evidence of a resource pool of volunteers for this applicant.

Because proforma expenses are understated, the application lacks evidence of necessary resources and is non-conforming to this criterion.

8. **The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.**

Gentiva fails to demonstrate that its proposed hospice agency will be coordinated with the existing health care system. In fact, the application shows little awareness of providers in the health care system in its proposed four-county service area. For example:

On page 26 of the application, Gentiva states, "Gentiva will contract with local hospitals and nursing facilities to provide inpatient care services for symptom management or respite care." However, Gentiva fails to document any contacts with local hospitals or nursing facilities. On page 115 of the application Gentiva states that a log of contacts is found in Exhibit 21:

> Gentiva has contacted many healthcare providers and agencies in Granville County and surrounding areas regarding this CON project, either in person, via phone or email. Please refer to Exhibits 20 and 21 for letters of support and for a log of contacts Gentiva made in the local community regarding this CON project.

However, Exhibit 21 does not exist in the application. The exhibits end at Exhibit 20, and a log of contacts Gentiva made in the local community, primarily Granville County, cannot be found in the application.

The one hospital and two nursing facilities contacted in Exhibit 20 are located in Wake County and are not local to the proposed service area. Gentiva defines "local" as Wake County; however residents in Granville, Vance, Franklin and Person Counties would much prefer to receive inpatient and respite care in the county where they live.

The application is non-conforming to this criterion.

13. **The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:**

a) **That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and**

Because the application over-projects its Medicare revenue, it is not clear that the applicant will be able to meet its forecast of Medicaid and Charity care and remain viable.

The application mentions African American communities, recognizing the demographics of the area, but provides no documentation of the means by which Gentiva will reach out to this population.

14. **The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.**

In Section V, the application provides no evidence of efforts to coordinate with the health professional training programs in any of the service area counties.

The application is non-conforming with this criterion.

18a. **The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for the service for which competition will not have a favorable impact.**

Competition

Like Continuum, Gentiva projects high net revenue per patient in Year 02. This suggests its intent is to retain more of its collections for shareholders, whereas the non-profit applicant will return more to patient care.

Cost Effectiveness

With the many flaws in the application's utilization and expense forecasts, this application cannot be judged cost effective.

Quality

Referring patients to inpatient and respite providers outside the service area when comparable providers exist in the service area will not improve quality for local residents.

Access

With no coordination with referral sources outside Franklin County, this application cannot be judged as improving access to residents of the other three counties in its proposed service area.

(b) Applications must also conform to Special Rules adopted by the Department for Hospices. The following discusses rules to which the Gentiva application should be found non-conforming.

10A NCAC 14C .1502 Information required of applicant

(b) An applicant proposing to develop a hospice shall provide the following information:

(2) the projected number of duplicated hospice patients to be served by quarter for the first 24 months following completion of the project and the methodology and assumptions used to make the projections;

In response to the above requirement the applicant states: "Please refer to Section IV.5.(a) and (b)." However, in Section IV.5.(a) and (b) the applicant does NOT provide the required number of duplicated hospice patients to be served for the first 24 months. In fact, nowhere in their application does the applicant provide the projected number of duplicated hospice patients to be served in the first 24 months following completion of the project.

In Section IV.5.(a) and (b) the applicant lists the number of <u>unduplicated</u> hospice patients to be served in the first 24 months. The list of unduplicated patients by month satisfies the required information in Section II.(b).1 but not Section II.(b).2 as stated above. In Exhibit 17 the applicant does provide the hospice average daily census (ADC) by level of care for each of the first 24 months of operation. However, ADC by level of care is <u>not</u> the same as duplicated hospice patients served in the month. Therefore, the applicant is non-conforming with completing the required sections of the application.

In response to instructions in Section IV.5(a) and (b), the applicant failed to provide the number of hospice patients to be served in each month. Instead, the applicant lists the unduplicated number of hospice patients admitted each of the first 24 months.

In the corresponding methodology explained in sub-section (b) the applicant uses conflicting, unsupported and confusing methodologies, assumptions and formulas to project patient census by month.

The application is non-conforming to this special rule.

The following page contains excerpts from Gentiva Section IV.5

IV.5. (a) **Project the number of hospice patients to be served in each of the first 24 months following completion of the project (i.e., caseload by month). Complete the following table for each of the first two operating years.**

Proposed Granville County Hospice Home Care Office
Projected Unduplicated Hospice Patients, Year One

Project Year One (FY2015)	Unduplicated Hospice Patients
Oct-14	1
Nov-14	3
Dec-14	6
Jan-15	6
Feb-15	5
Mar-15	9
Apr-15	7
May-15	9
Jun-15	10
Jul-15	11
Aug-15	12
Sep-15	12
Total	**92**

Proposed Granville County Hospice Home Care Office
Projected Unduplicated Hospice Patients, Year Two

Project Year Two (FY2016)	Unduplicated Hospice Patients
Oct-15	11
Nov-15	11
Dec-15	13
Jan-16	12
Feb-16	12
Mar-16	14
Apr-16	13
May-16	14
Jun-16	15
Jul-16	15
Aug-16	15
Sep-16	16
Total	**163**

(b) **Provide the data and describe the methodology and assumptions that were used to make the projections.**

(7) **documentation of attempts made to establish working relationships with sources of referrals to the hospice services and copies of proposed agreements for the provision of inpatient care.**

The applicant failed to document attempts to establish working relationships with sources of referral within the primary service area and has failed to provide copies of proposed inpatient agreements within the primary or secondary service areas.

On page 73 of the application Gentiva defines its primary service area as Granville County and its secondary service area as Vance, Franklin, and Person counties. The applicant fails to document any attempts to contact referral sources or providers of inpatient care in the majority of the proposed service area. On page 17 the applicant states, "Please refer to Exhibit 20 for letters of support, including letters from an acute care hospital and skilled nursing facilities documenting their willingness to work with Gentiva to provide inpatient services for hospice patients." Exhibit 20 contains a few letters of support from Wake County and Franklin County. None of the providers contacted to provide inpatient care or respite care reside in the primary or secondary service area. The providers in Exhibit 20 that are willing to provide inpatient care are WakeMed, Universal Healthcare of North Raleigh, and Litchford Falls Rehab Center, each located in Wake County. Wake County is not listed within the service area of the applicant. Based on Gentiva statements and from the providers contacted in Exhibit 20, Gentiva intends to transfer Granville, Vance, Franklin and Person county residents to Wake County for inpatient care and respite care. This long distance transfer of patients from the primary service area to Wake County creates a hardship for the patient and family and increases the cost of care. The applicant has failed to demonstrate that they can provide quality cost effective inpatient or respite care to the residents of Granville, Vance, Franklin and Person counties.

On page 26 of the application Gentiva states, "Gentiva will contract with local hospitals and nursing facilities to provide inpatient care services for symptom management or respite care." However, Gentiva fails to document any contacts with local hospitals or nursing facilities. On page 115 of the application Gentiva states that a log of contacts is found in Exhibit 21:

Gentiva has contacted many healthcare providers and agencies in Granville County and surrounding areas regarding this CON project, either in person, via phone or email. Please refer to Exhibits 20 and 21 for letters of support and for a log of contacts Gentiva made in the local community regarding this CON project.

However, Exhibit 21 does not exist in the application. The exhibits end at Exhibit 20, and a log of contacts Gentiva made in the local community, primarily Granville County, cannot be found in the application. The one hospital and two nursing facilities contacted in Exhibit 20 are located in Wake County and are not local to the proposed service area. Gentiva defines "local" as Wake County; however residents in Granville, Vance, Franklin and Person Counties live one and more hours from Wake County providers and families would manage frequent contact much easier if inpatient and respite care is located in the county where they live.

Section II.4 Page 31, of the application requests, "Identify proposed providers of residential and inpatient care and provide documentation of the availability of the services." In its response Gentiva does not identify any proposed providers, but refers to the same Exhibit 20 for letters from acute care hospitals and skilled nursing facilities in Wake County. It would be inappropriate for residents of Granville, Vance, Franklin and Person counties to be limited to Wake County providers.

In summary, Gentiva fails to document contacts made in the local community, fails to document potential referral sources in the primary service area, and fails to provide evidence of the availability of inpatient and respite care in the proposed service area.

The application is non-conforming to this special rule.

History Note: *Authority G.S. 131E-177(1); 131E-183;*
Eff. July 1, 1994;
Amended Eff. November 1, 1996;
Temporary Amendment Eff. January 1, 2003;
Amended Eff. August 1, 2004;
Temporary Amendment Eff. February 1, 2006;
Amended Eff. November 1, 2006.

Attachment C

MULTIPLE FACILTIY/AGENCY LISTING

FACILITY	MAILING ADDRESS	STREET ADDRESS	CITY/STATE/ZIP	STATE LICENSE #	County
Continuum Home Care & Hospice	3391 Henderson Drive Extension	3391 Henderson Drive Extension	Jacksonville, NC 28546	HC1209	ONSLOW
Continuum Home Care of Chapel Hill	1716 Legion Road	1716 Legion Road	Chapel Hill, NC 27514	HC1201	ORANGE
Continuum Home Care of Charlotte	9200 Glenwater Dr	9200 Glenwater Dr	Charlotte, NC 28262	HC1202	MECKLINBURG
Continuum Home Care of Clyde	PO Box 459	47 Morgan St	Clyde, NC 28721	HC1203	HAYWOOD
Continuum Home Care of Davidson	706 Piney Wood Road	706 Piney Wood Road	Thomasville, NC 27360	HC1204	DAVIDSON
Continuum Home Care of Edenton	P.O. Box 566	1341 Paradise Road	Edenton NC 27932	HC1205	CHOWAN
Continuum Home Care of Franklin	PO Box 1449	3195 Old Murphy Rd.	Franklin NC 28744	HC1206	MACON
Continuum Home Care of Goldsboro	2401 Wayne Memorial Drive	2401 Wayne Memorial Drive	Goldsboro NC 27530	HC1207	WAYNE
Continuum Home Care of Greensboro	308 West Meadowview Road	308 West Meadowview Road	Greensboro, NC 27406	HC1362	GUILFORD
Continuum Home Care of Hamlet	P.O. Box 1489	769 Old Cheraw Rd	Hamlet, NC 28345	HC1208	RICHMOND
Continuum Home Care of Kinston	P.O. Box 3527	317 Rhodes Avenue	Kinston NC 28501	HC1211	LENOIR
Continuum Home Care of Louisburg	1704 NC Hwy. 39 N	1704 NC Hwy. 39 N	Louisburg, NC 27549	HC1212	FRANKLIN
Continuum Home Care of Madison	1721 Bald Hill Loop	1721 Bald Hill Loop	Madison NC 27025	HC1213	ROCKINGHAM
Continuum Home Care of Morganton	107 Magnolia Drive	107 Magnolia Drive	Morganton, NC 28655	HC1214	BURKE
Continuum Home Care of New Bern	P.O. Box 3397	2600 Old Cherry Point Road	New Bern, NC 28563	HC1215	CRAVEN
Continuum Home Care of North Chase	3015 Enterprise Drive	3015 Enterprise Drive	Wilmington, NC 28405	HC1224	NEW HANOVER
Continuum Home Care of Outer Banks	430 W. Health Center Dr.	430 W. Health Center Dr.	Nags Head NC 27959	HC1216	DARE
Continuum Home Care of Pamlico	290 Keel Rd.	290 Keel Rd.	Grantsboro NC 28529	HC1217	PAMLICO
Continuum Home Care of Piedmont	P.O. Box 1250	33426 Old Salisbury Road	Albemarle, NC 28002	HC1218	STANLEY
Continuum Home Care of Raleigh	3609 Bond St	3609 Bond St	Raleigh NC 27604	HC1221	WAKE
Continuum Home Care of Smithfield	P.O. Box 2390	515 Barbour Road	Smithfield, NC 27577	HC1219	JOHNSTON
Continuum Home Care of Snow Hill	1304 S. E. 2nd Street	1304 S. E. 2nd Street	Snow Hill, NC 28580	HC1220	GREENE
Continuum Home Care of Washington	P.O. Box 398	250 Lovers Lane	Washington, NC 27889	HC1222	BEAUFORT
Continuum Home Care of Wilkesboro	1016 Fletcher Street	1016 Fletcher Street	Wilkesboro, NC 28697	HC1223	WILKES
Continuum Home Care of Wilson	403 Crestview Avenue	403 Crestview Avenue	Wilson, NC 27893	HC1225	WILSON

FACILITY	Parent/Branch	Street Address	City/State	State License
Continuum II Home Care & Hospice, Inc.	Parent	3391 Henderson Drive	Jacksonville, NC 28546	
Continuum Home Care & Hospice of Pitt County	Branch	128 Snow Hill Road	Ayden, NC 28513	HOS3249
Continuum Home Care & Hospice of Cumberland County	Branch	2461 Legion Road	Fayetteville, NC 28304	HOS3272
Continuum Home Care & Hospice of Guilford County	Branch	308 N. Meadowview Road	Greensboro, NC 27406	HOS3251
Continuum Home Care & Hospice of Mecklenburg County	Branch	9200 Glenwater Drive	Charlotte, NC 28262	HOS3253
Continuum Home Care & Hospice of Harnett County	Branch	604 Lucas Road	Dunn, NC 28334	HOS3306
Continuum Home Care & Hospice of Forsyth County	Branch	728 Piney Grove Road	Kernersville, NC 27284	HOS3255
Continuum Home Care & Hospice of Robeson County	Branch	1170 Linkhaw Road	Lumberton, NC 28358	HOS3270
Continuum Home Care & Hospice of Franklin County	Branch	1704 NC 39 Hwy North	Louisburg, NC 27549	HOS3250
Continuum Home Care & Hospice of Rockingham County	Branch	1721 Bald Hill Loop	Madison, NC 27025	HOS3262
Continuum Home Care & Hospice of Burke County	Branch	107 Magnolia Drive	Morganton, NC 28358	HOS3263
Continuum Home Care & Hospice of Craven County	Branch	2600 Old Cherry Point Road	New Bern, NC 28563	HOS3238
Continuum Home Care & Hospice of Carteret County	Branch	210 Foxhall Road	Newport, NC 28570	HOS3239
Continuum Home Care & Hospice of Johnston County	Branch	515 Barbour Road	Smithfield, NC 27577	HOS3252
Continuum Home Care & Hospice of Beaufort County	Branch	250 Lovers Lane	Washington, NC 27889	HOS3315
Continuum Home Care & Hospice of Wilkes County	Branch	1016 Fletcher Street	Wilkesboro, NC 28697	HOS3257
Continuum Home Care & Hospice of Wilson County	Branch	403 Crestview Avenue	Wilson, NC 27893	HOS3271
Continuum Home Care & Hospice of Washington County	Branch	1084 US 64 East	Plymouth, NC 27962	HOS3260
Continuum Home Care & Hospice of Halifax County		208 Cary Street	Enfield, NC 27823	HOS3256
Continuum Home Care & Hospice of North Hampton County	Branch	200 Hampton Woods Complex	Jackson, NC 27845	HOS3259
Continuum Home Care & Hospice of Pender County	Branch	15444 US Hwy 17 N. Bldg 16 Rm D2 Hampstea	Hampstead, NC 28443	HOS3242
Continuum Home Care & Hospice of Pamlico County	Branch	290 Keel Road	Grantsboro, NC 28529	HOS3308
Continuum Home Care & Hospice of Wake County	Branch	3609 Bond Street	Raleigh, NC 27604	HOS3305
Continuum Home Care & Hospice of Wayne County	Branch	2401 Wayne Memorial Drive	Goldsboro, NC 27534	HOS3307
Continuum Home Care & Hospice of Macon County	Branch	3195 Old Murphy Road	Franklin, NC 28734	HOS3312
Continuum Home Care & Hospice of Vance County	Branch	1245 Park Avenue	Henderson, NC 27536	HOS3314
Continuum Home Care & Hospice of Stanly County	Branch	33426 Old Salisbury Road	Albemarle, NC 28002	HOS3311
Continuum Home Care & Hospice of Greene County	Branch	1304 S.E. 2nd Street	Snow Hill, NC 28580	HOS3310
Continuum Home Care & Hospice of Nash County	Branch	7369 Hunter Hill Road	Rocky Mount, NC 27804	HOS3309
Continuum Home Care & Hospice of Orange County	Branch	1716 Legion Road	Chapel Hill, Nc 27517	HOS3318
Continuum Home Care & Hospice of Martin County	Branch	119 Gatling Street	Williamston, NC 27892	HOS3317
Continuum Home Care & Hospice of Davidson County	Branch	706 Pineywood Road	Thomasville, NC 27360	HOS3316
Continuum Home Care & Hospice of Richmond County	Branch	Hwy 177 South	Hamlet, NC 28345	HOS3324
Continuum Home Care & Hospice of Union County	Branch	3315 Faith Church Road	Indian Trail, NC 28079	HOS3321
Continuum Home Care & Hospice of Dare County	Branch	430 W. Health Center Drive	Nags Head, NC 27959	HOS3320
Continuum Home Care & Hospice of Chowan County	Branch	1341 Paradise Road	Edenton, NC 27932	HOS3319
Continuum Home Care & Hospice of New Hanover County	Branch	3015 Enterprise Drive	Wilmington, NC 28405	HOS3322
Continuum Home Care & Hospice of Rowan County	Branch	1808 N. Cannon Blvd.	Kannapolis, NC 28083	HOS3323
Continuum Home Care & Hospice of Graham County	Branch	811 Snowbird Road	Robbinsville, NC 28771	HOS3325

Continuum Home Care & Hospice of Lenoir County	Free Stand	704 M Plaza Boulevard,	Kinston, NC 28504	HOS3261

Attachment D

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOSPICES THAT FOCUS ON NURSING FACILITY RESIDENTS

Daniel R. Levinson
Inspector General

July 2011
OEI-02-10-00070

EXECUTIVE SUMMARY

OBJECTIVES

1. To describe the growth of the Medicare hospice benefit in nursing facilities from 2005 to 2009.
2. To identify hospices with a high percentage of their Medicare beneficiaries residing in nursing facilities in 2009.
3. To describe characteristics of such hospices and their beneficiaries.

BACKGROUND

The Medicare hospice benefit allows a beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care. The Office of Inspector General (OIG) has recently raised a number of concerns about Medicare hospice care for nursing facility residents. OIG found that 31 percent of Medicare hospice beneficiaries resided in nursing facilities in 2006 and that 82 percent of hospice claims for these beneficiaries did not meet Medicare coverage requirements. Also, the Medicare Payment Advisory Commission (MedPAC) noted in a report to Congress in 2009 that hospices and nursing facilities may be involved in inappropriate enrollment and compensation.

This report is the first in a series by OIG that addresses the concerns identified by OIG and MedPAC. This first report describes the growth in hospice care from 2005 to 2009 and focuses on hospices that served a high percentage of nursing facility residents in 2009. It is based primarily on the Minimum Data Set and the hospice 100-percent Standard Analytical File from the Centers for Medicare & Medicaid Services (CMS). Companion reports will assess the marketing practices of a sample of these hospices, as well as their business relationships with nursing facilities.

FINDINGS

Medicare spending on hospice care for nursing facility residents has grown nearly 70 percent since 2005. Total Medicare spending for hospice care for nursing facility residents grew by 69 percent from 2005 to 2009, increasing from $2.55 billion to $4.31 billion. At the same time, the number of hospice beneficiaries in nursing facilities increased by 40 percent. The total number of hospices providing care to Medicare beneficiaries also grew, with a continuing trend toward for-profit

hospices. In 2009, for-profit hospices were reimbursed, on average, 29 percent more per beneficiary than nonprofit hospices and 53 percent more per beneficiary than government-owned hospices.

Hundreds of hospices had more than two-thirds of their beneficiaries in nursing facilities in 2009; most of these hospices were for-profit. Almost 8 percent of hospices had two-thirds or more of their Medicare beneficiaries residing in nursing facilities. In total, there were 263 such hospices, hereinafter referred to as high-percentage hospices. Seventy-two percent of high-percentage hospices were for-profit, compared to 56 percent of all hospices. On average, high-percentage hospices served beneficiaries in 20 nursing facilities.

High-percentage hospices received more Medicare payments per beneficiary and served beneficiaries who spent more time in care. Medicare paid an average of $3,182 more per beneficiary for beneficiaries served by high-percentage hospices than it paid per beneficiary for those served by hospices overall. High-percentage hospices served beneficiaries who spent more days in hospice care, which contributed to higher Medicare payments. By the end of 2009, the median number of days in hospice care for a beneficiary served by a high-percentage hospice was 3 weeks longer than the median number of days for a typical hospice beneficiary.

High-percentage hospices typically enrolled beneficiaries whose diagnoses required less complex care and who already lived in nursing facilities. Together, beneficiaries with ill-defined conditions, mental disorders, and Alzheimer's disease accounted for over half (51 percent) of the beneficiaries served by high-percentage hospices. In contrast, 32 percent of all hospice beneficiaries had one of these three conditions as their terminal diagnoses; beneficiaries with these conditions typically received routine home care, which is less complex and costly than other levels of hospice care.

In 2009, the vast majority—almost 90 percent—of beneficiaries who lived in nursing facilities and received care from high-percentage hospices had resided in the facilities before electing hospice care. In comparison, 79 percent of all hospice beneficiaries who received care in nursing facilities resided in the facilities before electing hospice care.

RECOMMENDATIONS

Some hospices may be seeking out beneficiaries with particular characteristics, including those with conditions associated with longer but less complex care. Such beneficiaries are often found in nursing facilities. By serving these beneficiaries for longer periods, the hospices receive more Medicare payments per beneficiary, which can contribute to higher profits.

As the growth in Medicare spending on hospice care for nursing facility residents continues, special attention should be paid to hospices that depend heavily on nursing facility residents. OIG plans to look at the marketing practices of these hospices and their relationships with nursing facilities. Also, the Patient Protection and Affordable Care Act requires Medicare hospice payment reform not earlier than October 1, 2013. In light of this requirement, CMS may find this report helpful as it considers options for reforming the hospice payment system.

We recommend that CMS:

Monitor hospices that depend heavily on nursing facility residents. CMS should target its monitoring efforts on hospices with a high percentage of beneficiaries in nursing facilities and should closely examine whether these hospices are meeting Medicare requirements.

Modify the payment system for hospice care in nursing facilities. Medicare currently pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private homes. The current payment structure provides incentives for hospices to seek out beneficiaries in nursing facilities, who often receive longer but less complex care. To lessen this incentive, CMS should reduce Medicare payments for hospice care provided in nursing facilities, seeking statutory authority, if necessary. Unlike private homes, nursing facilities are staffed with professional caregivers and are often paid by third-party payers, such as Medicaid. These facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of our recommendations. In response to our first recommendation, to monitor hospices that depend heavily on nursing facility residents, CMS stated that it will share the information in this report with Recovery Audit Contractors (RAC) and Medicare Administrative Contractors (MAC). RACs review Medicare claims on a postpayment basis to identify inappropriate payments. Further, CMS noted that it will continue to emphasize to the MACs the importance of this issue when prioritizing their medical review strategies or other interventions.

In response to our second recommendation, to modify the payment system for hospice care in nursing facilities, CMS agreed that incentives to seek out beneficiaries in nursing facilities may exist in the current payment structure. CMS stated that it is in the early stages of its reform efforts. It is conducting initial analysis and will convene a technical advisory panel. Finally, CMS stated that it intends to analyze a variety of data and information on patient resource use by site, length of stay, and patient characteristics. We support CMS's efforts and encourage it to focus its analysis and reform efforts on lessening the incentive for hospices to inappropriately seek out beneficiaries in nursing facilities.

Attachment E

APR 2 5 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345101	A. BUILDING _____ B. WING _____	03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 CARY ST ENFIELD, NC 27823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to notify the physician of an	F 157	**Response Preface** Enfield Oaks Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of our residents. The plan of correction is submitted as written allegation of compliance. Enfield Oaks Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Enfield Oaks Nursing and Rehabilitation Center reserves the right to submit documentation to statement of deficiencies through informal dispute resolution, formal appeal procedures and/or any other legal proceedings.	4/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4/20/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 20 (DNS). The DNS indicated she would have expected the staff to assist a resident who is unable to do oral care or to complete the care by his self. She continued she would have expected staff to notice a visual build up in the resident ' s mouth and provided care.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to identify, assess, and treat 3 unstageable pressure ulcers on 1 (Resident #61) of 2 sampled residents with pressure ulcers;. Findings included: Resident # 61 was admitted to the facility on 1/30/13 and readmitted to the facility on 3/7/13. Review of the hospital History and Physical of 2/26/13 revealed the resident the resident was being followed by the wound care center at the hospital for a stage IV sacral pressure ulcer and right ischial pressure ulcer. Additional diagnoses included paraplegia from the waist down to the	F 314	Resident #61 was provided foot care by the assigned CNA on 3/28/13 and will continue to receive foot care per facility policy. Resident #61 bilateral feet were assessed by the DON and Facility Consultant on 3/28/13 and by the Wound Care Consultants on 4/1/13, 4/2/13, and 4/3/13. The MD was notified of resident #61 bilateral feet unstageable pressure ulcers by the treatment nurse on 3/28/13. Resident # 61 was sent to the wound clinic on 4/5/13 related to unstageable feet pressure ulcers. Resident #61 unstageable feet pressure ulcers will continue to be treated per physician's orders. A 100% body assessment of all residents to include resident # 61 was completed by the treatment nurse, Wound Care Consultant, and RN Charge Nurse on 4/2/13. The MD was immediately notified of all identified areas of concern by the treatment nurse.	4/25/13

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F 314	Continued From page 21 lower extremities. Review of a Nurse Admission Assessment of 1/30/13 revealed a stage IV pressure ulcer of the right rear thigh that measured 2.7 cm (cubic centimeters) by 2.0 cm x 3.0 cm deep. The resident was also assessed as having had a stage IV pressure ulcer of the sacrum that measured 11.5 cm x 12.6 cm x 3.0 cm deep. An observation was made of the wound treatment for the resident's sacrum on 3/28/13 at 11:30 AM with the treatment nurse. When the resident was turned to her left side, her left outer ankle was exposed and a blackened area of 2.5 inches was noted over the bone. The treatment nurse stated she was unaware of the area. During additional observation of the resident's feet revealed the resident's left inner heel had a darkened, purple colored circular area. The treatment nurse reported the skin under the area was soft. Observation of the resident's right heel revealed a darkened, purple colored circular area. On the center to outer right heel was a dark purple colored area covered by dry peeling skin and also surrounded the area. The resident's feet were covered by multiple dry hardened peeling skin on her toes, tops of her feet, and bottoms of each foot. The treatment nurse reported she was unaware of the areas of the resident's heels. During an observation of the resident's right ankle and heels with the Director of Nursing (DON) on 3/28/13 at 11:45 AM, the DON reported the areas on the resident's heels were unstageable pressure ulcers and requested the resident's feet were thoroughly washed and	F 314	Continued From page 21 On 3/28/13 an inservice was initiated by the Director of Nursing with all CNAs and License Nurses regarding prevention intervention, routine skin check observation, reporting changes and abnormalities in residents to include skin abnormalities, foot care, notification of acute changes in condition to include skin condition, and skin alerts. An inservice with all licensed nurses was initiated on 4/18/13 by the DON regarding completing skin referral forms. All newly hired CNAs and License Nurses will be inserviced regarding prevention intervention, routine skin checks, observation and reporting changes and abnormalities in residents to include skin abnormalities, foot care, notification of acute changes in condition to include skin condition, skin alters, and skin referral forms by the DON during orientation. Skin checks on all residents to include resident # 61 will be completed by the CNAs daily during routine care. If any abnormalities are noted the CNA will complete a skin alert. Licensed nurses	4/23/13

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F 314	Continued From page 22 lation applied.. During an observation of the resident ' s right ankle and heels with the DON and Nurse Consultant at 2:30 PM on 3/28/13, the blackened area of the right ankle was opened in a circular area with the top layer of skin removed. The discoloration of the heels remained. The DON and Nurse Consultant stated the heels were probably Stage IV pressure ulcers and the right ankle was a Stage II pressure ulcer. Review of the resident ' s medical record revealed no documentation was recorded for the areas on the resident ' s heels and ankle prior to the observation on 3/28/13. During an interview with NA #1 on 3/28/13 at 12:26 pm, the NA reported NAs were expected to wash resident's feet every day with their bath and the resident's feet did not look like they have been cared for in a long time. The NA stated NAs reported changes in residents ' skin to their nurse when discovered during a bath. An interview was conducted with the DON on 3/28/13 at 10:37 AM. The DON stated she expected NAs did skin checks to monitor for any red or opened areas or changes in residents ' skin. When they found any concerns, they were expected to notify the nurse and enter it into the point click care system. The DON reported there were no skin concerns documented in the point click care system and she was unaware of the condition of Resident #61 ' s feet.	F 314	Continued From page 22 will assess all residents with skin alerts, complete a skin referral form, and treat according to the MD order or facility protocol for all skin abnormalities noted. The treatment nurse will review the skin referral form and ensure the skin abnormality has been assessed and treated according to the MD order or facility protocol. The Treatment Nurse and RN Charge nurse will assess all residents to include resident #61 weekly x 4 weeks, Bi weekly x 4 weeks, and then Monthly x 2 months to ensure all skin abnormalities have been assessed and treated per physician's order or facility protocol utilizing a Skin Check QI Tool. Any identified areas of concern will be addressed immediately by the Treatment Nurse or RN Charge nurse. The DON will review the Skin Check QI Tools weekly x 4 weeks, Bi weekly x 4 weeks, and Monthly x 4 for completion. The Director of Nursing will compile audit results of the Skin Check Monitoring QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required.	4/25/13
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS			

Attachment F

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	345156	A. BUILDING _____ B. WING _____	C 01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HALL NURSING AND REHABILITATION CENTER	312 WARREN AVENUE KINSTON, NC 28502

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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure the safety of 1 of 2 residents who sustained a fracture above the right knee. (Resident # 1). Findings include: 1. Resident # 1 was admitted to the facility on 2/29/2000 with a diagnosis of Alzheimer's Disease. A review of the 5-Day / Quarterly Minimum Data Set (MDS) assessment of 10/19/12 revealed the resident had severe cognitive loss, no speech, and was dependent in all aspects of care. Resident # 1 required maximum assistance with bed mobility, and transferred with a mechanical lift and assistance of one. A review of the Care Area Assessment (CAA) for Falls dated 7/27/12 revealed the resident had no falls, was assessed as being at low risk for falls, and was no longer care planned for falls due to being dependent for all aspects of mobility. A review of the Care Plan dated 10/19/12 and Resident Care Guide (care plan for nursing assistants) revealed the resident was transferred with a mechanical lift with assistance of one until 12/28/12. From 12/28/12, the mechanical lift was	F 323	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alan Chambers RN	DON	1-23-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1	F 323		

to be utilized with the assistance of two.
A review of the Nurses Notes for 12/28/12 12:45 PM revealed, "called to room by cna (certified nursing assistant) regarding resident right lower leg. Res (resident) usually stiff and contracted but is moving more freely than usual. No bruising noted but edema noted at knee and thigh area. Does have some facial grimacing noted but does not seem to be severe pain." The physician was notified and Resident # 1 was sent to the Emergency Room (ER) for evaluation.
During an interview on 1/8/13 at 3:01 PM, Nurse # 1 stated the NA # 1 reported the resident's leg was usually stiff and was not like that now and wanted her to check it. Nurse # 1 stated she assessed Resident # 1's right leg and found the right thigh swollen from above the knee. Nurse # 1 stated there was no bruising present.
During an interview on 1/8/13 at 3:15 PM, Nursing Assistant (NA) # 1 stated she worked with the resident on 12/27/12 and 12/28/12. NA # 1 stated she bathed the resident on 12/27/12 and 12/28/12 and there was no bruising or swelling of the right leg. NA # 1 stated both the Resident # 1's legs were stiff. NA # 1 stated when she dressed Resident # 1 on 12/28/12, she noticed her right leg was not as stiff. NA # 1 stated she transferred Resident # 1 from the bed to the geri-chair using the mechanical lift after her bath on 12/28/12. NA # 1 stated the resident did not bump the side rails during care or the mechanical lift during transfer. NA # 1 stated she put Resident # 1 back to bed after lunch using the mechanical lift. NA # 1 stated the resident did not bump the side rails during care or the mechanical lift during transfer. NA # 1 stated when she changed the resident's clothes, she noticed the right leg moved more freely and there was

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F 323	Continued From page 2 swelling above the knee. NA # 1 stated she reported to the nurse, "I don't know if this is anything or not, but there is something different about her right leg. It is more free moving and there is swelling." NA # 1 stated there was no bruising present on the right leg. A review of the ER record dated 12/28/12 revealed the following: "Pt (patient) from (name of facility). Rt (right) knee swelling. Pt groins (sic) on arrival with palpation of rt knee nonambulatory." The musculoskeletal assessment comment revealed: "Rt knee pain and swelling since this AM. Pt nonambulatory and staff states not dropped." The integumentary (skin) assessment revealed: "WNL (within normal limits)." A review of the x-ray report of the right leg dated 12/28/12 revealed a comminuted fracture (a fracture in which the bone is broken into several pieces) of the distal right femur. There was no documentation of demineralization or osteoporosis of the right femur. Resident # 1 was admitted to the surgical floor. A review of the hospital History & Physical dated 12/28/12 revealed an examination of Resident # 1's extremities showed the following: "The patient has contractures of the bilateral lower extremities, no pitting edema, bilateral extremities are in foot drop prevention boots." On 12/30/12, surgery was performed. During an interview on 1/9/13 at 3:48 PM, the orthopedic surgeon (OS) stated, "There was enough force to the knee to cause the lower bone to push up into the femur causing it to shatter. It was a very pretty straight transverse fracture where the knee snapped the femur up above the knee." Resident # 1 had not returned to the facility from the hospital on 1/9/13.	F 323		

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F 323	Continued From page 3 A review of the facility investigation revealed direct care staff and nursing staff who cared for the resident from 12/26/12 - 12/28/12 reported there was no bruising or swelling of the right leg until 12/28/12. During an interview on 12/8/13 at 3:50 PM, the Administrator stated during the investigation they learned that on 12/26/12, 11-7 NA # 2 gave Resident # 1 a shower. NA # 2 did not use the mechanical lift to transfer Resident # 1, but transferred Resident # 1 three times by lifting the resident in his arms. NA # 2 was suspended on 12/29/12 until the investigation was completed, and then terminated for improper transfers. During an interview on 1/9/13 at 3:06 PM, NA # 2 stated he knew Resident # 1 was supposed to be transferred with the mechanical lift, but forgot to use it when he gave the shower on 12/26/12. NA # 2 stated he gently lifted the Resident # 1 from the bed with one arm around the middle of the back, and one arm under the knees, and gently sat Resident # 1 in the geri-chair. NA # 2 stated he lifted the resident in the same way when transferring from the geri-chair to the shower chair, and back to the geri chair following the shower. NA # 2 stated Resident # 1's knee was not bumped during the transfers or the shower. During an interview on 1/9/13 at 3:58 PM, the Administrator stated they were unable to determine if an injury occurred due to improper transfers because there was no bruising, and swelling did not occur until 12/28/12. The Administrator stated they were not able to determine how or when the fracture occurred. The Administrator stated the fracture could have occurred after Resident # 1 left with EMS or at the hospital. Further review of the facility investigation on	F 323		

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F 323	Continued From page 4 1/9/13 revealed Resident # 1 ' s care plan and Resident Care Guide were updated to reflect transfers were to be performed using a mechanical lift with assistance of two staff on 12/28/12. A 24-Hour Report and a 5 Working Day report was sent to the appropriate state agency within the mandated timeframe. NA # 2 was suspended pending the outcome of the investigation, and terminated at the conclusion of the investigation on 1/4/13 due to improper transfers based on Resident # 1 ' s care guide. Group and individual inservices were conducted beginning 12/29/12 and included all nursing and direct care staff on Safe Resident Handling & Movement Policy and use of the Resident Care Guide for the correct transfer technique. Quality Assurance (QA) interventions were integrated into the QA program by 1/4/13 utilizing audits during routine rounds to monitor one transfer per nursing station per week, including rotating shifts at random and was ongoing. The audits were to be reviewed at the next monthly QA meeting. During an interview on 1/8/13 at 3:15 PM, NA # 1 stated she attended the inservice on Safe Resident Handling & Movement Policy. NA # 1 stated the information regarding resident transfers was on the Resident Care Guide after they were evaluated for the safest transfer. NA # 1 stated she checked the Resident Care Guide before each transfer. During an interview on 1/9/13 at 2:06 PM, NA # 3 stated she had attended the inservice on Safe Resident Handling & Movement Policy. NA # 3 stated residents were evaluated to determine the safest mode of transfer, and the information was written on the Resident Care Guide. NA # 3 stated she checked the Resident Care Guide for her assigned residents daily because the	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HALL NURSING AND REHABILITATION CENTER	312 WARREN AVENUE KINSTON, NC 28502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 information could change from day to day. On 1/9/13 at 2:06 PM, an observation of a transfer using the mechanical lift and assistance of one staff was conducted. NA # 3 checked the Resident Care Guide for the safest transfer technique for Resident # 4. NA # 3 prepared the mechanical lift and explained the procedure to Resident # 4. The transfer was completed correctly.	F 323		

Harmony Hall Nurs_g and Rehabilitation Cen._r

PO Box 3527
312 Warren Avenue
Kinston, NC 28502

Corrective Action Plan

1. All nursing staff were rein-serviced on the following:
   a. Review of the resident care guide prior to rendering care
   b. Proper use of lift equipment with return demonstration
   c. Handling residents carefully to avoid injury
   d. Maintaining the resident care area clear of hazards that could result in injury
   e. Reporting/evaluation of resident changes in condition
2. Nursing staff will be monitored on daily rounds by management personnel to assure compliance with care being administered by the resident care guide.
3. A QI plan was put in place to monitor staff with the use of lifts and following planned lift procedures. Staff performance with the lift will be reviewed each shift on three randomly selected employees weekly for four weeks, then once weekly each shift for four weeks to be followed by random checks as necessary. Staff retraining to take place as needed if issues with lift procedure are identified.
4. Results of the monitoring process will be review and discussed at the monthly CQI meeting with revisions to the corrective plan if warranted.

Attachment G

Incoming Correspondence for No Review Request, Exempt from Review Request Review Determination Request & Acquisitions, Material Compliance, Change of Ownership and Declaratory Ruling Requests

FROM:	DATE OF LETTER	DATE RECORDED	TYPE/FACILITY/ COUNTY	ASSIGNED TO:	DRAFT DUE	DATE MAILED
Name: Melissa Brown **Agency:** Magnolia Lane Nursing & Rehabilitation Center	1/1/2011	1/12/2011	Change of Ownership and Name Change/ From Britthaven of Morganton To Magnolia Lane Nursing and Rehabilitation Center/ Change of Ownership From Britthaven To Granite Falls LTC, LLC/	Fatimah Wilson	1/26/ 2011	
Name: Jamie Lilley **Agency:** Roanoke Landing Nursing and Rehab Center	1/1/2011	1/12/2011	Change of Ownership and Name Change/ From Plumblee Nursing Center To Roanoke Landing Nursing and Rehab Center/ Change of Ownership From Britthaven, Inc. To Tar River LTC Group, LLC/	Bernetta Thorne Williams	1/26/ 2011	
Name: Deloris Roberson **Agency:** Northampton Nursing & Rehab Center	1/1/2011	1/12/2011	Change of Ownership and Name Change/ From Hampton Woods Health & Rehab Center, Inc. To Northampton Nursing & rehab Center/ Change of Ownership From Britthaven To Tar River LTC Group, LLC/	Bernetta Thorne Williams	1/26/ 2011	
Name: Candice Baldwin **Agency:** Cumberland Nursing & Rehab Center	1/1/2011	1/12/2011	Change of Ownership and Name Change/ From Campbellton Health Care Center To Cumberland Nursing and Rehabilitation Center/ Change of Ownership From Britthaven To Maple LTC Group, LLC/	Greg Yakaboski	1/26/ 2011	
Name: Nancy Hughes **Agency:** Kerr Lake Nursing & Rehabilitation Center	1/1/2011	1/12/2011	Change of Ownership and Name Change/ From Britthaven of Henderson To Kerr Lake Nursing and Rehabilitation Center/ Change of Ownership From Britthaven, Inc. To Eagle Peak LTC, LLC/	Mike Mckillip	1/26/ 2011	
Name: Donna Stephens **Agency:** Graham Healthcare & Rehabilitation	1/1/2011	1/12/2011	Change of Ownership and Name Change/ From Britthaven of Graham To Graham Healthcare and Rehabilitation Center/ Change of Ownership From Britthaven Inc. To	Les Brown	1/26/ 2011	

Name: Frank Hall **Agency:** Greendale Forest Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Snow Hill To Greendale Forest Nursing and Rehabilitation Center/ Change of Ownership From Britthaven Inc. To River Neuse LTC Group, LLC/	Jane Rhoe Jones	1/27/ 2011	
Name: Brandy Humphrey **Agency:** Carolina Rivers Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Onslow To Carolina Rivers Nursing & Rehabilitation Center/ Change of Ownership From Britthaven Inc. To Maple LTC Group, LLC/	Jane Rhoe Jones	1/27/ 2011	
Name: Tonya Hemric **Agency:** Jacob's Creek Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Madison To Jacob's Creek Nursing & Rehabilitation Center/ Change of Ownership From Britthaven Inc. To Granite Falls LTC Group, LLC/	Lisa Pittman	1/27/ 2011	
Name: Janice Hedrick **Agency:** Pine Ridge Health & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Davidson To Pine Ridge Health & Rehabilitation Center/ Change of Ownership From Britthaven Inc. To Spruce LTC Group, LLC/	Gebrette Miles	1/27/ 2011	
Name: Dean Picot **Agency:** Harmony Hall Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Kinston To Harmony Hall Nursing & Rehabilitation Center/ Change of Ownership From Britthaven Inc. To Redwood LTC Group, LLC/	Jane Rhoe Jones	1/27/ 2011	
Name: Sharon Huneycutt **Agency:** Richmond Pines Healthcare & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Hamlet To Richmond Pines Healthcare & Rehabilitation Center/ Change of Ownership From Britthaven Inc. To Spruce LTC Group, LLC/	Tanya Rupp	1/27/ 2011	

Name: Amanda Farmer **Agency:** Enfield Oaks Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Enfield To Enfield Oaks Nursing & Rehabilitation Center/ Change of Ownership From Enfield Care, Inc. To Eagle Peak LTC Group, LLC/	Bernetta Thorne Williams	1/27/ 2011	
Name: Carl Kline **Agency:** Wilson Pines Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Wilson To Wilson Pines Nursing & Rehabilitation Center/ Change of Ownership From Britthaven, Inc. To Spruce LTC Group, LLC/	Bernetta Thorne Williams	1/27/ 2011	
Name: Arlene Palmer **Agency:** Colony Ridge Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Outer Banks To Colony Ridge Nursing & Rehabilitation Center/ Change of Ownership From Outer Banks Haven To Tar River LTC Group, LLC/	Bernetta Thorne Williams	1/27/ 2011	
Name: Paul Stockett **Agency:** Riverpoint Crest Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of New Bern To Riverpoint Crest Nursing & Rehabilitation Center/ Change of Ownership From Britthaven of New Bern To River Neuse Group LTC Group, LLC/	Jane Rhoe Jones	1/27/ 2011	
Name: Bonnie Ard **Agency:** Willow Creek Nursing & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Britthaven of Goldsboro To Willow Creek Nursing & Rehabilitation Center/ Change of Ownership From Britthaven To Birch LTC Group, LLC/	Jane Rhoe Jones	1/27/ 2011	
Name: William Grinwis **Agency:** Smoky Mountain Health & Rehabilitation Center	1/1/2011	1/13/2011	Change of Ownership and Name Change/ From Smoky Mountain Healthcare & Rehab Center To Smoky Mountain Healthcare & Rehabilitation Center/ Change of Ownership From Britthaven, Inc. To Snowshoe LTC Group, LLC/	Les Brown	1/27/ 2011	

Attachment H

Direct Cost Per Day Benchmarks: Trends - Level 1

# of Providers			33	147	1,141
Direct Cost Per Day: Level 1	**2011**	**2012**	**NC**	**Reg IV**	**Natl**
Physician Services	$ 1.05	$ 1.13	$ 3.00	$ 3.29	$ 3.12
Physical Therapy	$ 1.43	$ 1.04	$ 0.26	$ 0.10	$ 0.12
Occupational Therapy	$ 0.17	$ 0.15	$ 0.04	$ 0.02	$ 0.04
Speech / Language Pathology	$ 0.13	$ 0.01	$ 0.03	$ 0.02	$ 0.02
Medical Social Services - Direct	$ 6.59	$ 7.58	$ 8.15	$ 7.00	$ 7.64
Spiritual Counseling	$ 3.09	$ 2.77	$ 2.75	$ 3.11	$ 3.29
Dietary Counseling	$-	$-	$ 0.18	$ 0.16	$ 0.07
Counseling - Other	$-	$-	$ 1.17	$ 2.42	$ 2.69
Home Health Aides & Homemakers	$ 8.81	$ 8.66	$ 9.15	$ 9.15	$ 9.29
Other-Patient and Family Support	$-	$-	$ 0.18	$ 0.72	$ 1.41
Nursing Care	$ 32.63	$ 34.15	$ 33.76	$ 39.30	$ 42.66
Visiting Services Cost	$ 53.90	$ 55.49	$ 58.67	$ 65.29	$ 70.35
Drugs Biologicals and Infusion	$ 16.70	$ 13.50	$ 8.96	$ 9.40	$ 9.57
Durable Medical Equip and Oxygen	$ 5.87	$ 4.85	$ 5.97	$ 5.97	$ 6.41
Patient Transportation	$ 1.50	$ 1.85	$ 0.92	$ 0.86	$ 0.53
Imaging Services	$ 0.08	$ 0.08	$ 0.13	$ 0.13	$ 0.10
Labs and Diagnostics	$ 0.22	$ 0.14	$ 0.19	$ 0.17	$ 0.16
Medical Supplies	$ 1.42	$ 1.46	$ 2.09	$ 2.17	$ 2.13
Outpatient Services	$ 0.20	$ 0.48	$ 0.64	$ 0.40	$ 0.39
Radiation Therapy	$-	$ 0.07	$ 0.08	$ 0.21	$ 0.17
Chemotherapy	$ 0.08	$ 0.92	$ 0.78	$ 0.33	$ 0.24
Other					
Bereavement Programs Costs	$ 2.86	$ 2.72	$ 2.87	$ 2.68	$ 2.53
Volunteer Program Costs	$-	$ 0.03	$ 0.14	$ 0.12	$ 0.22
Fundraising	$ 0.37	$ 0.25	$ 2.06	$ 1.70	$ 2.15
Other Services Cost	$ 29.30	$ 26.35	$ 24.82	$ 24.13	$ 24.59
Total Net Revenue per Day	$ 140.49	$ 139.37	$ 167.83	$ 173.40	$ 174.03
Total Expenses per Day	$ 110.30	$ 109.16	$ 152.13	$ 160.13	$ 162.35
Margin (Per Day)	$ 30.19	$ 30.21	$ 15.70	$ 13.27	$ 11.67
Percent Margin	21.49%	21.67%	9.35%	7.65%	6.71%
Payer Mix - Patients					
Medicare	82.80%	88.00%	87.22%	85.04%	84.44%
Medicaid	7.70%	6.40%	4.78%	4.92%	4.21%
Other	9.50%	5.60%	8.00%	10.04%	11.35%
Payer Mix - Days					
Medicare	89.30%	92.10%	89.92%	89.14%	88.51%
Medicaid	5.70%	3.90%	4.78%	4.92%	4.31%
Other	5.10%	4.10%	5.31%	5.94%	7.18%
Length of Stay					
Total Patients - all Payers	92.68	106.12	43.26	49.19	50.10
Medicare	99.90	111.06	44.60	51.56	52.51
SNF	78.95	220.41	83.24	77.15	50.54
Medicaid	61.00	63.60	38.84	43.80	45.38
Other Payers	55.38	77.31	31.30	31.74	33.87
Level of Care					
Routine	99.31%	99.00%	92.46%	93.21%	97.77%
General Inpatient	0.37%	0.49%	6.97%	5.39%	1.61%
Respite	0.31%	0.47%	0.51%	0.63%	0.43%
Continuous	0.01%	0.04%	0.06%	0.77%	0.19%

Total Cost Per Day Benchmarks: Trends - Level 1

# of Providers			33	147	1,141
Total Cost Per Day: Level 1	**2011**	**2012**	**NC**	**Reg IV**	**Natl**
Physician Services	$ 1.34	$ 1.40	$ 5.35	$ 5.26	$ 4.63
Physical Therapy	$ 1.81	$ 1.53	$ 0.33	$ 0.14	$ 0.19
Occupational Therapy	$ 0.22	$ 0.19	$ 0.08	$ 0.02	$ 0.06
Speech / Language Pathology	$ 0.17	$ 0.01	$ 0.03	$ 0.02	$ 0.03
Medical Social Services - Direct	$ 8.52	$ 9.44	$ 10.58	$ 10.42	$ 11.81
Spiritual Counseling	$ 4.02	$ 3.48	$ 3.87	$ 4.43	$ 5.07
Dietary Counseling	$-	$-	$ 0.31	$ 0.24	$ 0.12
Counseling - Other	$ 0.10	$-	$ 0.09	$ 0.15	$ 1.89
Home Health Aides & Homemakers	$ 11.39	$ 10.77	$ 12.55	$ 13.70	$ 14.99
Other-Patient and Family Support	$-	$ 2.20	$ 0.74	$ 0.88	$ 1.71
Nursing Care	$ 41.87	$ 42.71	$ 46.57	$ 59.90	$ 69.63
Visiting Services Cost	$ 69.44	$ 71.73	$ 80.51	$ 95.17	$ 110.13
Drugs Biologicals and Infusion	$ 21.21	$ 16.74	$ 12.33	$ 13.33	$ 14.17
Durable Medical Equip and Oxygen	$ 7.46	$ 6.01	$ 8.11	$ 8.25	$ 9.22
Patient Transportation	$ 1.91	$ 2.29	$ 1.18	$ 1.18	$ 0.77
Imaging Services	$ 0.10	$ 0.10	$ 0.17	$ 0.17	$ 0.14
Labs and Diagnostics	$ 0.27	$ 0.17	$ 0.31	$ 0.23	$ 0.22
Medical Supplies	$ 2.07	$ 1.81	$ 2.82	$ 3.44	$ 3.37
Outpatient Services	$ 0.26	$ 0.59	$ 0.81	$ 0.52	$ 0.53
Radiation Therapy	$-	$ 0.09	$ 0.11	$ 0.29	$ 0.24
Chemotherapy	$ 0.10	$ 1.14	$ 1.03	$ 0.43	$ 0.39
Other					
Bereavement Programs Costs	$ 3.82	$ 3.64	$ 4.20	$ 3.92	$ 3.93
Volunteer Program Costs	$ 0.03	$ 0.04	$ 0.52	$ 0.32	$ 0.48
Fundraising	$ 0.51	$ 1.01	$ 2.66	$ 2.12	$ 2.89
Other Services Cost	$ 37.74	$ 33.63	$ 34.24	$ 34.22	$ 36.35
Total Net Revenue per Day	$ 140.49	$ 139.37	$ 167.83	$ 173.40	$ 174.03
Total Expenses per Day	$ 110.30	$ 109.16	$ 152.13	$ 160.13	$ 162.35
Margin (Per Day)	$ 30.19	$ 30.21	$ 15.70	$ 13.27	$ 11.67
Percent Margin	21.49%	21.67%	9.35%	7.65%	6.71%
Payer Mix - Patients					
Medicare	82.80%	88.00%	87.22%	85.04%	84.44%
Medicaid	7.70%	6.40%	4.78%	4.92%	4.21%
Other	9.50%	5.60%	8.00%	10.04%	11.35%
Payer Mix - Days					
Medicare	89.30%	92.10%	89.92%	89.14%	88.51%
Medicaid	5.70%	3.90%	4.78%	4.92%	4.31%
Other	5.10%	4.10%	5.31%	5.94%	7.18%
Length of Stay					
Total Patients - all Payers	92.68	106.12	43.26	49.19	50.10
Medicare	99.90	111.06	44.60	51.56	52.51
SNF	78.95	220.41	83.24	77.15	50.54
Medicaid	61.00	63.60	38.84	43.80	45.38
Other Payers	55.38	77.31	31.30	31.74	33.87
Level of Care					
Routine	99.31%	99.00%	92.46%	93.21%	97.77%
General Inpatient	0.37%	0.49%	6.97%	5.39%	1.61%
Respite	0.31%	0.47%	0.51%	0.63%	0.43%
Continuous	0.01%	0.04%	0.06%	0.77%	0.19%

Attachment I

VERNON HILL BAPTIST CHURCH
80 VERNON HILL CHURCH ROAD
P. O. BOX 512
OXFORD, NC 27565
REV. OLLIE F. ELLISON PASTOR

September 28, 2013

Ms. Lisa Macon Harrison
Health Director
Granville Vance District Health Department
101 Hunt Drive
PO Box 367
Oxford, NC 27565

Dear Lisa,

The congregation of Vernon Hill Baptist Church is so glad to hear that Granville Vance District Health Department (GVDHD) is applying for an opportunity to provide hospice services in our community. We most support you wholeheartedly in submitting an application for a new hospice home care office in Granville County.

Some of our members have benefited from the excellent care provided by the Granville Vance District Home Health and it helps to have people you know and trust provide care. Many people do not seek health care services in our community because of a lack of trust in the system. Working with people you know and trust is critical.

Hospice and end-of-life care is an important service for so many families. We prefer to support a local provider that we know will devote the time, energy, and expertise to provide an exceptional home care and hospice experience while providing staff the kind of professional support they need to do a good job.

If this Certificate of Need is approved for Granville County, we will offer our prayer, assistance with education, volunteering and fund raising.

Sincerely,

Rev Ollie F. Ellison

Rev. Ollie F. Ellison

To: Lisa Macon Harrison, Health Director
We are glad to hear that Granville Vance District Health Department is applying for an opportunity to bring hospice to Granville County.
I support you in submitting your application and have signed below to show that support.

September 29, 2013

NAME	POSITION	CHURCH
Odessa Downey		WGCMBC
REV Nathaniel Davis	Co pastor	Raleigh Road
Martha Davis		
Rev Robert Harris	Pastor	Raleigh Rd.
Barbara Tisdale	Member	New Grassy Creek Baptist Church
Edgar E. Shotwell Jr.	Member	New Light B.C.
Brenda Cotton	member	Huntsville Baptist Church
EDWARD CATER	"	Huntsville Baptist
Johnny Webb	Deacon	Whetstone Baptist Church
Kenneth Webb	Member	Whetstone Baptist
Chris Blue	DEACON	NEW JONATHANS CREEK MISS BAPT CHURCH
Rev. Abigail + Rev Sandy Jones	minister	Blue Ridge Baptist Church
Steve Hargrove	Deacon	Whetstone
Marion Worrell	Deacon	1st Baptist Church of Stovall
Sarah L Mayfield	Member	Verna Hill Baptist
John T. Dowdy	Deacon	St. Matthew Bapt Church
Juanella R. Hargrove	Member	Huntsville Baptist
Wanda Dreyer	member	Huntsville Baptist Church
Rick D. Harding	Deaconess	Whetstone Baptist Church

To: Lisa Macon Harrison, Health Director
We are glad to hear that Granville Vance District Health Department is applying for an opportunity to bring hospice to Granville County.
I support you in submitting your application and have signed below to show that support.

September 29, 2013

NAME	POSITION	CHURCH
Rejena P. Wilson	Deaconess	Whetstone
Marvin T. Wilson	Deacon	Huntsville
Rev James E. Wade	Minister	Vernon Hill
[illegible]	Deacon	Vernon Hill
[illegible]	Trustee	Vernon Hill
[illegible]	Member	Vernon Hill
Rev James Manson	Rev	Vernon Hill
Naomi Reed	Member	Vernon Hill
Louise Allen	Member	Vernon Hill
Gertrude Wilson	Member	Vernon Hill
Chris Wade	Member	Vernon Hill
Rev John H. Jones	Minister/Member	Baptist Grove Baptist Church
[illegible]		Baptist Grove Church
Annie Toler	Member	Huntsville Baptist
Alfred Toler	Deacon	Huntsville Baptist Church

P.O. Box 429
108 College St.
Oxford, NC 27565

UNION
Bank & Trust Co.

Telephone (919) 603-5030
Facsimile (919) 603-5130

September 26, 2013

Ms. Lisa Macon Harrison
Health Director
Granville-Vance District Health Department
101 Hunt Drive
PO Box 367
Oxford, NC 27565

Dear Ms. Harrison:

We were pleased to learn that the Granville-Vance District Health Department (GVDHD) was applying for a Certificate of Need in the hopes of providing hospice services in our community. We fully support your application to open a hospice home care office in Granville County, which would enable you to continue the excellent patient-focused and community-centered work GVDHD has maintained for so long.

We are aware that the Granville-Vance District Home Health (GVHH), in association with the GVDHD, provides high-quality clinical and preventive care for both Granville and Vance counties and has been doing so for nearly 40 years. We appreciate GVHH's work as the primary provider of home health agency services in Granville and surrounding counties.

Hospice and end-of-life care is an important service for so many people. We prefer to support a local provider that will devote the time, energy, and expertise to provide an exceptional home care and hospice experience for its patients and also will provide professional support for its staff.

As a local community bank in Granville, Vance, Wake, Franklin, and Person counties, we are committed to supporting your endeavor. Our corporate headquarters is located in Oxford, and if your Certificate of Need is approved for our county, we will offer volunteers, referrals, fundraising, and the like. As a local community bank, we know the importance of community relationships.

Sincerely,

Thomas M. Combs
President and CEO

VANCE-GRANVILLE
COMMUNITY COLLEGE

Office of the President

YOUR GATEWAY TO ENDLESS POSSIBILITIES

P.O. BOX 917 - HENDERSON, N.C. 27536 - (252) 738-3227 - FAX (252) 431-0197

August 29, 2013

Lisa M. Harrison, MPH
Health Director
Granville-Vance District Health Department
101 Hunt Drive
Oxford, NC 27565

Dear Ms. Harrison:

I am writing this letter to express support for the Certificate of Need application filed by Granville-Vance District Health Department to develop and operate a new Medicare-certified hospice home care agency in Granville County. I am also writing to express interest in using your proposed agency as a clinical training site for our students in appropriate fields of study. I understand that the health department will manage the proposed agency. I also understand that the health department has a reputation for providing quality healthcare services in North Carolina. We have students, in the fields of nursing and allied health, who would benefit from a training opportunity with your staff.

I look forward to working with your agency in any way possible to enhance our health education programs. Having your agency to serve as a clinical training site could be a great asset to our program.

Many of our graduating students begin their healthcare careers in Granville County. A new Medicare-certified hospice home health office opening in Granville County would be welcomed. Our students would also be a good staffing resource for your office.

Sincerely,

Dr. Stelfanie Williams
President

SOUTH CAMPUS
P.O. Box 39
Creedmoor, NC 27522
(919) 528-4737
Fax: (919) 528-1201

FRANKLIN CAMPUS
P.O. Box 777
Louisburg, NC 27549
(919) 496-1567
Fax: (919) 496-6604

WARREN CAMPUS
P.O. Box 207
Warrenton, NC 27589
(252) 257-1900
Fax: (252) 257-3612

www.vgcc.edu

Greater Ransom Way
of the Cross Temple
90 South Lake Lodge Road Ext. 27537
P.O. Box 17
Henderson, NC 27536-0017

Bishop Johnny L. Alston, Pastor
Home: 252-492-2401

Church: 252-492-1824
Secretary: 252-492-0675
Pastor's Study: 252-430-1034

September 28, 2013

Ms. Lisa Macon Harrison
Health Director
Granville Vance District Health Department
101 Hunt Drive
PO Box 367
Oxford, NC 27565

Dear Lisa,

The congregation of Greater Ransom Way of the Cross Temple is glad to hear that Granville Vance District Health Department (GVDHD) is applying for an opportunity to provide hospice services in our community. We wholeheartedly support you in submitting an application for a new hospice home care office in Granville County.

Our members know about the excellent care provided by the Granville Vance District Home Health and it helps to have people you know and trust provide care. Many people do not seek health care services in our community because of a lack of trust in the system. Working with people you know and trust is critical.

Hospice and end-of-life care is an important service for so many families. We prefer to support a local provider that we know will devote the time, energy, and expertise to provide an exceptional home care and hospice experience while providing staff the kind of professional support they need to do a good job.

If this Certificate of Need is approved for our county, we will offer prayer, assistance with education, outreach, advice, volunteering and making referrals.

Sincerely,

Elder Michael R. Alston, Sr.

Elder Michael R. Alston, Sr.
Assistant Pastor

"Except the Lord builds the house, they labor in vain who build it." Psalms 127:1

Attachment J

Final FY 2014 Hospice Wage Index

CMS 1499-F published in the Federal Register, August 7, 2013
Table A and Table B, posted on August 1, 2013 at CMS Hospice Center
Final FY2014 Rates published as part of Final Rule August 7, 2013
North Carolina

State	CBSA Code	State County Code	County Name	Final FY2014 Wage Index	Final FY 2014 Routine Home Care	Final FY 2014 Continuous Care	Final FY 2014 General Inpatient	Final FY 2014 Inpatient Respite
NC	15500	34000	ALAMANCE	0.8642	$ 141.50	$ 825.80	$ 633.85	$ 149.55
NC	25860	34010	ALEXANDER	0.8837	$ 143.59	$ 838.00	$ 642.51	$ 151.26
NC	34	34020	ALLEGHANY	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	16740	34030	ANSON	0.9385	$ 149.47	$ 872.29	$ 666.86	$ 156.05
NC	34	34040	ASHE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34050	AVERY	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34060	BEAUFORT	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34070	BERTIE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34080	BLADEN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	48900	34090	BRUNSWICK	0.9324	$ 148.81	$ 868.48	$ 664.15	$ 155.51
NC	11700	34100	BUNCOMBE	0.8713	$ 142.26	$ 830.24	$ 637.00	$ 150.17
NC	25860	34110	BURKE	0.8837	$ 143.59	$ 838.00	$ 642.51	$ 151.26
NC	16740	34120	CABARRUS	0.9385	$ 149.47	$ 872.29	$ 666.86	$ 156.05
NC	25860	34130	CALDWELL	0.8837	$ 143.59	$ 838.00	$ 642.51	$ 151.26
NC	34	34140	CAMDEN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34150	CARTERET	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34160	CASWELL	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	25860	34170	CATAWBA	0.8837	$ 143.59	$ 838.00	$ 642.51	$ 151.26
NC	20500	34180	CHATHAM	0.9701	$ 152.85	$ 892.07	$ 680.90	$ 158.81
NC	34	34190	CHEROKEE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34200	CHOWAN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34210	CLAY	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34220	CLEVELAND	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34230	COLUMBUS	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34240	CRAVEN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	22180	34250	CUMBERLAND	0.9137	$ 146.81	$ 856.77	$ 655.84	$ 153.88
NC	47260	34251	CURRITUCK	0.9378	$ 149.39	$ 871.86	$ 666.55	$ 155.98
NC	34	34270	DARE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34280	DAVIDSON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	49180	34290	DAVIE	0.8820	$ 143.41	$ 836.94	$ 641.76	$ 151.11
NC	34	34300	DUPLIN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	20500	34310	DURHAM	0.9701	$ 152.85	$ 892.07	$ 680.90	$ 158.81
NC	40580	34320	EDGECOMBE	0.9062	$ 146.00	$ 852.08	$ 652.51	$ 153.22
NC	49180	34330	FORSYTH	0.8820	$ 143.41	$ 836.94	$ 641.76	$ 151.11
NC	39580	34340	FRANKLIN	0.9663	$ 152.45	$ 889.69	$ 679.22	$ 158.48
NC	16740	34350	GASTON	0.9385	$ 149.47	$ 872.29	$ 666.86	$ 156.05
NC	34	34360	GATES	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34370	GRAHAM	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34380	GRANVILLE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	24780	34390	GREENE	0.9873	$ 154.70	$ 902.83	$ 688.55	$ 160.31
NC	24660	34400	GUILFORD	0.8797	$ 143.16	$ 835.50	$ 640.73	$ 150.91
NC	34	34410	HALIFAX	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34420	HARNETT	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65

State	CBSA Code	State County Code	County Name	Final FY2014 Wage Index	Final FY 2014 Routine Home Care	Final FY 2014 Continuous Care	FInal FY 2014 General Inpatient	Final FY 2014 Inpatient Respite
NC	11700	34430	HAYWOOD	0.8713	$ 142.26	$ 830.24	$ 637.00	$ 150.17
NC	11700	34440	HENDERSON	0.8713	$ 142.26	$ 830.24	$ 637.00	$ 150.17
NC	34	34450	HERTFORD	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	22180	34460	HOKE	0.9137	$ 146.81	$ 856.77	$ 655.84	$ 153.88
NC	34	34470	HYDE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34480	IREDELL	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34490	JACKSON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	39580	34500	JOHNSTON	0.9663	$ 152.45	$ 889.69	$ 679.22	$ 158.48
NC	34	34510	JONES	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34520	LEE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34530	LENOIR	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34540	LINCOLN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34560	MACON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	11700	34570	MADISON	0.8713	$ 142.26	$ 830.24	$ 637.00	$ 150.17
NC	34	34580	MARTIN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34550	MC DOWELL	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	16740	34590	MECKLENBURG	0.9385	$ 149.47	$ 872.29	$ 666.86	$ 156.05
NC	34	34600	MITCHELL	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34610	MONTGOMERY	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34620	MOORE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	40580	34630	NASH	0.9062	$ 146.00	$ 852.08	$ 652.51	$ 153.22
NC	48900	34640	NEW HANOVER	0.9324	$ 148.81	$ 868.48	$ 664.15	$ 155.51
NC	34	34650	NORTHAMPTON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	27340	34660	ONSLOW	0.8104	$ 135.73	$ 792.13	$ 609.94	$ 144.85
NC	20500	34670	ORANGE	0.9701	$ 152.85	$ 892.07	$ 680.90	$ 158.81
NC	34	34680	PAMLICO	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34690	PASQUOTANK	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	48900	34700	PENDER	0.9324	$ 148.81	$ 868.48	$ 664.15	$ 155.51
NC	34	34710	PERQUIMANS	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	20500	34720	PERSON	0.9701	$ 152.85	$ 892.07	$ 680.90	$ 158.81
NC	24780	34730	PITT	0.9873	$ 154.70	$ 902.83	$ 688.55	$ 160.31
NC	34	34740	POLK	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	24660	34750	RANDOLPH	0.8797	$ 143.16	$ 835.50	$ 640.73	$ 150.91
NC	34	34760	RICHMOND	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34770	ROBESON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	24660	34780	ROCKINGHAM	0.8797	$ 143.16	$ 835.50	$ 640.73	$ 150.91
NC	34	34790	ROWAN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34800	RUTHERFORD	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34810	SAMPSON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34820	SCOTLAND	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34830	STANLY	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	49180	34840	STOKES	0.8820	$ 143.41	$ 836.94	$ 641.76	$ 151.11
NC	34	34850	SURRY	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34860	SWAIN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34870	TRANSYLVANIA	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34880	TYRRELL	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	16740	34890	UNION	0.9385	$ 149.47	$ 872.29	$ 666.86	$ 156.05
NC	34	34900	VANCE	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	39580	34910	WAKE	0.9663	$ 152.45	$ 889.69	$ 679.22	$ 158.48
NC	34	34920	WARREN	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65

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NC	34	34930	WASHINGTON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34940	WATAUGA	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	24140	34950	WAYNE	0.8718	$ 142.31	$ 830.55	$ 637.22	$ 150.22
NC	34	34960	WILKES	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	34	34970	WILSON	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65
NC	49180	34980	YADKIN	0.8820	$ 143.41	$ 836.94	$ 641.76	$ 151.11
NC	34	34981	YANCEY	0.8424	$ 139.16	$ 812.15	$ 624.16	$ 147.65

Total Counties **100**

CBS

A	**40**
Rural	**60**