ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: June 28, 2013

PROJECT ANALYST: Tanya S. Rupp
TEAM LEADER: Lisa Pittman

PROJECT I.D. NUMBER: B-10090-13 / CarePartners Foundation and Community CarePartners, Inc. d/b/a CarePartners Health Services and d/b/a CarePartners Hospice / Convert five hospice residential beds to five hospice inpatient beds for a facility total of 25 hospice inpatient beds and 2 hospice residential beds / Buncombe 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

CarePartners Foundation and Community CarePartners, Inc. d/b/a CarePartners Health Services and d/b/a CarePartners Hospice (**CarePartners Hospice**) operate a 27-bed hospice facility with 20 inpatient hospice beds and 7 residential hospice beds at the John F. Keever, Jr. Solace Center, located in Asheville, in Buncombe County. In July 2012, the applicant submitted a petition to the NC State Medical Facilities Planning Section for an adjusted need determination for additional hospice inpatient beds in Buncombe County. That petition was approved, and the 2013 State Medical Facilities Plan (2013 SMFP) identifies an adjusted need determination for five hospice inpatient beds in Buncombe County. In this application, the applicant proposes to convert five hospice residential beds to five hospice inpatient beds, for a total of 25 hospice inpatient beds and two hospice residential beds upon completion of the project. The applicant proposes to convert no more than five hospice residential beds to hospice inpatient beds. Thus, the application is conforming to the adjusted need determination in the 2013 SMFP.

Additionally, Policy GEN-3 on pages 42 – 43 of the 2013 SMFP is applicable to this review. Policy GEN-3: Basic Principles states:

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

Safety and Quality

In Section III.3, page 42 – 43, the applicant states:

> *"CarePartners Hospice is committed to the safety of its patients, staff and visitors, and to delivery of high-quality hospice services. … CarePartners Hospice maintains state licensure, Medicare and Medicaid certification, and national accreditation as follows:*
>
> *… CarePartners Hospice is licensed by the State of North Carolina, Department of Health and Human Services, Division of Health Service Regulation to operate a hospice with 20 inpatient and 7 residential beds. …*
>
> *… CarePartners Hospice is certified under both Medicare and Medicaid to provide services to beneficiaries. Reference Exhibits 7 and 8 for copies of the Medicare and Medicaid participation documentation.*
>
> *… CarePartners Hospice is accredited by the Accreditation Commission for Health Care, Inc. (ACHC).*
>
> *…*
>
> *Quality of care will be further improved when CarePartners Hospice converts 5 residential beds to become inpatient beds. All staff will have a larger core population of patients to work with, thereby increasing the staff's experience level. … quality of care will be increased since patients will have access to more appropriate care at the end of life.*
>
> *… CarePartners also maintains a Performance Improvement Program which includes numerous tools for tracking, reporting, communication and analysis*

> *of opportunities for improvement. All staff are expected to participate in performance improvement. Senior Leadership regularly review operational, financial, and quality metrics, including a Balanced Score Card, to analyze and ensure efficient, high quality patient services. Quality metrics include bench-marking against industry norms for outcomes and patient satisfaction. All clinical staff are licensed and/or certified in their areas. Hospice staff includes board-certified physicians in hospice and palliative care…."*

The applicant adequately demonstrates how the proposal will promote safety and quality in the delivery of hospice services in Buncombe County.

Promote Equitable Access

In Section III.3, page 43, the applicant describes how the proposal will promote equitable access to hospice services in Buncombe County. Specifically, the applicant states it will provide hospice services:

> *"… for all residents in the service area, including those with limited financial resources. Access will increase since 5 more inpatient hospice beds will become available. CarePartners Hospice provides hospice services to everyone who needs services, regardless of race, religion, handicap, sexual orientation, age, gender, national origin, existence or lack of existence of advanced care directives and/or ability to pay. CarePartners is also committed to providing residential care for those patients who need it."*

In addition, in Section VI.5, pages 68 – 70, the applicant details its commitment to providing hospice inpatient and residential care to all patients in need of hospice care, without regard to ability to pay, age, race, handicap, gender, sexual orientation, religion, or any other reason.

The applicant adequately demonstrates how the proposal will promote equitable access to the delivery of hospice services in Buncombe County.

Maximize Health Care Value

In Section III.3, page 43, the applicant describes how the proposed project will maximize healthcare value for hospice services in Buncombe County. The applicant states that converting existing hospice residential beds to hospice inpatient beds will save potential expenses, so that the costs to patients are minimized. On page 43 the applicant states:

> *"Conversion costs will be minimal, particularly compared with what it would cost to construct a new facility or to convert beds in another setting in which rooms were not constructed to house hospice beds. Any other provider would face considerable capital costs in order to provide 5 inpatient hospice beds. Additionally, any other provider would have considerable staffing expense to run a hospice unit with only 5 beds. Increasing the number of inpatient beds and reducing the number of underutilized residential beds while holding the current overhead costs constant will*

allow the fixed costs of operating the hospice to be spread over more beds, making the cost per licensed bed less than it is now.

Hospice care is shown to be more cost effective than care provided in other settings at the end of life. If a patient requires inpatient hospice care but no bed is available, that patient typically remains in the acute care hospital on is admitted to a nursing facility. Such settings are less effective in terms of end-of-life care and are generally more expensive than hospice care. In fact, according to a Duke University study published in 2007, Hospice care saved Medicare an average of $2,309 per patient compared with conventional care at the end of life. The Duke study concludes that the hospice model is that rare case where something that improves quality of life appears also to reduce costs."

The applicant adequately demonstrates the proposed project will maximize health care value for hospice services in Buncombe County.

Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities, on page 43 of the 2013 SMFP is not applicable to this review, because the capital cost associated with this project is below $2 Million.

In summary, the application is conforming to the adjusted need determination in the 2013 SMFP for five hospice inpatient beds in Buncombe County, and is conforming to Policy GEN-3. Therefore, the application is conforming to 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

CarePartners Hospice provides palliative care to persons with terminal or life-threatening illnesses in its John F. Keever, Jr. Solace Center in Asheville. CarePartners Hospice has been providing hospice care since 1980, and operates the only inpatient and residential hospice facility in Buncombe County. In 2007, CarePartners Hospice established the John F. Keever, Jr. Solace Center to provide residential and inpatient hospice services to those patients whose end of life needs could not be met in the home. Currently, the facility has 20 hospice inpatient beds and seven hospice residential beds. In this application, CarePartners Hospice proposes to convert five residential hospice beds to five inpatient hospice beds, for a total of 25 inpatient hospice beds and two residential hospice beds in the facility upon project completion.

<u>Population to be Served</u>

In Section III.12, pages 52 – 53, the applicant provides tables to illustrate the population it projects to serve in its hospice facility. See the following table, compiled by the project analyst from information provided by the applicant on pages 52 – 53:

YEAR 1 FY 2014						
COUNTY	INPATIENT		RESPITE		RESIDENTIAL	
	NO. OF PATIENTS	% OF TOTAL	NO. OF PATIENTS	% OF TOTAL	NO. OF PATIENTS	% OF TOTAL
Buncombe	608	80.6%	101	89.0%	32	86.5%
Madison	58	7.7%	7	6.6%	0	0.0%
Henderson	13	1.7%	2	2.2%	2	5.4%
Yancey	10	1.4%	0	0.0%	1	2.7%
Other*	66	8.6%	2	2.2%	2	5.4%
Total	755	100.0%	113	100.0%	37	100.0%
YEAR 2 FY 2015						
	INPATIENT		RESPITE		RESIDENTIAL	
	NO. OF PATIENTS	% OF TOTAL	NO. OF PATIENTS	% OF TOTAL	NO. OF PATIENTS	% OF TOTAL
Buncombe	654	80.6%	108	88.5%	34	87.2%
Madison	62	7.6%	8	6.5%	0	0.0%
Henderson	14	1.7%	3	2.4	2	5.1%
Yancey	11	1.4%	0	0.0	1	2.6%
Other*	71	8.7%	3	2.4	2	5.1%
Total	812	100.0%	122	100.0%	39	100.0%

*In the tables on pages 52 – 53, the applicant defines *other* as *"undefined, Avery, Ashe, Burke, Caldwell, Cherokee, Clay, Cleveland, Gaston, Graham, Haywood, Jackson, Macon, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Wake and out of state."*

In Section III.13, page 54, the applicant states the population to be served is based on the population historically served for the most recent 12 months prior to submission of this application, and modified for the expected opening of inpatient hospice facilities in Haywood and McDowell Counties. Furthermore, no change in patient origin is projected. The applicant adequately identified the population to be served in the hospice facility.

Demonstration of Need

In Section III.1(a), page 34, the applicant states the 2013 SMFP indicates a need in Buncombe County for five hospice inpatient beds, pursuant to petition for an adjusted need determination submitted by CarePartners Hospice. The applicant states:

> *"The application is developed in accordance with the 2013 State Medical Facilities Plan's projection of 5 new inpatient beds needed in Buncombe County by 2013, and CarePartners Hospice's special need petition filed and approved in 2012."*

In Section III.1(a), pages 34 - 41, the applicant provides the assumptions and methodology it uses to demonstrate the need for the conversion of five hospice residential beds to five hospice inpatient beds. On page 34, the applicant states:

"For the past two years, CarePartners Hospice has been operating its inpatient hospice beds at over 93% capacity, as demonstrated in the chart below. This is well over the target utilization rate of 85% as stated in the SMFP. Please note that from October 2010 - January 2011 there were 15 inpatient beds and 12 residential beds. In January 2011, 5 of the residential beds were converted to become 5 inpatient beds. Those beds were filled quickly, bringing the utilization rate from February - September 2011 to 93.4%. (If the bed complement had remained at 15 inpatient beds during that time, yet somehow all the days of care that were provided could have been provided, the utilization rate would have been 124.6%.)

The applicant provides a chart to illustrate the historical utilization described above. See the following table, from information provided on page 34:

INPATIENT BED UTILIZATION	OCT 2010 – JAN 2011 120 DAYS OF CARE	FEB – SEPT 2011 240 DAYS OF CARE	FY 2012 365 DAYS OF CARE
Inpatient	1,724	4,119	6,469
Respite	166	403	677
Inpatient Beds	15	20	20
Inpatient Bed Utilization (Occupancy)	104.2%	93.4%	97.7%

However, the information is misleading. Instead of adding inpatient and respite days of care to calculate the utilization, the performance standards promulgated in 10A NCAC 14C .4000, *Criteria and Standards* for *Hospice Inpatient Facilities and Hospice Residential Care Facilities* indicate that utilization is to be calculated for each level of care individually. Furthermore, inpatient days of care are provided at a different level of hospice care and at a different reimbursement rate than are other days of care (respite and residential). The applicant states in Section II.2, page 14 and in Section III.1, page 40 that it provides respite care in the inpatient beds; however, for utilization projections, only the inpatient days of care are counted. Therefore, the project analyst prepared a similar table, with the historical utilization calculated as follows:

INPATIENT BED UTILIZATION	OCT 2010 – JAN 2011 120 DAYS OF CARE	FEB – SEPT 2011 240 DAYS OF CARE	FY 2012 365 DAYS OF CARE
Inpatient	1,724	4,119	6,469
Inpatient Beds	15	20	20
Inpatient Bed Utilization (Occupancy)	95.78%	85.81%	88.6%

The occupancy was calculated by taking the inpatient days of care, divided by the total days of care in the reporting period, divided by the number of inpatient beds. Therefore, calculating only inpatient days of care for the periods listed in the table above still yields occupancy rates that are in excess of the standard set forth in the rules at 10A NCAC 14C .4000.

In addition, on pages 35 – 36, the applicant describes the low historical utilization of hospice residential care beds at its facility. The applicant states on page 35:

"There are currently 7 residential beds in the Solace Center. Before January 2011 there were 12 residential beds, and 5 of these were converted in January 2011 to become inpatient beds. … Two beds would be sufficient for current demand."

Residential Utilization	***FY 2012 Days***
Residential	*457*
Beds	*7*
% Utilization	*17.9%*

The applicant states that the population of those persons age 65 and older is projected to grow at a faster rate in Buncombe County than in North Carolina as a whole. Furthermore, the applicant states the older population groups are more likely to use hospice services than the younger age groups. On page 36, the applicant states:

"The majority of patients at CarePartners Hospice are age 65 or older. [I]*n FY 2012, 84.5% of hospice patients overall were patients with Medicare coverage, those age 65 and older. For inpatient, respite, and residential care the percentages of Medicare days of care were 83.4%, 93.2%, and 91.7% respectively.*

Buncombe County has a higher proportion of people age 65+ than the state average, therefore the needs of those 65+ will affect Buncombe County to a greater degree than the state overall. The projection for July 2013 is that 17.30% of Buncombe County's population will be age 65+, compared with 14.20% for the state overall. By 2016 the proportion for Buncombe County is projected to grow to 18.54%, compared with 15.25% for the state overall…."

On page 37, the applicant cites the National Hospice and Palliative Care Organization's report that, in 2011, 44.6% of deaths nationally were served by hospice. By comparison, the applicant states that the Carolinas Center for Hospice and End of Life Care reports that in Buncombe County in 2010, 44.0% of all deaths were served by hospice.

On page 38, the applicant states:

"From FY 10 – FY I2, the [national] *average daily census (ADC) has risen an average of 11% each year. However, since the Solace inpatient beds are being used to nearly maximum capacity, there is less room for growth in Solace. Solace ADC has grown only an average of 5.6% per year from FY 10 – FY I2."*

Furthermore, on pages 39 -40, the applicant describes how hospice inpatient treatment is a more economically viable option for patients requiring hospice services who may otherwise be cared for in an acute care hospital setting. The applicant states:

"Hospice care is shown to be more cost effective and of higher quality than care provided in other settings at the end of life. If a patient requires inpatient hospice care but no bed is available, that patient typically remains in the acute care hospital

or is admitted to a nursing facility. Such settings are less effective in terms of end-of-life care and are generally more expensive than hospice care. In fact, according to a Duke University study published in 2007, Hospice care saved Medicare an average of $2,309 per patient compared with conventional care at the end of life. The Duke study concludes that the hospice model is that rare case where something that improves quality of life appears also to reduce costs, New research from Mount Sinai's Icahn School of Medicine, published in the March 2013 issue of Health Affairs, found that hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries at all lengths of service tested."

In 2010, CarePartners Hospice applied and was approved for the conversion of five residential beds to become inpatient beds. Those beds, according to the applicant, have been consistently utilized. According to the information cited above and in the Hospice License Renewal Applications, the utilization rate of hospice inpatient beds at the CarePartners Hospice in Asheville has been well above 80% for the last 36 months. That utilization, combined with the population growth projections of people over the age of 65 for Buncombe County, shows a need for additional hospice inpatient beds.

Projected Utilization

In Section III.1, pages 40 – 41, the applicant states:

"CarePartners assumes a growth rate in inpatient/respite admissions of 10% the first year following the conversion of beds, 7.6% for year two, and 7.6% for year three. Year two and three are consistent with the State Medical Facilities Plan's projection. The larger increase in year one is because the Solace facility is currently operating at capacity - 97.9% utilization for inpatient beds (includes inpatient and respite levels of care) in fiscal year 2012. There is current demand for more inpatient beds, and CarePartners believes those beds will be filled at a faster rate in the first year to make up for unmet current demand. At these rates of growth, the inpatient beds at the Solace Center will be at near maximum capacity by the end of year three."

On page 40, the applicant provides a table to illustrate projected utilization. Once again, the applicant combines the projected inpatient days of care with the projected respite days of care, as shown in the following table:

YEAR	INPATIENT DAYS OF CARE	RESPITE DAYS OF CARE	NUMBER OF INPATIENT BEDS	% OCCUPANCY
Total Year 1 (FY 2014)	7,116	745	25	86.1%
Total Year 2 (FY 2015)	7,657	801	25	92.7%
Total Year 3 (FY 2016)	8,239	862	25	99.8%

The project analyst projected the inpatient utilization using the applicant's projections, but only for inpatient days of care and not inpatient and respite days of care combined, as explained above. See the following table:

YEAR	INPATIENT DAYS OF CARE	NUMBER OF INPATIENT BEDS	% OCCUPANCY
Total Year 1 (FY 2014)	7,116	25	77.98%
Total Year 2 (FY 2015)	7,657	25	83.91%
Total Year 3 (FY 2016)	8,239	25	90.29%

As stated above with regard to the analysis of historical utilization, projections of inpatient days of care for the periods listed in the table above still yields occupancy rates that are in excess of the standard set forth in the rules at 10A NCAC 14C .4000.

Access

In Section V.5, page 68, the applicant states that hospice services provided at the Solace Center will continue to be available to all patients who need hospice care.

In summary, the applicant adequately identifies the population to be served, adequately demonstrates the need to convert five of its existing hospice residential beds to five hospice inpatient beds in the John F. Keever, Jr. Solace Center, and adequately demonstrates the extent to which all residents, including the medically underserved, will have access to hospice services. Therefore, the application is conforming to this Criterion.

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

C

CarePartners Hospice operates a 27-bed hospice facility with 20 inpatient hospice beds and 7 residential hospice beds located in Asheville. The applicant proposes to convert five hospice residential beds to five hospice inpatient beds, for a total of 25 hospice inpatient beds and two hospice residential beds upon completion of the project. Therefore, the applicant proposes to reduce the number of hospice residential beds from 7 beds to 2 beds upon completion of the project. In Section III.1, page 35, the applicant states:

> *"There are currently 7 residential beds in the Solace Center. Before January 2011 there were 12 residential beds, and 5 of these were converted in January 2011 to become inpatient beds. Residential beds are utilized at a low rate …. Two beds would be sufficient for current demand."*

On page 36, the applicant provides a table that illustrates hospice residential utilization for FY 2012. According to the information provided by the applicant, in FY 2012 CarePartners Hospice provided 457 days of hospice residential care in seven beds, which is a utilization rate of 17.9% [(457 days of care / 365 days) / 7 beds = 0.1789]. The applicant states:

> *"Although residential beds are currently underutilized, even if residential volume remained totally flat, there would still be a need for 2 residential beds. If there were only one bed, that bed would be utilized at 125%, which is not possible. Given that it is also not possible to have a partial bed, and that the inpatient beds are typically too full to easily swing down to residential at any given time, 2 residential beds are needed to be sure that a residential patient is not turned away in their time of need. Retention of 2 residential beds is necessary in order to right-size the facility based on trends in inpatient, respite, and residential volumes, and to stay true to CarePartners' mission of helping people live fully through life's journey.*
>
> ...
>
> *Since the demand for hospice residential beds is much lower than the demand for hospice inpatient beds in Buncombe County, redistributing 5 beds would be a better utilization of those beds."*

In addition, in Section III.6(a), on page 47, the applicant states:

> *"… the Solace Center has experienced low utilization of its 7 residential beds. For the past 9 months, utilization is at 19.4%, for which only 1.4 beds would be needed. In the previous two fiscal years, utilization has been less than 18%, as shown in the chart below. If 5 of the 7 residential beds were converted to inpatient beds, the remaining beds would still be sufficient to meet the need for residential beds. It should be noted that some patients who were under the residential level of care were waiting to be put under the inpatient level of care when inpatient beds were full, and were actually receiving inpatient services even though they were listed and billed as residential patients."*

Furthermore, the applicant states that Buncombe County has a high number of skilled nursing beds available to patients. The applicant states that skilled nursing and adult care beds can provide the same level of care as would be offered to its hospice residential patients, so that if the two remaining hospice residential beds at the Solace Center are filled and a need for another hospice residential bed does arise, then that patient could be adequately served in one of the county's skilled nursing or adult care home beds.

Additionally, in Section III.7, page 47, the applicant states:

> *"The conversion of 5 of 7 residential beds to become inpatient beds will have a positive impact on the population presently served. Having increased*

availability of inpatient beds will be a better utilization of beds to meet the needs of current and future patients, since utilization of the existing 20 inpatient beds is typically above 93% while residential beds are only used less than 1/5 of the time."

Therefore, although the applicant proposes a reduction in the number of hospice residential beds in Buncombe County, the data shows utilization of hospice residential care beds continues to decline. In addition, the applicant documents that hospice residential patients can and will be served in the facility's existing residential beds or in the county's existing skilled nursing or adult care home beds if necessary.

In summary, the applicant adequately demonstrates that the needs of the residential hospice care population will continue to be adequately met by the John F. Keever, Jr. Solace Center and area nursing homes. Therefore, the proposed reduction in the number of hospice residential care beds at the Solace Center will not adversely affect access to hospice residential services by medically underserved groups in Buncombe County. The application is conforming to this criterion.

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

CA

CarePartners Foundation and Community CarePartners, Inc. d/b/a CarePartners Health Services and d/b/a CarePartners Hospice is currently licensed for 20 hospice inpatient beds and seven hospice residential beds. The applicant proposes to convert five of its seven hospice residential beds to five hospice inpatient beds, for a total of 25 hospice inpatient beds and two hospice residential beds upon completion of the project. The applicant states in Section III.14, pages 54 - 55, that it considered four alternatives in addition to the one represented in this application, which included: 1) Maintaining the status quo; 2) Adding additional beds to the existing facility; 3) Locating available beds in a nursing facility for its hospice inpatients; and 4) Locating hospice inpatient beds in a local hospital. The applicant adequately explains why it chose to convert five its seven hospice residential beds, rather than one of the other alternatives. Furthermore, the application is conforming to all other applicable statutory review criteria. Therefore, the applicant adequately demonstrates that the selected proposal represented in its application is its least costly or most effective alternative to meet the identified need for hospice inpatient beds in Buncombe County. Consequently, the application is conforming to this criterion and is approved subject to the following conditions:

1. **CarePartners Foundation and Community CarePartners, Inc. d/b/a CarePartners Health Services and d/b/a CarePartners Hospice shall materially comply with all representations made in its certificate of need application.**

2. **CarePartners Foundation and Community CarePartners, Inc. d/b/a CarePartners Health Services and d/b/a CarePartners Hospice shall convert five**

hospice residential beds to five hospice inpatient beds and shall be licensed for a total of 25 hospice inpatient beds and two hospice residential beds upon completion of this project.

3. **CarePartners Foundation and Community CarePartners, Inc. d/b/a CarePartners Health Services and d/b/a CarePartners Hospice shall acknowledge acceptance of 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.

C

In Section VIII.1, page 85, the applicant projects that the total capital cost of the project will be $14,050; including $4,050 for consultant fees (Certificate of Need application) and $10,000 for contingency fees. In Section VIII.5, page 86; the applicant states the entire capital cost will be funded with the accumulated reserves of CarePartners Hospice. In Exhibit 42 the applicant provides a March 1, 2013 letter signed by the Assistant Treasurer of CarePartners Foundation that states:

> "*This letter is to certify that as of January 31, 2013, CarePartners Foundation has a total of $605,199 in cash and cash equivalents.*"

In Exhibit 43, the applicant provides the audited financial statements of CarePartners Foundation for fiscal years ending September 30, 2010 and September 30, 2009. Those statements show that, as of September 30, 2010, CarePartners Foundation had $1,659,000 in total current assets, and $1,289,000 in cash and cash equivalents. Those statements also show that the applicant had total net assets (total assets less total liabilities) in the amount of $57,672,000.

In the pro forma statements, Form B, on pages 111 - 113; and Form C, on pages 115 - 117, the applicant projects that revenue will exceed expenses in all three operating years, as shown in the table below, prepared by the project analyst.

	PY 1 (FY 2014)	**PY2 (FY 2015)**	**PY 3 (FY 2016)**
Revenue	$5,874,334	$6,278,514	$6,711,233
Expenses	$5,867,677	$6,204,811	$6,565,229
Profit (loss)	$ 6,658	$ 73,703	$ 146,003

In Section X.3, page 95, the applicant projects the following reimbursement rates and charges for the first three years of operation of the proposed hospice facility.

SOURCE OF PAYMENT BY TYPE OF CARE	10/01/2013 – 09/30/2014	10/01/2014 – 09/30/2015	10/01/2015 – 09/30/2016
Hospice Inpatient			
Private Pay	$754.00	$754.00	$754.00
Commercial Insurance	$754.00	$754.00	$754.00
Medicare / Reimbursement	$754.00 / $678.22	$754.00 / $678.22	$754.00 / $678.22
Medicaid / Reimbursement	$754.00 / $678.22	$754.00 / $678.22	$754.00 / $678.22
Other (Indigent and Contract)	$754.00	$754.00	$754.00
Hospice Respite Care			
Private Pay	$190.00	$190.00	$190.00
Commercial Insurance	$190.00	$190.00	$190.00
Medicare / Reimbursement	$190.00 / $159.09	$190.00 / $159.09	$190.00 / $159.09
Medicaid / Reimbursement	$190.00 / $159.09	$190.00 / $159.09	$190.00 / $159.09
Other (Indigent and Contract)	$190.00	$190.00	$190.00
Hospice Residential Care	Room & Board	Room & Board	Room & Board
Private Pay	$190.00	$190.00	$190.00
Commercial Insurance	$190.00	$190.00	$190.00
Other (Indigent and Contract)	$190.00	$190.00	$190.00
Hospice Home Care Rate	$190.00	$190.00	$190.00
Medicare Homecare Rate / Reimbursement	$190.00 / $151.83	$190.00 / $151.83	$190.00 / $151.83
Medicaid Homecare Rate / Reimbursement	$190.00 / $151.83	$190.00 / $151.83	$190.00 / $151.83

In Section X.4, page 95, the applicant states there are no planned rate increases through 2015. Furthermore, the applicant states it calculated Medicare and Medicaid reimbursement rates using a 5% increase for year one, and no increase in years two and three.

In summary, the applicant adequately demonstrates the availability of sufficient funds for the proposed conversion of five hospice residential beds to five hospice inpatient beds. Additionally, the applicant adequately demonstrates the financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing hospice inpatient, residential and respite care services. Therefore, the application is conforming to this criterion.

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

C

CarePartners Foundation currently operates the John F. Keever, Jr. Solace Center, a 27-bed hospice inpatient and residential care facility with 20 hospice inpatient beds and seven hospice residential care beds. In this application CarePartners Hospice proposes to convert five of the seven hospice residential care beds to five hospice inpatient hospice beds, for a total bed complement of 25 hospice inpatient care beds and two hospice residential care beds upon project completion. The applicant applied for and was granted an adjusted need determination in the 2013 SMFP for the five hospice inpatient beds. The application is conforming to the five-bed adjusted need determination in the 2013 State Medical Facilities Plan. The applicant adequately demonstrates the need for the five additional hospice inpatient beds.

In Section III.1, page 34, the applicant provides a chart to illustrate utilization of the CarePartners Hospice facility for FY 2012. During that time, the facility had 6,469 inpatient patient days, which is an 88.6% occupancy rate [(6,469 inpatient care days / 365 days per year) / 20 inpatient beds = 0.8862]. The applicant reasonably projects that its inpatient occupancy will be 84.0%, which will exceed the 65% occupancy required by the performance standards in 10A NCAC 14C .4003(a)(2). In fact, the applicant adequately demonstrates that its current occupancy exceeds the 65% occupancy rate that an applicant is required to project by the second operating year of a project, since its most recent occupancy was 88.6%. Furthermore, on page 35, the applicant shows the occupancy for the past nine months was 87.9% [(4,749 inpatient days of care / 270 days) / 20 beds = 0.8794]. Moreover, of the six counties that are roughly contiguous to Buncombe (Henderson, Haywood, Madison, McDowell, Rutherford and Yancey); only three currently have hospice inpatient facilities (Haywood, Henderson, and Rutherford). Additionally, Rutherford County joins Buncombe County only on Rutherford's southeastern tip, and Hospice of Rutherford County is nearly 65 miles distant from Asheville. Therefore, the applicant adequately demonstrates that the proposed project will not result in the unnecessary duplication of existing or approved hospice services in Buncombe County, and the application is conforming to this criterion.

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

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In Section VII, Table VII.2, on pages 79 - 80, the applicant provides proposed staffing for the facility in the second year following completion of the project. See the following table:

POSITION	INPATIENT FTEs	RESPITE FTEs	RESIDENTIAL FTEs	TOTAL FACILITY FTEs
Routine Services				
Medical Director	0.16	0.01	0.00	0.17
RNs	16.35	0.52	0.32	17.18
LPNs	3.80	0.12	0.07	3.99
CNAs	18.25	0.58	0.36	19.18
Pharmacist	0.27	0.01	0.01	0.29
Pharmacy Tech	0.28	0.01	0.00	0.29
Physicians	1.41	0.04	0.03	1.47
Family Nurse Practitioner	0.35	0.30	0.01	0.39
Office Professional	1.26	0.04	0.03	1.32
Director of Solace – RN	0.95	0.03	0.02	1.00

Medical Records	0.09	0.01	0.00	0.10
Clinical Specialists	1.75	0.06	0.047	1.85
Intake Coordinator	1.04	0.03	0.029	1.10
Dietary Services				
Dietician	0.27	0.03	0.01	0.31
Cooks	0.96	0.10	0.07	1.13
Nutrition Services	0.96	0.10	0.07	1.13
Social Work Services				
Social Workers	2.84	0.07	0.05	2.95
Chaplain	1.54	0.04	0.02	1.60
Ancillary Services				
Physical Therapist	0.04	0.01	0.01	0.06
Speech Therapist	0.01	0.00	0.00	0.01
Occupational Therapist	0.10	0.00	0.00	0.10
Other				
Housekeeping	1.43	0.05	0.02	1.50
Maintenance	0.96	0.02	0.01	1.00
Director of Hospice	0.17	0.01	0.00	0.18
Hospital Liaisons	0.94	0.03	0.03	1.00
Volunteer Services Coordinator	0.47	0.01	0.13	0.50
Total FTE Positions Year 2	**56.55**	**1.92**	**1.22**	**59.69**

In Section VII.3, page 76, the applicant states:

> *"All positions except nursing are based on a 40-hour work week. Nursing positions (RN, LPN, CNA) are based on a 36-hour work week, or 1,872 hours per year."*

In addition, in Section VII.5, page 81, the applicant states:

> *"Staff are allocated among inpatient, respite, and residential based on the percentage of total patient days. 85.5% is allocated to inpatient, 8.9% to respite, and 5.5% to residential."*

In Section VII.7, page 83, the applicant projects to provide 8.43 nursing hours per patient day (NHPPD) for inpatient services [64,562.08 nursing hours for inpatient beds / 7,657 hospice inpatient days of care = 8.43 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 to this criterion.

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

In Section II, pages 24 - 25, the applicant states that CarePartners Hospice currently provides all the necessary ancillary and support services, including nursing services, social work services, bereavement and counseling services, physician services, and pharmaceutical services. In Exhibit 12, the applicant provides a copy of a March 1, 2013 letter from the Executive Director of the CarePartners Hospice which confirms that those services will continue to be provided following completion of this project. Exhibits 10 and 31 contain letters from existing area health care providers and hospice providers expressing their support for the project and their intention to continue working with and providing referral services to CarePartners Hospice. In Section V.2, page 62, the applicant states that it currently has transfer agreements with area healthcare providers, including Angel Home Health and Hospice, Haywood Regional Medical Center Hospice, and Hospice of Yancey County. The applicant also states it has current transfer agreements with area skilled nursing facilities and hospitals, and provides copies of those agreements in Exhibits 40 and 41. In Section V.3(c), page `63, the applicant states Dr. John Langlois currently serves as interim Medical Director for the John F. Keever Solace Center and will continue in that role following project completion, until a permanent medical director is in place. In Exhibit 35 the applicant provides a February 28, 2013 letter signed by Dr. Langlois, expressing his intention to continue as the Medical Director until a permanent medical director is in place. 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 is conforming to 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

(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;

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In Section VI.3, page 67, the applicant provides the historical payor mix during FY 2012 for the existing facility, as shown in the table below.

PAYOR CATEGORY	HOSPICE INPATIENTS	HOSPICE INPATIENT DAYS OF CARE
BCBS	3.4%	3.2%
Commercial	2.5%	1.7%
Government	0.4%	0.1%
Indigent	0.1%	0.3%
Medicaid	8.3%	8.4%
Medicare	83.4%	84.3%
Other	1.3%	1.5%
Private pay	0.6%	0.6%
Total	**100.0%**	**100.0%**

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 for Buncombe County and Statewide.

	TOTAL # OF MEDICAID ELIGIBLES AS % OF TOTAL POPULATION	TOTAL # OF MEDICAID ELIGIBLES AGE 21 AND OLDER AS % OF TOTAL POPULATION	% UNINSURED CY 2008-2009 (ESTIMATE BY CECIL G. SHEPS CENTER)
Buncombe	36.0%	16.1%	18.3%
Statewide	17.0%	6.7%	19.7%

*More current data, particularly with regard to the estimated uninsured percentages, was not available.

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 hospice services offered by the applicant.

Moreover, the number of persons eligible for Medicaid assistance may be greater than the number of Medicaid eligibles who actually utilize health services. The DMA website includes information regarding dental services which illustrates this point. For dental services only, DMA provides a comparison of the number of persons eligible for dental services with the number actually receiving services. The statewide percentage of persons eligible to receive dental services who actually received dental services was 45.9% for those age 20 and younger and 30.6% for those age 21 and older. Similar information is not provided on the website for other types of services covered by Medicaid. However, it is reasonable to assume that the percentage of those actually receiving other types of health services covered by Medicaid is less than the percentage that is eligible for those services.

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 is available by age, race or gender. However, a direct comparison to the applicants' current payer mix would be of little value. The population data by age, race or gender does 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 (CCH) reports the following payer mix for hospice patients served during FFY 2010 for both North Carolina and the US:

PAYER CATEGORY	% OF HOSPICE PATIENTS	% OF HOSPICE PATIENT DAYS OF CARE
Medicare	86.3%	91.6%
Medicaid	4.9%	3.4%
Private Insurance	5.9%	3.4%
Self pay / Other	2.8%	1.6%

Total	**100.0%**	**100.0%**

Source: *2011 Fiscal Year North Carolina Hospice Data & Trends,* CCH

Annual data provided by CCH also reports the following hospice admissions by race and ethnicity for both North Carolina and the US:

	% HOSPICE PATIENTS NC DATA 2010	% HOSPICE PATIENTS NATIONAL DATA 2010
Race		
White/Caucasian	80.5%	77.3%
Black/African American	15.4%	8.9%
Asian, Hawaiian, Other Pacific Islander	0.4%	2.5%
Another Race	2.7%	11.0%
American Indian or Alaskan Native	1.0%	0.3%
Ethnicity		
Hispanic or Latino Origin	0.7%	5.7%
Non-Hispanic or Latino Origin	99.3%	94.3%
Totals	100.0%	100.0%

Annual data provided by CCH also reports the following hospice admissions by age for both North Carolina and the US:

AGE CATEGORY	% HOSPICE PATIENTS NC DATA 2010	% HOSPICE PATIENTS NATIONAL DATA 2010
0 – 34	0.8%	1.3%
35 – 64	17.4%	16.1%
65 – 74	18.4%	15.9%
75 – 84	29.5%	27.9%
85+	33.9%	38.9%
Total	**100.0%**	**100.0%**

In Section VI, pages 68 - 70, the applicant describes how CarePartners Hospice has and will provide hospice services to all patients, including the elderly, Medicare and Medicaid recipients, racial and ethnic minorities, women, handicapped persons, and other underserved persons. In Exhibit 11 the applicant provides a copy of the admission policies and procedures. The applicant adequately demonstrates that medically underserved populations currently have adequate access to hospice services provided by CarePartners Hospice and the John F. Keever Solace Center. Therefore, the application is conforming to this criterion.

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

Recipients of Hill-Burton funds were required to provide uncompensated care, community service and access by minorities and handicapped persons. In Section VI.5, page 68, the applicant describes its commitment to provide services for all patients, *"regardless of race, religion, handicap, sexual orientation, age, gender, national origin, existence or lack of existence of advanced care directives and/or ability to pay."* In Section VI.10, page 74, the applicant states no civil rights equal access complaints were filed against *"any facility owned by the applicant in North Carolina."* The application is conforming to this criterion

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

C

In Section VI.4, page 67, the applicant projects the following payor mix in the second project year (FY 2015):

PAYOR CATEGORY	HOSPICE INPATIENTS	HOSPICE INPATIENT DAYS OF CARE
BCBS	3.4%	3.2%
Commercial	2.5%	1.7%
Government	0.4%	0.1%
Indigent	0.1%	0.3%
Medicaid	8.3%	8.4%
Medicare	83.4%	84.3%
Other	1.3%	1.5%
Private pay	0.6%	0.6%
Total	**100.0%**	**100.0%**

As shown in the table above and the tables in Criterion (13a), the applicant assumes no change in payor mix following the addition of hospice inpatient beds.

In Section VI.5, page 68, the applicant states it will continue to provide access to hospice care to all people. The applicant demonstrates that it will continue to provide adequate access to medically underserved groups following project completion. Therefore, the application is conforming to 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 71, the applicant states persons in need of hospice services have and will continue to have access to its facility through referrals from physicians, hospitals, nursing homes, assisted living facilities, other hospices and hospice

agencies, social service agencies, clergy, family member, and self referral. The applicant states the project is not expected to effect current referral patterns. The application is conforming to 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(b) and (c), pages 61 - 62, the applicant states it currently provides clinical training opportunities with several area medical schools and residency programs for students and physicians, as well as clinical training opportunities for nursing students. The applicant also states:

> *"In 2011, CarePartners Hospice launched the Asheville Hospice and Palliative Medicine Fellowship program, offering 2 fellows each year the opportunity to gain in-depth training in hospice and palliative medicine. Each fellow spends 4 weeks at the Solace Center, and can spend additional time at Solace through elective time or selective rotation."*

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 to 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

CarePartners Hospice currently operates the John F. Keever, Jr. Solace Center in Asheville, with 20 hospice inpatient beds and seven hospice residential beds. In this application, CarePartners Hospice proposes to convert five of its existing hospice residential care beds to five hospice inpatient beds. The current and projected utilization exceeds the planning standard for hospice inpatient facilities outlined in the 2013 SMFP.

In Section III.4, pages 45 - 46, the applicant discusses the impact of the proposed conversion of five hospice residential beds to five hospice inpatient beds on competition in the service area as it relates to promoting cost-effectiveness, quality and access to hospice services. The applicant states:

> *"CarePartners Hospice is the only Hospice inpatient provider in Buncombe County, and currently operates a 20 bed inpatient and 7 bed residential hospice facility. Converting existing underutilized residential beds to become inpatient beds is the most cost-effective, clinically and administratively efficient way to add the 5 inpatient beds that are needed in Buncombe County. The facility is centrally located in the county and is located close to two interchanges for Interstate 40. It is on the main CarePartners Health Services campus, and shares resources with the rest of CarePartners. It is also located close to the county's acute care hospital and other healthcare providers.*
>
> *Three adjoining counties, Haywood to the west, Henderson to the south, and Rutherford to the southeast, each have their own inpatient hospice facilities. Buncombe County residents living near the border to those counties can have the option of traveling to one of those providers' facilities if it is more geographically accessible. The facility in Henderson County was utilized only 67.63% of the time in the previous licensure year, and the facility in Rutherford 86.00%. Given those utilization rates, Henderson and Rutherford both have room for patients from Buncombe County who live closer to those facilities than to the Solace Center."*

See also Sections II, III, V, VI and VII where the applicant discusses the impact of the project on 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 in the service area include a positive impact on cost-effectiveness, quality and access to the proposed hospice services. This determination is based on the information in the application and the following analysis:

- The applicant adequately demonstrates the need to convert five existing hospice residential care beds to five hospice inpatient beds, and that it is a cost-effective alternative;
- The applicant adequately demonstrates it will continue to provide quality services; and
- The applicant adequately demonstrates it will continue to provide adequate access to medically underserved populations.

The application is conforming to 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.

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CarePartners Hospice /John F. Keever, Jr. Solace Center is certified by the Centers for Medicare and Medicaid for participation in the Medicare and Medicaid programs, and licensed by the NC Division of Health Service Regulation as a hospice inpatient facility. According to files in the Acute and Home Care Licensure and Certification Section in the Division of Health Service Regulation, no incidents have occurred at the Solace Center within the eighteen months immediately preceding the date of the decision for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to 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.1, pages 15 - 17, the applicant provides the projected number of hospice inpatient, residential and respite admissions, deaths, and other discharges to be served in the hospice inpatient facility in each of the first three years following completion of the project. See the following table, compiled by the project analyst form the data on pages 15 – 17:

	FY 2014 (YEAR 1)	FY 2015 (YEAR 2)	FY 2016 (YEAR 3)
Inpatient			
Number of Patients	755	812	874
Admissions	724	779	838
Deaths	626	673	725
Other Discharges	122	131	141
Respite			
Number of Patients	113	122	131
Admissions	112	121	130
Deaths	0	0	0
Other Discharges	134	144	155
Residential			
Number of Patients	37	39	40
Admissions	2	2	2
Deaths	6	6	6
Other Discharges	26	27	28

The methodology and assumptions used to develop the projections are provided in Section III.1 pages 34 - 41, and Section IV.2, pages 56 - 58. See Criterion (3) for discussion of reasonableness.

(2) the projected annual number of hospice patients, admissions, deaths, and other discharges <u>for each level of care</u> 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- In Section IV.4, page 59, 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, as shown in the table below. The methodology and assumptions used to develop the projections are provided in Section IV, pages 57 - 59. See Criterion (3) for discussion of reasonableness.

Total CarePartners Hospice Projected Utilization

	2014	2015	2016
Admissions – Unduplicated	1,412	1,520	1,635
Deaths	1,186	1,276	1,373
Discharges	208	224	241

*Source: Application, page 59

(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- In Section IV.2, pages 57 - 58, the applicant shows the 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 in Section III.1, pages 34 - 41. See Criterion (3) for discussion.

Total CarePartners Hospice Projected Patient Care Days

CARE LEVEL	YEAR 1 FY2014	YEAR 2 FY2015	YEAR 3 FY2016
Inpatient	7,116	7,657	8,239
Respite	745	801	862
Residential	475	494	511
Total	8,336	8,952	9,612

(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, pages 15 - 18, the applicant provides the projected average length of stay (ALOS) for the inpatient, residential, and respite levels of care, as shown in the table below:

CARE LEVEL	YEAR 1 FY2014	YEAR 2 FY2015	YEAR 3 FY2016
Inpatient	9.6	9.6	9.6
Residential	13.3	13.3	13.3
Respite*	6.9	6.9	6.9

The methodology and assumptions used to develop the projections are provided in Section III.1, pages 34 – 41, and Section II, pages 15 - 17.

(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 19, the applicant projects a readmission rate for each level of hospice care, as shown in the table below:

READMISSION LEVEL	YEAR 1 FY2014	YEAR 2 FY2015	YEAR 3 FY2016
Inpatient	5.5%	5.5%	5.5%
Residential	8.3%	8.3%	8.3%
Respite	51.5%	51.5%	51.5%

The methodology and assumptions used to develop the projections are provided in Section IV.2, pages 57 - 58.

(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.6, page 20, the applicant provides the projected average cost per patient day by level of care, as shown in the table below. The applicant likewise provides the assumptions used to project average annual cost.

CARE LEVEL	YEAR 1 FY2014	YEAR 2 FY2015	YEAR 3 FY2016
Inpatient	$766.99	$753.30	$740.31
Residential	$338.29	$341.82	$345.48
Respite	$338.29	$341.82	$345.48

(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.2, page 20, the applicant states, *"As a hospice provider with 33 years experience, CarePartners Hospice … has long established relationships with hospitals, physicians, nursing homes, adult care homes, and other healthcare facilities in Buncombe County and surrounding communities. These referral sources are supportive of the proposed project."* In Exhibits 10 and 31, the applicant provides copies of letters of support from area physicians and other healthcare providers.

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

-C- In Exhibit 10, the applicant provides letters of support from area healthcare providers, which also project future referrals. In Section III.8, page 21, the applicant provides a table that summarizes the historical and projected number of referrals to CarePartners Hospice.

(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- CarePartners Hospice 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- CarePartners Hospice 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 11 contains copies of the applicant's admission policies.

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 22, and in Section IV.2(a), page 57, the applicant projects an average occupancy rate for the licensed beds for each level of care in excess of 50 percent for the last six months of the first operating year following completion of 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; and

-C- In Section II, pages 22 - 23, and in Section IV.2(a), pages 57 - 58, the applicant projects an average occupancy rate for the licensed beds for each level of care in excess of 65 percent for the second operating year following completion of project.

(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- In Section IV.1, pages 23 - 24, the applicant reports an average occupancy rate for the licensed hospice inpatient beds was 96.8% for the nine months immediately preceding the submittal of the proposal. However, the applicant counts respite days of care in its calculation of inpatient occupancy rates. The average inpatient occupancy rate was actually 87.94%, still in excess of the 65% as required by this rule [(4,749 inpatient days of care / 270 days) / 20 beds = 0.8794].

(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- In Section II.2, page 25, the applicant states, *"As an existing Medicare/Medicaid-certified and licensed hospice, CarePartners Hospice currently provides all of the core services listed above. These services will continue to be provided in the existing John F. Keever, Jr. Solace Center."* In Exhibit 12, the applicant provides documentation from the executive director of CarePartners Hospice that medical services as required in this rule will be provided following project completion.

(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 II.3, page 25, the applicant states, *"CarePartners Hospice currently provides nursing care 24 hours a day, 7 days a week in the Solace Center, and will continue to do so upon completion of the proposed project."* In Exhibit 12, the applicant provides documentation from the executive director of CarePartners Hospice that medical services as required in this rule will be provided following project completion.

(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.3, page 25, the applicant states *"Covered pharmaceutical services are and will continue to be provided by the CarePartners in-house pharmacy and staffed through a contract with Mission Hospital."* In Exhibit 13, the applicant provides a copy of the existing pharmaceutical agreement.

(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 25, the applicant states *"Covered pharmaceutical services are and will continue to be provided by the CarePartners in-house pharmacy and staffed through a contract with Mission Hospital."* In Exhibit 13, the applicant provides a copy of the existing pharmaceutical agreement. In Exhibits 14 and 15, the applicant

provides copies of contracts with Advanced Home Care and Care Solutions for medical supplies as required by this rule.

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, pages 25 - 26, 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 26, the applicant states, *"CarePartners will maintain a staffing pattern consistent with 10A NCAC 13K as it currently does in its inpatient, residential, and homecare divisions."*

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

-C- In Section II.2, pages 26 - 27, applicant states, *"Training for all staff and volunteers meets the requirements as specified in 10A NCAC 13K .0400, Hospice Licensing Rules, Personnel.* In Exhibit 12 the applicant provides a letter from the executive director of CarePartners Hospice which confirms that statement. In addition, in Exhibit 16, the applicant provides a copy of its staff training policies.

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.2, pages 27 - 28, the applicant describes how the facility will provide a home-like setting for its patients.

(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.2, page 28, the applicant states that its existing services are and will continue to 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. In Exhibit 20 the applicant provides documentation which confirms zoning will be provided in conformity with the requirements of this rule; and in Exhibit 21, the applicant provides documentation

which confirms the water supply services will be provided in conformity with the requirements of this rule.

(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- CarePartners Hospice is not proposing a new facility in this application.