WRITTEN COMMENTS ON CUMBERLAND COUNTY

2025 MEDICARE-CERTIFIED HOSPICE HOME CARE OFFICE AGENCY NEED DETERMINATION

SUBMITTED BY WELL CARE HOME HEALTH OF CUMBERLAND, INC. / PROJECT ID M-012594-25

Well Care Home Health of Cumberland, Inc. (Well Care) proposes to develop a hospice home care office in Cumberland County (Project ID M-012594-25). Two additional applications were submitted in response to the need determination in the 2025 State Medical Facilities Plan ("SMFP") for one new Medicare-certified home health agency in Cumberland County:

Applicant / Project ID	Well Care Written Comments Begin on Page #
VIA Health Partners Project ID M-012590-25	10
VITAS Healthcare Corporation Project ID M-012592-25	18

These comments are submitted by Well Care in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to evaluate the representations made in the competing applications. This includes a comparative analysis and a discussion of the most significant issues concerning the applicants' compliance with the statutory and regulatory review criteria (the Criteria) set forth in N.C. Gen. Stat. § 131E-183(a) and (b).

It is important to note that additional non-conformities in the competing applications may exist beyond those addressed herein. Furthermore, nothing in these comments is intended to modify, supplement, or amend the Well Care application, and no portion of this submission should be construed as an amendment to the Well Care application as originally submitted.

COMMENTS REGARDING COMPARATIVE REVIEW

The following factors have been utilized in prior competitive reviews for new hospice home care agencies, most recently the 2020 Rowan County hospice home care office competitive review:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Historical Utilization
- Geographic Accessibility (Location within the Service Area)
- Competition (Access to a New or Alternate Provider)
- Access by Service Area Residents
- Access by Underserved Groups: Charity Care
- Access by Underserved Groups: Medicaid
- Access by Underserved Groups: Medicare
- Projected Average Net Revenue per Patient
- Net Revenue per Day of Care
- Projected Average Operating Expense per Patient
- Cost per Day of Care
- Direct Care Salaries
- Average Case Load

The following pages compare the applications submitted in this review among the previous comparative factors.

Conformity to CON Review Criteria

Three CON applications have been submitted seeking one home health agency in Cumberland County. Based on the 2025 SMFP's need determination for one additional home health agency, only one application can be approved. Only applicants demonstrating conformity with all applicable Criteria can be approved, and only the application submitted by Well Care demonstrates conformity to all Criteria:

Conformity of Competing Applications

Applicant	Project I.D.	Conforming/ Non-Conforming
Well Care	M-012594-25	**Yes**
VIA	M-012590-25	No
VITAS	M-012592-25	No

The Well Care application for a new home health agency is based on reasonable and supported volume projections and sound financial estimates of costs and revenues. In contrast, as detailed elsewhere in this document, the competing applications contain significant errors and deficiencies, leading to one or more non-conformities with the statutory and regulatory review Criteria. Given its demonstrated need and

financial feasibility, **Well Care** represents the **most effective** and credible alternative in ensuring conformity with the review Criteria.

Scope of Services

Generally, the application proposing to provide the broadest scope of services is the more effective alternative with regard to this comparative factor. With regard to scope of services, all of the applications submitted are in response to the 2025 SMFP which includes a need determination for one Medicare-certified hospice home care office in Cumberland County. All of the applicants propose to develop one Medicare-certified hospice home care office in Cumberland County. Regarding this comparative factor, the competing applications are equally effective alternatives.

Historical Utilization

Each of the applicants has experience providing hospice home care services, either in North Carolina or outside of North Carolina. Therefore, the competing applications are equally effective alternatives.

Geographic Accessibility (Location within the Service Area)

Since a hospice home care office serves patients in their place of residence, the Agency has historically determined that the geographic location of the office is not a deciding factor. Additionally, all three applicants propose to develop a new home care office in Cumberland County. Therefore, the applications are equally effective regarding geographic access.

Access By Service Area Residents

Chapter 12 of the 2025 SMFP states, "*A Medicare-certified home health agency or office's service area is the county in which the agency or office is located. Each of the 100 counties in the state is a separate service area.*" Therefore, for the purpose of this review, Cumberland County is the service area. Facilities may also serve residents of counties not included in the service area.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

Access By Service Area Residents, Project Year 3

	Well Care	VIA	VITAS
Total # of New (Unserved) Cumberland County Residents Served	121	150	307
Total # of New (Unduplicated) Patients Served	312	242	371
Cumberland County Residents as a % of Total New Patients Served	38.8%	61.7%	82.7%

As shown in the table above, VITAS projects to serve the highest number and percentage of Cumberland County residents. However, as described separately in these comments, the patient utilization projections for VIA and for VITAS are not reasonable or adequately supported and, thus, neither applicant can be approved. Therefore, **Well Care** is the **most effective** alternative in this review.

Access By Underserved Groups

Underserved groups are defined in G.S. 131E-183(a)(13) as follows:

"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."

Projected Charity Care

The following table shows projected charity care to be provided in the third full fiscal year following project completion for all applicants in the review. Generally, the application proposing to provide the most charity care is the more effective alternative with regard to this comparative factor.

Applicant	Charity Care	Total # of Patients Served	Charity Care Per Patient	Total Gross Revenue	Charity Care as a % of Total Gross Revenue
Well Care	**$134,069**	403	**$333**	$5,629,532	**2.4%**
VIA	$52,224	287	$182	$3,876,537	1.3%
VITAS	$60,498	371	$163	$7,414,944	0.8%

Source: Form C.6, Form F.2

As shown in the previous table, Well Care projects the highest total charity care in dollars, the highest charity care per patient, and the highest charity care percentage of total gross revenue. Therefore, regarding overall access to Charity Care, **Well Care** is the **most effective** alternative, and the remaining applications are less effective with respect to this comparative factor.

Projected Medicare Access

The following table compares projected access by Medicare patients in the third full fiscal year following project completion for all applicants in the review. Generally, the application projecting the highest Medicare revenue is the more effective alternative with regard to this comparative factor to the extent Medicare revenue represents Medicare patients served.

Provider	Projected Total Medicare	Total # of Patients Served	Medicare Per Patient	Total Gross Revenue	Medicare as a % of Total Gross Revenue
Well Care	**$5,035,125**	403	$12,494	$5,629,532	**89.4%**
VIA	$3,424,436	287	$11,932	$3,876,537	88.3%
VITAS	$6,972,001	371	$18,792	$7,414,944	94.0%

Source: Form C.6, Form F.2

As discussed separately in these comments neither VIA nor VITAS are approvable, and neither can be an effective alternative. As shown in the previous table, Well Care projects the second highest Medicare revenue and Medicare as a percentage of total gross revenue. Thus, **Well Care** is the **most effective** alternative with regard to access by Medicare recipients.

Projected Medicaid Access

The following table compares projected access by Medicaid patients in the third full fiscal year following project completion for all the applicants in the review. Generally, the application projecting the highest Medicaid revenue is the more effective alternative with regard to this comparative factor to the extent Medicaid revenue represents Medicaid patients served. As described in the Well Care application (p. 58), the Medicaid-eligible population in Cumberland County has increased materially in recent years.

Provider	Projected Total Medicaid	Total # of Patients Served	Medicaid Per Patient	Total Gross Revenue	Medicaid as a % of Total Gross Revenue
Well Care	**$392,772**	403	**$975**	$5,629,532	7.0%
VIA	$276,723	287	$964	$3,876,537	7.1%
VITAS	166,449	371	$449	$7,414,944	2.2%

Source: Form C.6, Form F.2

Well Care projects the highest total Medicaid revenue during the third project year, as well as the highest Medicaid revenue per patient. Therefore, **Well Care** is the **most effective** alternative with respect to access for Medicaid hospice patients and the other applicants are less effective with respect to this competitive factor.

<u>Projected Average Net Revenue Per Unduplicated Patient</u>

The following table compares the projected average net revenue per patient for the third year of operation following project completion for all applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Applicant	Total # of Patients Served	Net Revenue	Net Revenue per Patient
Well Care	403	$5,240,509	$13,004
VIA	287	$2,674,887	$9,320
VITAS	371	$7,146,166	$19,262

Source: Form C.5 and Form F.2 from each application

Regarding this factor, historically the Agency has generally considered the application proposing the lowest average net revenue as the more effective alternative citing the rationale that "a lower average may indicate a lower cost to the patient or third-party payor." As discussed separately in these comments neither VIA nor VITAS is approvable; therefore, the respective applications cannot be effective alternatives. Well Care is an effective alternative because its application is based on reasonable and supported patient and revenue projections.

Projected Average Net Revenue Per Day of Care

The following table compares the projected average net revenue per day of care for the third year of operation following project completion for all the applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Applicant	Days of Care	Net Revenue	Net Revenue per Day of Care
Well Care	29,203	$5,240,509	$179
VIA	19,059	$2,674,887	$140
VITAS	31,739	$7,146,166	$225

Source: Form C.5 and Form F.2 from each application

Well Care projects the second lowest net revenue per day of care in the third full fiscal year following project completion. As discussed separately in these comments neither VIA nor VITAS is approvable; thus, their respective applications cannot be considered. Therefore, regarding this comparative factor, the application submitted by **Well Care** is the **most effective** alternative.

Average Operating Expense Per Patient

The following table compares the projected average operating expense per patient for the third year of operation following project completion for all applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Applicant	Total # of Patients Served	Operating Expense	Operating Expense per Unduplicated Patient
Well Care	403	$3,809,155	$9,452
VIA	287	$2,583,072	$9,000
VITAS	371	$7,114,770	$19,177

Source: Form C.5 and Form F.2 from each application

Regarding this factor, historically the Agency has considered the application proposing the lowest average operating expense as the more effective alternative citing the rationale that "a lower average cost may indicate a lower cost to the patient or third-party payor or a more cost-effective service."

As discussed separately in these comments neither VIA nor VITAS is approvable; therefore, their respective applications cannot be considered effective alternatives. Well Care proposes the second lowest operating expense per patient. Therefore, the application submitted by **Well Care** is the **most effective** alternative regarding this comparative factor.

Cost Per Day of Care in Project Year 3

The following table compares the cost per day of care for the third year of operation following project completion for all applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Applicant	Days of Care	Operating Expense (Cost)	Operating Expense (Cost) Per Day of Care
Well Care	29,203	$3,809,155	**$130**
VIA	19,059	$2,583,072	$136
VITAS	31,739	$7,114,770	$224

Source: Form C.5 and Form F.2 from each application

Regarding this factor, historically the Agency has considered the application proposing the lowest operating expense per day of care as the more effective alternative citing the rationale that "a lower average cost may indicate a lower cost to the patient or third-party payor or a more cost-effective service."

As shown in the previous table. Well Care proposes the lowest operating expense per day of care. Therefore, the application submitted by **Well Care** is the **most effective** alternative regarding this comparative factor.

Salaries for Key Direct Care Staff: RN, CNA/Aides, Social Worker

The following table compares the average salaries for key staff for the third year of operation following project completion for all applicants, based on the information provided in Form H of the applicants' pro forma financial statements (Section Q).

Applicant	Registered Nurse	CNA/Aides	Social Worker
Well Care	**$97,277**	**$46,362**	$80,111
VIA	$90,696	$40,977	$65,564
VITAS	$93,145	$37,477	$87,215

Salaries play a significant role in the recruitment and retention of quality staff. As shown above, Well Care proposes to offer the highest salaries for both Registered Nurses and CNAs, as well as a competitive salary for Social Workers. These staff members provide the highest level of care to patients. By offering higher salaries **Well Care** can engage and retain the highest quality staff making its application the **most effective** regarding this competitive factor.

Average Case Load for Key Direct Care Staff

In hospice, average case load means the preferred number of patients for which a staff member has responsibility or to which she or he is assigned at any one time. The following table compares case load for key staff for the third year of operation following project completion, based on information provided by the applicants.

Applicant	Registered Nurse	Social Worker	Hospice Aide
Well Care	**10**	**25**	10
VIA	N/A	N/A	N/A
VITAS	11	30	8

Source: Section Q of each application

As seen in the previous table, Well Care proposes the lowest case load for both registered nurses and social workers. By providing a lower case load for these key staffers, Well Care can provide more dedicated and focused patient care. VITAS proposes a lower case load for hospice aides. VIA's application did not provide average case load data. The **Well Care** application is **most effective** regarding this comparative factor.

Competition (Access to a New or Alternate Provider)

None of the applicants and/or related entities have a hospice home care office, or in-patient hospice facility, located in the service area of Cumberland County; therefore, all the applicants would qualify as a new or alternative provider located in the service area. Therefore, regarding this comparative factor, the applications are equally effective alternatives.

Summary

The following table lists the comparative factors and indicates the relative effectiveness of each applicant for each metric. The following table makes no assumptions on the factor "Conformity with Review Criteria."

Comparative Factor	Well Care	VIA	VITAS
Conformity with Statutory Review Criteria	**Most Effective**	Least Effective	Least Effective
Scope of Services	Equally Effective	Equally Effective	Equally Effective
Historical Utilization	Equally Effective	Equally Effective	Equally Effective
Geographic Accessibility	Equally Effective	Equally Effective	Equally Effective
Access by Service Area Residents: Number of Residents	Least Effective	More Effective	**Most Effective**
Charity Care Dollars	**Most Effective**	More Effective	Least Effective
Charity Care Per Patient	**Most Effective**	More Effective	Least Effective
Charity Care % of Gross Revenue	**Most Effective**	More Effective	Least Effective
Medicare Dollars	More Effective	Least Effective	**Most Effective**
Medicare Revenue Per Patient	More Effective	Least Effective	**Most Effective**
Medicare % of Gross Revenue	More Effective	Least Effective	**Most Effective**
Medicaid Dollars	**Most Effective**	More Effective	Least Effective
Medicaid Revenue Per Patient	**Most Effective**	More Effective	Least Effective
Medicaid % of Gross Revenue	Equally Effective	Equally Effective	Least Effective
Projected Average Net Revenue per Patient	More Effective	**Most Effective**	Least Effective
Net Revenue per Day of Care	More Effective	**Most Effective**	Least Effective
Projected Average Operating Expense per Patient	More Effective	**Most Effective**	Least Effective
Average Cost Per Patient	More Effective	**Most Effective**	Least Effective
Average Cost per Day of Care	**Most Effective**	More Effective	Least Effective
Direct Care Salaries: RN	**Most Effective**	Least Effective	More Effective
Direct Care Salaries: SW	**Most Effective**	More Effective	Least Effective
Direct Care Salaries: HA	More Effective	Least Effective	**Most Effective**
Average Case Load: Registered Nurse	**Most Effective**	N/A	Least Effective
Average Case Load: Social Worker	**Most Effective**	N/A	Least Effective
Average Case Load: Hospice Aide	Least Effective	N/A	**Most Effective**
Competition (Access to New or Alternative Provider)	Equally Effective	Equally Effective	Equally Effective

# Comparatives "Most Effective"	**11**	4	6

Well Care is the most effective alternative for nine comparative factors, which is the most of any applicant in this Review. Therefore, the **Well Care** application is the **most effective** alternative proposed in this review for one Hospice Home Care Office for Cumberland County and should be approved.

COMMENTS SPECIFIC TO VIA APPLICATION, PROJECT ID M-012590-25

Comments Regarding Criterion (3)

The VIA application fails to adequately demonstrate the need for the proposed project because its projected utilization is based on unreasonable and unsupported assumptions.

On page 137, in its Form C.6 Methodology and Assumptions, Step 1, VIA calculates the projected population of its proposed service area using inflated population figures. *See* the following table on page 137 of the VIA application.

1. Service Area Population Projections

The first step in the methodology is to calculate the projected population for the primary service area of Cumberland County, and for the secondary service area of Harnett, Robeson, and Sampson counties, as provided by the North Carolina Office of State Budget and Management population projections.

Service Area Population Projections

Year	2025	2026	2027	2028	2029	2030
Cumberland	344,230	344,694	345,055	345,336	345,554	345,728
Harnett	148,515	151,521	153,541	155,457	156,877	158,600
Robeson	119,873	121,009	122,142	123,270	124,398	125,522
Sampson	60,032	60,237	60,393	60,512	60,602	60,672

Source: NCOSBM, Vintage 2023

VIA uses these population projections as the basis of its projection methodology. However, these population projections include active duty military personnel in Cumberland and Harnett counties which results in overstated population projections and utilization projections. As stated in the 2025 SMFP, the hospice home care office methodology "exclude[s] the active-duty military population for any county with more than 500 estimated active-duty military personnel" (page 260). Cumberland and Harnett counties in Table 13B of the 2025 SMFP include a "**" note which indicates that "Population projections were adjusted to exclude active duty military personnel." The table below highlights the discrepancies between the 2026 population projections in the VIA application and the 2025 SMFP.

2026 Population Projections

County	2025 SMFP, Col. C	VIA Application	% Overstated by VIA
Cumberland	313,056	344,694	**10.1%**
Harnett	146,744	151,521	**3.3%**
Robeson	121,009	121,009	0.0%
Sampson	60,237	60,237	0.0%

Source: VIA application page 137 and Table 13B of 2025 SMFP

The population projections serve as a cornerstone of VIA's methodology. However, since these projections are overstated, they create a cascading impact that undermines the integrity of VIA's entire methodology. This overstatement inflates both the revenue projections and the overall reliability of the analysis, rendering the projections fundamentally flawed and unreliable.

Due to the population overstatement and other unsupported assumptions, VIA's projections for hospice deaths (Step 5, page 138) significantly exceed the 2025 SMFP's projections. As shown below, VIA overestimates hospice deaths in its service area by 168 deaths (6.5%) in 2026.

2026 Projected Hospice Deaths

County	2025 SMFP, Col. I	VIA Application	% Overstated by VIA
Cumberland	1,126	1,255	11.5%
Harnett	520	546	5.0%
Robeson	646	656	1.5%
Sampson	302	305	1.0%
Total	**2,594**	**2,762**	**6.5%**

Source: VIA application page 138 and Table 13B of 2025 SMFP.

By applying its market share assumptions to these inflated hospice death projections, VIA further exaggerates the projected number of hospice deaths it expects to serve. This results in an overall projected utilization that is artificially inflated and thus is neither reasonable nor adequately supported.

The Agency previously addressed a similar issue in the 2020 Rowan County Hospice Home Care Review, where it found Adoration's application non-conforming with Criterion (3). The Agency determined that Adoration had "reworked" the SMFP using an alternative methodology, leading to deviations from Table 13B's projected hospice deaths. The Agency stated:

> The applicant based its "reworking" of the Table 13B of the 2020 and 2021 SMFP based on a different methodology, not because of any demonstrated mathematical or data input error.
>
> There is no basis for the Project Analyst to deviate from the data in Chapter 13 of the 2020 SMFP or the 2021 SMFP.
>
> If the projected deficits of deaths in need to be served from Table 13B of the 2020 and 2021 SMFP were used in the applicant's methodology the projected deaths to be served by the applicant in both Rowan and Stanly Counties would be dramatically less, and in the case of PY2 and PY3 for Rowan County, the projected number of unserved deaths to be served by the applicant would be zero ("0") as per the 2021 SMFP there was no deficit in Rowan County. Therefore, the projected utilization is not reasonable or adequately supported.

See page 27 of Agency Findings for 2020 Rowan County Hospice Home Care Office Review

Similarly, VIA has "reworked" the 2025 SMFP using a different methodology by including active-duty military personnel and other assumptions, and the downstream impact is an inherent deviation from Table 13B's projected hospice deaths. Had VIA adhered to the 2025 SMFP's projected hospice deaths, its projected utilization would be lower. Like Adoration in the 2020 Rowan Review, VIA's projected utilization is unreasonable and inadequately supported.

For these reasons, the VIA application does not conform with Criterion (3).

Comments Regarding Criterion (5)

VIA's financial projections are not based on reasonable or adequately supported assumptions.

Error in Annual Charge Increase

On page 151, VIA states that its charges will increase by 2.5% annually.

			2026	2027	2028	2029
(7)	Annual Expense Inflation Rate					
		Supplies/Non-salary	3.25%	3.25%	3.25%	3.25%
	source: Hospice & Palliative Care Charlotte Region historical experience & projection					
(8)	Annual Charge Increase		2.50%	2.50%	2.50%	2.50%
	source: Hospice & Palliative Care Charlotte Region historical experience & projection					

However, Form F.6 contradicts this assertion by showing a 3.0% annual increase in charges, as evidenced below.

Form F.6 Hospice Home Care Charges and Reimbursement Rates per Visit	Partial FY F: 04/01/2026 T: 09/30/2026		1st Full FY F: 10/01/2026 T: 09/30/2027		2nd Full FY F: 10/01/2027 T: 09/30/2028		3rd Full FY F: 10/01/2028 T: 09/30/2029	
	Charge	Reimbursement Rate	Charge	Reimbursement Rate	Charge	Reimbursement Rate	Charge	Reimbursement Rate
Routine Home Care								
Self Pay	$231.75	$185.40	$238.70	$190.96	$245.86	$196.69	$253.24	$202.59
Hospice Medicare *	$231.75	$179.75	$238.70	$184.24	$245.86	$188.85	$253.24	$193.57
Hospice Medicaid *	$231.75	$196.00	$238.70	$200.90	$245.86	$205.93	$253.24	$211.07
Private Insurance *	$231.75	$177.61	$238.70	$182.94	$245.86	$188.43	$253.24	$194.08
Other (Please Specify)								
Inpatient Care								
Self Pay	$1,236.00	$988.80	$1,273.08	$1,018.46	$1,311.27	$1,049.02	$1,350.61	$1,080.49
Hospice Medicare *	$1,236.00	$1,028.82	$1,273.08	$1,054.54	$1,311.27	$1,080.90	$1,350.61	$1,107.92
Hospice Medicaid *	$1,236.00	$1,080.36	$1,273.08	$1,107.37	$1,311.27	$1,135.05	$1,350.61	$1,163.43
Private Insurance *	$1,236.00	$947.27	$1,273.08	$975.69	$1,311.27	$1,004.96	$1,350.61	$1,035.11
Other (Please Specify)								
Respite Care								
Self Pay	$618.00	$494.40	$636.54	$509.23	$655.64	$524.51	$675.31	$540.24
Hospice Medicare *	$618.00	$456.16	$636.54	$467.57	$655.64	$479.26	$675.31	$491.24
Hospice Medicaid *	$618.00	$505.87	$636.54	$518.52	$655.64	$531.48	$675.31	$544.77
Private Insurance *	$618.00	$473.64	$636.54	$487.84	$655.64	$502.48	$675.31	$517.55
Other (Please Specify)								
Continuous Care (Hourly)								
Self Pay	$64.38	$51.50	$66.31	$53.05	$68.30	$54.64	$70.34	$56.28
Hospice Medicare *	$64.38	$59.30	$66.31	$60.78	$68.30	$62.30	$70.34	$63.86
Hospice Medicaid *	$64.38	$61.34	$66.31	$62.87	$68.30	$64.45	$70.34	$66.06
Private Insurance *	$64.38	$49.34	$66.31	$50.82	$68.30	$52.34	$70.34	$53.91
Other (Please Specify)								

As an example, VIA's Form F.6 routine home charges increase 3.0% annually, not 2.5% as stated in its assumptions. *See* the following table.

VIA Routine Home Care Charge Increase

Routine Home Care	Partial Year	*Increase*	1st Full FY	*Increase*	2nd Full FY	*Increase*	3rd Full FY
Self Pay	$231.75	*x 103%*	$238.70	*x 103%*	$245.86	*x 103%*	$253.24
Hospice Medicare	$231.75	*x 103%*	$238.70	*x 103%*	$245.86	*x 103%*	$253.24
Hospice Medicaid	$231.75	*x 103%*	$238.70	*x 103%*	$245.86	*x 103%*	$253.24
Private Insurance	$231.75	*x 103%*	$238.70	*x 103%*	$245.86	*x 103%*	$253.24

Source: VIA Form F.6 on page 149

The inherent problem lies in the misalignment between the stated charge increase of 2.5% and the incorrect application of a 3% inflation factor. This discrepancy artificially inflates the projected charges, which subsequently overstates gross revenue, net revenue, and net income.

The compounding effect amplifies the issue over time. When charges are overstated in the first year, the inflated figure becomes the baseline for subsequent increases. Each successive year's charge escalation is applied to an already overstated amount, causing the overstatement to grow exponentially. This results in a snowballing effect that significantly distorts financial projections, undermining the accuracy and credibility of the entire financial model.

The annual charge increase is a foundational assumption because it directly influences the calculation of gross revenue, which is the starting point for most financial projections. Since gross revenue forms the basis for determining net revenue (after accounting for deductions like payer discounts and bad debt) and net income (after accounting for operating expenses), any error in the charge increase assumption cascades through the entire financial model.

VIA projects a net income of only $91,815 in Year 3—meaning that if the correct 2.5% rate were applied, the project could operate at a loss in its third year. A project that is not financially viable by the third project year does not conform to Criterion (5).

Additionally, VIA's projections for initial operating costs and working capital are understated due to the overstatement of its charges and the resulting overstatement of gross and net revenue. As a result, VIA's financial projections are not based on reasonable and supported assumptions.

VIA Understates Pass-Through Expenses

VIA significantly understates its expenses, specifically "Pass-through Expenses."

Under Federal Law, for Medicaid and dual eligible[1] hospice patients residing in nursing homes, hospice agencies are paid by the state for the hospice care provided including an amount for the nursing home room and board costs. The hospice then passes the payment directly to the nursing home ("Pass-through Expense").

[1] Dual eligible beneficiaries are those who qualify for both Medicare and Medicaid.

For Medicaid and dual eligible patients receiving respite care, hospice nursing facility room and board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the state's skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the nursing facility.[2]

In Cumberland County, Medicaid reimbursement rates for skilled nursing facility room and board fees range from approximately $317 to $644 per day. *See* the table on following page.

By way of example, for a Medicaid or dual eligible patient, if a nursing facility's reimbursement rate is $340 per day for room and board, the amount paid by the State to the hospice agency would be $323 per day ($340 x 95% = $323), and the hospice agency would then "pass-through" that $323 back to the nursing facility for that day.

The state pays at the general inpatient rate when general inpatient care is provided. As an example, for a Medicaid or dual eligible patient receiving hospice inpatient care, the State would pay the hospice agency $1,080.36 per day, and the hospice agency would then "pass-through" that $1,080.36 back to the inpatient care facility for each day of care.[3]

As shown on page 151 of VIA's application, Pass Through Expenses are projected to be only $4.76 per patient day in 2026 and increase annually by 3% to $5.23 in 2029 – figures that are vastly lower than actual Medicaid reimbursement rates for skilled nursing facilities in Cumberland County, which range from $317 to $644 per day:

(5)	Indirect Expenses	2026	2027	2028	2029
	Pass-through Expenses (includes inpatient expense, consulting physicians, inpatient respite, nursing home room & board)	$4.76	$4.91	$5.07	$5.23

See page 151 of VIA application.

The following table summarizes 2025 Medicaid daily room and board reimbursement rates for Cumberland County nursing homes.

[2] https://www.medicaid.gov/medicaid/benefits/hospice-benefits/hospice-payments/index.html
[3] The FY2025 Medicaid payment rate for general inpatient care is $1,080.36..

Daily Room & Board Reimbursement Rates for Cumberland County Skilled Nursing Facilities, Effective: January 1, 2025 - March 31, 2025

License Number	Facility Name	2025 Reimbursement Rates	
		Medicaid Managed Care Short Stay Rates	Medicaid Long-Term Care Rates
NH0629	Autumn Care of Fayetteville	$548	$347
NH0254	Bethesda Health Care Facility	$519	$322
NH0593	Carolina Rehab Center of Cumberland	$593	$334
NH0454	Haymount Rehabilitation & Nursing Center	$569	$340
NH0117	Highland House Rehabilitation and Healthcare	$523	$330
NH0076	Liberty Healthcare Services of Golden Years Nursing Center	$566	$317
NH0501	The Carrolton of Fayetteville	$596	$332
NH0502	Village Green Health and Rehabilitation	$644	$365
NH0001	Whispering Pines Nursing & Rehabilitation Center	$549	$355
NH0577	Woodlands Nursing and Rehabilitation Center	$565	$353

Source: North Carolina Department of Health and Human Services, Division of Health Benefits, Nursing Facility Rates Fee Schedules (https://ncdhhs.servicenowservices.com/fee_schedules)

VIA's daily pass through expenses are significantly lower compared to daily room and rates for Cumberland County nursing homes. As shown on page 151 of its application, VIA assumes an expense of only $5.23 per day for respite care days and inpatient care days, which results in a Year 3 total pass through expense of only $998 [$5.23 x (152 respite care days + 38 inpatient care days)]. However, there is no logical rationale to support VIA's projected pass through expense of $5.23 per day for respite care days and inpatient care days when Federal Law requires that respite care is reimbursed at 95% of the skilled nursing facility room and board rate and inpatient care is reimbursed at the inpatient reimbursement rate.

VIA's projected inpatient care reimbursement rate during project year 3 ranges from $1,035 to $1,163 (*see* Form F.6, pg. 149) and the room and board reimbursement rates for Cumberland County skilled nursing facilities in the previous table range from $317-$644. Thus, Via's average daily expenses for respite and inpatient care should be more comparable to the projected reimbursement rates.

In the following table, Well Care estimates VIA's projected pass through in accordance with Federal Law requiring that respite care (for Medicaid and dual eligible patients) be reimbursed at 95% of the skilled nursing facility room and board rate and inpatient care be reimbursed at the inpatient reimbursement rate.

VIA's Understatement of Pass-Through Expenses

		1st Full FY	2nd Full FY	3rd Full FY
A	VIA's Projected Medicaid Inpatient Reimbursement Rate	$1,107	$1,135	$1,163
B	Via's Projected Inpatient Care Days	111	134	152
A x B = C	**Pass-Through Expense for Inpatient Days**	**$122,918**	**$152,097**	**$176,841**
D	Lowest SNF Room & Board Rate ($317 x 95% = $301)	$301	$301	$301
E	VIA's Projected Respite Care Days	28	34	38
D x E = F	**Pass-Through Expense for Respite Care Days**	**$8,435**	**$10,243**	**$11,448**
C + F = G	**Total Pass-Through Expense for Inpatient and Respite Care Days**	**$131,353**	**$162,339**	**$188,289**
H	VIA's Pass-Through Expenses as Understated on F.3b	$679	$852	$998
G – H = I	**VIA's Understatement of Pass Through Expenses**	**$130,674**	**$161,487**	**$187,291**

Source: Row A: VIA Form F.6 (pg. 149)
Row B: VIA Form C.6 (pg. 136)
Row C: Calculated by Well Care (Row A x Row B)
Row D: See Daily Room & Board Reimbursement Rates for Cumberland County Skilled Nursing Facilities Table (beginning of page 14)
Row E: VIA Form C.6 (pg. 136)
Row F: Calculated by Well Care (Row D x Row E)
Row G: Row C + Row F
Row H: Form F.3b (pg. 148)

VIA's projected pass-through expenses fall tens of thousands of dollars short of actual required payments, making its expenses understated and revenue projections inflated. The result is that VIA's financial projections are fundamentally unreliable.

As shown in Forms F.2b and F.3b of Well Care's application, Well Care projects all revenue associated with respite and general inpatient care will pass through as an expense. Similarly, VITAS allocates considerable expenses to room & board and general inpatient care. VIA's pass-through expenses are categorically erroneous.

VIA's error in calculating pass-though expenses render the application non-conforming to Criterion (5).

Impact on VIA's Working Capital

Due to the errors in projecting annual charges and projecting pass through expenses, VIA materially understates initial operating costs and working capital needs. In Section F, VIA projects only a three-month Initial Operating period which would undeniably be protracted based on lower revenue projections.

Conclusion

Due to its inflated charge escalation, understated initial operating expenses, and inaccurate pass-through cost projections, VIA's financial projections are not based on reasonable or adequately supported assumptions. Consequently, VIA should be found non-conforming with Criterion (5).

Impact on Other Review Criteria

Based on the previously described facts which render the VIA application non-conforming to Criteria (3) and (5), the application is also **non-conforming to Criteria (1), (4), (6), and (18a)**.

COMMENTS SPECIFIC TO VITAS APPLICATION, PROJECT ID M-012592-25

Comments Impacting Multiple Review Criteria

As explained below, VITAS has improperly included projections for a non-hospice service -- Part B physician services -- in its Application seeking CON approval for its proposed hospice home care agency.

This is a significant issue because it results in VITAS adding non-hospice revenues into its pro forma financial projections for its hospice home care agency. Without those added revenues, VITAS is not financially feasible in Year 3.

"Hospice care" is covered by Medicare Part A which is sometimes called Hospital Insurance. Medicare Part A also covers inpatient hospital stays, care in a skilled nursing facility, and some home health care (https://www.medicare.gov/publications/02154-medicare-hospice-benefits.pdf).

When a hospice home care agency takes on a Medicare patient, ALL the services provided by the hospice home care agency are paid for by Medicare Part A. This includes the services of the doctor who participates on the patient's care team. Other payors, including Medicaid, pay for hospice home care in a similar manner.

Importantly, the services offered by a hospice home care agency are NOT reimbursed under Medicare Part B which is sometimes called Medical Insurance. Medicare Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

When a doctor cares for a VITAS patient receiving hospice care, that service is reimbursed, and VITAS is paid as part of the Medicare Part A hospice benefit. The patient does not receive a separate bill and Medicare does not pay VITAS any separate Part B payment for physician services rendered by it to its hospice patients.

Notwithstanding the above, VITAS has assumed that its proposed hospice home care agency will not only receive revenue under Medicare Part A for hospice home care services but that it will also receive separate revenue/reimbursement under Medicare Part B for physician services. This additional revenue assumption is reflected on Form F.2b on the line "Other (Physician Part B)" and in its assumptions, VITAS states that no other revenues are anticipated "other than Physician Part B visits." (Section Q, p. 16).

Because ALL services rendered by a hospice home care agency – including physician services -- are paid under the Medicare benefit (through Part A), it is unclear how VITAS can project that its proposed hospice home care agency will provide and be reimbursed additional sums under Medicare Part B for physician services/visits.

If VITAS patients do receive some "outside" additional physician services beyond those furnished as part of the hospice benefit under Part A (which assumption is completely unexplained and questionable), those Part B payments for physician services falling outside the domain of the Part A hospice benefit are not paid to VITAS' hospice home care agency and certainly are not appropriately included in the financial projections for the hospice agency proposed in the VITAS CON Application.

The VITAS home care agency will receive Part A reimbursement for any physician services it provides. VITAS will not receive some additional amount of Part B revenue for providing "other" physician services.

Any physician services VITAS' hospice home care agency provides will be paid for by Medicare Part A because VITAS is obligated to provide ALL the physician services the patient needs once the patient elects to and is determined eligible to receive the hospice benefit.

Here, VITAS projected to receive $59,870 in "Other (Physician Part B)" revenue in Year 3. VITAS only projected Net Income of $31,396 in Year 3. Without this "Other (Physician Part B)" revenue, the VITAS Form F.2b does not show financial feasibility in the 3rd Full Fiscal Year.

This issue with the VITAS' CON Application renders it non-conforming to Criterion (5) and also renders questionable the VITAS utilization projections, patient origin projections, and demonstration of need.

Since VITAS appears to have assumed it would collect revenue for "other" physician services under Medicare Part B, its CON Application essentially incorporates projections for non-hospice services into its hospice home care agency projections. This is akin to a Medicare-certified home health agency applicant adding private duty nursing revenue into its home health agency financial projections. A home health agency is paid under Part A for furnishing all the home health services its patients requires – it cannot bill and collect for "other" non-home-health services and "throw those in" to its financial projections for its proposed home health agency.

VITAS's projections are problematic from a conformity perspective <u>and</u> would serve to skew the comparison of the applications in this batch review. If VITAS is permitted to "add" non-hospice revenue to not only enhance its financial projections but to alter the numbers used to compare the applicants, this prevents Well Care and the other applicant in this batch review from competing on a level playing field.

If the Agency allows VITAS to include non-hospice revenue in its projections in this batch review, that precedent could be cited by future applicants who could then seek to add revenues for services other than the service-at-issue to their financial showings. For instance, if VITAS is allowed to add non-hospice revenues (for Part B Physician Visits) to its hospice revenue projections, a provider like Well Care could argue that it should similarly be allowed to include some of its home health revenues in projections for a future hospice home care agency in an area where it provides home health services.

It has long been understood that the CON process (which works from the CON Application Form) requires an evaluation of projections for the service for which the CON is sought – here, for a hospice home care agency. While a provider can show a proposed service as part of a larger project (such as showing an MRI as an addition to a multi-modality diagnostic center), the service for which the CON is sought (the MRI service) must be shown to be financially feasible in its own right. And, in that circumstance, an MRI applicant is compared to other applicants in the batch review using its proposed CON-regulated MRI service revenues, not that service along with revenues (and patient origin, volume projections, etc.) from other non-CON services like x-ray and ultrasound.

Allowing one applicant to go beyond the scope of the established application process would create a fundamentally unfair dynamic for all other applicants. The applications for both Well Care and VIA were properly based on hospice home care services, revenue, and expenses. Allowing VITAS the advantage of bolstering its application with revenues for out-of-scope services unfairly disadvantages the other applications in this batch review.

If VITAS is evaluated using revenue projections that incorporate non-hospice care (as VITAS has shown in its application) but the other applicants are judged only on hospice home care agency revenue

projections, the comparisons among the competing applicants cannot be viable apples-to-apples comparisons. Including revenues associated with services other than those of the CON-regulated hospice home care taints the numbers that would otherwise be used to evaluate the applicant and compare it to the other proposals in the batch review. If one applicant is allowed to "bake in" revenue from some other service, this eliminates the ability of the Agency to properly evaluate that applicant and to meaningfully compare that applicant to others in the review.

Permitting VITAS to "throw in" revenue for "Other (Physician Part B)" services would create a slippery slope that would open the door to all manner of added revenues being potentially included to bolster an applicant's proposal for the service which required it to secure a CON approval in the first place. Clearly, the CON at issue here is for a hospice home care agency and the revenues shown for any such proposed agency should only include the revenues that the hospice home care agency would expect to receive for furnishing the CON-regulated hospice service. As explained above, physician services are paid as part of the hospice benefit under Medicare Part A (and in a comparable fashion for other beneficiaries).

The CON Section should reject as unreasonable and unsupported the VITAS projections for gross revenue associated with "Other" physician service visits paid for under Part B and should find that the VITAS projections, as stated, do not demonstrate financial feasibility.

Comments Regarding Criterion (3)

VITAS fails to demonstrate need due to unreasonable and unsupported utilization projections.

Deviation from SMFP Methodology

On page 8 of its Section Q Forms and Assumptions, VITAS presents its projected hospice deaths for its service area, relying on unsupported and inconsistent assumptions, including increasing death rates and increasing hospice penetration rates. These key assumptions deviate from the 2025 SMFP and lead to significantly inflated projections of hospice deaths in the service area. The following table compares the assumptions of the 2025 SMFP hospice home care methodology and the deviations from the SMFP methodology made in the VITAS application.

	Growth Assumption	
	SMFP Hospice Methodology	**VITAS Hospice Methodology**
Death Rate/1000 Population		
Cumberland	0%	2.0%
Harnett	0%	2.0%
Hoke	0%	3.5%
Robeson	0%	3.5%
Hospice Deaths Served		
Cumberland	1.50%	1.50%
Harnett	1.50%	1.50%
Hoke	1.50%	1.50%
Robeson	1.50%	1.50%
% Deaths Served By Hospice		
Cumberland	0%	1.5%, 2%, 2%
Harnett	0%	1.5%, 2%, 2%
Hoke	0%	1.5%, 2%, 2%
Robeson	0%	1.5%, 2%, 2%

Source: 2025 SMFP, Table 13B and VITAS application, Section Q pp. 4-6

As shown below, VITAS projects 135 more hospice deaths (5.5%) than the 2025 SMFP, with particularly excessive overstatements in Hoke County (29.1%):

2026 Projected Hospice Deaths

County	2025 SMFP, Col. I	VITAS Application	% Overstated by VITAS
Cumberland	1,126	1,174	4.3%
Harnett	520	564	8.5%
Hoke	179	231	**29.1%**
Robeson	646	637	-1.4%
Total	**2,471**	**2,606**	**5.5%**

Source: VITAS application, Section Q p. 7 and Table 13B of 2025 SMFP

More significantly, VITAS projects 46 more unserved hospice deaths in Cumberland County (143 – 97 = 46) and 133 more unserved hospice deaths overall in its service area (385 – 252 = 133) during 2026 compared to the SMFP hospice home care office methodology. *See* the following table.

2026 Unserved Hospice Deaths

County	2025 SMFP, Col. K	VITAS Application	% Overstated by VITAS
Cumberland	97	143	47.4%
Harnett	60	104	73.3%
Hoke	1	53	5200.0%
Robeson	94	85	-9.6%
Total	**252**	**385**	**52.8%**

Source: VITAS application, Section Q, p. 7 and Table 13B of 2025 SMFP

By applying market share assumptions to these inflated hospice death projections, VITAS further exaggerates its projected patient utilization. Consequently, VITAS's projected utilization is neither reasonable nor adequately supported.

The Agency previously found an application non-conforming with Criterion (3) in the 2020 Rowan County Hospice Home Care Review when Adoration similarly manipulated SMFP data with unreasonable methodology and assumptions. The Agency stated:

> The applicant based its "reworking" of the Table 13B of the 2020 and 2021 SMFP based on a different methodology, not because of any demonstrated mathematical or data input error.
>
> There is no basis for the Project Analyst to deviate from the data in Chapter 13 of the 2020 SMFP or the 2021 SMFP.
>
> If the projected deficits of deaths in need to be served from Table 13B of the 2020 and 2021 SMFP were used in the applicant's methodology the projected deaths to be served by the applicant in both Rowan and Stanly Counties would be dramatically less, and in the case of PY2 and PY3 for Rowan County, the projected number of unserved deaths to be served by the applicant would be zero ("0") as per the 2021 SMFP there was no deficit in Rowan County. Therefore, the projected utilization is not reasonable or adequately supported.

See page 27 of Agency Findings for 2020 Rowan County Hospice Home Care Office Review.

VITAS has employed a similarly flawed approach, deviating from Table 13B of the 2025 SMFP by artificially inflating projected deaths using unsupported death rates and hospice penetration rates. Had VITAS adhered to SMFP projections, its projected hospice deaths—and consequently, its patient utilization—would be significantly lower. Like Adoration, VITAS's projected utilization is not reasonable or adequately supported.

The inflated hospice patient projections result in similarly inflated financial projections which render any comparison of VITAS's patient utilization, revenue, and expenses unreliable.

Unreasonable and Unsupported Market Share Assumptions

In Step 10 of its methodology (Section Q, page 8), VITAS presents overly ambitious and unsupported market share projections for its proposed hospice agency.

Step 10: VITAS Projected Market Share

County	Partial Year 7/1-12/31 2026	Full FY 1 2027	Full FY 2 2028	Full FY 3 2028
Cumberland	12.50%	15.00%	17.00%	18.50%
Harnett	1.00%	1.50%	2.00%	2.50%
Hoke	1.00%	1.50%	2.00%	2.50%
Robeson	2.00%	2.50%	3.00%	3.50%
Total*	**6.43%**	**7.76%**	**8.86%**	**9.73%**

**Total for partial year 2026 reflects the market share for 6 months only.*

*Note the application appears to contain a typographical error by listing 2028 twice in the previous table.

VITAS's projected market shares exceed the bounds of reality and credibility. VITAS projects that in its first six months of operation, it will achieve 12.5% market share of hospice deaths in Cumberland County despite not having 1) any existing community awareness or reputation, 2) referral partner relationships, or 3) ownership of any complementary health service in the area that it could utilize to leverage care transitions to hospice. Furthermore, VITAS failed to provide any evidence of its ability to achieve comparable market shares in similar markets.

The 12.5% market share during the first six months of operation is the foundation on which VITAS projects to achieve 15% market share during Year 1, 17% market share during Year 2, and 18.5% market share during Year 3. Without an existing presence to secure referrals, VITAS's market share assumptions are assumptions are speculative, unrealistic, and lack adequate evidentiary support.

The Agency has previously rejected similar unsupported market share projections. In the 2024 Wake County Acute Care Bed Review, the Agency found that Novant projected unrealistically high market share growth despite having no existing services in the area. As a result, the Agency found Novant's application non-conforming with Criterion (3), stating:

> Proposing that a brand-new small community hospital, unsupported by an existing hospital system within the Wake County acute care bed service area and competing with three long established hospitals systems within the service area would reasonably command a 20%/10% market shift within a designated group of patients within its first three years of operation is not reasonable or supported by the application, exhibits to the application, comments, response to comments, remarks at the public hearing, or information publicly available during the review and used by the Agency.

See page 38 of Agency Findings for the 2024 Wake County Acute Care Bed and OR Review.

VITAS's projections suffer from the same fundamental flaw that the Agency identified in Novant's application: a lack of local experience and referral relationships to justify its ambitious market share capture.

While VITAS included letters of support in its Exhibit Book, these letters fail to demonstrate substantive backing from providers within the proposed service area. Specifically, based on simple internet searches,

many of the individuals providing letters of support are not located within the service area, making their relevance to the application questionable:

- Dr. Rodney Sessoms' practice is located in Clinton, NC (Sampson County), which is not located within VITAS's identified service area.
- Arlene Imes is located in Salisbury, NC (Rowan County), which is not located within VITAS's identified service area.
- Colonel Claude Schmid is located in Spartanburg, SC, which is not located within VITAS's identified service area.
- Kimberly Johnson MD is located in Durham, NC (Durham County), which is not located within VITAS's identified service area.
- Melody Taylor, President of Black Nurses Rock, is located in Orlando, Florida, which is not located within VITAS's identified service area.
- Kiana Cooper, President of Central Carolina Black Nurses Council, is located in Durham, NC (Durham County), which is not located within VITAS's identified service area.
- Lisa Johnson, Beta Chapter President of Lambda Psi Nu Sorority, is located in Bowie, MD, which is not located within VITAS's identified service area.

Given that none of these individuals or organizations are based in the identified service area, VITAS has failed to demonstrate local provider support necessary to substantiate its projected market share assumptions.

VITAS's lack of operational history in North Carolina, absence of established referral sources, and failure to provide meaningful support from providers within the proposed service area further undermine its already unrealistic market share projections.

VITAS's projected utilization translates into unreasonable and unsupported market share growth assumptions. The VITAS projections lack support as to the patients to be served from Cumberland County as well as patients expected to originate from Hoke and Robeson counties. Both Hoke and Robeson Counties are rural counties that present additional challenges for both patient service and staffing.

VITAS's projected utilization is not adequately supported given that VITAS, unlike Well Care: (1) lacks existing referral relationships; (2) has no track record of providing patient service (of any kind) in the proposed service areas; (3) has no "brand recognition" to support its entry into the communities it expects to serve; and (4) has no complementary lines of service of any sort in the area, creating no basis for referring physicians or patients to know or trust its operations. VITAS has none of the support that Well Care will have as a trusted resource, with ample existing referral relationships, with high brand awareness and with local patient, family, and staff connections. Although VITAS lacks all these characteristics, it presents aggressive utilization projections. This casts significant doubt on the reasonableness and supportability of the VITAS projections, especially considering the existing competitors already active in these proposed markets.

Accordingly, VITAS should be found non-conforming with Criterion (3).

Comments Regarding Criterion (4)

Notably, VITAS chose to identify zero alternatives in Section 4. Obviously, VITAS has available alternatives to the project as proposed such as identifying the counties it would serve. Here, VITAS chose to ignore Johnston County, a growing area with a substantial deficit of hospice agencies.

Comments Regarding Criterion (5)

Unsubstantiated Financial Assumptions and Discrepancies

On page 22 of its Section Q Forms and Assumptions, VITAS presents its Form F.6, which contains several critical inconsistencies and unsupported financial projections. Notably:

- **Unrealistic Medicare Inpatient Reimbursement Assumptions** – As indicated in Form F.6 (Section Q, page 22). VITAS projects higher reimbursement than charges for Inpatient Medicare and Continuous Care services in 2027, 2028, and 2029 (*see* highlighted figures below), a scenario that is financially implausible given established Medicare reimbursement structures.

Form F.6 Hospice Home Care Charges and Reimbursement Rates Per Visit	Partial FY		1st Full FY		2nd Full FY		3rd Full FY	
	F: 7/1/2026		F: 1/1/2027		F: 1/1/2028		F: 1/1/2029	
	T: 12/31/2026		T: 12/31/2027		T: 12/31/2028		T: 12/31/2029	
	Charge	Reimbursement Rate	Charge	Reimbursement Rate	Charge	Reimbursement Rate	Charge	Reimbursement Rate
Routine Home Care								
Self Pay	$ 160.34	$ (0.0)	$ 173.91	$ 0.0	$ 177.20	$ 0.0	$ 206.60	$ 0.0
Hospice Medicare *	$ 219.97	$ 42.69	$ 203.59	$ 183.51	$ 209.94	$ 185.77	$ 219.40	$ 190.70
Hospice Medicaid *	$ 190.63	$ 41.28	$ 208.80	$ 184.77	$ 208.32	$ 184.75	$ 218.88	$ 189.75
Private Insurance *	$ 174.75	$ 32.92	$ 187.78	$ 161.70	$ 187.75	$ 162.16	$ 196.51	$ 166.22
Other (Physician Part B)		$ 0.38		$ 0.42		$ 0.46		$ 0.46
Inpatient Care								
Self Pay	$ 1,011.57	$ 0.00	$ 1,032.03	$ -	$ 1,062.69	$ -	$ 1,093.98	$ -
Hospice Medicare *	$ 1,125.33	$ 224.62	$ 1,149.52	$ 1,196.89	$ 1,181.99	$ 1,229.33	$ 1,216.08	$ 1,262.36
Hospice Medicaid *	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,217.02	$ 1,232.36
Private Insurance *	$ -	$ -	$ -	$ -	$ 1,086.72	$ 1,298.36	$ 1,094.48	$ 1,067.44
Other		$ 74.67		$ 80.83		$ 82.14		$ 80.93
Respite Care								
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hospice Medicare *	$ 501.63	$ 111.73	$ 510.80	$ 496.75	$ 525.95	$ 511.53	$ 541.15	$ 526.32
Hospice Medicaid *	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Private Insurance *	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other (Physician Part B)								
Continuous Care (Hourly)								
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hospice Medicare *	$ 64.00	$ 14.49	$ 65.19	$ 63.62	$ 66.77	$ 65.17	$ 68.31	$ 66.65
Hospice Medicaid *	$ -	$ -	$ -	$ -	$ 67.90	$ 66.30	$ 68.22	$ 66.60
Private Insurance *	$ -	$ -	$ -	$ -	$ 60.14	$ 66.03	$ 61.39	$ 66.35
Other (Physician Part B)		$ 2.50		$ 3.48		$ 4.00		$ 4.00

- **Discrepancies Between Financial Forms** – There is no correlation between Form F.6 and Form F.2b, raising concerns about internal consistency and financial accuracy. Specifically:
    - When applying VITAS's own projected days of care, payor mix, and projected charges and reimbursement, the resulting gross and net revenue exceed the figures reported on Form F.2b, suggesting an understatement or miscalculation of projected revenue.
    - Such misalignment indicates flawed financial modeling and an unreliable projection of financial feasibility.

- **Lack of Justification for Physician Part B Revenue Projections** – It is VITAS's responsibility to clearly delineate the assumptions for its utilization. However, VITAS fails to provide any assumptions or methodology for the Physician Part B Revenue, making it impossible to assess their accuracy or feasibility. Furthermore, as described in detail above, hospice is only paid by Medicare Part A.

Physician Part B revenues should not be included with hospice home care revenues. It is possible that the Physician Part B revenues reflect revenue for physicians' services associated with VITAS's palliative care program; however, VITAS cannot include revenues from another health service (i.e., palliative care) with the proposed hospice home care program.

Notably, VITAS projects a net income of $31,396 during Project Year 3. However, if Physician Part B revenues were removed from Form F.2b, VITAS would not be financially viable during project year 3 [$31,396 - $59,870 = ($28,474)].

Form F.2b Projected Revenues and Net Income upon Project Completion	Partial FY	1st Full FY	2nd Full FY	3rd Full FY
	F: 7/1/2026	F: 1/1/2027	F: 1/1/2028	F: 1/1/2029
VITAS Healthcare Corporation of North Carolina Hospice Home Care Services	T: 12/31/2026	T: 12/31/2027	T: 12/31/2028	T: 12/31/2029
Patient Services Gross Revenue				
Self Pay	$ 5,711	$ 26,215	$ 41,817	$ 60,157
Insurance *	9,786	59,339	107,471	156,467
Medicare *	500,088	2,839,698	5,258,735	6,972,001
Medicaid *	10,294	63,685	109,926	166,449
Other (Physician Part B)	2,271	20,896	45,898	59,870
Total Patient Services Gross Revenue	528,150	3,009,832	5,563,847	7,414,944
Other Revenue (1)				
Total Gross Revenue (2)	528,150	3,009,832	5,563,847	7,414,944
Adjustments to Revenue				
Charity Care	417,726	26,453	42,122	60,498
Bad Debt	911	24,735	45,713	61,191
Contractual Adjustments (Medicare Sequestration)	2,200	59,552	110,301	147,089
Total Adjustments to Revenue	420,836	$110,740	$198,136	$268,778
Total Net Revenue (3)	107,314	$2,899,092	$5,365,712	$7,146,166
Total Operating Costs (from Form F.3)	$963,921	$3,444,401	$5,720,335	$7,114,770
Net Income (4)	($856,607)	($545,308)	($354,624)	$31,396

With Total Net Revenue reduced by $59,870, VITAS projects a negative Net Income of $28,474.

Failure to Demonstrate Financial Feasibility Within First 36 Months (Three Years)

The Definitions for Terms Used in the Application Form (p. 10) define the "Initial Operating Period" as the number of months, if any, during which the facility's total cash outflow (operating costs) exceeds its total cash inflow (revenues).

On page 142, VITAS states that its Initial Operating Period will extend for 39 months. This indicates that the facility will not achieve financial feasibility within the first 36 months of operation—commonly considered the initial three years. As a result, this constitutes a non-conformity with Criterion (5).
For these reasons, the VITAS application does not conform with Criterion (5).

VITAS is new to North Carolina and may have been unaware of the Criterion (5) requirement to demonstrate "financial feasibility." Multiple Agency witnesses have testified, both in depositions and hearings, that to meet this standard, a project must achieve profitability—where revenues exceed expenses—by its third year of operation.

Unlike an MRI unit installed within a hospital, where the applicant can rely on the hospital's overall profitability even if the MRI itself operates at a loss for more than three years, the VITAS project is a stand-alone hospice agency. It does not have the financial cushion of a larger healthcare system and fails to demonstrate financial feasibility within three years of commencing operations. This fundamental shortcoming constitutes a clear and critical non-conformity with Criterion (5).

Inadequate Funding Documentation

In Section F, VITAS states that the proposed project will be funded "by the parent corporation" (p. 141). However, Section F.2c3 specifically requires applicants to "document that the cash and cash equivalents, accumulated reserves, or owner's equity that will be used to finance the capital cost are reasonably likely to be available when needed."

In its response to Section F.23, VITAS fails to explicitly affirm that the necessary funds "are reasonably likely to be available when needed." (p. 141). This omission raises concerns about the project's financial viability and the applicant's ability to secure funding in a timely manner. Without clear documentation demonstrating the availability of capital, VITAS does not meet the financial feasibility requirements outlined in Criterion (5), further reinforcing its non-conformity.

News reports indicate that VITAS is in an aggressive expansion phase, making substantial, high-dollar acquisitions:

> "As it considers potential acquisitions, VITAS Healthcare is focused on large assets in certificate of need (CON) states. VITAS is a subsidiary of Chemed Corp. (NYSE: CHE). The company this year made its return to the M&A market after a hiatus of several years. In April [2024], VITAS acquired Covenant Health and Community Services' hospice operations as well as one assisted living facility in an $85 million deal. With that transaction under its belt, more are likely on the way, according to Mike Witzeman, vice president and CFO for Chemed."[4]

While VITAS is undeniably part of a large, for-profit hospice network, it is also actively engaged in and strategically positioned for continued merger-and-acquisition activity. This expansion strategy suggests significant financial commitments and potential demands on cash reserves. Given this context, it was crucial for a VITAS representative to explicitly confirm that sufficient funds would be available "when needed," as required by the CON application form. However, this assurance is conspicuously absent from VITAS's CON application, further casting doubt on the project's financial feasibility. Consequently, the application should be found nonconforming to Criterion (5).

<u>Impact on Other Review Criteria</u>

Based on the previously described facts which render the VITAS application non-conforming to Criteria (3), (4), and (5), the application is also **non-conforming to Criteria (1), (6), and (18a)**.

[4] Parker, J. (2024, November 13). VITAS seeking large acquisitions in hospice con states. Hospice News.