ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: February 26, 2014

PROJECT ANALYST: Mike McKillip
TEAM LEADER: Lisa Pittman

PROJECT I.D. NUMBER: M-10233-13 / United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville / Establish a new hospice home care office / Cumberland 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

The 2013 State Medical Facilities Plan (2013 SMFP) establishes a need determination for one hospice home care office in Cumberland County. United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville **[PHH-Fayetteville]** submitted the only application to the Certificate of Need Section. Policy GEN-3 of the 2013 SMFP is applicable to the review.

Policy GEN-3 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 CON 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*."

In Section II.10, pages 85-92, the applicant discusses how its proposal will promote quality care. Exhibit 18 contains a copy of the applicant's patient care and quality management policies. The applicant adequately demonstrates how its proposal will promote safety and quality. In Section II.12, pages 93-94, and Section III.2, pages 125-126, the applicant discusses how its proposal will improve access to hospice care for patients in the service area. Additionally, in Section VI, pages 182-191, the applicant discusses how the proposal will ensure access to services by underserved populations. The applicant adequately demonstrates how its proposal will promote equitable access to hospice services. In Section III.2, pages 128-129, the applicant discusses how its proposal will maximize healthcare value for resources expended. The applicant adequately demonstrates that the project is a cost effective approach. Therefore, the application is consistent with Policy GEN-3 and 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

The applicant, United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville (PHH-Fayetteville), proposes to develop a new hospice home care office at 2905 Breezewood Avenue, Suite 201, in Fayetteville, which is located in Cumberland County.

Population to be Served

In Section III.4, page 132, the applicant identifies the proposed service area as Cumberland, Bladen, Hoke, and Sampson counties. The projected patient origin for Project Year 1 (FFY2015) and Project Year 2 (FFY2016) are shown in the following table.

Projected PHH-Fayetteville Patient Origin by County

County	FFY2015	FFY2016
Cumberland	57.1%	55.8%
Sampson	23.5%	32.7%
Hoke	18.4%	10.6%
Bladen	1.0%	0.5%
Total	**100.0%**	**100.0%**

Source: Application page 133.

In Section III.4, pages 133-134, the applicant describes its assumption and methodology for its projected patient origin in the first two operating years. The applicant adequately identified the population proposed to be served.

Need for the Project

In Section III.1(a) of the application, the applicant describes the factors supporting the need for the proposed project, including the need determination methodology in the 2013 SMFP (pages 96-97), the low historical percentage of deaths served by hospice in the service area (page 97), the need for a local provider with *"established ties"* and a commitment to *"changing the service area culture"* to increase access to hospice services (pages 98-100), healthcare cost savings associated with hospice use (page 101), the need for a new provider to *"stimulate competition"* and improve access to hospice services (pages 101-102), population growth and aging in the service area counties (pages 102-104), relatively high death rates in the service area counties, the need for a provider that *"understands military culture"* (page 106), and the low utilization of hospice services from patients in nursing homes (page 110).

As discussed above, the applicant's proposed service area includes Cumberland, Bladen, Hoke, and Sampson counties. The 2013 SMFP (Table 13B, Column K) provides the projected number of additional patient deaths that will need home hospice services by county in 2014. Those projections for the proposed service area counties are summarized below:

Projected Deficits in Deaths to be Served by Hospice Home Care for 2014

County	Projected Number of Additional Patient Deaths to be Served
Cumberland	108
Bladen	24
Hoke	44
Sampson	76
Total	**252**

Source: 2013 State Medical Facilities Plan, Table 13B.

In Section III.1(b), pages 112-113, the applicant provides its projections of the number of additional patient deaths to be served by hospice home care by county for FFY2015 and FFY2016. The applicant's projections are summarized in the following table:

Applicant's Projected Deficits in Deaths to be Served by Hospice Home Care

County	FFY2015	FFY2016
Cumberland	111	121
Bladen	9	4
Hoke	46	47
Sampson	91	95
Total	**258**	**267**

Source: Application page 123, applicant's Table III.31.

On pages 111-112, the applicant states,

> "*The* [tables summarized above] *use the 2013 SMFP methodology and project the need for additional hospice services in Cumberland, Bladen, Hoke, and Sampson*

Counties for FY 2014, FY 2015 and FY 2016. … Population estimates in the calculated need methodology are as of October 2013 and are more current than the population estimates used in the 2013 SMFP. … Forecast deaths in need of hospice services are lower in FY2015 because PHH-Fayetteville used the more current metric for median deaths served in hospice from the 2014 Draft State Medical Facilities Plan (39.6 percent versus 42.5 percent). See Column E. This metric accounts for changes that occurred in Medicare hospice eligibility guidelines, particularly related to 'failure to thrive' patients in 2012."

On page 133, the applicant provides the following table showing that it proposes to serve 98 unduplicated patients in Project Year 1 (FFY2015) and 217 unduplicated patients in Project Year 2 (FFY2016).

Projected PHH-Fayetteville Patient Admissions by County

County	FFY2015	FFY2016
Cumberland	56	121
Sampson	23	71
Hoke	18	23
Bladen	1	1
Total	**98**	**217**

Source: Application page 133.

In Section III.4, pages 133-134, the applicant describes its assumptions for projecting admissions by county in the first two operating years as follows:

"Step 1. Determine the PHH-Fayetteville market share of unserved hospice patients in each service area county in each project year.

Table III.36 – PHH-Fayetteville Market Share Forecast Unserved Hospice Home Care Patients

County	*2015 (Year 01)*	*2016 (Year 02)*
Cumberland	*50%*	*100%*
Bladen	*10%*	*25%*
Hoke	*40%*	*50%*
Sampson	*25%*	*75%*

Source: Application page 133.

Assumptions:

- *Market share in each service area county is conservatively estimated based on United Hospice, Inc. and UH-Smithfield experience in the area.*
- *Market share takes into account a conservative startup period in Year 01. Market share also takes into account the rural nature of the service area and its low hospice usage.*
- *Market share for Cumberland County presumes that PHH-Fayetteville will be sufficiently organized to meet the entire forecast deficit in Cumberland by Year 02.*

- *Market share for Bladen and Hoke Counties assumes PHH-Fayetteville will serve a fewer* [sic] *amount of people in the communities closest to the Cumberland County border. This would be consistent with historical patterns and anecdotal reports from United Hospice interviews.*
- *Market share of Sampson County assumes that PHH-Fayetteville will build on its established relationships in that county. PHH-Fayetteville will identify more closely with cultural patterns of the community and gain more acceptance of hospice use by county residents.*

Step 2. To determine Projected Patients served by PHH-Fayetteville, multiply market share in Table III.36 above by unserved hospice home care patients in Table III.31.

Table III.37 – Projected Patients Served by PHH-Fayetteville – Year 01

County	***Projected Number of Additional Patients in Need of Hospice Services FY2015 (a)***	***PHH-Fayetteville Market Share of Forecast Unserved Hospice Home Care Patients (b)***	***Projected Patients Served by PHH-Fayetteville – FY 2015***
Source	*Table III.31*	*Table III.36*	*a * b*
Cumberland	*111*	*50%*	*56*
Bladen	*9*	*10%*	*1*
Hoke	*46*	*40%*	*18*
Sampson	*91*	*25%*	*23*
Total	***258***		***98***

Table III.38 – Projected Patients Served by PHH-Fayetteville – Year 02

County	***Projected Number of Additional Patients in Need of Hospice Services FY2016 (a)***	***PHH-Fayetteville Market Share of Forecast Unserved Hospice Home Care Patients (b)***	***Projected Patients Served by PHH-Fayetteville – FY 2016***
Source	*Table III.31*	*Table III.36*	*a * b*
Cumberland	*121*	*100%*	*121*
Bladen	*4*	*25%*	*1*
Hoke	*47*	*50%*	*29*
Sampson	*95*	*75%*	*71*
Total	***267***		***217***

In Section IV.5(a), page 149, the applicant provides the projected duplicated patients to be served in each of the first 24 months following completion of the project, as shown in the following table.

PHH-Fayetteville - Projected Duplicated Patients – PY1 and PY2			
Month/Year	**Number of Patients**	**Month/Year**	**Number of Patients**
October 2014	1	October 2015	27
November 2014	3	November 2015	29

December 2014	6	December 2015	31
January 2015	9	January 2016	31
February 2015	10	February 2016	32
March 2015	13	March 2016	35
April 2015	15	April 2016	35
May 2015	16	May 2016	36
June 2015	20	June 2016	38
July 2015	22	July 2016	39
August 2015	23	August 2016	40
September 2015	27	September 2016	42
Total	**165**	**Total**	**415**

In Section IV.5(b), pages 150-151, the applicant describes it assumptions for projecting duplicated patients in the first two operating years as follows:

> *"**Step 1.** For routine home care patients, start with an average daily census (ADC) of one in the first month of the first project year and increase the ADC by 2.19 patients per month in Year 01 and 1.25 in Year 02. … In month four of Year 01, start with an ADC of 3.75 routine patients in nursing homes and increase by 0.25 per month.*
>
> *Assumptions:*
> - *The unmet need is as forecast in Section III.1*
> - *The agency will serve no Medicaid patients until Month 4 and no Medicare until Month 3, because of delays associated with certification visits.*
> - *The agency will be permitted to serve Medicare and Medicaid patients at Month 3 and 4, respectively, although it will not receive payment until much later. See Exhibit 33 for documentation.*
> - *This is a reasonable rate to sustain the market share in III.4(c).*
> - *As the average daily census increases and the new facility reaches more of the underserved population, the rate of increase will slow down.*
> - *UH has a strong presence in this service area and a budget for community education and will be able to sustain this ADC. See responses in Section I.16, I.17, and IV.3.*
> - *PHH-Fayetteville will hire an experienced Community Relations Representative. See staffing in Section VII.*
>
> ***Step 2.** For respite patients, starting in month two, assume an ADC of 0.05 patients per month for the first project year, and an ADC of 0.05 patients per month for all months in the second project year.*
>
> *Assumptions: PHH-Fayetteville will have a service pattern that resembles the NC average total respite patients per month and UH experience.*
>
> ***Step 3.** For inpatients, starting in month 4, assume an ADC of one patient in months 4, 7, 10 and 12 of year 01 and one patient a month in Year 02. Multiply ADC by days in month to get patient days in month.*

Assumptions:

- *This estimate is lower than the state average for all hospice agencies, but consistent for hospice agencies that do not have an inpatient hospice unit. Among agencies that served Cumberland County in 2013 inpatient days represented as few as zero percent to three percent among agencies without an inpatient unit and up to 18 percent for 3HC, which has an inpatient facility, Kitty Askins Center. See Exhibit 51 for details.*
- *The pattern in Year 01 spreads patients towards the end of the year when a larger patient load will more likely have crises that require an inpatient stay.*
- *The applicant is aware that this creates an uneven distribution of patients from one month to the next, but believes it is reasonable for budgeting purposes.*

Step 4. *For continuous care patients, starting in month 3, assume an ADC of one patient every third month (months 3, 6, 9 and 12) for Years 01 and 02. Multiply ADC by days in month to get patient days in month.*

Assumption: Continuous care will distribute evenly across the year and represent a very small portion of patients.

Step 5. *Sum ADC for Routine, Respite, Inpatient and Continuous Care to get duplicated patients served each month."*

In Section IV.5, page 152, the applicant projects the average length of stay (ALOS) for routine home care hospice patients as 69.5 days in PY1 and 76.25 days in PY2. In Section IV.5(b), page 153, the applicant provides the projected unduplicated patients to be served in each of the first 24 months following completion of the project, as shown in the following table.

PHH-Fayetteville - Projected Unduplicated Patients – PY1 and PY2			
Month/Year	**Number of Patients**	**Month/Year**	**Number of Patients**
October 2014	1	October 2015	16
November 2014	2	November 2015	15
December 2014	10	December 2015	18

January 2015	4	January 2016	18
February 2015	5	February 2016	16
March 2015	12	March 2016	19
April 2015	7	April 2016	17
May 2015	7	May 2016	19
June 2015	15	June 2016	19
July 2015	9	July 2016	20
August 2015	15	August 2016	20
September 2015	11	September 2016	20
Total	**98**	**Total**	**217**

In Section IV.5(b), pages 151-154, the applicant describes it assumptions for projecting unduplicated patients in the first two operating years as follows:

> *"**Step 6.** Multiply ADC for each level of care as determined in Steps 1 through 4 above by days in month to get patient days by month.*
>
> ***Step 7.** For each level of care, determine an Average Length of Stay (ALOS) Factor in each project year. Factors are based on UH operating experience and are used in UH budgeting.*

Table IV.8 – ALOS Factor by Level of Care

Level of Care	*Year 01*	*Year 02*
Routine Care Room & Board (nursing home)	*50*	*49*
Routine	*69.5*	*76.25*
Respite	*4*	*4*
Inpatient	*6*	*6*
Continuous	*8*	*8*

> *Assumption: ALOS for routine care will be longer in second year, as hospice becomes more accepted. ALOS in other levels will be relatively constant.*
>
> ***Step 8.** Divide patient days in each level of care in each month by ALOS Factor for the level to get new starts (admissions) in the month.*
>
> ***Step 9.** Sum new admissions by level of care to get unduplicated admissions for the year.*

In Section IV.5(b), pages 153, the applicant provides tables showing its projected unduplicated admissions to the proposed hospice home care agency by level of care in the first two operating years, which are summarized below:

Unduplicated Admissions by Level of Care – Year 1

Month/Year	Routine	Respite	Inpatient	Continuous	Total
October 2014	1	0	0	0	1
November 2014	1	1	0	0	2
December 2014	2	1	6	1	10

January 2015	3	1	0	0	4
February 2015	4	1	0	0	5
March 2015	5	1	5	1	12
April 2015	6	1	0	0	7
May 2015	6	1	0	0	7
June 2015	7	1	6	1	15
July 2015	8	1	0	0	9
August 2015	9	1	5	0	15
September 2015	9	1	0	1	11
Total					**98**

Unduplicated Admissions by Level of Care – Year 2

Month/Year	Routine	Respite	Inpatient	Continuous	Total
October 2015	9	1	6	0	16
November 2015	9	1	5	0	15
December 2015	10	1	6	1	18
January 2016	11	1	6	0	18
February 2016	10	1	5	0	16
March 2016	11	1	6	1	19
April 2016	11	1	5	0	17
May 2016	12	1	6	0	19
June 2016	12	1	5	1	19
July 2016	13	1	6	0	20
August 2016	13	1	6	0	20
September 2016	13	1	5	1	20
Total					**217**

In Section IV.5(b), pages 153-154, the applicant describes it assumptions as follows:

Assumptions:

- *Each patient is considered a new start of care.*
- *Fill up is conservative and based on the experience of UH in starting new hospice home care agencies in Georgia, South Carolina, and North Carolina.*
- *The ALOS factor represents the average length of stay for respite, inpatient, and continuous care. The ALOS for routine care is a mathematical factor that accounts for patients who are served in more than one month.*
- *This relatively low average length of stay is reasonable in UH experience with a start-up hospice in an area with a history of low use of hospice services. It was evaluated by experienced hospice administrators who have worked in the service area, UH Regional Director, Zack Lee, and UH-Smithfield Administrator, Jason Whiteside.*
- *For calculation purposes, patient use patterns are consistently distributed across all months and length of stay patterns are changed only at the start of a new year. The applicant realizes the patients will be a mixture of short and long stay individuals."*

In Section IV.6, pages 155-164, the applicant provides the projected number of visits by level of care and discipline for the first two project years.

PHH-Fayetteville - Hospice Visits by Level of Care and Discipline										
	PY1					PY2				
	Home	Respite	Inpatient	Continuous	Total	Home	Respite	Inpatient	Continuous	Total
Physician	46	0	17	0	63	121	0	52	0	173
Nursing	1,391	5	73	4	1,474	3,637	6	219	4	3,866
PT/ST*	22	0	0	0	22	82	0	0	0	82
Social Worker	139	0	18	1	159	364	1	55	1	420
CNA	1,761	8	0	2	1,771	4,607	10	0	2	4,619
Diet Counseling*	14	0	0	0	14	108	0	0	0	108
Bereavement	93	0	2	0	95	242	0	7	0	249
Spiritual	185	1	18	2	206	485	1	55	2	543
Volunteer	464	0	0	0	464	1,212	0	0	0	1,212
Nurse Practitioner	46	0	1	0	47	121	0	4	0	125
Total	4,161	15	131	9	4,316	10,979	18	392	9	11,398

Source: Application pages 155-164. Totals rounded to the nearest whole number.
*Physical therapy, speech therapy (PT/ST) and Diet Counseling services will be provided through contract with United Rehab and United Clinical Services.

On page 154, the applicant describes the methodology for projecting visits by discipline and level of care as follows:

> *"In the tables* [shown on pages 155-164], *patient days per month determined in Section IV.5 and detailed in Exhibit 53 were multiplied by a factor for visits per patient day by provider type by level of care. … Factors for each provider type and level of care were determined from UH experience and a review of hospice license renewal applications for providers who served Cumberland County in 2012. The latter are contained in Exhibit 51. … In determining visits per patient day by provider type, the applicant also considered the startup nature of the project and the likelihood of shorter stays and lower visits that have occurred in recent months."*

The distribution of visits by discipline in the first two project years indicates that over 74 percent of total visits are nursing visits (includes CNAs). Volunteer and spiritual counseling comprise the second and third highest percentage of total visits, respectively.

PHH-Fayetteville Percentage of Total Hospice Visits by Discipline		
	PY1	PY2
Physician	1.5%	1.5%
Nursing	34.1%	33.9%
Physical Therapy/Speech Therapy	0.5%	0.7%
Social Worker	3.7%	3.7%
CNA	41.0%	40.5%

Diet Counseling	0.3%	0.9%
Bereavement Counseling	2.2%	2.2%
Spiritual Counseling	4.8%	4.8%
Volunteer	10.8%	10.6%
Nurse Practitioner	1.1%	1.1%
Total	100.0%	100.0%

Source: Application, Tables IV.11-20, pp 155-164.

In Section IV.8(a), pages 165-166, the applicant projects the hospice patient care days by level of care. The two tables labeled IV.21 and IV.22, depicting PY1 and PY2 patient days of care by level, are combined below into one table.

PHH-Fayetteville Hospice Patient Care Days by Level of Care		
	PY1	**PY2**
Routine Home Care Days	4,635	12,124
Inpatient Care Days	122	365
Respite Care Days	15	18
Continuous Home Care Hours	32	32

Source: Application pages 165-166.

On page 166, the applicant describes its methodology for projecting patient days of care by level of care as follows:

> *"Step 1. Projected patient days by level of care were calculated according to the methodology described in response to Section IV.5(b), Step 6.*
>
> *Step 2. Continuous care hours were projected by multiplying continuous care patient days by eight hours.*
>
> *Assumptions:*
> - *Recent experience with short stay patients will sustain through the first two project years.*
> - *UH Eastern North Carolina experience in the recent 12 months provides a more reasonable estimate of levels of care than the state average.*
> - *UH Eastern North Carolina experience closely resembles experience of other providers in Eastern North Carolina that do not have a hospice inpatient unit in the area."*

The applicant's projections of unduplicated patients, duplicated patients, average length of stay, patient days of care, and visits by discipline are based on its experience operating hospice home care agencies in North Carolina, including UH Eastern North Carolina, which currently serves patients in the proposed service area. The applicant adequately demonstrates that projected utilization is based on reasonable, credible and supported assumptions.

Access

The applicant projects 98% of the patients will be covered by Medicare (96%) and Medicaid (2%). The applicant demonstrates adequate access for medically underserved groups to the proposed services.

In summary, the applicant adequately identified the population to be served, adequately demonstrated the need the population projected to be served has for the proposed project, and demonstrated all residents of the service area, and, in particular, underserved groups, are likely to have access to the services proposed. 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.

NA

(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

In Section III.7, pages 138-140, the applicant discusses the alternatives it considered prior to submitting this application, which include:

a) Maintaining the status quo, which the applicant states was rejected because of the need determination for one additional hospice home care office for Cumberland County and because the relatively low utilization rates for hospice home care in the service area indicates a lack of access to those services.
b) Developing a hospice home care office in a location other than Fayetteville, which the applicant states was rejected because Fayetteville is the area's largest population center and is centrally located in the service area.
c) Limiting the service area to only Cumberland County, which the applicant states was rejected because of the unmet need for services in Hoke, Sampson, and Bladen counties.

After considering those alternatives, the applicant states the alternative represented in the application is the most effective alternative.

Furthermore, the application is conforming to all other statutory and regulatory review criteria, and thus, is approvable. A project that cannot be approved cannot be an effective alternative.

In summary, the applicant adequately demonstrates that the proposal is the least costly or most effective alternative to meet the need. Therefore, the application is conforming to this criterion and approved subject to the following conditions:

1. **United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville shall materially comply with all representations made in the certificate of need application.**

2. **United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville shall establish no more than one additional hospice home care office in Cumberland County.**

3. **United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure in Section VIII of the application or that would otherwise require a certificate of need.**

4. **United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville shall acknowledge acceptance of and agree to comply 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 212, the applicant projects the capital cost for the project will be $180,180. In Section VIII.3, page 213, the applicant states PHH-Fayetteville will finance the capital costs with *"cash from ongoing operations of UHS, Inc., United Hospice's parent company."* In Section IX.1, the applicant projects $81,459 in start-up expenses and $1,653,655 in initial operating expenses, for total required working capital of $1,735,114. In Section IX.3, page 218, the applicant states the working capital will be funded with accumulated reserves of UHS. In Exhibit 8, the applicant provides a letter from the Chief Development Officer for UHS Pruitt Corporation which states

> *"This letter documents the availability of funds necessary for equity requirements for the following project:*
>
> - *A proposed new hospice home care agency in Cumberland County; United Hospice, Inc. d/b/a PruittHealth Hospice-Fayetteville*
>
> *United Health Services, Inc. hereby commits to provide to United Hospice, Inc. all funds necessary to successfully develop the proposed project. We intend to use funds available from our cash flow from operations. United*

Hospice, Inc. will repay United Health Services, Inc., interest free, as funds are available. We are prepared to obligate $2,200,000 for fixed and operating cash requirements for this project. The officers for both corporations are the same and have authority to commit and obligate funds for both.

For the past three years, consolidated balance sheets for the company have reflected in excess of $3,000,000 in cash net of all financing and cash flow obligations. This is reflected in our Audited Financials, Consolidated Statement of Cash Flows. … As a financial representative of United Health Services, Inc. and United Hospice, Inc., I am authorized to commit and obligate funds necessary for the development of this project."

Exhibit 58 of the application contains audited financial statements for United Health Services, Inc. and Subsidiaries (UHS), which document that UHS had $4.0 million in cash and cash equivalents as of June 30, 2013. The applicants adequately demonstrated the availability of sufficient funds for the capital and working capital needs of the proposal.

In Section X.1, page 221, the applicant provides a table showing projected cost per day for each level of care. In Section X, pages 234-235, the applicant projects charges by payer and level of care for the first two operating years. Projected costs and charges are summarized in the following table.

PHH-Fayetteville					
	Payer Source	**Routine**	**Respite**	**Inpatient**	**Continuous Care (hourly)**
Projected Charges Yr 1	Medicare	$147	$155	$659	$36
Projected Cost Yr 1		$198	$369	$894	$62
Projected Charges Yr 2	Medicare	$150	$158	$670	$36
Projected Cost Yr 2		$126	$294	$819	$39
Projected Charges Yr 1	Medicaid	$147	$155	$659	$36
Projected Cost Yr 1		$198	$369	$894	$62
Projected Charges Yr 2	Medicaid	$150	$158	$670	$36
Projected Cost Yr 2		$126	$294	$819	$39
Projected Charges Yr 1	Commercial	$147	$155	$659	$36
Projected Cost Yr 1		$198	$369	$894	$62
Projected Charges Yr 2	Commercial	$150	$158	$670	$36

Projected Cost Yr 2		$126	$294	$819	$39
Projected Charges Yr 1	Self/Charity	$147	$155	$659	$36
Projected Cost Yr 1		$198	$369	$894	$62
Projected Charges Yr 2	Self/Charity	$150	$158	$670	$36
Projected Cost Yr 2		$126	$294	$819	$39

On pages 221 and 225, the applicant states,

> *"Costs for all years are net of the nursing home pass-through for Medicaid patients.… Charges are based on 'usual and customary' Medicare rates for the service area. Medicare and Medicaid reimbursement rates were used for projecting net revenue for each level of care."*

In the pro forma financial statements for the proposed hospice home care agency (Form B), the applicant projects revenues will exceed expenses in the second operating year, as shown below:

PHH-Fayetteville

	FY2015 Year 1	**FY2016 Year 2**
Total Revenue	$862,369	$2,320,066
Total Expenses	$1,173,480	$2,208,426
Net Income (Loss)	($311,111)	$77,147

Operating costs and revenues are based on reasonable assumptions including projected utilization. See the pro forma financial statements in the application for the assumptions. See Criterion (3) for discussion regarding utilization assumptions which is incorporated hereby as if set forth fully herein. The applicant adequately demonstrated that the financial feasibility of the proposal is based upon reasonable projections of operating costs and revenues, and 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.

C

The 2013 SMFP identifies a need determination for one additional hospice home care office in Cumberland County. There are currently four existing hospice home care agencies located in Cumberland County. PHH-Fayetteville does not propose to develop more than one new hospice home care office in Cumberland County. See Criterion (3) for discussion regarding need which is hereby incorporated as if set forth fully herein. Therefore, the applicant adequately demonstrates that the proposed project is not an unnecessary duplication of existing hospice home care services. Consequently, 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.

C

In Section VII.2, pages 206-207, PHH-Fayetteville projects staffing for the second operating year of the proposed hospice home care agency, as shown below in the table.

PHH-Fayetteville Staffing – PY2		
Position	**FTEs**	**Contract Visits**
Hospice Administrator	1.00	
Administrative Assistant	1.00	
Hospice DHS	1.00	
Hospice RN Case Manager	3.86	
Hospice Aide	4.23	
Dietary Counselor		108
Hospice Social Worker	0.49	
Hospice Bereavement Coordinator	0.28	
Physical Therapist		70
Speech Therapist		12
Hospice Chaplain	0.65	
Hospice Medical Director		Annual fixed fee
Hospice Volunteer Coordinator	1.00	
Director of Nursing	1.00	
Nurse Practitioner	0.13	
TOTAL	**14.64**	

Source: Table VII.2, pages 207-208.

In Section VII.1, page 192, the applicant provides the following performance standards regarding how many visits per day could be made by each discipline.

PHH-Fayetteville	
Category	**Visits/Day**
Patient/Family Coordinator	N/A
RN	4.21
CNA	4.57
Dietary Counselor	PRN
Social Worker	3.90
Bereavement Counselor	4.57
Physical Therapist	PRN
Speech Therapist	PRN
Clergy	3.76

Medical Director	PRN
Nurse Practitioner	4.21

Source: Application page 119

On page 192, PHH-Fayetteville describes its assumptions regarding staffing the proposed hospice home care agency as follows:

> *"Therapists, dietary counselor, and medical director are under contract and utilized as needed. The social worker, along with the chaplain, assume the duties of a patient/family coordinator, family counselor, and bereavement counselor. … The administrator, hospice representative and volunteer coordinator are not expected to visit patients. … All assumptions are consistent with UH's operational experience in currently operating hospice programs in North Carolina."*

To determine if PHH-Fayetteville's proposed staffing for Project Year 2 is sufficient, the Project Analyst divided the projected visits by the visits per day assumption, which results in the total work days required to complete the visits. The resulting quotient was divided by 260 work days per year (2,080 work hours per year per FTE position / 8 hours per day = 260 work days per year). This results in the number of required FTE positions. The number of required FTE positions was then compared to the number of projected FTE positions provided by the applicant in Section VII of the application. This calculation was performed for each discipline and is illustrated in the following table.

Discipline	**Projected Visits Project Year 2 (Sections IV.1) (A)**	**Visits per Day Performance Standard (Section VII) (B)**	**Required FTE Positions* [(A)/(B)] / 260**	**Projected FTE Positions Project Year 2 (Section VII)**
Registered Nurse	3,866	4.21	3.53	3.86
Certified Nursing Assistant	4,619	4.57	3.89	4.23
Social Worker	420	3.90	0.41	0.49
Bereavement Counselor	249	4.57	0.21	0.28
Spiritual (Clergy)	543	3.76	0.56	0.65
Nurse Practitioner	125	4.21	0.11	0.13

*Calculated by the Project Analyst.

As shown in the table above, PHH-Fayetteville projects adequate direct patient care staff during the second operating year. In Section VII.5, pages 196-201, the applicant describes its recruitment and retention procedures, and indicates that it does not anticipate any difficulties identifying, hiring, and retaining qualified staff for the proposed project. In Section VII.4, page 196, the applicant identifies Nitin Desai, M.D. as the Medical Director for the proposed hospice home care agency. Exhibit 27 contains a letter from Dr. Desai indicating his willingness to serve as the Medical Director. The applicant adequately demonstrates the availability of sufficient health manpower and management personnel to provide the proposed 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.

C

In Section II.3, pages 68-76, and Exhibits 25 and 26, the applicant documents that all of the necessary ancillary and support services for the proposed services will be provided by the applicant or through a contract with United Rehab, United Clinical Services, or another provider. In Sections V.2 and V.3, pages 173-177, and Exhibits 24, 25, 28, and 29, the applicant provides documentation of efforts to develop relationships with local physicians and the community. The applicant adequately demonstrates that necessary ancillary and support services will be available and that the proposed project will be coordinated with the existing health care system. Therefore, the application is conforming 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

(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

PHH-Fayetteville is not an existing hospice home care agency. However, UHS operates United Hospice of Eastern Carolina-Smithfield which currently serves patients in the applicant's proposed service area. In Section VI.8, page 190, the applicant reports the following payer mix for United Hospice of Eastern Carolina-Smithfield for the period from July 1, 2012 through June 30, 2013:

United Hospice of Eastern Carolina-Smithfield Payer Category	**FY2013 Days of Care as % of Total**
Medicare	96%
Medicaid and Veteran	2%
Commercial Insurance	2%
Self Pay	1%
Total	**100%**

Source: Application page 190.

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

County	**Total # of Medicaid Eligibles as % of Total Population June 2010**	**Total # of Medicaid Eligibles Age 21 and older as % of Total Population June 2010**	**% Uninsured CY 2008-2009 (Estimate by Cecil G. Sheps Center)**
Cumberland	18%	7.4%	20.3%
Bladen	25%	12.4%	19.4%
Hoke	19%	6.9%	21.9%
Sampson	25%	10.1%	24.0%

Statewide	17%	6.7%	19.7%

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 proposed in this application.

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 48.6% for those age 20 and younger and 31.6% 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.

The applicant demonstrates that medically underserved populations currently have adequate access to the applicant's existing services and are 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;

C

In Section VI.7, page 190, the applicant states:

"PHH-Fayetteville does not have any obligation under any applicable regulations to provide uncompensated care, community service or access by minorities and handicapped persons. Via admissions policies, PHH-Fayetteville provides services without regard to race, creed, age, religion, sex, handicap or other minority standing or ability to pay."

In Section VI.6 (a), page 189, the applicant states that no Office of Civil Rights complaints have been filed against them in last five years. 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.9, page 191, the applicant provides the projected payer mix for the second full fiscal year of operation (FY2016) for the proposed hospice home care agency, as shown in the table below.

PHH-Fayetteville Payer Category	**FY2016 Days of Care as % of Total**
Medicare	89.9%
Medicaid	4.6%
Commercial Insurance	3.5%
Self Pay/Indigent	2.0%
Total	**100%**

The applicant projects that 94.5% of its hospice days will be provided to recipients of Medicare and Medicaid. The applicant's projected payer mix percentages are consistent with the experience of its existing hospice home care agency, United Hospice of Eastern Carolina-Smithfield, which currently serves patients in the proposed service area. The applicant demonstrates that medically underserved populations will have adequate access to the proposed services. 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.5, page 188, the applicant describes the range of means by which a person will have access to the proposed services. The information provided is reasonable and credible and supports a finding of conformity 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, page 171, the applicant states that it has contacted an area training program to offer the proposed agency as a clinical training site. Exhibit 46 contains copies of letters sent to area health professional training programs, including Fayetteville Technical Community College and Sandhills Community College, offering to make the proposed agency available as a training site. The information provided in Section V.1 is reasonable and credible and supports a finding of conformity 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

There are currently four existing hospice home care agencies or offices in Cumberland County, as shown in the following table.

Existing Hospice Home Care Agencies Located in Cumberland County	Location
Cape Fear Valley Home Care and Hospice	1830 Owen Drive, Suite 203, Fayetteville
Community Home Care and Hospice	5301 Morganton Road, Fayetteville
HealthKeeperz	4155 Ferncreek Drive, Fayetteville
Liberty Home Care and Hospice	1830 Owen Drive, Suite 103, Fayetteville

PHH-Fayetteville does not currently own or operate a hospice home care agency in Cumberland County. However, United Hospice, Inc. owns 28 hospice home care agencies, including five hospice home care agencies in other counties in North Carolina. The closest one is located in Johnston County.

In Section II.12, pages 93-95, the applicant discusses the impact of the proposed project on competition in the service area including how any enhanced competition will have a positive impact on the cost-effectiveness, quality and access to acute care services. The applicant states,

> *"By providing healthy competition in hospice services, PHH-Fayetteville will improve access for all residents of the proposed service area. The hospice providers who presently serve the proposed service area have not met the identified need, as evidenced by the 2013 State Medical Facilities Plan (SMFP) which shows a need for an additional*

hospice home care agency in Cumberland County and in the other three counties in the service area. … An examination of the percentage of deaths served by hospice in the proposed service area counties provides evidence that a need for hospice services exists in this area. … The significantly low number of deaths served by hospice in the above counties indicates that there is a lack of access to hospice services in those counties. Furthermore, the low number of deaths served by hospice suggests insufficient competition and choice in the service area….

In addition, competition has the effect of improving the quality of services if only because each hospice provider must be more receptive and responsible to patients and their families in order to retain referrals. Competition encourages creativity among providers and improvement in services offered, along with an awareness of cost effectiveness since more than one provider is available to negotiate for hospice services….

Hospice is a demonstrated cost effective program that permits patients to die in comfort and with dignity. … The project requires minimal capital expenditure and thus, PHH-Fayetteville can provide services to residents within the Medicare and Medicaid rates, providing services to inpatient and respite care patients beyond what is covered in the day rates for these services. … In addition, PHH-Fayetteville will maximize the use of volunteer services that will result in cost-savings."

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 any enhanced competition in the service area will have a positive impact on cost-effectiveness, quality and access to the proposed services. This determination is based on the information in the application and the following analysis:

- The applicant adequately demonstrates the need to develop a hospice home care agency in Cumberland County and that it is a cost-effective alternative;
- The applicant adequately demonstrates that it will provide quality services; and
- The applicant demonstrates that it will 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.

C

PHH-Fayetteville is not an existing provider. However, United Hospice of Eastern Carolina-Smithfield, which is owned by United Hospice, Inc. and located in Johnston County,

currently serves patients in Cumberland County. United Hospice of Eastern Carolina-Smithfield is certified by CMS for Medicare and Medicaid participation, and licensed by the NC Department of Health and Human Services. According to files in the Acute and Home Care Licensure and Certification Section in the Division of Health Service Regulation, the agency operated in compliance with all Medicare conditions of participation during the eighteen months immediately preceding the date of the decision. 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 a hospice home care office. The specific criteria are discussed below.

Section .1500 - CRITERIA AND STANDARDS FOR HOSPICES

10A NCAC 14C .1502 Information Required of Applicant

(a) An applicant proposing to develop a hospice shall complete the application form for Hospice Services.

-C- PHH-Fayetteville completed the *Hospice Home Care Agency* application form.

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

(1) the annual unduplicated number of hospice patients projected to be served in each of the first two years following completion of the project and the methodology and assumptions used to make the projections;

-C- In Section IV.4, page 153, the applicant projects to serve 98 unduplicated patients in PY1 and 217 unduplicated patients in PY2. The assumptions are provided on pages 153-154.

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

-C- In Section IV.5, page 149, the applicant projects to serve 165 duplicated patients in PY1 and 415 duplicated patients in PY2. The assumptions are provided on pages 150-152.

(3) the projected number of patient care days, by level of care (i.e., routine home care, respite care, and inpatient care), by quarter, to be provided in each of the first two years of operation following completion of the project and the methodology and assumptions used to make the projections shall be stated;

-C- In Section II.2, page 58, the applicant projects days of care by level of care. The assumptions used to project the days of care is provided on pages 166-168. See Criterion (3) for discussion of the reasonableness of the assumption regarding projected days of care and is incorporated as if fully set forth herein.

(4) the projected number of hours of continuous care to be provided in each of the first two years of operation following completion of the project and the methodology and assumptions used to make these projections;

-C- In Section IV.8, pages 165-166, the applicant projects continuous care hours. The assumptions are provided on pages 166-168.

(5) the projected average annual cost per hour of continuous care for each of the first two operating years following completion of the project and the methodology and assumptions used to make the projections;

-C- In Section X.1, page 221, the applicant projects the cost per hour of continuous care to be $61.94 in PY1 and $39.16 in PY2. The assumptions are provided on pages 221-224 and Exhibit 52.

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

-C- In Section X.1, page 221, the applicant provides the average annual cost per patient day by level of care, as shown in the following table. The assumptions are provided on pages 221-224 and Exhibit 52.

PHH-Fayetteville		
	PY1	PY2
Routine Home Care	$197.72	$126.09
Respite Care	$368.89	$294.24
Inpatient Care	$894.16	$819.10

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

-C- In Sections V.2 and V.3, pages 173-178, and in Section VI.5, pages 188-189, the applicant discusses efforts made to establish working relationships with referral sources. Exhibit 24 contains copies of physician surveys. See also Exhibits 28, 29, 34, and 56 for copies of letters of support and documentation of the applicant's efforts to establish working relationships with referral sources.

(c) An applicant proposing to develop a hospice shall commit that it shall comply with all certification requirements for participation in the Medicare program within one year after issuance of the certificate of need.

-C- In Section II.2, page 59, the applicant states it will comply with all certification requirements for participation in the Medicare program within one year after issuance of the certificate of need.

10A NCAC 14C .1503 PERFORMANCE STANDARDS

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

-C- In Section IV.10(b), page 170, the applicant provides the days of care and the percentage of days of care at 97.1% and 96.9% to be provided to Medicare and Medicaid recipients in their homes for PY1 and PY2, respectively, as shown in the following table.

PHH-Fayetteville - % Days in Patient's Residence /% Routine Home Care Days Year 1 - FY 2015			
	Medicare Days	**Medicaid Days**	**Total**
Days in Residence	4,171	206	4,377
Total Patient Days	-	-	4,507
% of Days Provided in Residence	-	-	97.1%
% Days in Patient's Residence /% Routine Home Care Days Year 2 - FY 2016			
Days in Residence	10,903	558	11,461
Total Patient Days	-	-	11,824
% of Days Provided in Residence	-	-	96.9%

Source: Application, page 170.

The application is conforming to this rule. See Criterion (3) for a discussion of the reasonableness of the applicant's projections which is hereby incorporated by reference as if fully set forth herein.

10A NCAC 14C .1504 SUPPORT SERVICES

(a) An applicant proposing to develop a hospice shall demonstrate that the following core services will be provided directly by the applicant 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 61, the applicant states all of the above services will be provided directly by the agency.

(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.2, page 61, the applicant states that nursing services will be available 24 hours a day, seven days a week.

(c) An applicant proposing to develop a hospice shall provide documentation that the following services, when ordered by the attending physician and specified in the care plan, shall either be provided directly by the hospice or provided through a contract arranged by the hospice:
(1) hospice inpatient care provided in a licensed hospice inpatient facility bed, licensed acute care bed or licensed nursing facility bed,
(2) physical therapy,
(3) occupational therapy,
(4) speech therapy,
(5) home health aide services,
(6) medical equipment,
(7) respite care,
(8) homemaker services, and
(9) continuous care.

-C- In Section II.2, page 62, the applicant states that all of these services will be provided directly by the agency staff or through contract arranged by PHH-Fayetteville. The applicant states hospice inpatient and respite care will be provided through contractual agreements with local hospitals and nursing homes. Exhibit 26 contains copies of letters to local providers and Exhibit 47 contains copies of sample

contracts. The applicant states physical therapy, occupational therapy, and speech therapy services will be provided through contract with United Rehab, medical equipment will be provided through contract with United Medical, and pharmacy services will be provided through contract with United Pharmacy.

(d) For each of the services listed in Paragraph (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 their interest in working with the proposed facility.

-C- Exhibits 25, 26 and 27 contain copies of letters of interest and sample contracts for the services identified in Paragraph (c) above.

10A NCAC 14C .1505 STAFFING AND STAFF TRAINING

(a) An applicant proposing to develop a hospice shall document that staffing for hospice services will be provided in a manner consistent with G.S. 131E, Article 10.

-C- In Section II.2, page 64, the applicant states that projected staffing is consistent with G.S. 131E, Article 10.

(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 64, and Exhibit 30, the applicant states projected staffing is consistent with the Hospice Licensing Rules.

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

-C- In Section II.2, page 64, the applicant states that training for staff and volunteers will meet the requirements in the Hospice Licensing Rules. See Exhibit 18 and 20 for staff competency-related policies and procedures and staff training and development requirements, and Exhibit 30 for documentation of the applicant's intention to comply with these training requirements.

(3) a volunteer program will be established and operated in accordance with 10A NCAC 13K .0400 and .0500 and 42 CFR 418.70;

-C- In Section II.2, page 65, the applicant states that the volunteer program will be established and operated in accordance with the requirements set forth above. See Exhibit 30 for a letter documenting the applicant's commitment to meet the requirements in all hospice licensing rules.

(4) an interdisciplinary team will be established which includes, a physician, a licensed nurse, a social worker, a clergy member, and a trained hospice volunteer, as specified in G.S. 131E-201;

-C- In Section II.2, page 66, the applicant states that the interdisciplinary team will include all members listed above. See Exhibits 30 and 31 for documentation of the applicant's intention to establish the interdisciplinary team.

(5) a coordinator as set forth in 42 CFR 418.68 will coordinate the hospice interdisciplinary team to assure implementation of an integrated care plan and the continuous assessment of the needs of the patient and the patient's family or significant others;

-C- In Section II.2, page 66, the applicant states that the interdisciplinary team will be coordinated by the direct care nurses.

(6) a written care plan will be developed by the attending physician, the medical director or medical director's physician designee, and the interdisciplinary team before care is provided to a patient and the patient's family or significant others;

-C- In Section II.2, page 66, the applicant states that a written care plan will be developed in accordance with this rule.

(7) meetings of the interdisciplinary care team and other invited personnel will be held on a frequent and regular basis, at least once every two weeks, for the purpose of care plan review and staff support; and

-C- In Section II.2, page 66, the applicant states that the interdisciplinary team will meet at least once every two weeks.

(8) each interdisciplinary team member will be provided orientation, training, and continuing education programs appropriate to their responsibilities and to the maintenance of skills necessary for the physical care of the patient and the psychosocial and spiritual care of the patient and the patient's family or significant others.

-C- In Section II.2, page 67, and Exhibits 18, 20, 30 and 31, the applicant states that it will provide a comprehensive and on-going in-service training program for all staff and volunteers.