ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: August 24, 2012

PROJECT ANALYST: Les Brown
SECTION CHIEF: Craig R. Smith

PROJECT I.D. NUMBER: F-8824-12 / Hospice & Palliative Care Charlotte Region / Convert four hospice residential beds to four hospice inpatient beds at the Levine & Dickson Hospice House for a total of 16 hospice inpatient beds and no hospice residential beds / Mecklenberg County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(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, operating rooms, or home health offices that may be approved.

C

Hospice & Palliative Care Charlotte Region (HPCCR) operates the Levine & Dickson Hospice House (LDHH), a 16-bed hospice care facility in Huntersville with 12 hospice inpatient beds and 4 hospice residential beds. The applicant, HPCCR, proposes to convert four hospice residential beds to four hospice inpatient beds at the Levine & Dickson Hospice House for a total of 16 hospice inpatient beds and no hospice residential beds upon completion of the project.

The 2012 State Medical Facilities Plan (SMFP) identifies a need determination for seven new hospice inpatient beds in Mecklenburg County. The Certificate of Need Section received two hospice applications for projects in Mecklenberg County in response to the 7-hospice bed need determination in the 2012 SMFP. The two applications received include: 1) This application, Project I.D. #F-8824-12, in which the applicant, Hospice & Palliative Care Charlotte Region, proposes to convert four hospice residential beds to four hospice inpatient beds for a total of 16 hospice inpatient beds and no hospice residential beds upon completion of the project and 2) Project I.D. #F-8832-12, in which Presbyterian Hospital Matthews proposes to develop three hospice inpatient beds. Because the total number of

hospice beds proposed in the two projects is 7 beds, the applications are not competitive and both projects can be approved and be conforming to the need determination in the 2012 SMFP.

The applicant proposes to convert no more than four beds, thus the application is conforming to the need determination in the 2012 SMFP.

Policy GEN-3 of the 2012 SMFP is applicable to this review. Policy GEN-3: Basic Principles states:

> *"A CON 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 (SMFP) 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 CON 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 CON applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the SMFP as well as addressing the needs of all residents in the proposed service area."*

Maximize Healthcare Value

The applicant proposes to convert four existing hospice residential beds to four hospice inpatient beds with no construction cost. The only cost included as a capital cost in Section VIII is $25,000 for consultant fees. On page 53 the applicant states the following regarding how the proposal promotes healthcare value:

> *"Promote Cost Effective Approaches*
>
> *HPCCR proposes to expand the LDHH inpatient hospice service by four (4) inpatient hospice beds. With the rising demand for inpatient services that are driven by a growing community, an aging population and an expanding physician referral base, HPCCR believes that any hospice patients who may benefit from the care at an inpatient hospice facility should have access to those services; the expansion of the LDHH will open up capacity to Mecklenberg County Hospice patients. This proposed project will not hinder any existing providers' ability to compete.*
>
> *Choice helps promote competition and competition helps promote better alternatives for the patients. HPCCR will complement the needs and ever growing demands of the patients, staff, and physicians within the service area. This project will promote an* [sic] *community-based inpatient hospice facility that will be open to all patients within the service area."*

The applicant adequately demonstrates that proposed project will maximize healthcare value.

Promote Safety and Quality

On page 54 the applicant states the following with regard to how the proposal will promote safety and quality:

> *"Encourage Quality Health Care Services*
>
> *The aging population and the demands from the baby boomer generation continue to force the provision of care services into a 'consumerism' mentality. Today's patients demand better care, better access to information, better outcomes, more patient (consumer) focus from the provider and their physician, and more economical options for health care services. HPCCR will address these demands in an ever growing segment of the heath care delivery system: inpatient hospice services.*
>
> *LDHH is designed to be homelike; a friendlier, relaxed, and less intimidating environment to the patient. The patients and their families will have a facility that is easily accessible and easy to find. A freestanding inpatient hospice facility lessens the anxiety associated with end-of-life issues.*
>
> *HPCCR offers an extensive continuum of care, recognized for its innovation and excellence (NHPCO award winner). HPCCR is recognized as a NHPCO 'Quality Partner' and provides the leadership to encourage quality care."*

Staff Orientation and Competence Policies and Procedures are included in Exhibit L. Quality Assessment and Performance Improvement Policies are included in Exhibit Q. The applicant adequately demonstrates that the proposed project will promote safety and quality.

Promote Equitable Access

On pages 53-54 the applicant states the following with regard to how the proposal will promote equitable access:

> *"Expand Health Care Services to the Medically Underserved*
>
> *Low income persons needing hospice services will have access to the facility. As an existing North Carolina health care provider, HPCCR has provided hospice services to Mecklenberg and surrounding counties for over 30 years. HPCCR remains committed to providing care for the uninsured, under-insured, and charity care patients.*
>
> *All persons, including patients covered by Medicare, Medicaid, Commercial Insurance, Self-Pay (including self-pay, indigent, charity care), and any others will have access to appropriate services. HPCCR will render appropriate medical care to all persons in need of hospice care regardless of their ability to pay."*

On page 84 the applicant further states how the proposal will promote equitable access:

> *"HPCCR is and will continue to be accessible to all persons, including the medically indigent and terminally ill children.*
> …
>
> *HPCCR will continue to be available to all in need of care, without discrimination."*

The applicant provides the Admission Criteria Policy and the Special Financial Consideration Policy in Exhibits I and V, respectively. The applicant adequately demonstrates that medically underserved groups will have equitable access to the proposed services. See also Criterion (13).

Projected Volumes Incorporate GEN-3 Concepts

The applicant adequately demonstrates the need for the proposal. The applicant demonstrates that projected volumes for the proposed hospice facility incorporate the basic principles in meeting the needs of patients to be served. See Criteria (3) and (5). Consequently, the application is consistent with Policy GEN-3. In summary, the applicant is conforming to the need determination in the 2012 SMFP and is consistent with Policy GEN-3. Therefore, the application is conforming with this criterion.

(2) Repealed effective July 1, 1987.

(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.

C

Hospice & Palliative Care Charlotte Region (HPCCR) operates the Levine & Dickson Hospice House (LDHH), a 16-bed hospice care facility in Huntersville with 12 hospice inpatient beds and 4 hospice residential beds. The applicant, HPCCR, proposes to convert four hospice residential beds to four hospice inpatient beds at the Levine & Dickson Hospice House for a total of 16 hospice inpatient beds and no hospice residential beds upon completion of the project.

Population to be Served

In Section III.4, page 54, the applicant states that the proposed service area includes Mecklenberg, Lincoln, Cabarrus, Union, Iredell, Gaston and Catawba counties, as well as South Carolina.

In Section III.11, pages 59-60, the applicant provides patient origin for the first two years of operation, as shown in the tables below:

LDHH Projected Patient Origin Year 1

	Inpatient Patients		Residential Patients*	
County	**Projected # of Patients**	**Percent of Total Patients**	**Projected # Residential Patients**	**Percent of Total Residential Patients**
Mecklenberg	462	75.9%	31	81.6%
Lincoln	48	7.9%	3	7.9%
Cabarrus	26	4.3%	1	2.6%
Iredell	23	3.8%	2	5.3%
Gaston	19	3.1%		0.0%
Union	13	2.1%	1	2.6%
Catawba	5	0.8%		0.0%
Other State	13	2.1%		0.0%
TOTAL	**609**	**100.0%**	**38**	**100.0%**

*Hospice residential care patients can use hospice inpatient beds.

LDHH Projected Patient Origin Year 2

	Inpatient Patients		Residential Patients*	
County	**Projected # of Inpatients**	**Percent of Total Inpatients**	**Projected # Residential Patients**	**Percent of Total Residential Patients**
Mecklenberg	482	75.9%	31	81.6%
Lincoln	50	7.9%	3	7.9%
Cabarrus	27	4.3%	1	2.6%
Union	24	3.8%	2	5.3%
Iredell	20	3.1%		0.0%
Gaston	14	2.1%	1	2.6%
Catawba	5	0.8%		0.0%
Other State	14	2.1%		0.0%
TOTAL	**636**	**100.0%**	**38**	**100.0%**

*Hospice residential care patients can use hospice inpatient beds.

The applicant adequately identifies the population projected to be served by the proposed facility.

Demonstration of Need

In Section III.1, page 46, the applicant states:

"*HPCCR utilized the following information to determine to submit a CON application for the expansion of LDHH by one (1) inpatient hospice bed* [conversion of four hospice residential beds to four hospice inpatient beds]:

- *State Medical Facilities Plan*
- *Federal and State Regulations*
- *Hospice Home Care Utilization*
- *Mecklenberg County Demographics*
- *Palliative Medicine Deaths*
- *Inpatient Hospice Bed Statistical Need"*

In Section III.1, page 46, the applicant states that HPCCR proposes to convert four (4) hospice residential beds to (4) hospice inpatient beds and that the 2012 SMFP has determined a need for 7 hospice inpatient beds in Mecklenberg County.

In Section II.2, pages 19-31, the applicant provides documentation that the application is in compliance with the Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Facilities. On page 47 the applicant provides Mecklenberg County hospice home care utilization growth from 2005 through 2010, as shown in the table below.

Mecklenberg County	2005	2010	# Change	% increase
Hospice Days of Care	128,970	196,963	67,993	52.7%
Hospice Deaths	1,432	2,316	884	61.7%

Additionally, the applicant notes that there were 10 hospice programs serving Mecklenberg County in 2005 and 13 county offices in 2010.

The Carolinas Center for Hospice and End of Life Care's annual report, Hospice Data & Trends, confirms a steady increase in the percentage of Mecklenburg deaths served by hospice from 2006 through 2010 The table below shows the percent of Mecklenburg County deaths served by hospice and the rank of Mecklenberg County compared with other NC counties for years 2006 – 2010.

Year	Percent Mecklenberg County Deaths Served by Hospice	Mecklenberg County Rank Among NC Counties
2006	32.66%	26
2007	37.43%	20
2008	39.24%	23
2009	42.07%	17
2010	45.77%	15

In Section III.1, page 50, the applicant provides data from the NC Office of State Budget and Management for projected population growth in Mecklenberg County from 2007 through 2017, as shown in the table below.

Population	2007	2012	Projected 2017	2007- 2012 % Change	2012-2017 % Change
Mecklenburg County Total	857,379	958,571	1,045,140	11.80%	9.03%
65+	69,879	90,102	113,154	28.94%	25.58%
% 65+	8.15%	9.40%	10.83%		

As illustrated in the table above, the population age 65 and older is projected to grow 25.58% from 2012 to 2017 to become 10.83% of Mecklenberg County total population in 2017.

On page 50 the applicant states: *"HPCCR has developed an extensive palliative medicine consultation service over the past eight years. The HPCCR Palliative Medicine Program cared for 2,739 patients in 2010 and 3,316 patients in 2011, of which 719 in 2010 and 865 in 2011 transitioned to hospice care."*

In regard to the statistical need for the proposed project, the applicant states on page 51 that the 2012 State Medical Facilities Plan contains a need determination for 7 hospice inpatient beds in Mecklenberg County. The applicant states: *"Within two years of LDHH becoming operational, the facility has been operating at 100.0 percent of capacity for its 12 inpatient hospice beds."* Additionally, the applicant states that in 2010, LDHH had an average daily census of 11.9 patients.

Projected Utilization

Utilization Projections by Level of Care

In Section IV.2(a), page 63, the applicant provides the projected utilization for LDHH for the first two years following completion of the project by level of care, as shown in the table below.

	Inpatient Days	Percentage Occupancy	Residential Patient Days*	Percentage Occupancy	Respite Patient Days*	Percentage Occupancy	Total Patient Days	Percentage Occupancy
FFY 2013	4,618	79.1%	791	NA	240	NA	5,648	96.7%
FFY 2014	4,768	81.6%	791	NA	240	NA	5,799	99.3%

* No beds designated for these patients who will be served in inpatient beds.

Inpatient Utilization

On pages 66-67 the applicant provides the projected inpatient utilization, and the methodology and assumptions used for these projections, as described below.

Levine & Dickson Hospice House (LDHH) Inpatient Utilization

	Historical		Projected			
	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2014**	**FY2015**
Mecklenberg County	390	424	442	462	482	482
Other Counties	131	135	141	147	154	154
Total Admissions	521	559	584	609	636	636
Ave length of Stay	7.84	7.75	7.66	7.58	7.50	7.50
Total Days of Care	4,082	4,330	4,472	4,618	4,768	4,768
Avg Daily Census	11.18	11.86	12.22	12.65	13.06	13.06
% Occupancy	101.7%	98.9%	101.8%	79.1%	81.6%	81.6%

Step 1) The applicant reviewed historical utilization for LDHH and noted that Mecklenberg County patients increased 8.7% from FY2010 to FY2011. The applicant projected that for years FY2012, FY2013 and FY2014, the number of Mecklenberg County patients served will increase 4.0% per year, with no change in patients served in FY2015.

Step 2) The applicant reviewed historical utilization for LDHH patients originating from counties other than Mecklenberg and noted that 135 patients or 24.2% of all LDHH hospice inpatients resided outside Mecklenberg County in FY2010. The applicant assumed that LDHH's percentage of inpatients from outside Mecklenberg County would remain constant at 24.2% through FY2015.

Step 3) The applicant reviewed historical average length of stay (ALOS) for LDHH and found a decrease in ALOS from 7.84 days in 2010 to 7.75 days in 2011, which was attributed to better screening of prospective hospice inpatients. The applicant assumed continued improvements in screening and assumed the ALOS would decrease to 7.58 in FY2013 and 7.50 days for FY2014 and FY2015.

Step 4) The applicant projected LDHH total days of care by multiplying LDHH total hospice inpatient admits times the ALOS.

Step 5) The applicant projected the average daily census by dividing the LDHH total days of care by 365 days.

Step 6) The applicant projected the occupancy rate by dividing the LDHH average daily census from Step 5 by 16 beds.

Residential Utilization

In Section IV, page 68, the applicant provides the following table illustrating the historical and projected LDHH hospice residential patient utilization.

Levine & Dickson Hospice House (LDHH) Residential Utilization

	Historical		**Projected**			
	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2014**	**FY2015**
Mecklenberg County	42	31	31	31	31	31
Other Counties	8	7	7	7	7	7
Total Admissions	50	38	38	38	38	38
Ave length of Stay	23.4	20.7	20.7	20.7	20.7	20.7
Total Days of Care	1,171	791	791	791	791	791
Avg Daily Census	3.2	2.2	2.2	2.2	2.2	2.2

The methodology and assumptions used to project LDHH hospice residential utilization provided on pages 68-69 are outlined below.

Step 1) The applicant noted that LDHH's Mecklenburg County residential admissions decreased from 42 in FY2010 to 31 in FY2011. The applicant assumed the number of Mecklenburg residential care patients will remain constant from FY2011 through FY2015.

Step 2) The applicant assumed that the 7 patients from outside Mecklenburg County would remain constant from FY2011 through FY2015.

Step 3) The applicant assumed that the ALOS, total patient days of care and average daily census would remain constant from FY2011 through FY2015.

Respite Care Utilization

In Section IV, page 70, the applicant provides the following table illustrating the historical and projected LDHH hospice respite patient utilization.

LDHH Historical and Projected Respite Care Utilization

	Historical		Projected			
	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2014**	**FY2015**
Total Admissions	48	51	51	51	51	51
Ave length of Stay	4.7	4.7	4.7	4.7	4.7	4.7
Total Days of Care	226	240	240	240	240	240

On page 70 the applicant assumed that the total respite care admissions, ALOS and patient days of care would remain constant from FY2011 through FY2015.

Projected Total Hospice Agency Utilization

In Section IV.4, page 73, the applicant provides the projected utilization for the first three years following project completion for its hospice agency offices in Mecklenburg County, which include HPCCR Uptown Office, South Charlotte Office and Lake Norman Office, as shown in the table below.

	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
Admissions	1,742	1,823	1,688	2,188	2,210	2,232	2,254	2,277
Deaths	1,393	1,412	1,480	2,022	1,989	2,009	2,029	2,049
Discharges	349	411	208	166	221	223	225	228

The methodology and assumptions used to project HPCCR hospice agency admissions, deaths and discharges provided on page 73, as stated below.

"A. HPCCR Admits

HPCCR has experienced a dramatic two-year, 29.6% increase of unduplicated hospice program admits. In 2011, HPCCR had 2,188 unduplicated hospice program admissions and HPCCR conservatively projects that that number of unduplicated hospice admissions will increase by 1.0 percent per year through 2016. HPCCR believes that as the population ages, HPCCR will experience a slight increase in the number of elderly patients and families seeking end-of-life care through HPCCR.

B. Deaths

HPCCR has experienced a two-year average death rate of 90.0%. HPCCR projects that its death rate will remain constant through 2016.

C. Discharges

Discharges were calculated by subtracting death (B) from admits (A).”

In Section IV, page 75, the applicant provides the historical and projected number of patients who are residents of nursing homes and the total projected nursing home days of care, ALOS and place of death as shown in the table below.

HPCCR’s Uptown, South Charlotte, and Lake Norman Offices

	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
Nursing Home Patients	525	545	608	677	697	718	740	762
Nursing Home Patient Days of Care	22,881	33,610	41,872	45,153	46,508	47,903	49,340	50,820
ALOS	43.6	61.7	68.9	66.7	66.7	66.7	66.7	66.7
Place of Death	376	339	391	464	478	492	507	522

The methodology and assumptions used to project utilization illustrated above are on page 75 and stated below.

[No A]

“B. HPCCR Nursing Home patients

HPCCR has experienced a 29.0% increase in the number of nursing home patients that it served from FY2008 to FY2011. In 2011, HPCCR served 677 nursing home patients and HPCCR conservatively projects that that number of nursing home patients will increase by 3.0 percent per year through 2016.

C. Average Length of Stay (ALOS)

HPCCR has experienced a slight decrease in the average length of stay [from FY2010 to FY2011] *of its nursing home patients. HPCCR projects that its ALOS will remain constant through 2016.*

D. Place of Death

In FY2011, HPCCR experienced a death rate of 68.5% for its nursing home patients. HPCCR projects that this death rate will remain constant through 2016.”

In summary, the applicant’s projected utilization is reasonable based on the assumptions and methodology provided. The applicant adequately identifies the population it proposes to serve and adequately demonstrates the need to convert the hospice residential beds to hospice inpatient beds. On page 69 the applicant states: *“Beginning in FY2013, HPCCR will not operate residential beds, but will instead serve these patients in inpatient hospice beds.”* Therefore, the applicant would not be required to meet the performance standards for residential care hospice beds. The applicant adequately demonstrates the projected utilization

will exceed the performance standards for hospice inpatient beds as stated in 10A NCAC 14C .4003:

> *"(a) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall demonstrate that:*
> *(1) the average occupancy rate of the licensed hospice beds, for each level of care, in the facility is projected to be at least 50 percent for the last six months of the first operating year following completion of the project;*
> *(2) the average occupancy rate for the licensed hospice beds, for each level of care, in the facility is projected to be at least 65 percent for the second operating year following completion of the project;"*

Therefore the application is conforming with 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.

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On page 57 the applicant states:

> *"HPCCR operates a specialized 'hospice alternative residence team' serving over 60 long-term care and assisted living facilities, allowing individuals to receive hospice care in place, rather than relocating. Additionally, HPCCR can accommodate residential hospice patients in inpatient hospice beds, but cannot accommodate inpatient hospice patients in residential hospice beds."*

The hospice residential patients will continue to be served in the same location at the same level of care. The applicant demonstrates that the needs of the population presently served will be met adequately by alternative arrangements. See Criterion 13 with regard to access by medically underserved groups. Therefore, the application is conforming with 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.

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In Section III.13, page 61, the applicant states that there were three alternatives considered in the development of the proposed project, including: maintaining the status quo, constructing a freestanding hospice house and expanding the existing hospice inpatient facility. The applicant adequately demonstrates that its proposal is the least costly or most effective alternative, and the application is conforming with this criterion. The application is

conforming to all applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (7), (8), (13), (14), (18a) and (20) as well as 10A NCAC 14C .4000. The applicant adequately demonstrates that its proposal is an effective alternative. Therefore, the application is conforming with this criterion subject to the following conditions:

1. **Hospice & Palliative Care Charlotte Region shall materially comply with all representations made in its certificate of need application.**

2. **Hospice & Palliative Care Charlotte Region shall convert four hospice residential beds located at the Levine & Dickson Hospice House in Huntersville to four hospice inpatient beds upon completion of this project.**

3. **The Levine & Dickson Hospice House shall be licensed for a total of 16 hospice inpatient beds upon completion of this project.**

4. **Hospice & Palliative Care Charlotte Region shall acknowledge acceptance and compliance with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

(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.

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In Section VIII.1, page 96, the applicant projects that the total capital cost of the project will be $25,000 for consulting fees. Exhibit X contains the audited financial statements for HPCCR for the years ending December 31, 2010 and 2011. As of December 31, 2011, HPCCR had cash and cash equivalents of $3,934,397, total current assets of $14,664,391 and total net assets of $32,568,354 [total assets – total liabilities].

In Form B of the Pro Formas, the applicant projects LDHH's revenue and expenses for the first three operating years, as shown in the table below. HPCCR projects expenses will exceed revenues during years 2 and 3 of operation following completion of the project as shown in the table below.

	FY2013	FY2014	FY2015
Revenues	$3,521,974	$3,695,298	$3,763,877
Expenses	$3,576,135	$3,668,470	$3,747,705
Net Profit (Loss)	($54,161)	$26,828	$16,172

In Section X.3, page 107, the applicant projects the reimbursement rates/charges for the first three years of operation of the proposed hospice facility, as shown in the following table.

Projected Per Diem Charges

Payment Source by Level Care	FY2013	FY2014	FY2015
Hospice Inpatient			
Private Pay	$296.00	$296.00	$296.00
Commercial Insurance	$740.00	$740.00	$740.00
Medicare	$674.35	$687.84	$701.59
Medicaid	$674.35	$687.84	$701.59
Hospice Residential Care			
Medicare	$151.42	$154.45	$157.54
Hospice Respite			
Private Pay	$195.00	$195.00	$195.00
Commercial Insurance	$195.00	$195.00	$195.00
Medicare	$151.42	$154.45	$157.54

On page 107 the applicant states the following assumptions regarding its projected charges:

"Per Diem rates were calculated based on this year's actual rates for inpatient level of care as set by the Centers for Medicare and Medicaid Services, increased at 2.0 percent annually from FY2013 to FY2014; a conservative estimate. Commercial rates were based on historical rates."

In summary, the applicant adequately demonstrates the availability of sufficient funds for the proposed facility and adequately demonstrates that the financial feasibility of the proposed project is based on reasonable projections of costs and charges. Consequently, the application is conforming with 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.

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HPCCR currently operates a certified hospice agency in Mecklenburg County, including the Levine & Dickson Hospice House, a 16-bed hospice inpatient and hospice residential facility with 12 hospice inpatient beds and 4 hospice residential care beds. HPCCR received a certificate of need to develop ten hospice inpatient beds in south Charlotte on November 15, 2011 (Project ID #F-8677-11). In this application, HPCCR proposes to convert four hospice residential care beds to four hospice inpatient beds at LDHH. LDHH averaged 98.9% occupancy at the inpatient care level during FY2011 and the hospice residential care occupancy rate was 54.2% in FY2011.

There are currently thirteen hospice providers in Mecklenburg County. As reported in Hospice Data and Trends for FY2007 – FY2011, Mecklenberg County residents utilized the two largest providers of hospice services, Presbyterian Hospice and HPCCR, as illustrated in the tables below.

Presbyterian Hospice	FY2007	FY2008	FY2009	FY2010	FY2011	% Growth FY2007 – FY2011
Patients Admitted	637	699	714	694	658	3.3%
Days of Care	28,208	25,662	23,888	32,523	31,977	13.4%
Deaths	557	547	597	551	573	2.9%

HPCCR	FY 2007	FY2008	FY2009	FY2010	FY2011	% Growth FY2007 – FY2011
Patients Admitted	1,076	1,202	1,212	1,236	1,262	17.3%
Days of Care	104,160	117,947	110,975	120,940	121,211	16.4%
Deaths	928	1,059	1,056	1,094	1,157	24.7%

Both Presbyterian Hospice and HPCCR operate inpatient units/facilities in Mecklenburg County with a third unit approved. HPCCR received a certificate of need to develop ten hospice inpatient beds in south Charlotte on November 15, 2011 (Project ID #F-8677-11).

In the most recent years for which data are available, these two hospice inpatient facilities were operating at occupancy rates above the performance standards as stated in 10A NCAC 14C .4003, as shown in the table below:

	Beds	Patient Days of Care	Average Daily Census	Occupancy Rate
HPCCR Hospice Inpatient Beds	11	4,330	11.9	107.9%
Presbyterian Hospital Hospice Inpatient Beds	8	2,215	6.1	75.9%

Source: NC Hospice & Data Trends, FFY 2011

The applicant adequately demonstrates the need to convert four hospice residential beds to four hospice inpatient beds. The applicant adequately demonstrates that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is conforming with 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.

C

In Section VII, pages 89-90, the applicant provides the staffing for the existing hospice facility. On pages 91-92 the applicant provides the proposed staffing for the LDHH in the second operating year following completion of the project to convert four hospice residential beds to four hospice inpatient beds. The applicant proposes no additional FTEs.

On page 93 the applicant projects the number of direct care staff. The applicant projects that a minimum of five staff members will be on duty at all times, including at least three registered nurses and two assistants per shift. The applicant states that nurses will work 12.5

hours per shift and nursing assistants will work 12.25 hours per shift. In the second year of operation, the applicant projects to provide 9.9 nursing hours per patient day (NHPPD) for inpatient services [(49,731 hours per year / 5,008 inpatient patient days of care = 9.9 NHPPD].

The applicant adequately demonstrates the availability of resources, including health manpower and management personnel, for the provision of the proposed hospice services. Therefore, the application is conforming with 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.

C

In Section II.3, page 41, the applicant states that HPCCR provides all of the listed hospice services. Exhibit J contains a letter from the President and CEO of HPCCR which states that HPCCR has provided hospice services to Mecklenberg and the surrounding counties for more than 30 years and that HPCCR provides the following services: nursing, social work, counseling, bereavement, volunteer, physician and medical supply services.

Exhibit P contains copies of agreements between HPCCR and suppliers of durable medical equipment and medical gases. Exhibit K contains an agreement with Hospice Pharmacia for pharmaceuticals. Exhibit H contains letters of support from area physicians, Presbyterian Hospital Huntersville, Presbyterian Cancer Center and LDHH volunteers. Exhibit T contains service agreements between HPCCR and existing healthcare providers.

In Section II.2, page 23, the applicant states:

> *"HPCCR has established working relationships with many sources of referrals because it is the operator of an existing inpatient hospice facility in Mecklenberg County, LDHH, and because it is the largest provider of hospice services in Mecklenberg County, over 80% of total hospice days of care are provided by HPCCR."*

The applicant adequately demonstrates that necessary ancillary and support services will be available and that the proposed services will be coordinated with the existing health care system. Therefore, the application conforms with this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:
(i) would be available under a contract of at least 5 years duration;
(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
(iii) would cost no more than if the services were provided by the HMO; and
(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

NA

In Section XI.7, page 119, and in Section VIII the applicant documents that there are no construction costs associated with the proposed project to convert four beds from hospice residential care to hospice inpatient care.

(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;

C

The Division of Medical Assistance (DMA) maintains a website which offers information regarding the number of persons eligible for Medicaid assistance and

estimates of the percentage of uninsured for each county in North Carolina. The following table illustrates those percentages as of June 2010 and CY 2009, respectively. The data in the table was obtained on August 9, 2012. More current data, particularly with regard to the estimated uninsured percentages, were not available.

	Total # of Medicaid Eligibles as % of Total Population	**Total # of Medicaid Eligibles Age 21 and older as % of Total Population**	**% Uninsured CY 2009***
Statewide	17%	6.8%	19.7%
Mecklenberg	15%	5.1%	20.1%

*Source: Cecil G. Sheps Center

The majority of Medicaid eligibles are children under the age of 21. This age group does not utilize the same health services at the same rate as older segments of the population, particularly the services offered by hospice inpatient and residential facilities.

The Office of State Budget & Management (OSBM) maintains a website which provides historical and projected population data for each county in North Carolina. In addition, data are available by age, race or gender. However, a direct comparison to the applicant's current payor mix would be of little value. The population data by age, race and gender do not include information on the number of elderly, minorities or women utilizing health services. Furthermore, OSBM's website does not include information on the number of handicapped persons.

Annual data provided by the Carolinas Center for Hospice and End of Life Care reports that hospice patients in North Carolina had the following payor mix during FFY 2011.

NC Hospice Patients by Payor Mix

Payor	**% Patient Days**	**% Patients**
Hospice Medicare	91.6%	86.3%
Hospice Private Insurance	3.4%	5.9%
Hospice Medicaid	3.4%	4.9%
Self Pay / Other	1.6%	2.8%
Total	100.0%	100.0%

The following table shows North Carolina and national hospice patients by race and ethnicity.

Hospice Patients by Race and Ethnicity

	% of Hospice Patients NC Data (2011)	% of Hospice Patients National Data (2010)
Race:		
White/ Caucasian	80.1%	77.3%
Black/ African American	13.6%	8.9%
Asian, Hawaiian, Other Pacific Islander	2.7%	2.5%
American Indian or Alaskan Native	1.0%	0.3%
Other Race	2.5%	11.0%
	100.0%	**100.0%**
Ethnicity		
Hispanic or Latino Origin	1.0%	5.7%
Non-Hispanic or Latino Origin	99.0%	94.3%
	100.0%	**100.0%**

Source: Carolinas Center for Hospice and End of Life Care

The following table shows North Carolina and national hospice patients by age groups for FFY09, which indicates more than 80% are age 65+ and will be Medicare eligible.

Hospice Patients by Age Categories

Age Category	% of Hospice Patients NC Data (2011)	% of Hospice Patients National Data (2010)
0-34	0.8%	1.3%
35-64	16.5%	16.1%
65-74	18.2%	15.9%
75+	64.5%	66.8%
	100.0%	**100.0%**

Source: Carolinas Center for Hospice and End of Life Care

In Section VI.1, page 82, the applicant provides the current payor mix for hospice inpatients and hospice inpatient days of care for FFY2012, as shown in the table below.

Payor	Hospice Patients	Hospice Inpatient Days of Care	Hospice Residents	Hospice Residential Days of Care*
Medicare	83.7%	89.4%	100.0%	100.0%
Medicaid	6.4%	5.4%		
Commercial	8.3%	4.4%		
Private Pay	1.6%	0.8%		
Total	100.0%	100.0%	100.0%	100.0%

*Medicare residential care per diem rate for FFY 2012 is $148.45 for in-home care.

In Section VI.5, page 84, the applicant states:

> *"HPCCR participates in the Medicare and Medicaid program and other wise provides care to the elderly. HPCCR will continue to make available services to low-income persons needing care. HPCCR's Admission Criteria Policy guarantees equal access to hospice services for members of all racial, ethnic and religious minority groups. HPCCR does not discriminate on the basis of gender as stated in the Admission Criteria Policy. LDHH conforms to the North*

Carolina State Building Code, the National Fire Protection Association ... and any of the requirements of federal, state and local bodies. HPCCR is and will continue to be accessible to all persons, including the medically indigent and terminally ill children."

Exhibit I contains a copy of the Admission Criteria Policy. Exhibit V contains a copy of the Special Financial Consideration Policy.

The applicant adequately demonstrates that medically underserved populations currently have adequate access to hospice services provided by HPCCR. Therefore, the application is conforming with 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;

C

In Section VI.9, page 86, the applicant states that there have been no such complaints filed against HPCCR or LDHH. Therefore, the application is conforming with 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

C

In Section VI.4, page 84, the applicant provides the projected payor mix for inpatient and residential care services for the second year of operation, as shown in the table below.

Payor	Hospice Inpatients	Hospice Inpatient Days of Care	Hospice Residential	Hospice Residential Days of Care*
Medicare	83.7%	89.4%	100%	100%
Medicaid	6.4%	5.4%		
Commercial	8.3%	4.4%		
Private Pay	1.6%	0.8%		
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

*Medicare residential care per diem rate for FFY 2012 is $148.45 for in-home care.

The projected payor mix is consistent with the statewide hospice payor mix provided in the FY2010 annual report from The Carolinas Center for Hospice and End of Life Care. The applicant adequately demonstrates that medically underserved groups will be adequately served by the proposed hospice facility. Therefore, the application is conforming with this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Section VI.9, page 86, the applicant state:

"Access to all hospice services requires a physician referral and certificate of eligibility. A current HPCCR patient's plan of care may include admission to the LDHH. The interdisciplinary team, including physician and medical director, makes the decisions regarding the care plan. A person seeking admission to the LDHH has to be referred by their attending physician and fulfill admission criteria for the inpatient hospice facility.

HPCCR staff provides ongoing public information about the LDHH including admission requirements. Admissions to the inpatient hospice facility are transfers from home, hospitals, nursing homes and other hospices."

Exhibit I contains a copy of the Admission Criteria Policy. The applicant adequately demonstrates the range of means by which a person will have access to the proposed hospice facility. Therefore, the application is conforming with this criterion.

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

C

In Section V.1(c), page 76, the applicant states:

"HPCCR and LDHH offers [sic] *an opportunity to educate health science students, especially medical students, medical residents, and nursing students, in palliative care, pain and symptom management, as well as the basic concepts of a hospice program. LDHH offers unique learning opportunities to counselors in training, as well as students in pastoral care and social work services."*

Exhibit S contains copies of training program affiliation agreements between HPCCR and Central Piedmont Community College, UNC-Charlotte, Western Carolina University, Winston-Salem State University and Queens University of Charlotte. The applicant adequately demonstrates that the facility will accommodate the clinical needs of health professional training programs in the area. Therefore, the application is conforming with this criterion.

(15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.

(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.

(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 a service on which competition will not have a favorable impact.

C

There are currently thirteen hospice providers in Mecklenburg County. Two providers operate inpatient units/facilities with a third unit approved. HPCCR received a CON to develop ten hospice inpatient beds in south Charlotte on November 15, 2011 (Project ID #F-008677-11). It is projected to be completed on November 30, 2012. See Sections II, III, V, VI and VII. In particular see Section V, page 80, in which LDHH discusses the impact of the proposed project on competition in the service area as it relates to promoting cost-effectiveness, quality and access. The information provided by the applicant in those sections is reasonable and credible and adequately demonstrates that the expected effects of the proposal on competition include a positive impact on cost-effectiveness, quality and access to dialysis services in Mecklenburg County. This determination is based on the information in the application, and the following::

- The applicant adequately demonstrates the need to convert four residential hospice beds to four hospice inpatient beds in Huntersville and that it is a cost-effective alternative.
- The applicant has and will continue to provide quality services: and
- The applicant has and will continue to provide adequate access to medically underserved populations.

Therefore, the application is conforming with this criterion.

(19) Repealed effective July 1, 1987.

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

C

HPCCR currently owns and operates a 16-bed hospice facility, the Levine & Dickson House, located in Huntersville in Mecklenberg County. In Section II.1, page 18, the applicant states that Levine & Dickson House is a licensed North Carolina hospice agency that operates a hospice facility and *"meets licensing standards in 10A NCAC 13K Hospice Licensing Rules and the Conditions of Participation for Medicare and Medicaid Title 42 CFR 418 Hospice*

Care and Social Security Act 1861, through Medicare surveys and accreditation with ACHC." According to the Acute and Home Care Licensure and Certification Section, DHSR, no incidents occurred within the eighteen months immediately preceding the date of this decision for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming wuth this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

C

The application is conforming to all applicable Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Care Facilities 10A NCAC 14C .4000. The specific criteria are discussed below.

10A NCAC 14C .4002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall complete the application form for Hospice Inpatient and Hospice Residential Care Services.

-C- The applicant used the correct application form;

(b) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall provide the following information:

(1) the projected annual number of hospice patients, admissions, deaths, and other discharges, <u>for each level of care</u> (i.e., respite care, hospice residential care and hospice inpatient care), to be served in the facility in each of the first three years following completion of the project and the methodology and assumptions used to make the projections;

-C- In Section II.2, page 20, and Section IV.3, page 71, the applicant provides the projected number of hospice inpatient, residential and respite admissions, deaths, and other discharges to be served in LDHH in each of the first three years following completion of the project, as shown in the table below. The methodology and assumptions used to develop the projections are provided in Section III, pages 64-72,

LDHH Projections by Level of Care

Level of Care	FY2013	FY2014	FY2015

Inpatient			
Patients	609	636	636
Admissions	609	636	636
Deaths	567	591	591
Discharges	43	45	45
Residential			
Patients	38	38	38
Admissions	38	38	38
Deaths	8	8	8
Discharges	30	30	30
Respite			
Patients	51	51	51
Admissions	51	51	51
Deaths	0	0	0
Discharges	51	51	51

(2) the projected annual number of hospice patients, admissions, deaths, and other discharges for each level of care to be served by the applicant's licensed hospice agency in each of the first three years following completion of the project and the methodology and assumptions used to make the projections;

-C- On page 21 the applicant projects the annual number of hospice patients, admissions, deaths, and other discharges for total hospice agency operations in each of the first three years following completion of the project. The methodology and assumptions used to develop the projections are provided in Criterion (3), based on the information on pages 66-74.

HPCCR Total Hospice Operations

Level of Care	Year 1 FY2013	Year 2 FY2014	Year 3 FY2015

Home Care			
Patients	2,210	2,232	2,254
Admissions	2,210	2,232	2,254
Deaths	1,989	2,009	2,029
Discharges	221	223	225
Inpatient			
Patients	1,022	1,120	1,120
Admissions	1,022	1,120	1,120
Deaths	951	1,041	1,041
Discharges	72	79	79
Residential			
Patients	38	38	38
Admissions	38	38	38
Deaths	8	8	8
Discharges	30	30	30
Respite			
Patients	63	63	63
Admissions	63	63	63
Deaths	0	0	0
Discharges	63	63	63

(3) the projected annual number of patient care days, for each level of care (i.e., respite care, hospice residential care and hospice inpatient care), to be provided in each of the first three years of operation following completion of the project and the methodology and assumptions used to make the projections;

-C- On pages 66-70 the applicant shows projected annual number of patient care days for the inpatient, residential and respite levels of care to be provided in each of the first three years of operation, as shown in the table below. The methodology and assumptions used to develop the projections are provided on pages 66-70.

LDHH Projected Patient Care Days

Care Level	Year 1 FY2013	Year 2 FY2014	Year 3 FY2015
Inpatient	4,618	4,768	4,768
Residential	791	791	791
Respite	240	240	240

(4) the projected average length of stay (ALOS) based on admissions to the applicant's facility, for each level of care, (i.e., respite care, hospice residential care and hospice inpatient care) and the methodology and assumptions used to make the projections;

-C- In Section II.2, page 22 and Section IV, pages 66-70, the applicant provides the projected average length of stay (ALOS) for the inpatient, residential care and respite levels of care, as shown in the table below:

LDHH Average Length of Stay

Care Level	Year 1 FY2013	Year 2 FY2014	Year 3 FY2015
Inpatient	7.58	7.50	7.50
Residential	20.7	20.7	20.7
Respite	4.7	4.7	4.7

The methodology and assumptions used to develop the projections are provided in Section IV, pages 66-70.

(5) the projected readmission rate, for each level of care, (i.e., respite care, hospice residential care and hospice inpatient care) and the methodology and assumptions used to make the projections;

-C- In Section II.2, page 23, the applicant states it anticipates no readmissions.

(6) the projected average annual cost per patient care day, by level of care (i.e., respite care, hospice residential care and hospice inpatient care) for each of the first three operating years following completion of the project and the methodology and assumptions used to project the average annual cost;

-C- In Section II.2, page 23, and in Form C, applicant provides the projected average annual cost per patient care day for the inpatient, residential care and respite levels of care for each of the first three operating years following completion of the project, as shown below. The methodology and assumptions are provided in Form C.

Care Level	Year 1 FY2012	Year 2 FY2013	Year 3 FY2014
Inpatient	$654.13	$653.01	$667.19
Residential	$503.65	$503.39	$513.82
Respite	$654.13	$653.01	$667.19

(7) documentation of attempts made to establish working relationships with sources of referrals to the hospice facility including copies of proposed agreements for the provision of inpatient care and residential care;

-C- In Section II, page 23, the applicant states:

"HPCCR has established working relationships with many sources of referrals because it is the operator of an existing inpatient hospice facility in Mecklenberg County, LDDH, and because it is the largest hospice provider of hospice services in Mecklenberg County, over 80% of total hospice days are provided by HPCCR. Please refer to Exhibit H for letters of support."

(8) documentation of the projected number of referrals to be made by each referral source;

-C- In Section II, page 24, the applicant states:

"HPCCR has working relationships with all of the referral physicians identified in Exhibit H, as well as with local hospitals and nursing homes. HPCCR's referral network is anticipated to refer over 500 patients per year to the LDHH, as the benefits of hospice care become more prevalent in Mecklenberg County, these physicians and HPCCR executives believe that inpatient hospice care will increase in utilization."

(9) *copies of the proposed contractual agreements, if the applicant is not a licensed hospice, with a licensed hospice or a licensed home care agency with a hospice designation on its license, for the provision of hospice services;*

-NA- HPCCR is a licensed hospice.

(10) *documentation of the projected number of patients to be referred for each payor type from the referring hospices, if the applicant is not a licensed hospice or if the applicant proposes to admit patients on a contractual basis; and*

-NA- HPCCR is a licensed hospice.

(11) *a copy of the admission policies, including the criteria that shall be used to select persons for admission to the hospice inpatient and residential care beds.*

-C- Exhibit I contains a copy of the Admissions Criteria Policy.

10A NCAC 14C .4003 PERFORMANCE STANDARDS

(a) *An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall demonstrate that:*

(1) *the average occupancy rate of the licensed hospice beds, for each level of care, in the facility is projected to be at least 50 percent for the last six months of the first operating year following completion of the project;*

-C- In Section II, page 25, the applicant states:

"HPCCR proposes to provide 2,315 inpatient hospice days of care during the last six months of the first operating year, which results in an average occupancy of 79.1% [(2,315 days of care / (16 beds X 183 days)].

HPCCR proposes to provide 2,832 hospice days of care (inpatient, respite, and residential care) during the last six months of the first operating year, which results in an average occupancy rate of 96.7 percent [(2,832 days of care / (16 beds X 183 days)]."

(2) *the average occupancy rate for the licensed hospice beds, for each level of care, in the facility is projected to be at least 65 percent for the second operating year following completion of the project; and*

`

-C- In Section II, page 25, the applicant states:

"HPCCR proposes to provide 4,768 inpatient hospice days of care during the second operating year, which results in an occupancy rate of 81.6 percent [(4,768 days of care / (16 beds X 365 days)}.

HPCCR proposes to provide 5,799 hospice day of care (inpatient, respite, and residential care) during the second operating year, which results in an occupancy rate of 99.3 percent [(5,799 days of care / (16 beds X 365 days)]."

(3) if the application is submitted to address the need for hospice residential care beds, each existing hospice residential care facility which is located in the hospice service area operated at an occupancy rate of at least 65 percent for the 12 month period reported on that facility's most recent Licensure Renewal Application Form.

-NA- The applicant does not propose to add hospice residential care beds.

(b) An applicant proposing to add hospice inpatient facility beds to an existing hospice inpatient facility shall document that the average occupancy of the licensed hospice inpatient facility beds in its existing facility was at least 65 percent for the nine months immediately preceding the submittal of the proposal.

-C- The applicant states *"LDHH provided 3,050 inpatient hospice days of care during the last nine months, which results in an average occupancy rate of 94.7 percent [(3,050 days of care / (11 beds X 274 days)].* The Project Analyst calculated the occupancy rate to be 92.8% [(3,050 days of care / 274) / 12 = 92.8%].

(c) An applicant proposing to add residential care beds to an existing hospice residential care facility shall document that the average occupancy of the licensed hospice residential care beds in its existing facility was at least 65 percent for the nine months immediately preceding the submittal of the proposal.

-NA- The applicant does not propose to add residential care beds to an existing facility.

10A NCAC 14C .4004 SUPPORT SERVICES

(a) An applicant proposing to develop a hospice inpatient facility beds or hospice residential care facility beds shall demonstrate that the following services will be provided directly by the applicant or by a contracted hospice to the patient and the patient's family or significant others:

(1) nursing services;
(2) social work services;

(3) counseling services including dietary, spiritual, and family counseling;
(4) bereavement counseling services;
(5) volunteer services;
(6) physician services; and
(7) medical supplies.

-C- Exhibit J contains a letter from the President and CEO of HPCCR documenting that the hospice services required by this rule will be provided.

(b) An applicant shall demonstrate that the nursing services listed in Paragraph (a) of this Rule will be available 24 hours a day, seven days a week.

-C- In Section VII.4, page 93, the applicant shows that at least 3.0 RNs and 2.0 CNAs will work each shift during the 24 hour period. In Section II.2, page 27, the applicant states that nursing services will be available 24 hours a day, seven days a week for the provision of direct patient care.

(c) An applicant proposing to develop a hospice inpatient facility or a hospice residential care facility shall provide documentation that pharmaceutical services will be provided directly by the facility or by contract.

-C- In Section II.2, page 27, the applicant states that Hospice Pharmacia will supply medications to LDHH patients and the inpatient hospice staff will administer medications per physicians' orders. Exhibit K contains a copy of the agreement between HPCCR and Hospice Pharmacia.

(d) For each of the services listed in Paragraphs (a) and (c) of this Rule which are proposed to be provided by contract, the applicant shall provide a copy of a letter from the proposed provider which expresses its interest in working with the proposed facility.

-C- In Section II.2, page 27, the applicant states that all services listed above are provided through HPCCR (Exhibit J) and Hospice Pharmacia (Exhibit K).

10A NCAC 14C .4005 STAFFING AND STAFF TRAINING

(a) An applicant proposing to develop a hospice inpatient facility beds or hospice residential care facility beds shall document that staffing will be provided in a manner consistent with G.S. 131E, Article 10.

-C- In Section II.2, page 28, the applicant states that the staffing will comply with the requirements of 131E, Article 10. In Section VII, the applicant provides staffing information.

(b) The applicant shall demonstrate that:

(1) the staffing pattern will be consistent with licensure requirements as specified in 10A NCAC 13K, Hospice Licensing Rules;

-C- In Section II.2, page 29, the applicant states:

"As identified in the 10A NCAC 13K staffing requirements and in the Section VII Staffing Table, LDHH will:

- *Staff a registered nurse 24 hours per day who will supervise all nursing services,*
- *Assure a minimum of two staff members will be on duty at all times,*
- *Assure all staff will be trained to meet the needs of the terminally ill and their families as discussed in the respective job descriptions,*
- *Assure all nurse aides will be supervised by a registered nurse, and*
- *Assure interdisciplinary teams will be available as required by the patient's plan of care."*

In addition, the proposed staffing shown in Table VII.2, pages 91-92, reflects that the above services will be provided.

(2) training for all staff will meet the requirements as specified in 10A NCAC 13K .0400, Hospice Licensing Rules.

-C- In Section II.2, page 30, applicant states:

"All LDHH staff will receive orientation, in-service training, and competency testing as provided through HPCCR job descriptions and policies and procedures. Policies and procedures are developed to meet the requirements of 10A NCAC 13K Rules."

In addition, Exhibit L contains copies of the policies related to the Orientation Process, Competency/Licensure and Supervision Policies. Exhibit M contains copies of job descriptions.

10A NCAC 14C .4006 FACILITY

An applicant proposing to develop new hospice inpatient facility beds or new hospice residential care facility beds shall document:

(1) that a home-like setting shall be provided in the facility;

-C- In Section II, page 31, the applicant states that LDHH is an existing facility and the facility was designed as a home-like setting.

(2) that the services will be provided in conformity with applicable state and local laws and regulations pertaining to zoning, physical environment, water supply, waste disposal and other relevant health and safety requirements; and

-C- In Section II, page 31, the applicant states that LDHH's existing services are provided in conformity with applicable state and local laws and regulations pertaining to zoning, physical environment, water supply, waste disposal and other relevant health and safety requirements.

(3) for new facilities, the location of the site on which the services are to be operated. If the site is neither owned by nor under option to the applicant, the applicant must provide a written commitment to pursue acquiring the site if and when the approval is granted, must specify a secondary site on which the services could be operated if acquisition efforts relative to the primary site ultimately fail, and must demonstrate that the primary and secondary sites are available for acquisition.

-NA- HPCCR is not proposing a new facility in this application.