ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE:	January 28, 2014
FINDINGS DATE	February 4, 2014
PROJECT ANALYST:	Jane Rhoe-Jones
TEAM LEADER:	Lisa Pittman
PROJECT I.D. NUMBER:	K-10172-13 / Wiregrass Hospice of South Carolina, LLC d/b/a Gentiva Hospice / Establish a new hospice home care agency / Granville County
	K-10173-13/ Granville-Vance District Health Department / Establish a new hospice home care agency / Granville County
	K-10174-13 / Continuum II Home Care and Hospice, Inc. d/b/a Continuum Home Care & Hospice of Granville County / Establish a new hospice home care agency / Granville 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.

-NC- Gentiva Hospice
-NC- Granville-Vance District Health Department
-NC- Continuum Home Care & Hospice of Granville County

The 2013 State Medical Facilities Plan (SMFP) contains a need methodology for determining the need for new hospice home care agencies. The 2013 SMFP identifies Granville County as a county with a need determination for one additional hospice home care office. Three competing applications for this review were received by the Certificate of Need Section. However, pursuant to the need determination, only one hospice home care agency may be approved in this review for Granville County. After a thorough analysis of each application

and a comparison of all three applications, no application is approvable. All three applicants propose to establish a new hospice home care agency in Granville County. None of the applicants propose to develop more than one hospice home care agency; therefore, all three applications are conforming to the 2013 SMFP need determination for hospice home care agencies.

Additionally, Policy GEN-3 on pages 42-43 in the 2013 SMFP is also applicable to this 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*."

The applicants respond to Policy GEN-3 as follows:

Gentiva Hospice - In Section III, pages 68-70, the applicant discusses how its proposal will promote quality care. Exhibit 4 contains an agency policy regarding corporate compliance for hospice. Exhibit 8 contains the agency policy regarding quality assessment and performance improvement (QAPI) and the agency policy regarding risk management. The applicant adequately demonstrates how its proposal will promote safety and quality. In Section III, page 71, the applicant discusses how its proposal will improve access to hospice care for Granville County patients. Additionally, in Section VI, pages 107-115, the applicant discusses access for underserved populations. The applicant adequately demonstrates how its proposal will promote equitable access to hospice services. In Section III, pages 71-72, the applicant discusses how its proposal will be a cost-effective approach. However, the applicant fails to adequately demonstrate the need for its proposal and therefore, does not demonstrate that the project is a cost effective approach. Furthermore, the applicant's projected revenue and expenses are unsupported and unreliable. See Criterion (3) for a discussion of need and Criterion (5) for a discussion of cost-effectiveness which are hereby incorporated by references as if fully set forth herein. Consequently, the application is not consistent with Policy GEN - 3 and is therefore not conforming to this criterion.

Granville-Vance District Health Department (GVDHD) - In Section III, page 72, the applicant discusses how its proposal will promote quality care. Exhibit 2 contains agency information on quality outcome measures and quality indicator training for staff. Exhibit 10 contains hiring standards. The applicant adequately demonstrates how its proposal will promote safety and quality. In Section III, pages 70-71, the applicant discusses how its proposal will improve access to hospice care for Granville County. Additionally, in Section VI, pages 112-117, the applicant discusses access for underserved populations. The

applicant adequately demonstrates how its proposal will promote equitable access to hospice services. In Section III, pages 73-74, the applicant discusses how its proposal will promote cost-effective care. However, the applicant fails to adequately demonstrate the need for its proposal and therefore, does not demonstrate that the project is a cost effective approach. Furthermore, the applicant's projected revenue and expenses are unsupported and unreliable. See Criterion (3) for a discussion of need and Criterion (5) for a discussion of cost-effectiveness which are hereby incorporated by references as if fully set forth herein. Consequently, the application is not consistent with Policy GEN - 3 and is therefore not conforming to this criterion.

Continuum Home Care & Hospice of Granville County (Continuum) - In Section II, pages 48 and 51, and in Section III, page 82, the applicant discusses how its proposal will promote quality care. Appendix F contains agency policies regarding quality improvement. The applicant adequately demonstrates how its proposal will promote safety and quality. In Section II, page 52, the applicant discusses how its proposal will improve access to hospice care for Granville County patients. However, the applicant fails to acknowledge that its proposal does not improve access to hospice care for Vance County patients because it has a licensed hospice home care office in Vance County, but it is not currently serving patients through that office. Additionally, in Section VI, pages 122-128, the applicant discusses access for underserved populations. The applicant does not adequately demonstrate how its proposal will promote equitable access to hospice services. In Section II, page 51, the applicant discusses how its proposal will promote cost-effective care. However, the applicant fails to adequately demonstrate the need for its proposal and therefore, does not demonstrate that the project is a cost effective approach. Furthermore, the applicant's projected revenue and expenses are unsupported and unreliable. See Criterion (3) for a discussion of need and Criterion (5) for a discussion of cost-effectiveness which are hereby incorporated by references as if fully set forth herein. Consequently, the application is not consistent with Policy GEN - 3 and is therefore not 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.

-NC- Gentiva Hospice
-NC- GVDHD
-NC- Continuum

Wiregrass Hospice of South Carolina, LLC d/b/a Gentiva Hospice proposes to develop a new hospice home care office at 107 East McClanahan Street in Oxford, which is located in Granville County.

Population to be Served - **Gentiva Hospice**

In Section III.1, page 46 and III.4, page 72, Gentiva Hospice identifies the proposed service area as Granville, Franklin, Person and Vance counties. The proposed patient origin and utilization for the first two operating years, Project Year 1 (PY1) and Project Year 2 (PY2) are shown are shown in the following table.

GENTIVA HOSPICE SERVICE AREA				
County	**Projected Patients PY1**		**Projected Patients PY2**	
Granville	82	88.9%	126	77.6%
Franklin	5	5.6%	17	10.5%
Person	2	2.0%	7	4.0%
Vance	3	3.4%	13	7.9%
Total	**92**	**100.0%**	**163**	**100.0%**

Source: Application pages 67 & 74.

In Section IV.4, page 81, the applicant proposes to serve 92 unduplicated patients in PY1 and 163 unduplicated patients in PY2.

Demonstration of Need - **Gentiva Hospice**

Gentiva Hospice projects to serve 92 unduplicated patients in PY1 and 163 unduplicated patients in PY2. On page 81 the applicant defines PY1 as October 2014-September 2015 and PY2 as October 2015-September 2016. The 2013 SMFP projects 99 additional patient deaths in need of hospice care for 2014 in Granville County. The 2013 SMFP projects hospice deaths based upon the projected average hospice deaths in North Carolina and the county death rate. The applicant projects the ALOS for routine home care hospice patients as 73.5 days. The applicant, in Section IV.5(a), pages 82-83, provides the projected unduplicated patients to be served in each of the first 24 months following completion of the project, as shown below in the following table.

GENTIVA HOSPICE - Projected Unduplicated Patients – PY1 and PY2			
Month/Year	**Number of Patients**	**Month/Year**	**Number of Patients**
October 2014	1	October 2015	11
November 2014	3	November 2015	11
December 2014	6	December 2015	13
January 2015	6	January 2016	12
February 2015	5	February 2016	12
March 2015	9	March 2016	14
April 2015	7	April 2016	13
May 2015	9	May 2016	14
June 2015	10	June 2016	15
July 2015	11	July 2016	15
August 2015	12	August 2016	15
September 2015	12	September 2016	16
***Total**	**92 [91]**	***Total**	**163 [161]**

*The Project Analyst calculated 91 patients in PY1 and 161 patients in PY2.

In Section IV, pages 83-85, Gentiva Hospice explains the monthly census as follows:

"*Routine Home Care Patients: Gentiva projects the proposed … agency will serve one routine home care patient during Month One (October 2014). Thereafter, Gentiva projects the average daily census (ADC) to increase by two patients per month each month during the first project year. Gentiva projects the ADC to increase by one patient each month during the second project year. Gentiva projects the ALOS for routine days of care based on the FY2012 statewide median ALOS per admission (73.5) per the Proposed 2014 SMFP.*

Respite Patients: … Gentiva projects 0.24% of its patient days of care will be provided to respite patients. Thus, Gentiva projects an ADC of 0.03 respite patients during PY1 (beginning in month two) and 0.07 patients in PY2.

Gentiva projects a respite care ALOS of five (5) days during the initial two project years. …

Hospice Inpatients: … During the initial project year, Gentiva Hospice projects 2.0% of all hospice patient days of care will be inpatient days. Thus, Gentiva projects an ADC of 0.3 hospice inpatient [sic] *during PY1 (beginning in month three) and PY2.*

…

Continuous Care: … Gentiva projects to serve one continuous care patient during each quarter of the initial two project years (four total patients per year).

Gentiva assumes the average number of continuous care hours provided to each patient will be eight (8). …

After projecting ADC by level of hospice care during each of the first 24 months of the proposed project, Gentiva Hospice's projected monthly patient census was calculated based on the following formula:

Patient Census = Average Daily Census x Days in Month/ALOS"

The applicant's methodology for monthly census, average daily census and number of unduplicated patients is not consistent. The methodology used to make projections is unclear. Using Gentiva Hospice's formula for average daily census from page 83: "*agency will serve one routine home care patient during Month One (October 2014). Thereafter, Gentiva projects the average daily census (ADC) to increase by two patients per month each month during the first project year*."

[October 2014 + November 2014 … August 2015 = 1+2+2+2+2+2+2+2+2+2+2 = 21]; and their formula for patient census:
[August 2015 Patient Census = Average Daily Census x Days in Month/ALOS = 21 x 31/73.5 = 651/73.5 = 8.9 patients] results in 9 patients for August 2015. Gentiva Hospice's table on page 82 indicates 12 patients.

In Section III.1, pages 43-67, Gentiva Hospice discusses the factors it considers in developing the proposal, which include:

- 2013 SMFP
- Granville County Population Growth
- Aging in Granville County
- Cancer Incidence Rates
- Disease Incidence and Death Rates
- Hospice Use Rates

In Section III, pages 43-46, the applicant discusses the 2013 SMFP methodology for projection of need for new hospice home care programs. In Section III, pages 58-67, the applicant discusses the methodology and assumptions it uses to project utilization for the first two operating years. The applicant states:

"*1) Service Area Deaths – Gentiva reviewed the historical number of deaths for the counties in the primary and secondary service area*."

GENTIVA HOSPICE - SERVICE AREA DEATHS					
	2008	**2009**	**2010**	**2011**	**3Yr CAGR**
Granville	548	491	457	446	-6.6%
Franklin	462	469	454	480	1.3%
Person	397	398	421	396	-0.1%
Vance	430	448	437	443	1.0%

Source: Application, page 58

"*The number of deaths in Granville County decreased during 2008-2011. Gentiva notes that the declining growth trend has diminished each year since 2008, and that the annual decrease during 2010 to 2011 was only -2.4 percent. … the population in Granville County is aging rapidly, suffers disproportionately from various cancers, and exhibits higher disease mortality statistics. Thus, it is not expected that Granville County will continue to experience a decrease in deaths. … Gentiva projects the number of deaths in Granville County to remain constant through FY2016.*

Gentiva projects deaths in Franklin and Vance counties to increase based on their respective 2008-2011 CAGRs, and that deaths in Person County will remain constant through FY2016.

2) Estimate County Death Rates – Based on the projected deaths by county in Step 1 and the projected population by county, Gentiva calculated the death rate/1,000 population by county."

See Section III, page 59 for the applicant's tables with projected deaths and with projected population by county. The applicant's projected death rates by county are shown below:

GENTIVA HOSPICE - PROJECTED DEATH RATE BY COUNTY					
	2012	**2013**	**2014**	**2015**	**2016**
Granville	7.9	7.8	7.8	7.8	7.8

Franklin	7.9	7.9	7.9	8.0	8.0
Person	10.1	10.1	10.1	10.0	10.0
Vance	9.8	9.9	10.0	10.1	10.2

Source: Application, page 60. Formula: Projected Deaths/(Population/1000)

"*3) 2-Year Trailing Average Growth Rate in Statewide Median % of Deaths Served – According to data provided in the Proposed 2014 SMFP, the following table calculates the 2-year trailing average growth rate for the statewide median percent of deaths served by hospice*."

Gentiva Hospice Table

Statewide Median % of Deaths Served by Hospice		
Year	**Median % of Deaths Served**	**Growth**
2010	34.09%	
2011	35.23%	3.3%
2012	36.21%	2.8%
2Yr Trailing Average Growth Rate		**3.1%**

Source: Application, page 60.

"*4) Project Statewide Median % of Deaths Served – To project the statewide median percent of deaths served by hospice, Gentiva applied the 2010-2012 two-year trailing average growth rate to the 2012 Statewide median HPR.*" (Hospice penetration rate (HPR) is the percent of all deaths that are served by hospice.)

Gentiva Hospice Table

Projected Statewide Median % of Deaths Served by Hospice				
	2013	**2014**	**2015**	**2016**
Statewide Median HPR	37.3%	38.5%	39.7%	40.9%

Source: Application, page 61.

"*5) Projected Hospice Eligible Deaths – To project hospice eligible deaths by county, Gentiva utilized the following formula: Projected Population/1,000 x Projected Death Rate x projected statewide median HPR.*"

GENTIVA HOSPICE Projected Hospice Eligible Deaths			
	2014	**2015**	**2016**
Granville	172	177	182

Franklin	192	200	209
Person	152	157	162
Vance	176	183	190

Source: Application, page 61.

[Projected 2014 Granville County hospice eligible deaths = (56,936/1,000) x 7.8 x .385 = 56.94 x 7.8 x .385 = 170.99)]

> "*6) Project Hospice Eligible Patients - … projected hospice eligible deaths are not equivalent to projected hospice eligible patients. Not all patients served by hospice die in the year of admission to a hospice agency, and some are discharged from care*."

The following table provides FY 2012 hospice admission and death rates for the counties in Gentiva Hospice's primary and secondary service area.

Gentiva Hospice Table

Hospice Admissions & Deaths FY 2012			
	Admissions	**Deaths**	**Admission: Death Ratio**
Granville	124	88	1.41
Franklin	131	112	1.17
Person	158	127	1.24
Vance	124	110	1.13

Source: Application, page 62.

> "*To project the number of hospice eligible patients in the proposed service area, Gentiva applied the respective Hospice Admission:Death Ratio to each county's projected hospice deaths*."

GENTIVA HOSPICE Projected Hospice Eligible Patients			
	2014	**2015**	**2016**
Granville	242	249	257
Franklin	225	234	245
Person	190	196	202
Vance	198	206	215

Source: Application, page 62.

> "*7) Projected Hospice Deaths Served – The 2013 SMFP standard methodology projects hospice deaths served by county based on application of the statewide two-year trailing average growth rate for hospice deaths (4.9%) to the number of 2011 hospice deaths. … Gentiva reviewed the historical number of hospice deaths served in each county of the identified primary and secondary service area*."

Gentiva Hospice Table

Historical Hospice Deaths Served FFY 2010 – FFY 2012				
	2010	**2011**	**2012**	**2Yr**

				CAGR
Granville	89	108	88	-0.6%
Franklin	114	106	112	-0.9%
Person	130	143	127	-1.2%
Vance	95	123	110	7.6%

Source: Application, page 63.

"*The number of hospice deaths served has decreased in all but Vance County of the proposed service area. Therefore, Gentiva Hospice determined … to project that hospice deaths remain constant for Granville, Franklin and Person counties rather than apply the statewide two-year trailing average growth rate for hospice deaths served per the 2013 SMFP standard methodology.*

Gentiva projects Vance County hospice deaths served based on its respective two-year trailing average growth rate (7.6%), which … is equivalent to the two-year trailing average growth rate utilized in the 2013 SMFP standard methodology for hospice deaths served."

GENTIVA HOSPICE
Projected Hospice Deaths Served
FFY 2014 – FFY 2016

	2014	2015	2016
Granville	88	88	88
Franklin	112	112	112
Person	127	127	127
Vance	121	127	133

Source: Application, page 63.

"*8) Project Number of Additional Patients in Need (Unserved Deaths) – Gentiva determined the projected number of additional patients in need (unserved deaths) by subtracting the projected hospice deaths served (Step 7) from the projected hospice eligible deaths (Step 5).*"

GENTIVA HOSPICE
Projected Number Unserved Deaths
FFY 2014 – FFY 2016

	2014	2015	2016
Granville	84	89	94
Franklin	80	88	97
Person	25	30	35
Vance	55	56	57

Source: Application, page 64.

[2014 Granville County Projected number of unserved deaths = 2014 projected number hospice eligible deaths – 2014 projected number hospice deaths served = 172-88 = 84]

In Section III, page 64, the applicant states that it used updated data from the NC Office of State Budget and Management (OSBM) that was released after publication of the 2013 SMFP. Therefore, the applicant uses the updated, lower population projections, which differ slightly from the projections identified in the 2013 SMFP.

"*9) Gentiva Market Share for Unserved Hospice Deaths – To project the number of hospice deaths for the proposed project, Gentiva estimates that it will achieve the following market share by county during the first two project years. … the projected market share is applicable to the projected <u>unserved</u> hospice deaths (Step 8) only, not all projected hospice deaths (Step 5).*" [Emphasis in original.]

GENTIVA HOSPICE Projected Market Share Unserved Hospice Deaths FFY2015 – FFY2016		
	2015	2016
Granville	65%	95%
Franklin	5%	15%
Person	5%	15%
Vance	5%	20%

Source: Application, page 65.

In Section III, page 65, the applicant states that it will target and primarily focus on serving unserved hospice deaths in Granville County; although it will also serve the neighboring counties of Franklin, Person and Vance.

"*10*) *Projected Gentiva Hospice Deaths – … Gentiva applied the projected market share estimates by county (Step 9) to the projected number of unserved hospice deaths (Step 8).*"

GENTIVA HOSPICE Projected Hospice Patient Deaths FFY2015 – FFY2016		
	2015	**2016**
Granville	58	90
Franklin	4	15
Person	2	5
Vance	3	11
Total	**67**	**121**

Source: Application, page 66.

"*11*) *Projected Gentiva Hospice Patients (Admissions) – … Gentiva applied the respective FY2012 Hospice Admission : Death Ratio (… Step 6) to the number of projected hospice deaths served (Step 10).*"

GENTIVA HOSPICE Projected Hospice Patient Admissions FFY2015 – FFY2016		
	2015	**2016**

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

Source: Application, page 67.

In Section IV.6, pages 86-93, the applicant provides the projected number of visits by level of care and discipline for the first two project years.

GENTIVA HOSPICE - Hospice Visits by Level of Care and Discipline											
	PY1						**PY2**				
	Home	**Respite**	**Inpatient**	**Continuous**	**Total**		**Home**	**Respite**	**Inpatient**	**Continuous**	**Total**
Physician	75	0	2	0	77		134	0	2	0	136
Nursing (incl. Dietary Counseling)	1,770	4	46	4	1,824		3,166	10	55	4	3,235
PT/ST/OT*	163	0	0	0	163		292	0	0	0	292
SW (incl. Family Counseling & Bereavement)	495	1	10	1	507		886	3	12	1	902
CNA/Aides (incl. Homemaker/Chore & Home Health Aide)	1,959	4	91	2	2,056		3,506	11	110	2	3,629
Clergy (incl. Family Counseling & Bereavement)	240	1	27	1	269		429	1	33	1	464
Volunteer**	0	0	0	0	0		0	0	0	0	0
Total	**4,702**	**10**	**176**	**8**	**4,896**		**8,413**	**25**	**212**	**8**	**8,658**

Source: Application, pages 86-93. Note: * = Therapy. ** = 0 Volunteer Visits.

The distribution of visits by discipline in the first two project years indicates that over 76 percent of total visits are nursing visits (includes CNAs). Social work and chaplain comprise the second and third highest percentage of total visits, respectively. However, as shown in Section IV.6, pages 86-93, the applicant does not project any Volunteer visits.

GENTIVA HOSPICE **Percentage of Total Hospice Visits by Discipline**		
	PY1	**PY2**
Physician	1.6%	1.6%

Nursing (incl. Dietary Counseling)	37.3%	37.4%
PT/ST/OT	3.3%	3.4%
SW (incl. Family Counseling & Bereavement)	10.4%	10.4%
CNA/Aides (incl. Homemaker/Chore & Home Health Aide)	42.0%	42.0%
Clergy (incl. Family Counseling & Bereavement)	6.0%	5.4%
Volunteer	0%	0%
***Total**	**100.6%**	**100.2%**

*Table does not foot due to rounding. Source: Application, Tables IV.6, pp 86-93.

In Section IV.8(a&b), page 99, the applicant projects the hospice patient care days by level of care. The two tables labeled IV.8, depicting PY1 and PY2 patient days of care by level are combined below into one table. The table below also includes the average daily census (ADC) for both project years.

GENTIVA HOSPICE Hospice Patient Care Days by Level of Care and ADC		
	PY1	**PY2**
Home	4,381	10,403
Inpatient	91	110
Respite	10	26
Continuous Hrs/Days	32/4	32/4
Total Days	**4,486**	**10,543**
ADC	**12.3**	**28.9**

Source: Application: pages 99. ADC Formula = patient days in period/total # days in period (365 days).

The average daily census for PY1 is twelve patients and PY2 average daily census is 29 patients.

Gentiva Hospice's assumptions regarding projected population for the service area, projected patients, projected total deaths for the service area, and projected hospice deaths in the service area are not reasonable and supported.

The applicant does not adequately demonstrate how it can reach 95% market share in Granville County in PY2. As the applicant noted on page 57, "*the service area has a history of very low hospice use compared to the state*. …" It is not reasonable to project going from serving no Granville County patients to serving 95% of the Granville County market. The applicant's projected Granville County market share in PY2 is not reasonable, credible and supported.

Moreover, the applicant projects the number of visits by dividing the average visits (by discipline) by admissions instead of by days of care. This method penalizes the patient for a longer stay which is per physician's order. The applicant's projections of visits by level of care are not based on reasonable, credible and supported assumptions.

In summary, **Gentiva Hospice's** projected number of patients, deaths served, days of care, and visits are not reasonable, credible and supported. Therefore, the applicant does not

adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not conforming to this criterion.

Granville-Vance District Health Department (GVDHD) proposes to develop a new hospice home care office at 101 Hunt Drive in Oxford, which is located in Granville County.

Population to be Served – **GVDHD**

In Section III.4, page 76, GVDHD identifies the proposed service area as Granville, Franklin, Person, Vance and Warren counties. The proposed patient origin and utilization for the first two operating years are shown in the table below from page 77.

From Table III.20

GVDHD Projected Annual Patients Served by County				
County	**Projected Patients (PY1)**		**Projected Patients (PY2)**	
Granville	80	58.4%	144	54.3%
Franklin	1	0.7%	9	3.4%
Person	5	3.6%	23	8.7%
Vance	48	35.0%	58	21.9%
Warren	3	2.2%	31	11.7%
Total	**137**	**100.0%**	**265**	**100.0%**

The table may not foot due to rounding.

However, in Table III.23, page 78, GVDHD provides the following number of projected admissions:

Table III.23

GVDHD Projected Admissions		
County	**PY1 2014-2015**	**PY2 2015-2016**
Granville	69	144
Franklin	35	58
Person	5	6
Vance	1	3
Warren	1	9
Total	**112**	**219**

In Section IV.4, page 85, the applicant proposes to serve 112 unduplicated patients in PY1 and 219 unduplicated patients in PY2. Although the applicant is consistent in the counties to be served by the proposal, it is not consistent in identifying the total number of patients to be served or the percentage of total patients to be served by each county in the service area. Therefore, GVDHD does not adequately identify the population to be served.

Demonstration of Need - **GVDHD**

GVDHD projects to serve 112 unduplicated patients in PY1 and 219 unduplicated patients in PY2. On page 85, the applicant defines PY1 as July 2014 – June 2015 and PY2 as July 2015 – June 2016. The 2013 SMFP projects 99 additional patient deaths in need of hospice care for 2014 in Granville County. The 2013 SMFP projects hospice deaths based upon the

projected average hospice deaths in North Carolina and the county death rate. The applicant projects the ALOS for routine home care hospice patients as 30 days in PY1 and 60 days in PY2. The applicant, in Section IV.5(a) pages 85-86, provides the projected unduplicated patients to be served in each of the first 24 months following completion of the project. However, there is a discrepancy in the number of PY2 projected patients on pages 85 and 86; 392 versus 219. The Project Analyst surmises that 392 is in error as 219 patients are projected elsewhere in the application, however, the inconsistency in the data is confusing. The projected unduplicated patients from page 86 are shown below in the table.

Table IV.1.b

GVDHD Projected Unduplicated Patients – PY 1 and PY 2			
Month/Year	**Number of Patients**	**Month/Year**	**Number of Patients**
July 2014	1	July 2015	19
August 2014	1	August 2015	19
September 2014	1	September 2015	19
October 2014	6	October 2015	18
November 2014	6	November 2015	18
December 2014	9	December 2015	18
January 2015	10	January 2016	18
February 2015	11	February 2016	18
March 2015	17	March 2016	18
April 2015	17	April 2016	18
May 2015	17	May 2016	18
June 2015	17	June 2016	18
Total	**112**	**Total**	**219**

GVDHD does not demonstrate the reasonableness or existence of an actual methodology for projecting patients served. In Section IV, page 86, GVDHD explains the monthly census as follows:

> "Step 1. *Calculate the number of admissions by month. Assume a six month lag for certification in the first year and gradually fill to the patients served listed in IV.4(a).*" [sic]
>
> "*Step 2. Assume a length of stay: Year 01 = 30 days; Year 02 = 60 days based on experience of HOWC and review against the benchmarks for the National Hospice and Palliative Care Organization*
>
> *Step 3. Multiply Admissions by ALOS to get patients served, if ALOS was less than 30. If greater than 30 assume admissions from the prior month are still active in the subsequent month.*
>
> …
>
> *Total patients served, as identified … above were admitted gradually, allowing for a six month lag in certification.* [sic] *in the first year. Caseload is increased gradually*

in subsequent months, allowing a slightly higher caseload in late summer, when deaths tend to increase."

In Section III.1, pages 56-65, GVDHD discusses the factors it considered in developing the proposal, which include:

"*The unmet need that necessitated the inclusion of each of the proposed hospice services …*"

- 2013 State Medical Facilities Plan identified the need for one new hospice home care agency in Granville County
- Percentage of deaths served by hospice
- Hospice home care provider with Granville County and service area healthcare system ties
- Established zoned staff
- Competition, choice and cost alternative
- Projected population growth in the service area
- Health status in the service area
- Low hospice utilization in service area nursing homes
- Referral source support

In Section III, pages 56-65, the applicant discusses the 2013 SMFP methodology for projection of need for new hospice home care programs. In Section III, pages 66-68, the applicant discusses the methodology and assumptions it uses to project utilization for the first two operating years. The applicant includes updated population data which lowers the projected number of additional patients in need of hospice home care (the deficit projected for PY1 - 2015 and PY2 - 2016). The applicant states:

"*Data from the Proposed 2014 State Medical Facilities Plan were used to forecast the deficit in FY 2015*"

Table III.9

GVDHD **Forecast Deficit of Hospice Patients Served in FY 2016**									
Column	**Colum**	**Column**	**Column**	**Column**	**Column**	**Column**	**Column**	**Column**	**Column**

A	n B	C	D	E	F	G	H	I	K
County	*2012 Estima-ted Deaths	2012 Reported Hospice Patient Deaths	% Deaths Served by Hospice	2007-2011 [2006-2010] Death Rate/1000 Populatio n	2015 Update d Popu-lation	Projected 2015 Deaths	2015 Projec-ted Hospice Deaths Served	Median Projec-ted Hospice Deaths	Projected # Additional Patients in Need Sur-plus (Deficit)
	2007 [2012] NC Vital Statis-tics	Table 13B Pro-posed 2014 SMFP	Column C/ Column B	Deaths NC Vital Statistics/ 1000	OSBM	Column E (Column F /1000)		Column G Pro-jected Hospice Death Rate **	Column C + Column I - Column H
Granville	550	88	16.00%	8.5	57,019	485	102	192	(90)
Vance	443	110	24.83%	10.1	45,633	461	127	183	(56)
Person	396	127	32.07%	10.7	39,434	422	147	167	(20)
Franklin	480	112	23.33%	7.9	63,504	502	129	199	(70)
Warren	213	29	13.62%	11.2	20,472	229	33	91	(58)
									(294)

Source: Application, page 64. *The 2012 estimated deaths do not match the estimated deaths on the NC Vital Statistics website as of 1.8.2014. Column J not shown here = Placeholder for New Hospice Office. **Proposed 2014 SMFP.

Table III.9

GVDHD			
County	**Projected 2012 Deaths**	**Population CAGR 2009-2012**	**Estimated 2013 Deaths (Table 111.10)**
Granville	550	1.69%	473[559]
Vance	443	-0.82%	439
Person	396	0.68%	408[399]
Franklin	480	1.92%	477[489]
Warren	212	-0.30%	224[211]

[Projected 2013 Granville County deaths = Granville County 2009-2012 Population CAGR x Granville County 2012 # deaths = (0.0169 x 550) + 550 = 559 not 473 as listed above and in Application, page 65]

The applicant further states:

> "*For FY 2016, GVDHD conservatively estimated deficits using trended North Carolina median projected hospice deaths and trended hospice deaths served in each county. Trends are down in Franklin and Warren.*"

Table III.10

GVDHD Forecast Deficit of Hospice Patients Served in FY 2016

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column K
County	2013 Estimated Deaths	2013 Reported Hospice Patient Deaths	% Deaths Served by Hospice	2006-2010* Death Rate/1000 Population	2016 Updated Population	Projected 2016 Deaths	2015 [2016] Projected Hospice Deaths Served	Median Projected Hospice Deaths	Projected # Additional Patients in Need Surplus (Deficit)
	Estimated **	Estimated **	Column C/ Column B	Estimated **	OSBM	Column E (Column F /1000)		Column G Projected Hospice Death Rate **	Column C + Column I - Column H
Granville	**473[559]**	85	18.09%	8.8	57,098	502	78	205	(127)
Vance	439	118	26.79%	10.1	45,669	461	144	188	(45)
Person	**408[399]**	132	32.29%	10.8	39,445	426	147	174	(27)
Franklin	**477[489]**	110	23.16%	7.9	64,017	506	106	207	(101)
Warren	**224[211]**	25	11.28%	11.4	20,386	232	17	95	(78)
									(378)

Source: Application, page 65. *Applicant says it is using 2007-2011 death rates but instead uses 2006-2010 death rates. **Estimated forward on historical CAGR.

The applicant states its methodology as follows:

"*<u>Estimated Deaths</u>*

<u>Step 1</u>. Estimated 2013 deaths for Table III.10 were calculated by multiplying the deaths from Table III.9 by the CAGR for the population of the county from 2009 through 2012."

Table III.11

GVDHD Service Area Population Growth					
County	**2009**	**2010**	**2011**	**2012**	**CAGR**
Granville	56,016	57,933	57,898	58,906	1.69%
Vance	44,702	43,730	43,592	43,606	-0.82%
Person	38,390	38,428	37,824	39,174	0.68%
Franklin	59,028	60,120	61,171	62,501	1.92%
Warren	19,920	19,830	19,864	19,741	-0.30%

Source: Application, page 66.

"*Step 2. The projected deaths for 2016 in Table III.10 (Column G) were calculated by multiplying the 2006-2010 death rates from the 2013 SMFP by the population for 2016 from NCOSBM.*"

[Projected 2016 Granville County deaths = Granville County 2006-2010 death rate x 2016 estimated population divided by 1,000 = 8.8 x 57,098/1,000 = 502.46]

"*<u>Hospice Deaths</u>*

Trended hospice deaths in Tables III.7, III.9 and III.10 were calculated as follows:

Step 3. Calculate the Compound Annual Growth Rate (CAGR) for the state median hospice death rate for FY 2010 through 2012."

GVDHD Table III.12

Deaths Served by NC Hospices				
	2010	**2011**	**2012**	**CAGR**
State Median	34.09%	34.23%	36.20%	3.10%

Source: Application, page 66.

"*A … Trend in Deaths Served was forecast using a simple Compound Annual Growth Rate (CAGR). The result for FY2014 in Table III.12* [sic]*… is more conservative than the forecast in the 2013 SMFP. The former* [sic] *was used in forecasts for FY 2014 in Table III.7 …, but the more conservative trend was used in FY 2015 and 2016 Tables III.8 and III.9 …*

Step 4. … calculate the state median hospice death rate in FY 2013, through FY 2016 by annually applying the State's FY 2006-2008 [sic] *CAGR's* from *Table III.12 …*"

GVDHD Table III.13

Projected Median Percent Hospice Deaths Served				
	2013	**2014**	**2015**	**2016**
State Median	37.3%	38.5%	39.6%	40.9%

Source: Application, page 67.

"*Step 5. Calculate the Hospice Deaths Served in Service Area Counties.*

For FY 2014 and 2015, use the forecast trailing average growth rates in from [sic] *the 2013 and Proposed 2014 SMFP Tables 13B respectively.*

For FY 2016, the forecast hospice deaths were derived from four-year actual trends in the service area counties."

GVDHD Table III.14

Reported Hospice Deaths					
County	**2009**	**2010**	**2011**	**2012**	**CAGR**
Granville	96	89	108	88	-2.86%
Vance	90	95	123	110	6.92%

Person	114	130	143	127	3.67%
Franklin	117	114	106	112	-1.45%
Warren	44	43	26	29	-12.97%
Total	**461**	**471**	**506**	**466**	

Source: Application, page 67.

"*Step 5* [sic]. *Calculate the Projected Hospice Deaths Served in Service Area Counties by multiplying the trended percent of patients served by hospice for 2016 in Table III.13 by the number of prior year deaths.*"

From Table III.15

GVDHD Projected Hospice Deaths Served Based on Current Trends				
County	**2013**	**2014**	**2015**	**2016**
Granville	85	83	81	78
Vance	118	126	134	144
Person	132	136	141	147
Franklin	110	109	107	106
Warren	25	22	19	17
Total	**470**	**476**	**482**	**492**

Source: Application, page 67.

Following Step 5 does not result in the number of deaths served as listed in Table III.15.
[Trended % of patients served by hospice for 2016 in Table III.13 x number of prior year deaths = .409 x 88 = 35.992]
The applicant apparently calculates projected hospice deaths served by multiplying the 2009-2012 CAGR by the number of prior year deaths.
[Granville County 2013 projected hospice deaths served = Granville County 2012 hospice deaths x Granville County 2009-2012 CAGR hospice deaths = (88 x -2.86%) + 88 = -2.52 + 88 = 85.48]

"*Assumption: Estimate are* [sic] *based on the last available year's data projected forward based on 2009-2012 CAGR from Table III.14 ….*

Step 6 [sic]. *Calculate the Median Projected Hospice Deaths in Service Area Counties (Column I) of Table III.10 by multiplying the projected deaths (Column G) projected* [sic] *Percent of Hospice Deaths Served for the state in Table III.13.*
Step 7 [sic]. *Calculate the Additional Patients in Need in Service Area Counties (Column K of Tables III.7, III.9 and III.10) by subtracting Colum* [sic] *H from Column I.*"

GVDHD Table III.16

Hospice Deaths – Projected Deficit Based on Current Trends			
County	**2014**	**2015**	**2016**
Granville	(78)	(90)	(127)

Vance	(43)	(56)	(45)
Person	(3)	(20)	(27)
Franklin	(79)	(70)	(101)
Warren	(67)	(58)	(78)
Total	**(270)**	**(294)**	**(378)**

Source: Application, page 68.

Step 7 [sic]. *Calculate the deficit of hospice deaths by project year. Adjust deaths to the project year start by multiplying the start year by 25 percent and the following year by 75 percent to account for the July start date.*

[Granville County PY1 projected deficit = ((.25 x 2014 projected deficit) + (.75 x 2015 projected deficit)) = ((.25 x 78) + (.75 x 90)) = 19.5 + 67.5 = 87.0]

Table III.17

GVDHD Hospice Deaths – Projected Deficit by Project Year		
County	**PY 1 2014-2015**	**PY 2 2015-2016**
Granville	(87)	(118)
Vance	(53)	(47)
Person	(16)	(26)
Franklin	(72)	(93)
Warren	(60)	(73)
Total	**(340)**	**(357)**

Source: Application, page 68.

After providing the number of patients served by county in Table III.20, the applicant explains its methodology as follows from pages 77-78:

Step 1. Multiply the Unserved Deaths by Project Year from Table III.17 by the county Estimated Market Share shown below.

Table III.22

GVDHD Market Share of Forecast Unmet Hospice Home Care Deaths		
Service Area County	**PY1**	**PY 2**
Granville	65%	100%
Vance	55%	100%
Person	0%	0%
Franklin	6%	5%
Warren	1%	3%

GVDHD Projected Patient Origin of Unserved Deaths		
Service Area County	**PY1**	**PY 2**
Granville	57	118
Vance	29	47
Person	0	0

Franklin	4	5
Warren	1	2
Total	**91**	**172**

Step 3 [2]. Multiply the County Unserved Deaths by 1.22 admits per deaths to get Patients in Need by County by Project Year.

GVDHD Table III.23

Patients in Need by County by Project Year (Admissions)		
Service Area County	**PY1**	**PY 2**
Granville	69 [70]	144
Vance	35	58 [57]
Person	5 [0]	6 [0]
Franklin	1 [5]	3 [6]
Warren	1	9 [2]
Total	**112 [111]**	**219 [209]**

Corrected numbers in [].

As shown above, the applicant's methodology does not result in the number of projected patients served by county (137 in PY 1 and 265 in PY 2). Furthermore, the methodology includes 0% market share for Person County, but 5 and 6 patients in PY 1 and PY 2, respectively and an incorrect number of patients for Franklin County in both project years and for Warren County in PY2. Therefore GVDHD's methodology is inconsistent and is not reasonable, supported and credible. GVDHD uses its projected number of "Patients in Need" as the unduplicated number of hospice patients to be served in each of the first two project years in Section IV.4(a), page 85.

In Section IV.4, page 85, the applicant projects to serve 112 patients in PY1 (FY15) and 219 patients in PY2 (FY16). In Section IV.5, page 85, the applicant projects the number of patients admitted by month for the first two operating years, as shown in the table below:

Table IV.1a

GVDHD Projected Number of Patients Admitted by Month First Two Operating Years		
Month	**PY1**	**PY2**
July	1	17

August	1	35
September	1	36
October	6	33
November	6	34
December	9	33
January	10	33
February	11	35
March	17	33
April	17	34
May	17	33
June	17	34
Total	**112**	**392**

Source: Application, page 85.

On page 86 the applicant describes the methodology and assumptions used to make the projections as follows:

Step 1: Calculate admissions by month. Assume a six-month lag for certification in the first year and gradually fill to 112 patients in PY1 and 219 patients in PY2.

Step 2: Assume ALOS of 30 days in PY1, and 60 Days in PY2, based on experience of HOWC and review against benchmarks for the National Hospice and Palliative Care Organization.

Step 3: Multiply admission by ALOS to get patients served, if ALOS was less than 30. If greater than 30, assume admissions from prior month are still active in the subsequent month. Caseload is increased gradually allowing a slightly higher caseload in late summer, when deaths tend to increase.

Table IV.1b

GVDHD Projected Number of Patients Admitted by Month First Two Operating Years		
Month	**PY1**	**PY2**
July	1	19
August	1	19
September	1	19
October	6	18
November	6	18
December	9	18
January	10	18
February	11	18
March	17	18
April	17	18
May	17	18
June	17	18
Total	**112**	**219**

Source: Application, page 86.

As shown above, the applicant provides two tables, with the same heading "*Projected Number of Patients Admitted by Month for the First Two Operating Years,*" but different totals for the number of patients admitted by month in PY2. In Table IV.1a, the applicant projects 392 patients admitted in PY2. In Table IV.1b, the applicant projects 219 patients admitted in PY2, which is consistent with representations made elsewhere in the application.

Table IV.1a might be the duplicated number of patients admitted in PY2. However, when the applicant was asked to provided the number of duplicated patients to be served by quarter in 10A NCAC 14C .1502 Information Required of Applicant, the applicant answered *"Please see Section IV.5 (a) and (b)."* which is both of these tables. The data is inconsistent and not credible.

In Section IV.6, pages 88-95, the applicant provides the projected number of visits by level of care and discipline for the first two project years. The applicant's assumptions regarding distribution of visits do not correlate to the actual number of visits listed in each table in Section IV.6, pages 88-90. Again, the data and methodology are inconsistent. On page 88, the applicant provides the following methodology for determining the number of hospice home care visits by discipline:

> "*Assume 0.72 visits per day and multiply days by visits per day to get total visits per year. … Assume the following distribution of visits:*

GVDHD Visit Distribution			
Physicians	20%	Bereavement	4%
Nursing	38%	Spiritual Counseling/Chaplain	5%
Social Work	11%	Volunteers	Based on monthly gradual increase to 4 per month
Hospice Aide	40%	Therapy	Low volume for safe PT transfers. 1 per month after 6 months
ST & OT	2/Q & 1/Q	Dietary	Low volume visits. 1 per month after 6 months

Source: Application, page 88.

[Total visits per year = 0.72 visits per day x total days per year.
PY1 total days = 112 patients x 30 ALOS = 3360 total days.
0.72 x 3360 = 2419 visits per year.]

However, the applicant projects 3,043 visits per year, and when divided by 0.72, equals 4,226 total days. Total days of 4,226 would equal an ALOS of 37.7 days, not 30 days as proposed by the applicant on page 86 of the application. [3043/0.72 = 4226.4 total days = 37.7 ALOS]
Furthermore, it is unclear how the applicant proposes to *"assume the distribution of visits"* as shown in the table immediately above. The percentages total 118%, not 100%; and *"2/Q & 1/Q"* for ST and OT apparently do not mean 2 visits per quarter for ST and 1 visit per quarter for OT, because ST shows 1 visit per quarter, not 2; while OT shows 2 visits for the entire year, not 4.

The applicant does not demonstrate that its methodology for projecting the number of visits by discipline is reasonable, credible and supported.

Tables IV.2a&5a and Tables IV.2b&5b

GVDHD Hospice Visits by Level of Care and Discipline											
	PY1 (Tables IV.2a&5a)						PY2 (Tables IV.2b&5b)				
	Home	**Respite**	**Inpatient**	**Continuous**	**Total**		**Home**	**Respite**	**Inpatient**	**Continuous**	**Total**
Physician	54	0	24	0	78		180	0	74	0	254

Nursing	1,034	9	158	13	1,214		3,435	35	530	47	4,047
PT	6	0	0	0	6		12	0	0	0	12
ST	4	0	0	0	4		4	0	0	0	4
OT	2	0	0	0	2		2	0	0	0	2
SW (incl *Family & Bereave-ment Counseling)	301	5	24	8	338		996	22	74	32	1,124
CNA (incl Home Health Aide,Homemaker /Chore)	1,089	10	0	0	1,099		3,614	36	0	0	3,650
Dietary	6	0	0	0	6		12	0	0	0	12
Spiritual (incl * Family & Bereave-ment Counseling)	136	0	24	0	160		451	7	80	0	538
Volunteer	301	0	0	0	301		996	0	0	0	996
****Total**	**3,043**	**24**	**230**	**21**	**3,318**		**10,066**	**100**	**758**	**79**	**11,003**

Source: Application, pages 88-95. Bereavement Counseling: PY1=110 hrs. PY2=364 hrs. Spiritual Counseling: PY1=160hrs. PY2=451 hrs. **Total includes Bereavement Counseling & Spiritual Counseling hours.

As shown below, the distribution of visits by discipline in the first two project years indicates that 70 percent of total visits are nursing visits (includes CNAs). Social work and volunteer visits comprise the second and third highest percentage of total visits, respectively.

GVDHD **Percentage of Total Hospice Visits by Discipline**		
	PY1	**PY2**
Physician	2.4%	2.3%
Nursing	36.6%	36.8%
PT/ST/OT	0.4%	0.2%
SW (incl Family Counseling)	10.2%	10.2%
CNA (incl Home Health Aide & Homemaker/Chore)	33.1%	33.2%
Diet	0.2%	0.1%
Bereavement (duties of SW & Spiritual)	3.3%	3.3%
Spiritual (incl Family Counseling)	4.8%	4.9%
Volunteer	9.1%	9.1%
***Total**	100.1%	100.1%

*Does not foot due to rounding. Source: Application, Tables IV.2a&5a & IV.2b&5b.

In Section IV.8a&b, pages 97-98, the applicant projects the hospice patient care days by level of care. Tables IV6.a and IV6.b, depicting PY1 and PY2 patient days of care by level are combined below into one table. The table below also includes the average daily census (ADC) for both project years.

From Tables IV.6a & 6b

GVDHD **Hospice Patient Care Days by Level of Care** **and Average Daily Census** **PY1 and PY2**

	PY1	PY2
Home	3,780	12,556
Inpatient	158	530
Respite	36	119
Continuous Hrs/Days	32/4	96/12
Total Days	**3,978**	**13,217**
ADC	**10.9**	**36.2**

Source: Application: pages 97-98. ADC Formula = patient days in period/total # days in period (365 days).

The average daily census for PY1 is 11 patients and for PY2 is 36 patients. However, on page 86, the applicant projects ALOS of 30 days in PY1 and 60 days in PY2, which equals 3,360 days in PY1 [112 x 30 = 3,360], and 13,140 days in PY2 [219 x 60 = 13,140]. Table IV.6a projects 3,978 total days in PY1, an 18% increase over its projected ALOS and number of patients.

GVDHD's assumptions regarding projected patients, projected total deaths for the service area, and projected hospice home care visits, and visits by discipline are not reasonable, credible and supported.

In summary, GVDHD's projected number of patients, deaths served, ALOS, days of care, and visits are not reasonable, credible and supported. Therefore, the applicant does not adequately demonstrate the need the projected population has for the proposed hospice home care agency. Consequently, the application is not conforming to this criterion.

Continuum Home Care & Hospice of Granville County (Continuum) proposes to develop a new hospice home care office at 106 Gilliam Street in Oxford, which is located in Granville County.

Population to be Served – **Continuum**

In Section III.4, page 86, Continuum identifies the proposed service area as Granville, and Vance counties. The proposed patient origin and utilization for the first two operational years are shown in the following table.

Continuum Service Area				
County	**Projected Patients (PY1)**		**Projected Patients (PY2)**	
Granville	91	100.0%	129	76.3%
Vance	0	0.0%	40	23.7%
Total	**91**	**100.0%**	**169**	**100.0%**

In Section IV.4, page 95, the applicant proposes to serve 91 unduplicated patients in PY1 and 169 unduplicated patients in PY2.

Demonstration of Need – **Continuum**

Continuum projects to serve 91 unduplicated patients in PY1 and 169 unduplicated patients in PY2. On page 95 the applicant defines PY1 as June 2014 – May 2015 and PY2 as June 2015 – May 2016. The 2013 SMFP projects 99 additional patient deaths in need of hospice care for 2014 in Granville County. The 2013 SMFP projects hospice deaths based upon the projected average hospice deaths in North Carolina and the county death rate. On page 97, the applicant projects the ALOS for hospice patients as 60 days in PY1 and 75 days PY2. In Section IV.5(a) page 96, the applicant provides the projected unduplicated patients to be served in each of the first 24 months following completion of the project.

CONTINUUM Projected Unduplicated Patients – PY 1 and PY 2			
Month/Year	**Number of Patients**	**Month/Year**	**Number of Patients**
June 2014	3	June 2015	12
July 2014	4	July 2015	12
August 2014	5	August 2015	13
September 2014	6	September 2015	13
October 2014	7	October 2015	13
November 2014	8	November 2015	14
December 2014	9	December 2015	14
January 2015	9	January 2016	15
February 2015	9	February 2016	15
March 2015	10	March 2016	16
April 2015	10	April 2016	16
May 2015	11	May 2016	16
Total	**91**	**Total**	**169**

In Section IV, pages 96-99, Continuum explains the monthly census as follows:

> "*1. First, we determined the most likely number of deaths served in PY1, which relied on adjustments made to the SMFP's standard need determination methodology, as described in Section 3 of this application. Please see response to Question 4 (b) … for detailed description of calculation of projected* ***DEATHS*** *served in Years 1 & 2.*
>
> 2. *Projected deaths served was then multiplied by a factor of 1.3, which is an approximate average of the ratio of admissions-to-deaths experienced by the existing agencies serving Granville County, existing agencies serving Vance County, all agencies serving the entire state, and Continuum's experience at it largest agency (in Onslow County). Please see Tables in response to Question 4 (b)…*"

The applicant provides the following data regarding the average number of admissions per death in Granville and Vance counties plus the state.

Continuum Table

Hospice Admissions, Deaths and Average Admissions Per Death Granville & Vance Counties & North Carolina				
Granville County Providers	**FY 2012**	**FY 2011**	**FY 2010**	**Average**
Admissions	124	137	133	

Deaths	88	108	89	
Admits per Death	1.41	1.27	1.49	1.39
Vance County Providers				
Admissions	124	166	122	
Deaths	110	123	95	
Admits per Death	1.13	1.35	1.28	1.25
Average All NC Providers				
Admissions	39,256	38,743	35,403	
Deaths	33,098	31,841	30,075	
Admits per Death	1.19	1.22	1.18	1.19
Source: 2012 & 2013 SMFPs and Proposed 2014 SMFP				

Source: Application, pages 95-96.

"3. *Continuum's admissions pattern reflects a "ramp-up" period during which the early months have lower admissions, as the agency works toward licensure and certification, as well as through the particularly challenging period of alerting the county's residents and health care providers to our presence. The preliminary work associated with community and provider education can be extensive, particularly in areas of hospice* ***need****, which typically have lower 'buy-in' to the hospice philosophy. Under these circumstances, it is not realistic to project that an agency will 'hit the ground' running at full capacity. We project continued gradual growth into the second year, reflecting what we believe will be a gradual change in the sentiment in the community toward hospice care and increased choice by resident and health care providers to seek out our services. Ultimately, the agency admissions will correspond to the projected total need of unserved deaths in Granville County, plus a portion of the Vance County deaths in Year 2.*

4. To calculate the Average Caseload, which is the number of patients under the care of the agency at all times (irrespective of a subsequent month's admissions), Continuum relied on the following assumptions:

5. Determine an Average Length of Stay (ALOS). Continuum utilized an ALOS of approximately 60 days in Year 1 and 75 days in Year 2. Continuum reached these ALOS conclusions based on the following rationale. First we determined the current ALOS for the service area, the state, and the nation, as shown below:" [Emphasis in original.]

Continuum

Average LOS Granville County, North Carolina (2012) and US (2011)			
License	**Agency**	**Facility County**	**ALOS**
HOS0021	Duke Hospice	Durham	45.80
HOS3826	Amedisys Hospice	Franklin	94.20

HOS2561	Community	Vance	44.00
HOS3269	United	Nash	115.00
HOS2281	Heartland	Wake	109.00
HOS3133	Hospice-Wake Co.	Granville	315.00
HOS3304	Liberty	Durham	67.00
		Average (excluding HOS3133)*	79.17
		Median (excluding HOS3133)*	80.60
		Average (excluding HOS3133, HOS2281 & HOS3304**	74.75
		Median (excluding HOS3133, HOS2281 & HOS3304**	70.00
		NC ALOS***	74.85
		US 2011 ALOS****	69.10
*This Granville County agency served one patient in FY 2012 and is excluded. Data not considered statistically significant.			
**These agencies served 7 out of 124 admissions/deaths and less representative of Granville County			
***Calculated from 2013 LRA database; excludes data more than 2 standard deviations (SD) from mean. Mean = 77.2; SD = 37.5 (see Appendix D)			
**** Calculated from report "*2012 NHPCO Facts & Figures: Hospice Care in America*, page 5. See Appendix D.			

Source: Application, page 98.

"*…, Continuum concluded that the ALOS for the service are is* [sic] *effectively comparable to the state average/median. We believe that,* ***for Year 2,*** *an ALOS of 74.75 is in-line with state and area averages. For* ***Year 1,*** *…, we decided that a more realistic ALOS is 60 days*."

Continuum Table

FY 2012 ALOS Granville County & Vance County Residents		
Granville County Patients	**Total Days**	**ALOS**
134	10,314	76.97
	ALOS (reported by four primary agencies)*	74.75

Vance County Patients	Total Days	ALOS
166	8,697	52.39
	NC ALOS**	74.85
	US 2011 ALOS***	69.10
*Includes four primary agencies: Duke Hospice, Amedisys Hospice, Community & United. Excludes: Heartland, Liberty & Hospice of Wake County.		
**NC ALOS: 2013 LRA database; excludes agency data greater that 2 standard deviations from mean. Mean = 77.2, SD = 37.35. See Appendix D.*		
***US ALOS: *2012 NHPCO Facts & Figures: Hospice Care in America*, page 5. See Appendix D.*		
Source: 2013 LRA database.		

Source: Application, pages 62 & 98. *The applicant states Appendix D on page 98, rather than the incorrect Appendix 5 as stated on page 62.

*Generally, areas that have hospice need **and** a … low presence of hospice agencies serving a county (in Granville Co. there is only a satellite office of Hospice of Wake County, and it served …one client in FY2012), we have found that the population **does not always embrace the hospice philosophy** to the same degree as areas with a greater hospice presence. This impact will be felt most in Year 1, as we work to implement our programming and earn the trust of residents and providers. Thus, while we believe we will make in-roads from the start, we also realize that we may admit clients who are further along in the dying process. As a result, these first admissions will necessarily be with the agency for a shorter period than if the individual or family already bought in to the hospice concept. This assumption is supported by the experience of United Hospice of Wilkes County, which was awarded a CON in 2009/2010 and has been in operation for over a year. Data from its first year of operation show the following:*" [Emphasis in original.]

Continuum

United Hospice of Wilkes County & NC Median, FY2012		
License/Agency	**County**	**ALOS**
HOS4413/United Hospice	Wilkes	58.00
2012 NC ALOS (excludes ALOSs exceeding 2 SDs from the mean)		74.85
United Projected ALOS (CON application)		70.00
Source: 2013 LRA database, 2009 Wilkes County CON Agency Findings		

Source: Application, page 99.

"*By Year 2, …, we will have established ourselves in the community and believe reaching the state/county ALOS (approximately 75 days is realistic).*

*6. The ALOS is significant in this calculation because it establishes the length of time the average client receiving services from the agency … Therefore, a client admitted in a given month will, **ON AVERAGE**, be with Continuum for 2.45 months. … Continuum has assumed that a single month is 30.45 days (365/12*).

For an ALOS of 74.75, the equivalent time period in terms of months is represented as: *(30.42 days (365/12)) + (30.42 days (365/12) + 13.92 days (74.75 – (30.42 + 30.32 = 74.75 days.*

… The projections above assume all patients are admitted on the first day of a given month, when in actuality, they will be spread over the entire month.

7. To calculate an accurate approximate ***CASE LOAD*** *(i.e., running total of admissions* ***PLUS*** *existing clients), each client is counted as a whole patient during their first (admission) month (100% or '1') and second month (100% or '1') with the agency, and then as a fraction of a patient in the third month with the agency, to account for the days in that month the client will be with Continuum. The third month fraction is 43% of the 30.42-day month, which is 13.92 days. …*

8. Over time, the average CASE LOAD of clients increases as the number of admissions increases and clients from prior months remain under Continuum's care, until the point in Year 2 when admissions have leveled off, which similarly impacts the overall CASE LOAD." [Emphasis in original.]

In Section III.1, pages 54-80, Continuum discusses the factors it considered in developing the proposal in Granville-Vance County, which include:

- 2013 State Medical Facilities Plan
- Stagnant Growth - Hospice Deaths Served
- Low Hospice Penetration Rate
- Limited In-county Hospice Options
- Average Length of Stay
- Access by Nursing Home Residents
- Racial Demographics
- Economics, Health Insurance and Medicaid
- Access to Levels of Hospice Care
- Disease Diagnoses & Causes of Death
- Provider Feedback

In Section III, pages 55-56, the applicant discusses the 2013 SMFP methodology for projection of need for new hospice home care program.

The applicant states:

"*1. 2013 State Medical Facilities Plan*

While the SMFP is the definitive source for determinations of need for various health services, these data must be accepted with caution. The reason: the planning process for CON determinations does not occur in 'real time.' Thus, there is often more recent data available to CON applicants following publication of the SMFP that is not accessible [sic] *the Medical Facilities Planning Section when preparing the*

SMFP. Continuum believes it is necessary to consider these data when assess [sic] whether or not there is actual need.

Based on our analysis, we determined that the 2013 SMFP does not reflect the most accurate picture of future need … Continuum conducted a separate need analysis utilizing the 2013 SMFP need determination methodology but using updated data." [Emphasis in original.]

"2. *Stagnant Growth in Hospice Deaths Served*

… As indicated in the following table, hospice care continues to expand in North Carolina, with an increasing number of deaths served." [Emphasis in original.]

Deaths Served by Hospice North Carolina 2010-2012		
Year	**Deaths Served**	**Growth**
2010	30,075	
2011	31,841	5.9%
2012	33,060	3.8%
	Two Year Average	4.9%
Source: Proposed 2014 SMFP		

Source: Application, page 56.

"*This increase in deaths served amounts to an average annual growth of nearly 5% for the entire state. Isolating these data for Granville County over the same time period, however, shows very different trends*:"

Deaths Served by Hospice Granville County 2010-2012		
Year	**Deaths Served**	**Growth**
2010	89	
2011	108	21.3%
2012	88	-18.5%
	Two Year Average	1.4%
Source: Proposed 2014 SMFP		

Source: Application, page 57.

"*… the number of hospice deaths served in Granville County is essentially flat over the past three years (starting at 89, spiking to 108 and back* [sic] *falling back to 88). Extending the look-back for Granville Co., deaths served several more years, the picture is even less encouraging*:"

Continuum

Deaths Served by Hospice Granville County 2008-2012		
Year	**Deaths Served**	**Growth**

2008	93	
2009	96	3.2%
2010	89	-7.3%
2011	108	21.3%
2012	88	-18.5%
	Four Year Average	-0.3%
Source: Proposed 2014 SMFP & prior SMFPs		

Source: Application, page 57.

On pages 57-59, the applicant discusses low hospice penetration rates. The applicant states,

"*3. Low Hospice Penetration Rates*

The other factor in the 'need' equation is 'the hospice penetration rate' (HPR) or, stated alternatively, the level of deaths that one could reasonably expect to be served by hospice. … To smooth out … discrepancies, the SHCC has adopted a methodology that utilizes the statewide median HPR. …

… The median HPR in North Carolina continues to represent a greater percentage of total deaths served.
…
The Granville County HPR ranged from 19.5% to 24.2%, and then, most recently, to 18.3%, all of which lag well behind the State median HPR, which increased from 32% to 35.5% over those three years.

Each of these indicators points to significant barriers to hospice care in Granville County. …

Similar to the scenario presented for Granville County, Vance County process statistics for the past three years show comparable, if perhaps not as extreme, trends:
…
The most notable takeaways from these data are as follows. First, Vance County residents receiving hospice care have decreased after an uptick between 2010 and 2011. Second, the HPR has shown a similar trend and, more significantly, it lags behind the state average considerably." [Emphasis in original.]

Continuum

2010-2012 Total Deaths & Hospice Deaths Granville County, Vance County and North Carolina			
	2012	**2011**	**2010**

Location	Hospice Deaths Served	Total Deaths	% Deaths Served	Hospice Deaths Served	Total Deaths	% Deaths Served	Hospice Deaths Served	Total Deaths	% Deaths Served
Granville	88	482	18.3%	108	446	24.2%	89	457	19.5%
Vance	110	460	23.9%	123	443	27.8%	95	437	21.7%
NC	33,060	80,425	41.1%	31,841	79,683	40.0%	301,075	78,604	38.3%
	Median		35.5%	Median		34.9%	Median		32.0%
Source: NC State Center Health Statistics; Draft 2014 SMFP									

Source: Application, page 59.

The applicant states that the trends shown in the table above justify the need for additional hospice access for residents in the service area.

"*4. Limited 'In-County' Hospice Agency Options*

Residents of Granville County currently have access to hospice care; however, it is considerably limited as compared to other counties. … there is only one (1) licensed hospice home care office in Granville County, and that is a branch of Hospice of Wake County. This office is located in Creedmoor, which is in the southern portion of Granville County. In FY 2012, this office served only one (1) patient. Most of the hospice care provided to Granville County residents, therefore, is from existing agencies located outside the county borders." [Emphasis in original.]

Continuum

Hospice Agencies Serving Granville & Vance County Residents – FY 2012							
Facility	Facility County	Patient County	Patients Served	Total Days	Patient County	Patients Served	Total Days
Duke Hospice	Durham	Granville	52	4,409	Vance	14	675
Amedisys Hospice	Franklin	Granville	35	3,147	Vance	27	2,449
Community	Vance	Granville	26	1,054	Vance	55	3,246
United	Nash	Granville	14	854	Vance	38	335
Heartland	Wake	Granville	4	374	Vance	1	48
Liberty	Durham	Granville	2	170	na	na	na
Hospice-Wake County	Granville	Granville	1	306	na	na	na
Totals		**Granville**	**134**	**10,314**	**Vance**	**135**	**6,753**
Source: 2013 LRA Database (FY2012 data). Source: Application, page 60.							

As shown in the above table, hospice agencies from Durham, Franklin, Vance and Nash County serve the majority of Granville County residents. Vance County has two hospice agencies based in the county, Community of Vance County and an office of Continuum that currently does not serve patients. The applicant notes that Community of Vance County served 32% fewer clients in FY 2012 (55) than in FY 2011 (81).

"*5. Low Average Length of Stay*"

The applicant states that the ALOS of approximately 75 days for Granville County residents is not far behind state and national averages of nearly 77 days. However, according to the

applicant, the Vance County ALOS is 52.4 days; while the state and national ALOS are 74.9 and 69.1 days, respectively.

Continuum Table

FY 2012 ALOS Granville County & Vance County Residents		
Granville County Patients	**Total Days**	**ALOS**
134	10,314	76.97
ALOS (reported by four primary agencies)*		74.75
Vance County Patients	**Total Days**	**ALOS**
166	8,697	52.39
	NC ALOS**	74.85
	US 2011 ALOS***	69.10
*Includes four primary agencies: Duke Hospice, Amedisys Hospice, Community & United. Excludes: Heartland, Liberty & Hospice of Wake County.		
**NC ALOS: 2013 LRA database; excludes agency data greater that 2 standard deviations from mean. Mean = 77.2, SD = 37.35. See Appendix V.*		
***US ALOS: *2012 NHPCO Facts & Figures: Hospice Care in America*, page 5. See Appendix V.*		
Source: 2013 LRA database.		

Source: Application, page 62. *Note: There is no Appendix V.

The applicant states, "*Continuum will work to bring the ALOS for its Vance County patients in-line with state and national averages, to ensure these individuals maximize the hospice benefit. This is accomplished through community and provider education efforts that focus on informing potential referral sources and hospice beneficiaries about the benefits of hospice care.*" [Emphasis in original.]

"*6. Hospice Need: Access for Nursing Facility Patients*"

The applicant provides the following information regarding access to hospice care in nursing homes.

Continuum Table

Hospice Days Provided in Nursing Facilities North Carolina, Granville County & Vance County						
	FY 2012			**FY 2011**		
	NC	**Granville**	**Vance**	**NC**	**Granville**	**Vance**
Total Hospice DOC	2,972,373	10,314	6,753	2,915,367	10,338	8,697
Total Hospice DOC in NF	669,684	0	437	675,689	308	4,199
% Total DOC in NF	22.5%	0.0%	6.5%	23.2%	3.0%	48.3%
Source: FY 2012 & FY 2011 LRA Databases						

Source: Application, page 63.

"*As these data … show, nursing home residents in Granville County are completely unserved (zero (0) days) by hospice agencies, which is striking considering that 22.5% of all days of care in North Carolina in FY2012 were provided to residents of nursing homes. This data point does not appear to be a total aberration, as the*

FY2011 percentage of days provided to Granville County nursing home residents was only 3%, as compared to the statewide 25.2%.

…

7. Hospice Need: Racial Composition of Service Area"

The applicant states that understanding the racial composition of the proposed service area is important to understanding the specific service needs of the area.

"*Whereas 22% of the entire North Carolina population is African American, over 32% of Granville County's, and almost 51% of Vance County's,* [sic] *population is*. …

… it is necessary to understand the degree to which different races access (and have access to) hospice care. The following table presents the past two years' (FY 2011 and FY 2012) data pertaining to this issue:"

Continuum Table

North Carolina Hospice Deaths by Race - FY 2012						
	American Indian	**African American**	**Asian**	**Caucasian**	**Other**	**Total**
2012 Hospice Deaths by Race	323	5,978	170	30,456	2,520	39,278
% 2012 Hospice Deaths	0.8%	15.2%	0.4%	77.5%	6.4%	100.0%
Source: 2013 LRA Database						

Source: Application, page 64.

"*What these data show is that, when analyzed in the context of the preceding table, while approximately 22% of the North Carolina population is African-American, only about 15% of total hospice deaths served are African Americans*."

The applicant discusses a study as to why this disparity exists. The applicant further states that it will work to overcome barriers to African-Americans using hospice care.

"*8. Hospice Need: Economics, Health Insurance & Medicaid*

An assessment of the economic landscape of Continuum's proposed service area reveals that there are several indicators of note."

Continuum Table

Economic Characteristics Granville & Vance Counties & North Carolina			
Category	**Granville**	**Vance**	**North Carolina**
Est. 2011Population	59,976	45,307	9,656,401

2011 % over 65 years old	42.3%	58.4%	34.5%
Projected 2013 Population	62,315	46,094	10,018,744
2008 Median Household Income	$48,210	$34,025	$45,570
October 2012 % Unemployed	9.0%	12.2%	8.8%
2006-2010 % Below Poverty	11.9%	27.5%	15.5%
2009-2010 % Non-Elderly (0-64) Uninsured (NCIOM)	19.3%	29.8%	19.6%
2011 VC/GC Health Opinion Survey	21.9%	18.2%	NA
http://quickfacts.census.gov/qfd/states; http://www.nciom.org; http://www.ncesc1.com/; http://data.osbm.stte.nc.us/pls/linc/dyn_linc_main.show			

Source: Application, page 65. NCIOM-North Carolina Institute of Medicine.

"*The statistics here that have most relevance to the proposed hospice services relate to unemployment, poverty and insurance. As the last three rows of data present, poverty is a concern in this region and, related thereto, unemployment is an issue in both counties. In the final row, it is noted that a sizable percentage of the non-elderly population appears to be uninsured in both counties.*"

Continuum's Projections of Need:

In Section IV.6, pages 100-103, the applicant provides the number of visits by level of care and discipline for the first two project years, as shown below.

CONTINUUM Hospice Visits by Level of Care and Discipline											
	PY1						PY2				
	Home	Respite	Inpatient	Continuous	Total		Home	Respite	Inpatient	Continuous	Total
Physician	88	0	3	0	91		205	1	7	0	213
Nursing	2,095	6	71	77	2,249		4,883	13	164	96	5,156

PT	12	0	0	0	12	28	0	1	0	29
ST	9	0	0	0	9	20	0	1	0	21
OT	0	0	0	0	0	0	0	0	0	0
SW (incl Family Counseling)	593	2	20	0	615	1,383	4	47	0	1,434
CNA (incl Home Health Aide & Home-maker /Chore)	2,308	6	78	52	2,444	5,379	15	181	72	5,647
Dietary	10	0	0	0	10	24	0	1	0	25
Bereave-ment (duties by SW)	124	0	4	0	128	289	1	10	0	300
Spiritual	300	1	10	0	311	700	2	24	0	726
Volunteer	320	1	11	0	332	746	2	25	0	773
Total	**5,859**	**16**	**197**	**129**	**6,201**	**13,657**	**38**	**461**	**168**	**14,324**

Source: Application, pages 100-103.

CONTINUUM **Percentage of Total Hospice Visits by Discipline**		
	PY1	**PY2**
Physician	1.5%	1.5%
Nursing	36.2%	36.0%
PT/ST/OT	0.3%	0.3%
SW (incl Family Counseling)	10.0%	10.0
CNA (incl Home Health Aide, Home-maker/Chore)	39.4%	39.4%
Diet	0.2%	0.2%
Bereavement	2.1%	2.1%
Spiritual	5.0%	5.1%
Volunteer	5.3%	5.4%
***Total**	**100.0%**	**100%**

Source: Application, pages 100-103.

The distribution of visits by discipline in the first two project years indicates that over 75 percent of total visits are nursing visits (includes CNAs). Social work and volunteer visits comprise the second and third highest percentage of total visits, respectively.

Projected Deaths and Admissions

In Section III, pages 87-90, Continuum discusses its projections for client deaths and admissions in its primary service area, Granville and Vance counties. On page 87, Continuum begins explaining its assumptions and methodology, stating that it projects to serve 91 admissions in PY1 and 169 admissions in PY2.

CONTINUUM **Projected Hospice Clients Served** **PY1 and PY2**		
PY1	**Deaths**	**Admits**
Granville County	70	91

Vance County	0	0
Total	**70**	**91**
PY2	**Deaths**	**Admits**
Granville County	99	129
Vance County	32	40
Total	**131**	**169**

Continuum's assumptions include:

- 4.9% annual increase in number of deaths served by existing hospice providers
- 5.3% annual increase in statewide median % deaths served by hospice (estimated 2012 total deaths)
- 88 hospice deaths served in Granville County in 2012
- 110 hospice deaths served in Vance County in 2012
- Admissions equal 1.3 times number of hospice deaths

Furthermore, Continuum states that it updated several data points in Table 13B of the 2013 SMFP. It uses data from the Draft 2014 SMFP including Projected Death Rate (from 2006-2010 to 2007-2011), and 2-year trailing growth rate. Population projections are also updated. The applicant's projections are shown below for Granville and Vance counties:

CONTINUUM Analysis of Projected Future Hospice Need
Granville County 2014-2016

	A	B	C	D	E	F	G	H
1	Year	Projected Population	Projected Deaths	Projected Statewide Median Projected Hospice Deaths	Projected Hospice Deaths (Col. C x Col. D)	Potential Increase in Hospice Deaths Served by Existing Providers (Assumes 4.9% Growth)	Difference (Potentially Unserved Hospice Deaths) (Col. F – Col. E)	Likely Admissions (1.3 Factor) (Col. G x 1.3)
2	2014	56,936	484	39.29%	190	97	-93	121
3	2015	57,019	485	41.36%	200	101	-99	129
4	2016	57,098	485	43.54%	211	106	-105	136

See page 87 for additional notes and assumptions.

CONTINUUM Analysis of Projected Future Hospice Need
Vance County 2014-2016

	A	B	C	D	E	F	G	H
1				Projected		Potential Increase in Hospice	Difference	

	Year	Projected Population	Projected Deaths	Statewide Median Projected Hospice Deaths	Projected Hospice Deaths (Col. C x Col. D)	Deaths Served by Existing Providers (Assumes 4.9% Growth)	(Potentially Unserved Hospice Deaths) (Col. F – Col. E)	Likely Admissions (1.3 Factor) (Col. G x 1.3)
2	2014	45,601	461	39.29%	181	121	-60	78
3	2015	45,633	461	41.36%	191	127	-64	83
4	2016	45,669	461	43.54%	201	133	-68	88

See page 88 for additional notes and assumptions.

In Section III.4(c), page 88, the applicant states it "*projects serving only 70 of the 93 projected*" unserved hospice deaths in Granville County in 2014 because of the challenges associated with opening a new hospice agency and entering a county with a *"culture of low hospice utilization."* Continuum projects, on page 89, that in 2015 (PY2) it will serve 100% of unserved deaths/admissions for Granville County and 50% of the Vance County deaths based on the following:

- The patient growth from Year 1 to Year 2 is reasonable because the need projected to be served in Year 2 is the unserved total based on the median statewide HPR.
- Granville and Vance counties are not currently well-served by hospice.
- The location in Oxford is close to Henderson, Vance County's largest population center.
- Serving all of Vance County would be unrealistic and might overextend resources.
- The most recent CON-approved hospice agency to open, United Hospice of Wilkes County, has demonstrated that clients from a secondary service area can realistically be met by a new agency.
- United Hospice's data also supports Continuum's projections.

However, Continuum's PY1 is not CY 2014, but FY 2015, and PY2 is not CY 2015, but FY 2016. Therefore, Continuum's projections on pages 88 and 89 are not for the correct project years, as shown below:

Continuum

Analysis of Projected Future Hospice Need	
Granville County	**Column G Potential Unserved Hospice Deaths**
2014	93
2015	99

2016	105
To calculate FY 2015: 2014 x 50% + 2015 x 50% = (93 x .5) + (99 x .5) = 46.5 + 49.5 = 96	
Vance County	**Column G Potential Unserved Hospice Deaths**
2014	60
2015	64
2016	68
To calculate FY 2015: 2014 x 50% + 2015 x 50% = (60 x .5) + (64 x .5) = 30 + 32 = 62	

Source: Application, page 87 - Granville County & page 88 - Vance County.

Furthermore, it not reasonable, credible and supported to project serving 73% (70/96) of Granville County's projected unserved deaths in PY1 or 97% of Vance County's unserved deaths in PY2, when seven hospice providers are currently serving Granville County patients and five hospice providers are currently serving Vance County patients.

In addition, Continuum did not demonstrate the reasonableness of projecting the HPR in Granville or Vance County to increase from the 2012 rates of 18.3% and 23.9%, respectively to the statewide rate of 41.1%. Moreover, Continuum did not demonstrate the reasonableness of projecting Vance County's ALOS to increase from 52.39 days in 2012 to 75 days in 2015-2016.

Continuum's assumptions regarding projected patients, projected total deaths for the service area, and projected hospice deaths in the service area are not reasonable and supported. The applicant's projected Granville County market share is not reasonable and supported. The applicant's visit projections are determined not to be reasonable and supported.

In summary, **Continuum's** projected numbers of patients, deaths served, ALOS and days of care are not reasonable, credible and supported. Therefore, the applicant does not adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not 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- Gentiva Hospice
-NA- GVDHD
-NA- Continuum

(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.

-NC- Gentiva Hospice
-NC- GVDHD

-NC- Continuum

Gentiva Hospice. In Section III.7, pages 77-78, the applicant discusses the alternatives to the proposed project that were considered prior to submission of this application and the basis for selecting to proceed with the proposed project.

- The first alternative that **Gentiva Hospice** considers is maintaining the status quo. However, the applicant states,

  > "*… However, this is not an effective alternative. … hospice services are currently underutilized in Granville County. During FY 2010, only 19.47 percent of Granville County deaths were served by hospice compared to the statewide median of 32.0 percent.*
  >
  > *The 2013 SMFP's methodology for projecting hospice need recognizes the need for increased hospice utilization in Granville County*. …
  >
  > *Thus, access to care for residents is unnecessarily limited by maintaining the status quo. Gentiva is committed to increasing community access to better serve the comprehensive hospice needs of the entire county*."

- The second alternative that **Gentiva Hospice** considers is to develop a joint venture with another provider. The applicant states having had discussions with a healthcare provider in the county. However, the applicant states that plan did not come to fruition and a joint venture is not an effective alternative.

- The third alternative that **Gentiva Hospice** considers is to establish an office in a location other than Oxford in Granville County. The applicant states that Oxford has the population, the commercial base, a central location and the supporting healthcare resources including the medical center and most referring physicians to support the hospice. Thus, the applicant states that a location other than Oxford would not be an effective alternative.

However, the **Gentiva Hospice** application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. Therefore, the application not conforming to this criterion and cannot be approved.

GVDHD. In Section III.7, pages 82-83, the applicant discusses the alternatives to the proposed project that were considered prior to submission of this application and the basis for selecting to proceed with the proposed project.

- The first alternative that **GVDHD** considers is maintaining the status quo. However, the applicant states,

> "*GVDHD and Hospice of Wake County, Inc. rejected the status quo because it is not reaching the population in need and it is not optimizing the resources of the health department or Hospice of Wake County, Inc. …*"

- The second alternative that **GVDHD** considers is to build an agency alone. However, the applicant states,

> "*… GVDHD leadership concluded that to offer a new service at a high quality level … would require assistance from an experienced operator. The learning curve is steep and the service requires intense coordination of both community resources and those of hospitals and physicians. GVDHD rejected this option as costly in reputation and money …*"

- The third alternative that **GVDHD** considers is a joint venture with a hospital and current hospice provider. The applicant concludes that this alternative is not an effective one because the hospital has no experience providing hospice care and the requirements of the established hospice agency will be too cumbersome.

- The fourth alternative that **GVDHD** considers and states is the most effective is to expand the health department. The applicant states that this alternative opens the door for cooperative relationships with local hospitals and nursing homes for inpatient care. Also, the applicant states that it will be able to capitalize on the expertise of Hospice of Wake County, Inc.

However, the **GVDHD** application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. Therefore, the application is not conforming to this criterion and cannot be approved.

Continuum. In Section III.7, pages 92-93, the applicant discusses the alternatives to the proposed project that were considered prior to submission of this application and the basis for selecting to proceed with the proposed project.

- One of the alternatives that **Continuum** considers is not applying for the Granville County hospice home care office. The applicant states, "*Not applying for this allocation was always an option; however, the clear demonstration of unmet need/underutilization of hospice services in Granville County and contiguous Vance County warrants issuance of a CON*."

- Another alternative that the applicant considers is to operate a branch office in Vance County. The applicant states,

> *"… to addresses the need identified, however; this option was deemed infeasible given the high volume of need. Continuum concluded, based on consideration of operational objectives and review of controlling regulations,*

> *that the need in the proposed service area can best be met through development of a hospice agency that is autonomous and certified separately from a parent company*."

- Therefore, **Continuum** concludes that to submit the application to establish a hospice home care agency is the most effective alternative. The applicant states,

> "*… Continuum was able to determine that a significant number of residents in the proposed service area likely* ***will not have adequate access*** *to hospice services in the future. As a result, Continuum intends to implement a fully licensed and certified hospice agency that will provide a quantitative increase in the number of patients and deaths served in this area, and that will focus on the specific areas of need identified above.*" (nursing facility residents, African Americans, patients with cancer and patients with Alzheimer's disease) [Emphasis in original.]

However, the applicant has chosen not to provide patient care from its Henderson hospice home care office in Vance County; less than 15 miles from this proposed Oxford hospice home care office in Granville County. Continuum has been licensed for the Henderson office since 2005.

Furthermore, the **Continuum** application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative.

The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. Therefore, the application is not conforming to this criterion and cannot be approved.

(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.

-NC- Gentiva Hospice
-NC- GVDHD
-NC- Continuum

Gentiva Hospice. In Section VIII.1, page 129, Gentiva Hospice projects a total capital cost of $107,000, which includes $38,000 for an annual lease, $24,000 for furniture and equipment, and $45,000 for consultant fees. On page 130, the applicant states the funding source for the project will be accumulated reserves. In Section IX, page 134, Gentiva Hospice projects start-up expenses of $55,000 and initial operating expenses of $375,000, for total working capital expenses of $430,000. The applicant projects an initial operating period of nine months, which is reasonable based on allowing time for recruitment of management and clinical staff, licensure and certification of the agency and time for reimbursement processing. Additionally, the Pro Forma cash flow Table IX.5 on page 136, projects a cash

flow deficit in the initial nine months of -$374,726. The applicant also projects a profit of $279,948 in PY2 (FY 2016). Exhibit 12 contains a letter from the Executive Vice President and Chief Financial Officer of Gentiva Hospice Health Services, Inc. which states, "*As Chief Financial Officer of Gentiva Hospice Health Services, I am authorized to commit all funds necessary for the development and operation of this project.*" Exhibit 13 contains the audited financial statements of Gentiva Hospice Health Services, Inc. for years ending December 31, 2012 and 2011. The FY 2012 balance sheet shows $207,052,000 in cash and cash equivalents, total assets of $1,510,934,000 and total net assets of $234,700,000 (total assets – total liabilities). The applicant projects a $328,557 loss for the first year and a $279,948 profit for the second project year. Gentiva Hospice Health Services, Inc. (the parent company) adequately demonstrates the availability of sufficient funds for the proposed hospice agency.

In Section X.1, page 138, the applicant provides the projected costs per level of care for the first two operating years; however, Gentiva Hospice does not provide the methodology and assumptions it uses to project the costs. On pages 141-142, the applicant provides the per diem charges per level of care and the projected charges by payor and level of care for the first two operating years.

Projected costs and charges are shown in the following table.

GENTIVA HOSPICE					
	Payor Source	**Routine**	**Respite**	**Inpatient**	**Continuous Care (hourly)**
Projected Charges Yr 1	Medicare	$158	$163	$701	$38
Projected Cost Yr 1		$220	$212	$396	$53
Projected Charges Yr 2	Medicare	$159	$165	$708	$39
Projected Cost Yr 2		$132	$169	$315	$42
Projected Charges Yr 1	Medicaid	$139	$147	$624	$34
Projected Cost Yr 1		$220	$212	$396	$53
Projected Charges Yr 2	Medicaid	$141	$149	$630	$34
Projected Cost Yr 2		$132	$169	$315	$42

Projected Charges Yr 1	Commercial	$158	$163	$701	$38
Projected Cost Yr 1		$220	$212	$396	$53
Projected Charges Yr 2	Commercial	$159	$165	$708	$39
Projected Cost Yr 2		$132	$169	$315	$42
Projected Charges Yr 1	Self/Charity/ No Source	$158	$163	$701	$38
Projected Cost Yr 1		$220	$212	$396	$53
Projected Charges Yr 2	Self/Charity/ No Source	$159	$165	$708	$39
Projected Cost Yr 2		$132	$169	$315	$42

On page 143, the applicant states,

> "*Projected charges for Medicare and Medicaid reflect per diem rates based on actual DMA FY2013 and projected CMS FY2014 rates. Gentiva Hospice sets self-pay and commercial insurance rates based on the Medicare per diem rate. All charges are comprehensive (equipment, supplies, travel, labor, contracted services, overhead, etc.)*
>
> *Gentiva Hospice assumes annual rate increases at 1.0%, which is lower than the projected Medicare hospice rate increase for 2014*."

The applicant fails to demonstrate that its projected costs and revenues are based on reasonable and supported assumptions and projected utilization. See Criterion (3) for a discussion of assumptions and projections which is hereby incorporated by reference as if fully set forth herein.

In summary, the applicant adequately demonstrates the availability of sufficient funding for the project. However, the applicant's projections for utilization are unreliable. Thus, costs and revenues based on the applicant's projections are also unreliable. Therefore, the applicant fails to demonstrate that the financial feasibility of the project is based upon reasonable and supported projections and costs. Therefore, the application is not conforming to this criterion.

GVDHD. In Section VIII.1, page 131, GVDHD projects a total capital cost of $143,200, which includes $55,200 for office equipment, $75,000 for consultant fees and $13,020 for contingency. On page 132, the applicant states the funding source for the project will be accumulated reserves. In Section IX, page 135, GVDHD projects start-up expenses of $5,000, initial operating expenses of $130,000 for total working capital of $135,000. The applicant projects an initial operating period of 13 months. Although the applicant has an existing office site and existing staff, the applicant states that the estimated initial operating period is the "*period of time from initial licensure of the facility until cash in-flow exceeds cash out-flow*." This is reasonable based on allowing time for licensure and certification of the agency, time for reimbursement processing and realizing a positive cash flow. Additionally, the pro forma cash flow tables IX.1a and IX.1b on pages 137-138, project cash flow in the initial nine months of -$129,906. The applicant projects a positive cumulative cash flow of $28,858 in the 2nd quarter of PY2, and a profit in PY2 of $220,856. Exhibit 8 contains a letter from the GVDHD Health Director which states, "*GVDHD hereby commits*

to provide up to $500,000 in funds to successfully develop and operate the proposed project with cash from ongoing operations. … As a financial representative of GVDHD, I am authorized to commit all funds necessary for the development and operation of this project." Exhibit 7 contains the audited financial statements of GVDHD for years ending June 30, 2012 and 2011. The FY 2012 balance sheet shows $4,265,275 in cash and cash equivalents, total assets of $5,246,936 and total net assets of $3,939,449 (total assets – total liabilities). GVDHD adequately demonstrates the availability of sufficient funds for the proposed hospice agency.

In Section X.1, page 139, the applicant provides the projected costs per level of care for the first two operating years. In Section X.2, pages 141-142, the applicant provides projected charges by payor and level of care for the first two operating years. Projected costs and charges for all payors are shown in the following table.

GVDHD Table X.2b

GVDHD					
	Payor Source	**Routine**	**Respite**	**Inpatient**	***Continuous Care (hourly)**
Projected Charges Yr 1	Medicare	$163	$163	$689	$41
Projected Cost Yr 1		$127	$231	$965	$63
Projected Charges Yr 2	Medicare	$165	$165	$695	$41
Projected Cost Yr 2		$96	$175	$747	$53
Projected Charges Yr 1	Medicaid	$163	$163	$689	$41
Projected Cost Yr 1		$127	$231	$965	$63
Projected Charges Yr 2	Medicaid	$165	$165	$695	$41
Projected Cost Yr 2		$96	$175	$747	$53
Projected Charges Yr 1	Commercial	$163	$163	$689	$41
Projected Cost Yr 1		$127	$231	$965	$63
Projected Charges Yr 2	Commercial	$165	$165	$695	$41
Projected Cost Yr 2		$96	$175	$747	$53
Projected Charges Yr 1	Self/Charity/ No Source	$163	$163	$689	$41
Projected Cost Yr 1		$127	$231	$965	$63
Projected Charges Yr 2	Self/Charity/ No Source	$165	$165	$695	$41
Projected Cost Yr 2		$96	$175	$747	$53

Source: Application, page 142. *Continuous Care hours were misstated as 32 total patient care hours for Year 2. However, the Pro Forma, pages 295-296, states 96 hours – the correct number of hours on which to base the hourly charges in Year 2.

In Section X, page 142, the applicant states that the projected costs in the above table were derived in accordance with Medicare and Medicaid cost report allocation guidelines. On page 143, the applicant further states,

> "*Charges are based on usual and customary' charges as compared to other Hospice Agencies. Medicare and Medicaid reimbursement rates were used for projecting net revenue for each level of care.*. [sic] *Please see 'Projected Schedule of Quarterly Revenues' in Tab 13.*
>
> …

Medicare was adjusted for a 2 percent sequestration. See Hospice Charges/Reimbursement Rates in Tab 13."

In the completed Form B, GVDHD projects a $102,824 loss in PY1 and a $220,856 profit in PY2. GVDHD did not project adequate nursing FTEs to cover the projected number of visits in PY2. See Criterion (7) for a discussion of the applicant's staffing which is hereby incorporated by reference as if fully set forth herein. Furthermore, staffing FTEs for administration and secretarial support in PY1 are not listed in Table VII.6a, page 127. It appears GVDHD may have budgeted for the expense in the Pro Forma detail on page 263. However, the applicant failed to demonstrate that its projected costs and revenues are based on reasonable and supported assumptions and projected utilization. See Criterion (3) for a discussion of assumptions and projections which is hereby incorporated by reference as if fully set forth herein.

In summary, the applicant adequately demonstrates the availability of sufficient funding for the project. However, the applicant's projections for utilization are unreliable. Thus, costs and revenues based on the applicant's projections are also unreliable. Furthermore, the applicant's expenses for nursing services are understated. The applicant fails to demonstrate that the financial feasibility of the project is based upon reasonable and supported projections and costs. Therefore, the application is not conforming to this criterion.

Continuum- In Section VIII.1, page 136, Continuum projects a total capital cost of $34,250, which includes $26,750 for office equipment and furniture, and $7,500 for an unspecified miscellaneous/other cost. On page 137, the applicant states the funding will come from its parent company's equity. In Section IX, page 139, the applicant projects start-up expenses of $60,730 and initial operating expenses of $171,061, for a total working capital requirement of $231,791 [$60,730 + $171,061 = $231,791]. The applicant projects an initial operating period of six months. In Section IX, pages 140-141, the applicant provides Pro Forma cash flow statements by quarter, which project cash flow of -$177,057 during the initial operating period. This is reasonable based on allowing time for licensure and certification of the agency, time for reimbursement processing and realizing a positive cumulative cash flow by the 4th quarter of PY1. Continuum projects a net loss of $69,910 in PY1 and a profit of $193,999 in PY2. Appendix O contains a letter from the President of Principle Long Term Care, Inc. which states, "*Principle Long Term Care, Inc. will fund from current assets, $34,250 for equity contribution and $231,791 for initial operating losses and start-up costs for a total of $266,041 for the proposed development and implementation of a new certified hospice home care agency in Granville County* …." [Emphasis in original.]

Appendix O also contains the audited financial statements for Principle Long Term Care, Inc. and Subsidiary for years ending September 30, 2012 and 2011. The FY 2012 balance sheet shows, as of September 30, 2012, cash which totals $792,000, total assets of $21,515,000, and total net assets of $15,888,000 (total assets – total liabilities). Therefore, Principle Long Term Care, Inc. adequately demonstrates the availability of sufficient funding for the proposed hospice home care agency.

In Section X.1, page 142-143, Continuum provides the projected cost per level of care and payor source for the first two operating years. In Section X, page 145, the applicant projects charges by payor and level of care for the first two operating years. Projected costs and charges are shown in the following table.

CONTINUUM					
	Payor Source	**Routine**	**Respite**	**Inpatient**	**Continuous Care (hourly)**
Projected Charges Yr 1	Medicare	$140	$148	$627	$34
Projected Cost Yr 1		$157	$187	$372	$33
Projected Charges Yr 2	Medicare	$140	$148	$626	$34
Projected Cost Yr 2		$126	$179	$370	$27
Projected Charges Yr 1	Medicaid	$140	$149	$629	$34
Projected Cost Yr 1		$157	$187	$372	$33
Projected Charges Yr 2	Medicaid	$143	$151	$640	$35
Projected Cost Yr 2		$126	$179	$370	$27
Projected Charges Yr 1	Commercial	$143	$148	$662	$36
Projected Cost Yr 1		$157	$187	$372	$33
Projected Charges Yr 2	Commercial	$145	$150	$674	$36
Projected Cost Yr 2		$126	$179	$370	$27
Projected Charges Yr 1	Self/Charity/ No Source	$143	$148	$662	$36
Projected Cost Yr 1		$157	$187	$372	$33
Projected Charges Yr 2	Self/Charity/ No Source	$145	$150	$674	$36
Projected Cost Yr 2		$126	$179	$370	$27

On pages 145 and 146, the applicant states,

> "*See Appendix P for documentation concerning Reimbursement Rates. They are inflated at 1.018% from 2014 to 2015 per Medicare increase, then reduced 2% for sequestration*.
>
> *The charges are fixed charges established by the Medicare and Medicaid Programs (i.e., all providers receive the same amount). They include sufficient funds to cover the costs of all direct and indirect expenses*."

In the completed Form B, Continuum projects a $69,910 loss in PY1 and a $193,999 profit in PY2. However, the applicant fails to demonstrate that its projected costs and revenues are based on reasonable and supported assumptions and projected utilization. See Criterion (3) for a discussion on assumptions and projections which is hereby incorporated by reference as if fully set forth herein.

In summary, the applicant adequately demonstrates the availability of sufficient funding for the project. However, the applicant's projections for utilization are not supported. Thus, costs and revenues based on the applicant's projections are also not reasonable and not supported. The applicant fails to demonstrate that the financial feasibility of the project is

based upon reasonable and supported projections and costs. Therefore, the application is not 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- Gentiva Hospice
-C- GVDHD
-NC- Continuum

The 2013 SMFP identifies a need determination for one hospice home care office in Granville County. There is currently one existing hospice home care office operating in Granville County, not operated by any of the three applicants in this review.

Gentiva Hospice does not propose to develop more than one new hospice home care program in Granville 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 services. Consequently, the application is conforming to this criterion.

GVDHD does not propose to develop more than one new hospice home care program in Granville 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 services. Consequently, the application is conforming to this criterion.

Continuum does not propose to develop more than one new hospice home care program in Granville County. The applicant has been licensed for a hospice home care office in Vance County, part of the proposed service area, since 2005 and is not currently providing services from that location. Furthermore, Continuum has a total of 38 licensed hospice home care offices in the state that are not currently serving patients. The applicant states on page 10 of the application that each of the non-operational offices is a branch of its Onslow County office. The applicant does not adequately demonstrate why it cannot provide the proposed services from the Vance County office. Therefore, the applicant does not adequately demonstrate the need for the proposed hospice agency in Granville County. See Criterion (3) for discussion regarding need which is hereby incorporated as if set forth fully herein. The applicant does not adequately demonstrate that the proposed project is not an unnecessary duplication of existing hospice services. Consequently, the application is not 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- Gentiva Hospice
-NC- GVDHD
-C- Continuum

Gentiva Hospice. In Section VII.2, page 122, Gentiva Hospice projects staffing for the second operating year of the proposed hospice home care agency, as shown below in the table.

GENTIVA HOSPICE Staffing – PY2		
Position	**FTEs**	**Contract Visits**
Executive Director	1.00	
Secretary/Medical Records Clerk	1.00	
Medical Director	.15	
Hospice Rep	1.00	
Admissions Coordinator	1.00	
Patient Care Manager	1.00	
RN (care provider)	3.00	
RN (on call)	1.00	
*CNA (incl Hospice Aide & Homemaker)	3.25	
Dietician	.10	
Pharmacist	.00	PRN
*Medical Social Worker (incl Bereavement Counselor & Family Counselor)	1.00	
*Clergy (incl Bereavement Counselor & Family Counselor)	.50	
Volunteer Manager	.00	
Physical Therapist (incl. Occupational Therapist & Speech Therapist)	1.00	292
TOTAL	**15.00**	**292+**

Source: Application page 119. *CNA performs duties of Hospice Aide & Homemaker. *Social Worker & Chaplain perform duties of Bereavement Counselor & Family Counselor.

In Section VII.1, page 119, the applicant provides the following performance standards regarding how many visits per day could be made by each discipline.

GENTIVA HOSPICE	
Category	**Visits/Day**
Patient/Family Coordinator	na
RN	4.5
CNA (incl Home Health Aide & Homemaker/Chore)	4.5
Dietary Counselor	PRN
Social Worker (incl Bereavement Counselor & Family Counselor)	3.5
Physical Therapist (incl Occupational Therapist & Speech Therapist)	PRN
Volunteers	3.0
Clergy (incl Bereavement Counselor & Family Counselor)	4.0
Medical Director	PRN

Source: Application page 119

On page 119, Gentiva Hospice makes the following assumptions regarding staffing the proposed hospice home care agency and states,

- "*Administrative and various support positions do not conduct patient visits.*
- *Gentiva Hospice will not use LPNs.*
- *The CNA performs the responsibilities of a Hospice Aid and a Homemaker.*
- *The Social Worker and the Chaplain perform the duties of Bereavement Counselor and Family Counselor*
- *Therapists and a Dietician are used relatively infrequently, and as needed, therapists via contract and Dietician via Gentiva Hospice regional staff.*
- *Volunteers typically perform administrative support as well as patient visits and support*."

An analysis of proposed staffing was conducted based on assumptions the applicant provides In Section VII, pages 119-123. In Section VII.7.b, page 125, the applicant describes the training requirements for its proposed hospice home care services, including orientation, in-service and competency assessments. The applicant refers the reader to Exhibit 9 for details of its staff training. Gentiva Hospice projects adequate direct patient care staff during the second operating year. Consequently, the application is conforming to this criterion.

GVDHD. In Section VII, Table VII.6b, page 128, GVDHD projects staffing for the second operating year of the proposed hospice home care agency, as shown below in the table.

GVDHD Staffing – PY2		
Position	**FTEs**	**Contract Visits**
Administrator	.60	
Secretary	.50	
RN (care provider)	3.40	
*CNA (incl Homemaker/Chore)	3.61	
Medical Records	.25	
**Social Worker (incl Bereavement Counselor)	1.44	
Volunteer Coordinator	.20	
Dietary Counselor		208
Physical Therapist		6
Occupational Therapist		2

Speech Therapist		4
Clergy		160
Medical Director		312
Physician Billable Services		125
TOTAL	**10.00**	**817**

Source: Application, * page 304, **page 251.

In Section VII.1, page 119, the applicant provides the following performance standards regarding how many visits per day could be made by each discipline.

GVDHD	
Category	**Visits/Day**
Patient/Family Coordinator	na
RN	4.4
CNA* (incl Home Health Aide)	3.9
Dietary Counselor	3.4
Social Worker** (incl Bereavement Program)	3.9
Family Counselor	na
Physical Therapist	4.4
Occupational Therapist	4.4
Speech Therapist	4.4
Volunteers	3.5
Clergy	3.4
Medical Director	3.8
Volunteer Coordinator	na

Source: Application, * page 304, **page 251.

On page 120, GVDHD makes the following assumptions regarding staffing the proposed hospice home care agency and states,

> "*CNA and RN positions will be staffed 260 days a year. On call is additional* [sic] *It is estimated all other positions will be staffed 240 days a year. Staff levels are sufficient to meet all projected visits.*"

An analysis of proposed staffing was conducted based on the assumptions the applicant provides on pages 119-120, and 128. Based on the stated assumptions, the applicant proposes that the Bereavement Counselor position will make 3.9 visits per day. The applicant states in the Pro Forma, page 251, that it includes the Bereavement program costs in Social Work. CNA and SW positions each have appropriate proposed staffing levels. However, GVDHD does not project enough nursing (RN) FTEs to cover the projected number of visits in PY2. GVDHD proposed 3.4 RN FTEs in PY2, but projected 4,047 RN visits in PY2 which equals 3.54 FTEs [(4047 visits/4.4 visits per day)/260 days per year = 919.77/260 = 4.54 FTEs needed]. Furthermore, in Table VII6a, page 127, GVDHD does not project any administrative services in PY1, although the Pro Forma includes expenses for administrative salary and wages in PY1.

In summary, the applicant does not demonstrate adequate staffing for the services it proposes. Therefore, the application is not conforming to this criterion.

Continuum. In Section VII, page 134, Continuum projects staffing for the second operating year of the proposed hospice home care agency, as shown below in the table.

CONTINUUM Staffing – PY2		
Position	**FTEs PY2**	**Contract Visits**
Administrator	1.00	
Secretary	.50	
Accounting	.50	
Patient/Family Care Coordinator	.50	
RN	2.00	
LPN	2.92	
*CNA (incl Homemaker/ Hospice Aide)	5.41	
Social Worker	1.85	
Bereavement Counselor	.39	
Clergy	.70	
Volunteer Coordinator	1.00	
Volunteers	1.49	
Medical Director		213
Nutrition	contract	25
Physical Therapist	contract	29
Occupational Therapist	contract	0
Speech Therapist	contract	21
TOTAL	**18.53**	**288**

Source: *Application, page 134.

In Section VII.1, page 129, the applicant provides the following performance standards regarding how many visits per day could be made by each discipline.

CONTINUUM	
Category	**Visits/Day**
Patient/Family Care Coordinator	1
RN	4
LPN	4
CNA	4
Hospice Aide	4
Dietary Counselor	3
Social Worker	3
Bereavement Counselor	3
Family Counselor	3

Physical Therapist	5
Occupational Therapist	5
Speech Therapist	5
Homemaker/Chore	4
Volunteers	3
Clergy	4
Medical Director	3
Volunteer Coordinator	3

An analysis of proposed staffing was conducted based on assumptions the applicant provides on pages 129-134. Continuum projects adequate direct patient care staff during the second operating year. Consequently, 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- Gentiva Hospice
-C- GVDHD
-NC- Continuum

Gentiva Hospice. In Section II.3, pages 22-31, Gentiva Hospice identifies the ancillary and support services required for its proposal. Exhibit 15 contains copies of various provider agreements, as well as other letters of intent to provide pharmaceutical and medical supply services, durable medical equipment and respiratory services, and physical, speech and occupational therapies. Exhibit 20 also contains letters of interest from various healthcare facilities to provide inpatient and/or respite services. In Section VII.4, page 123, the applicant identifies the proposed Medical Director for the agency. Exhibit 20 contains seven letters of support for the proposal. The applicant adequately demonstrates it will provide or make arrangements for the necessary ancillary and support services, and that the proposed services will be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

GVDHD. In Section II.3, pages 45-52, GVDHD identifies the ancillary and support services required for its proposal. Exhibit 32 contains letters of interest to provide inpatient and respite care, as well as letters of intent to contract for therapy services, medical equipment and supplies, pharmaceutical and nutritional services. Exhibit 45 contains information on persons having expressed interest in providing spiritual care and volunteer support services. Exhibit 25 contains a list of community contacts made by GVDHD. Exhibits 40, 41, 42, 43, and 44 contain letters of support from GVDHD board members, community agencies, healthcare, community individuals and referring physicians, respectively. In Section VII.4, page 121, the applicant identifies the proposed Medical Director for the agency. His letter of interest is in Exhibit 12. The applicant adequately demonstrates it will provide or make arrangements for the necessary ancillary and support services, and that the proposed services

will be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

Continuum. In Section II.3, pages 32-37 and 41-43, Continuum identifies the ancillary and support services required for its proposal. Exhibit D contains letters of interest to provide therapy services, nutritional counseling services, inpatient and respite care, and referrals to Continuum. In Section VII.4, page 130, the applicant identifies the proposed Medical Director for the agency. His letter of interest is in Appendix D. In Section II, page 43 of the application, the applicant identifies the proposed contractors for residential, general inpatient and respite care, pharmacy, durable medical equipment, ambulance, therapy services and dietary services. The applicant refers the reader to Appendix D for letters of intent to contract for these services. However, Appendix D does not include a letter from the proposed provider of medical equipment or pharmacy services; although sample contracts are provided in Appendix M. The applicant does not adequately demonstrate that it will provide or make arrangements for the necessary ancillary and support services, and that the proposed services will be coordinated with the existing health care system. Therefore, the application is not 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- Gentiva Hospice
-NA-GVDHD
-NA- Continuum

(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;

-NA- Gentiva Hospice
-NA-GVDHD
-NA- Continuum

None of the applicants currently provide hospice care to residents of Granville County.

(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- Gentiva Hospice
-C- GVDHD
-C- Continuum

Gentiva Hospice. In Section VI.6-7, pages 115-116, the applicant states that it doesn't operate any hospice home care agencies in North Carolina. The applicant states that in the past five years it has not had any civil rights equal access complaints filed against the home health agencies it has in North Carolina. The applicant also states that it is not obligated under federal regulations to provide uncompensated care, community service or minority or handicapped access to its facilities. However, it will continue to provide uncompensated care, community service and other services to local communities in this state. The applicant states that it does not discriminate based on race, creed, color, sex, age, religion, national origin, medical condition, disability, veteran status, sexual orientation, genetic information, or ability to pay. The application is conforming to this criterion.

GVDHD. In Section VI.6-7, page 117, the applicant states that in the past five years, no civil rights equal access complaints have been filed against any of its providers in North Carolina. The applicant states that it is not obligated under any regulations to provide uncompensated care, community service or minority or handicapped access to its facilities. The applicant also states that by the nature of its admissions' policies, it provides services without regard to race, creed, age, religion, sex, handicap or other minority status or ability to pay. The applicant states that it receives certain grants that require community service, preventive health programs and health department services. The application is conforming to this criterion.

Continuum. In Section VI.2(b), page 122, the applicant states that it does not discriminate based on age, gender, nationality, race, creed or disability. In Section VI.6-7, pages 125-126, the applicant states that in North Carolina in the past five years, no civil rights equal access complaints have been filed against any of its providers of health care services or agencies owned by its parent company. The applicant further states that it is unaware of any obligation under any regulations, to provide uncompensated care, community service, or access by minorities and handicapped persons. 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- Gentiva Hospice
-C- GVDHD
-C- Continuum

Gentiva Hospice. In Section VI.9, page 117, the applicant projects the following payor mix for the second operating year of the proposed hospice agency.

GENTIVA HOSPICE	
Payor	**Days of Care as % of Total Utilization**
Medicare	92.7%
Medicaid	3.9%
Commercial Insurance	2.4%
Self Pay	0.0%
Charity	1.0%
Total	**100.0%**

The applicant projects that 96.6% of its hospice days will be provided to recipients of Medicare and Medicaid. The applicant adequately demonstrates that it proposes to provide adequate access to hospice services for the medically underserved. Therefore, the application is conforming to this criterion.

GVDHD. In Section VI.9, page 118, the applicant projects the following payor mix for the second operating year of the hospice agency.

GVDHD	
Payor	**Days of Care as % of Total Utilization**
Medicare	84.0%
Medicaid	7.0%
Commercial Insurance	5.0%
Self Pay	0.0%
Charity	4.0%
Total	**100.0%**

The applicant projects that 91% of its hospice days will be provided to recipients of Medicare and Medicaid. The applicant adequately demonstrates that it proposes to provide adequate access to hospice services for the medically underserved. Therefore, the application is conforming to this criterion.

Continuum. In Section VI.9, page 126, the applicant projects the following payor mix for the second operating year of the hospice agency.

CONTINUUM	
Payor	**Days of Care as % of Total Utilization**
Medicare	91.8%
Medicaid	4.3%
Commercial Insurance	2.0%
Self Pay	0.9%
Charity	1.0%
Total	**100.0%**

The applicant projects that 96.1% of its hospice days will be provided to recipients of Medicare and Medicaid. The applicant adequately demonstrates that it proposes to provide adequate access to hospice services for the medically underserved. 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- Gentiva Hospice
-C- GVDHD
-C- Continuum

Gentiva Hospice. In Section VI.5, pages 112-114, the applicant states it will receive referrals from physicians, hospital discharge planners, social workers, HIV/AIDS case management programs, nursing bed facilities and adult care homes, home health and home care providers, other hospices and county government agencies. The

applicant adequately demonstrates that it will offer a range of means of access to the proposed hospice agency. Therefore, the application is conforming to this criterion.

GVDHD. In Section VI.5, pages 115-116, the applicant states it will receive referrals from physicians, other health care providers and agencies such as nursing homes, departments of social services, health departments, assisted living facilities, families, clergy and self referrals. The applicant adequately demonstrates that it will offer a range of means of access to the proposed hospice agency. Therefore, the application is conforming to this criterion.

Continuum. In Section VI.5, pages 124-125, the applicant states it will receive referrals from patients, families, caregivers, healthcare clinicians, acute care discharge planners, skilled or intermediate nursing facilities, other agencies and physician offices. The applicant adequately demonstrates that it will offer a range of means of access to the proposed hospice agency. Therefore, 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- Gentiva Hospice
-C- GVDHD
-C- Continuum

Gentiva Hospice. In Section V.1, page 104, the applicant states that it has contacted an area training program to offer the proposed agency as a clinical training site. Exhibit 16 contains a copy of a letter which was sent to Vance-Granville Community College and a sample training agreement. The applicant adequately demonstrates that the proposed hospice agency will accommodate the clinical needs of health professional training programs in the area. Therefore, the application is conforming to this criterion.

GVDHD. In Section V.1, page 103, the applicant states that it currently has relationships with several health professional training programs. GVDHD has also contacted several other health professional training programs in the service area about developing training relationships. Exhibit 28 contains such correspondence with Halifax Community College, Durham Technical Community College, Wake Tech Community College and Vance-Granville Community College. Exhibit 35 contains a copy of a letter which was sent to the UNC-Chapel Hill School of Public Health offering to become a training site. The applicant adequately demonstrates that the proposed hospice agency will accommodate the clinical needs of health professional training programs in the area. Therefore, the application is conforming to this criterion.

Continuum. In Section V.1, page 118, the applicant states that it has contacted Vance-Granville Community College to propose a working relationship as a clinical training site. Appendix L contains a copy of a response letter from Vance-Granville Community College welcoming the opportunity for another clinical training site. The applicant adequately demonstrates that the proposed hospice agency 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.

-NC- Gentiva Hospice
-NC- GVDHD
-NC- Continuum

Each of the three applicants propose to develop a new hospice home care office in response to the 2013 SMFP need determination for one new hospice home care office for Granville County. There is currently one existing hospice home care office located in Granville County: Hospice of Wake County, Inc., located at 509 N Main Street, Creedmoor.

Gentiva Hospice. In Section II.12, pages 40-42, the applicant states why it believes its proposed hospice home care office will enhance competition and will have a positive impact upon the cost effectiveness, quality, and access to the proposed services. See also Section III, pages 68-72, and Sections VI and VII of the application for additional discussion by the applicant about the impact of its proposal on cost effectiveness, quality and access to the proposed hospice home care services.

However, the information provided by the applicant is not reasonable and credible and does not adequately demonstrate that any enhanced competition includes a positive impact on the cost-effectiveness of hospice home care services in Granville County. The following conclusions are based on a review of the information in Sections II, III, IV, V, VII and the Pro Formas:

- The applicant does not adequately demonstrate the need to develop a new hospice home care office in Granville County. See Criterion (3) for discussion which is incorporated by reference as if fully set forth herein.
- The applicant does not adequately demonstrate that projected operating costs and revenues are reliable. See Criterion (5) for discussion which is incorporated by reference as if fully set forth herein. Therefore, the applicant does not adequately demonstrate that its proposal is a cost-effective alternative.

Therefore, the application is not conforming to this criterion.

GVDHD. In Section II.12, pages 54-55, the applicant states why it believes its proposed hospice home care office will enhance competition and will have a positive impact upon the cost effectiveness, quality, and access to the proposed services. See also Sections III, pages 59, 69-74, Sections VI and VII of the application for additional discussion by the applicant about the impact of its proposal on cost effectiveness, quality and access to the proposed hospice home care services.

However, the information provided by the applicant is not reasonable and credible and does not adequately demonstrate that any enhanced competition includes a positive impact on the cost-effectiveness of hospice home care services in Granville County. The following conclusions are based on a review of the information in Sections II, III, IV, V, VII and the Pro Formas:

- The applicant does not adequately demonstrate the need to develop a new hospice home care office in Granville County. See Criterion (3) for discussion which is incorporated by reference as if fully set forth herein.
- The applicant does not adequately demonstrate that projected operating costs and revenues are reliable. See Criterion (5) for discussion which is incorporated by reference as if fully set forth herein. Therefore, the applicant does not adequately demonstrate that its proposal is a cost-effective alternative.

Therefore, the application is not conforming to this criterion.

Continuum. In Section II.12, pages 49-52, the applicant states why it believes its proposed hospice home care office will enhance competition and will have a positive impact upon the cost effectiveness, quality, and access to the proposed services. See also Section III, pages 82-85, Section VI and Section VII of the application for additional discussion by the applicant about the impact of its proposal on cost effectiveness, quality and access to the proposed hospice home care services.

The information provided by the applicant is not reasonable and credible and does not adequately demonstrate that any enhanced competition includes a positive impact on the cost-effectiveness and access of hospice home care services in Granville County. The following conclusions are based on a review of the information in Sections II, III, IV, V, VII and the Pro Formas:

- The applicant has been licensed for a hospice home care office in Vance County since 2005 and does not provide services from that location. The Henderson site is less than 15 miles from the site proposed in this Granville County project. The applicant does not adequately demonstrate why this proposal is more cost effective than providing the services from the existing Vance County office.

- It is unclear whether the proposed agency will promote access given that the applicant does not provide services from 38 of its licensed home care offices; including the one in Vance County.
- The applicant does not adequately demonstrate the need to develop a new hospice home care office in Granville County. See Criterion (3) for discussion which is incorporated by reference as if fully set forth herein.
- The applicant does not adequately demonstrate that projected operating costs and revenues are reliable. See Criterion (5) for discussion which is incorporated by reference as if fully set forth herein. Therefore, the applicant does not adequately demonstrate that its proposal is a cost-effective alternative.

Therefore, the applicant does not adequately demonstrate that its proposal 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.

-NA- Gentiva Hospice
-C- GVDHD
-NA- Continuum

Gentiva Hospice. The applicant does not currently operate a health service facility or program in Granville County, or serve patients from Granville County.

GVDHD. This applicant as the public health department currently provides health services to residents of Granville County. According to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, within 18 months immediately preceding the date of this decision, the hospice agency has been in compliance with the Medicare Conditions of Participation. Therefore, the application is conforming to this criterion.

Continuum. The applicant does not currently operate a health service facility or program in Granville County or serve patients from Granville County.

(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.

-NC- Gentiva Hospice

The application is not conforming to all applicable Criteria and Standards for a hospice home care office. The specific criteria are discussed below.

-NC- GVDHD

The application is not conforming to all applicable Criteria and Standards for a hospice home care office. The specific criteria are discussed below.

-NC- Continuum

The application is not 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- All applicants.

(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- Gentiva Hospice. In Section IV.4, page 81, the applicant projects to serve 92 unduplicated patients in PY1 and 163 in PY2. The assumptions are provided on pages 58-67 and 83-85.

-C- GVDHD. In Section IV.4, page 85, the applicant projects to serve 112 unduplicated patients in PY1 and 219 in PY2. The assumptions are provided on pages 86-95 and 98. See Criteria (3) for a discussion of the reasonableness of the applicant's projections which is hereby incorporated by reference as if fully set forth herein.

-C- Continuum. In Section IV, page 95, the applicant projects to serve 91 unduplicated patients in PY1 and 169 in PY2. The assumptions are provided are pages 95-100.

(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;

-NC- Gentiva Hospice. See Section IV.5(a&b), pages 82-85. The applicant refers the reader to the projected unduplicated patients when it responds to this question in the application. The applicant does not discuss duplicated patient projections.

-NC- GVDHD. See Section IV.5(a&b), pages 85-86. The applicant refers the reader to the projected unduplicated patients when it responds to this question in the application. The applicant does not discuss duplicated patient projections.

-NC- Continuum. See Section IV.5(a & b), pages 96-99. The applicant refers the reader to the projected unduplicated patients when it responds to this question in the application. The applicant does not discuss duplicated patient projections.

(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- Gentiva Hospice. In Section IV, page 99, the applicant projects days of care by level of care. The assumption used to project the days of care is provided on page 94 and in Exhibit 17. 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.

-C- GVDHD. In Section IV, pages 97-98, the applicant projects days of care by level of care. The assumption used to project the days of care is provided on page 98. See Criterion (3) for discussion of the reasonableness of the assumptions regarding projected days of care and is incorporated as if fully set forth herein.

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-C- Continuum. In Section IV, pages 111-112, the applicant projects days of care by level of care. The assumption used to project the days of care is provided on pages 112-113. See Criterion (3) for discussion of the reasonableness of the assumptions 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- Gentiva Hospice. In Section IV, pages 96 and 99, the applicant projects continuous care hours. The assumptions are provided on pages 94-97.

-C- GVDHD. In Section IV, pages 97-98, the applicant projects continuous care hours. The assumption is provided on page 98.

-C- Continuum. In Section IV, pages 111-112, the applicant projects continuous care hours. The assumptions are provided on pages 112-113.

(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- Gentiva Hospice. In Section X.1, page 138, the applicant projects the cost per hour of continuous care to be $53 in PY1 and $42 in PY2. The assumptions are provided on pages 139.

-C- GVDHD. In Section X.1, page 139 and the Pro Forma Section, page 303, the applicant projects the cost per hour of continuous care to be $62.85 in PY1 and $52.53 in PY2. The assumptions are provided on pages 302-304.

-C- Continuum. In Section X.1, pages 142-143, the applicant projects the cost per hour of continuous care to be $33.01 in PY1 and $26.56 in PY2. The assumptions are provided on pages 142-143.

(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- Gentiva Hospice. In Section X.1, page 138, 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 138-139.

GENTIVA HOSPICE		
	PY1	PY2
Routine Home Care	$220	$132
Respite Care	$212	$169
Inpatient Care	$396	$315

-C- GVDHD. In Section X.1, page 139, the applicant provides the average annual cost per patient day by level of care, as shown in the following table. The assumptions are provided in Tab 13, Pro Forma, pages 302-304.

GVDHD		
	PY1	PY2
Routine Home Care	$126.89	$96.27
Respite Care	$231.43	$175.44
Inpatient Care	$965.01	$747.46

-C- Continuum. In Section X.1, pages 142-143, 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 142-143.

CONTINUUM		
	PY1	PY2
Routine Home Care	$156.54	$125.78
Respite Care	$187.45	$179.39
Inpatient Care	$371.79	$369.61

(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- **Gentiva Hospice.** In Section V, pages 104-106, and in Section VI, pages 112-115, the applicant discusses efforts made to establish working relationships with referral sources. Exhibit 20 contains letters of support from physicians and other healthcare referral sources. Exhibit 15 contains sample contracts for the provision of inpatient care and other services and therapies.

-C- **GVDHD.** In Section V, pages 104-111 and in Section VI, pages 115-116, the applicant discusses efforts made to establish working relationships with referral sources. Exhibit 44 contains letters of support from physicians and Exhibit 42 contains letters of support from other healthcare referral sources. Exhibit 33 contains a sample inpatient services contract. Exhibit 25 contains a log of contacts (including Department of Social Services, county health department and health care professionals) made in the community.

-NC- **Continuum**. In Section V, pages 118-121 and Section VI, pages 124-125, the applicant discusses efforts made to establish working relationships with referral sources. Appendix D contains letters of support from healthcare referral sources. Appendix M contains sample provider agreement contracts. However, the applicant does not provide documentation from a medical equipment provider.

(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- **Gentiva Hospice.** In Section II, page 17, 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.

-C- **GVDHD.** In Section II, page 38, 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.

-C- **Continuum**. In Section II, page 28, the applicant states that it provides documentation in Section XII that it shall comply with all certification requirements for participation in the Medicare program within one year after issuance of the certificate of need. In Section XII, the applicant indicates that it intends to be licensed and certified within one year after expected 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- **Gentiva Hospice.** In Section IV.10(b), pages 102-103, the applicant provides the days of care and the percentage of days of care at 94.3% and 95.3% to be provided to Medicare and Medicaid recipients in their homes for PY1 and PY2, respectively, as shown in the following table.

Gentiva Hospice - % Days in Patient's Residence /% Routine Home Care Days Year 1 - FY 2014			
	Medicare Days	**Medicaid Days**	**Total**
Days in Residence	4,061	171	4,232
Total Patient Days	-	-	4,486
% of Days Provided in Residence	-	-	94.3%
% Days in Patient's Residence /% Routine Home Care Days Year 2 - FY 2015			
Days in Residence	9,642	405	10,047
Total Patient Days	-	-	10,542
% of Days Provided in Residence	-	-	95.3%

Source: Application, page 102. *Continuous care days = 31 continuous care hours/8 hours = 3.87 days.

The application is conforming to this rule. However, 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.

-C- GVDHD. In Section IV.10(b), page 102, the applicant provides the days of care and the percentage of days of care at 86.4% and 86.6% to be provided to Medicare and Medicaid recipients in their homes in PY1 and PY2, respectively, as shown in the following table.

GVDHD - % Days in Patient's Residence /% Routine Home Care Days Year 1 - FY 2014			
	Medicare Days	**Medicaid Days**	**Total**
Days in Residence	3,196	266	3,462
Total Patient Days	-	-	4,008
% of Days Provided in Residence	-	-	86.4%
% Days in Patient's Residence /% Routine Home Care Days Year 2 - FY 2015			
Days in Residence	10,635	886	11,521
Total Patient Days	-	-	13,309
% of Days Provided in Residence	-	-	86.6%

Source: Application, pages 102. *See Section IV, page 97, Continuous care days = 32 continuous care hours/8 hours = 4.0 days. See Section IV, page 98, Continuous care days = 96 continuous care hours/8 hours = 12.0 days.

The application is conforming to this rule. However, 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.

-C- Continuum. In Section IV.10(b), page 115 the applicant provides the percentage of days of care at 96.1% to be provided to Medicare and Medicaid recipients in their homes in both PY1 and in PY2. However, this is the same payor mix the applicant

projects for the proposed agency in Section VI.9, page 126. Assuming all routine home care is provided at home, the applicant would project 92.7% of care days to be provided at home. Regardless of whether 96% or 92%, the percentage of days of care projects to provide to Medicare and Medicaid recipients in their homes exceeds the 80% standard required by this Rule. See the following table from Section IV.10, page 114.

Continuum - % Days in Patient's Residence/ Routine Home Care Days Year 1 - FY 2014			
	Medicare Days	**Medicaid Days**	**Total**
Days in Residence*	4,538	212	4,750
Total Patient Days	-	-	5,123
% of Days Provided in Residence	-	-	92.7%
% Days in Patient's Residence/ Routine Home Care Days Year 2 - FY 2015			
Days in Residence*	10,593	496	11,089
Total Patient Days	-	-	11,959
% of Days Provided in Residence	-	-	92.7%

*Continuous hours to continuous days=118+6 hours=124 hrs/8hrs = 15.5 days. ** Continuous hours to continuous days=154+7 hours=161 hrs/8hrs = 20.1days

The application is conforming to this rule. However, 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- Gentiva Hospice. In Section II.3, pages 23-28, the applicant states all of the above services will be provided directly by the agency except medical supplies, which will be provided by contract.

-C- GVDHD. In Section II.3, pages 40, 45-51, the applicant states the above services will be provided directly by the agency except medical equipment which will be provided by the company Medical Equipment Distributors. Exhibit 21 contains a letter from the Health Director and Board of Health Chair of Granville-Vance District Health Department confirming the provision of the above listed services.

-C- Continuum. In Section II.3, pages 28-30 and 33-37, the applicant states that the following services will be provided directly by agency employees: nursing, social work, spiritual, family and bereavement counseling, and volunteer; while the following services will be provided by contract: dietary counseling by Nutrition Plus, medical supplies by Neil Medical Group, DME and oxygen by Apria Healthcare, and physician services – Dr. Veerappan Sundar has agreed to serve as medical director.

(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- **Gentiva Hospice.** In Section II, pages 18 and 23, and Section VII., page 126, the applicant states that nursing services will be available 24 hours a day, seven days a week.

-C- **GVDHD.** In Section II, pages 40 and 45 and Section VII., page 124, the applicant states that nursing services will be available 24 hours a day, seven days a week.

-C- **Continuum**. In Section II, page 33 and Section VII, page 131, 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- Gentiva Hospice. In Section II, page 18 and pages 26-28, the applicant states that the following services will be provided directly: home health aide services, homemaker services, and continuous care. The following services will be provided via contract: hospice inpatient care with local hospitals and nursing facilities such as WakeMed Hospital and Litchford Falls Healthcare and Rehab; physical, occupational and speech therapies with Gentiva Hospice Home Health; medical equipment with Hospicelink; and respite care with WakeMed Hospital and Litchford Falls Healthcare and Rehab.

-C- GVDHD. In Section II, page 41 and pages 45-51, the applicant states that the following services will be provided directly: physical therapy, home health aide

services, homemaker services and continuous care. The following services will be provided via contract: hospice inpatient care by Granville Health System entities, Maria Parham Medical Center, Universal Healthcare and Hospice of Wake County; occupational therapy by Marcia Williams, OT of Theracare, Inc.; speech therapy by Christina Hite, MS, CCC, SLP; medical equipment by Medical Equipment Distributors; and respite care by Granville Health System entities, Maria Parham Medical Center, Universal Healthcare and Hospice of Wake County.

-C- **Continuum**. In Section II, pages 29-30, the applicant states that the following services will be provided directly: home health aide services, homemaker services and continuous care. The following services will be provided via contract: hospice inpatient care by Universal Healthcare of Oxford and Kerr Lake Nursing and Rehabilitation Center; physical, occupational and speech therapies by RehabCare; medical equipment by Neil Medical Group, and respite care by Universal Healthcare of Oxford and Kerr Lake Nursing and Rehabilitation Center.

(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- **Gentiva Hospice.** Gentiva Hospice states that it will provide home health aide services, homemaker services and continuous care. Exhibit 20 contains letters of intent to contract from the following service providers: hospice inpatient care – Universal Healthcare N. Raleigh, Litchford Falls Healthcare and Rehab and WakeMed Hospital; physical therapy, occupational therapy and speech therapy – Gentiva Hospice Home Health; medical equipment - Hospicelink; and respite care - Universal Healthcare N. Raleigh, Litchford Falls Healthcare and Rehab and WakeMed Hospital.

-C- GVDHD. GVDHD states that it will provide physical therapy, home health aide services, homemaker services and continuous care. Exhibit 32 contains letters of intent to contract from the following service providers: hospice inpatient care – Granville Health System, Maria Parham Medical Center Universal Healthcare and Hospice of Wake County; occupational therapy – Theracare, Inc.; speech therapy - Christina L. Hite, Speech Language Pathologist; medical equipment - Medical Equipment Distributors; and respite care - Granville Health System, Maria Parham Medical Center, Universal Healthcare and Hospice of Wake County.

-NC- C**ontinuum**. Continuum states that it will provide home health aide services, homemaker service, and continuous care. Appendix D contains letters of intent to contract from the following service providers: hospice inpatient care – Universal Health Care of Oxford and Kerr Lake Nursing and Rehabilitation Center; physical therapy, occupational therapy and speech therapy – RehabCare; home health aide services – Granville Senior Services; and respite care - Universal Health Care of Oxford and Kerr Lake Nursing and Rehabilitation Center. However, a letter of intent from Neil Medical Group to contract for provision of medical equipment is not included in Appendix D (as stated on page 30 of the application).

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- **Gentiva Hospice.** In Section VII, pages 119-120, the applicant projects staffing which is consistent with G.S. 131E, Article 10.

-C- **GVDHD.** In Section VII, pages 119-120 and Exhibit 21, the applicant projects staffing which is consistent with G.S. 131E, Article 10.

-C- **Continuum**. In Section VII, page 129-130, the applicant projects staffing which 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- **Gentiva Hospice.** In Section VII, page 122, the applicant projects staffing that is consistent with the Hospice Licensing Rules. In Section II, page 19, the applicant states that its staffing will be in compliance with all federal, state accreditation requirements.

-C- **GVDHD.** In Section VII, pages 127-128, the applicant projects staffing that is consistent with the Hospice Licensing Rules. Exhibit 21 contains documentation of the applicant's intent to staff consistent with requirements in 10 NCAC 13K. However, see Criterion (5) for a discussion of staffing related expenses which is hereby incorporated by reference as if fully set forth herein.

-C- **Continuum**. In Section VII, page 134, the applicant projects staffing that is consistent with the Hospice Licensing Rules. In Section II, page 31, the applicant states that its staffing patterns will be consistent with hospice licensure requirements as specified in 10 NCAC 13K.

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

-C- **Gentiva Hospice.** In Section II, page 20, the applicant states that training for staff and volunteers will meet the requirements in the Hospice Licensing Rules. See Exhibit 9 for staff competency-related policies and procedures and staff training and development requirements. See Exhibit 10 for staff role-specific job descriptions. However, the applicant does not provide any projected volunteer visits.

-C- **GVDHD.** In Section II, page 42, the applicant states that training for staff and volunteers will meet the requirements in the Hospice Licensing Rules. See Exhibit 21 for a letter documenting the applicant's commitment to meet the requirements in

all hospice licensing rules. See Exhibits 22 and 32 for the consulting agreement with Hospice of Wake County to provide training for GVDHD hospice staff and volunteer training.

-C- Continuum. In Section II, page 31, the applicant states that training for staff and volunteers will meet the requirements in the Hospice Licensing Rules. See Appendix Q for the applicant's proposed job descriptions which encompass job functions and responsibilities.

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

-C- Gentiva Hospice. In Section II, pages 20, the applicant states that the volunteer program will be established and operated in accordance with the requirements set forth above. See Exhibit 18, page 02-18, for a copy of the applicant's Hospice Policy Manual - Volunteer Services. However, the applicant does not provide any projected volunteer visits.

-C- GVDHD. In Section II, page 43, the applicant states that the volunteer program will be established and operated in accordance with the requirements set forth above. See Exhibit 21 for a letter documenting the applicant's commitment to meet the requirements in all hospice licensing rules.

-C- Continuum. In Section II, page 32, the applicant states that the volunteer program will be established and operated in accordance with the rules set forth above. See Appendix R for a copy of the applicant's Volunteer Services policy.

(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- Gentiva Hospice. In Section II, page 20, the applicant states that the interdisciplinary team will include all members listed above. See Exhibit 18 for the applicant's proposed policy for the interdisciplinary team.

-C- GVDHD. In Section II, page 43, the applicant states that the interdisciplinary team will include all members listed above. See Exhibit 19, page 698, for the policy to govern the interdisciplinary team and Exhibit 21, a letter which states that the applicant will create the interdisciplinary team.

-C- Continuum. In Section II, page 32, the applicant states that the interdisciplinary team will include all members listed above.

(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- Gentiva Hospice. In Section II, page 20, the applicant states that the interdisciplinary team will be coordinated by the executive director and the medical director.

-C- GVDHD. In Section II, page 44, the applicant states that a coordinator will be named for the interdisciplinary team.

-C- Continuum. In Section II, page 32, the applicant states that the interdisciplinary team will be coordinated by the agency administrator or another qualified health care professional.

(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- Gentiva Hospice. In Section II, page 21, the applicant states that a written care plan will be developed in accordance with this rule.

-C- GVDHD. In Section II, page 44, the applicant states that a written care plan will be developed in accordance with this rule.

-C- Continuum. In Section II, page 32, 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- Gentiva Hospice. In Section II, page 21, the applicant states that the interdisciplinary team will meet at least once every two weeks.

-C- GVDHD. In Section II, page 44, the applicant states that the interdisciplinary team will meet at least once every two weeks.

-C- Continuum. In Section II, page 32, 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- Gentiva Hospice. In Section II, page 21, the applicant states that it will provide a comprehensive and on-going in-service training program for all staff and volunteers.

-C- GVDHD. In Section II, page 44, the applicant states that each member of the interdisciplinary team will be provided orientation, training, and appropriate continuing education.

-C- Continuum. In Section II, page 32, the applicant states that each member of the interdisciplinary team will be provided orientation, training, and appropriate continuing education.

COMPARATIVE ANALYSIS OF THE COMPETING APPLICATIONS

Pursuant to N.C.G.S. 131E-183(a)(1) and the 2013 State Medical Facilities Plan, no more than one new hospice home care agency may be approved in this review for Granville County. Because the three applicants each propose to establish a new hospice home care agency, all of the applications cannot be approved. Therefore, after considering all of the information in each application and reviewing each application individually against all applicable review criteria, the Project Analyst also conducted a comparative analysis of the proposals to decide which proposal should be approved. For the reasons set forth below and in the rest of the findings, the applications submitted **by Wiregrass Hospice of South Carolina, LLC d/b/a Gentiva Hospice (Project ID# K-10172-13), Granville-Vance District Health Department (Project ID# K-10173-13), and Continuum II Home Care and Hospice, Inc., d/b/a Continuum Home Care & Hospice of Granville County (Project ID# K-10174-13)** are disapproved.

Consistency with SMFP Policy GEN-3

No applicant adequately demonstrates the need for its project. Thus, no applicant adequately demonstrates that its proposal was a cost-effective approach. See Criterion (1) for discussion. Therefore, no applicant is the most effective alternative.

Demonstration of Need

No applicant adequately demonstrates the need for its project. See Criterion (3) for discussion. Therefore, no applicant is the most effective alternative.

Services to the Medically Underserved

The applicants provide the following information in Section VI.9 regarding the projected percentage of total hospice days of care to be provided to recipients of Medicare and Medicaid in the second operating year.

	Payor Source	Projected % of Hospice Days of Care
Gentiva Hospice	Medicare	92.7%
	Medicaid	3.9%
	Total	96.6%
GVDHD	Medicare	84.7%
	Medicaid	7.0%
	Total	91.7%
Continuum	Medicare	91.8%
	Medicaid	4.3%
	Total	96.1%
NC 2011*	Medicare	90.8%
	Medicaid	4.0%
	Total	94.8%

*Source: *2012 Fiscal Year North Carolina Hospice Data & Trends* (Oct 1, 2010-Sep 30, 2011)

The 2012 FY *Hospice Data & Trends* report (page 9) shows the North Carolina 2011 statewide average percentage of total hospice days of care to Medicare recipients is 90.8% and 4.0% to Medicaid recipients. All three applicants are a reasonable alternative with regard to providing services to the medically underserved when compared to the statewide average. **Gentiva Hospice** is the most effective alternative with regard to access for the medically underserved population. **GVDHD** projects the lowest combined percentage of days of care to recipients of Medicare and Medicaid and therefore, is the least effective applicant.

Geographic Access/Location of Office

In Section III.4, all applicants propose to serve residents of Granville County. **Gentiva Hospice** also proposes to serve Franklin, Person and Vance counties. **GVDHD** also proposes to serve Vance, Person, Franklin and Warren counties. **Continuum** also proposes to serve Vance County. None of the applicants propose to expand geographic access to hospice services by locating the agency or proposing to serve patients in a county without hospice services. **Continuum** received a license in 2005 for a hospice home care office in Henderson, Vance County. **Continuum** does not serve patients from that office or from a total of 38 other licensed hospice home care offices in North Carolina. The licensed Vance County office is less than 15 miles from the proposed Granville County agency. **Continuum** does not adequately demonstrate why is cannot provide the proposed services from the Vance County office. Therefore, **Gentiva Hospice** and **GVDHD** are more effective alternatives with regard to geographic access to hospice services.

Charges and Costs per Level of Care

The following table illustrates the projected costs and Medicare charges per patient day provided by each applicant in Section X.1-3.

	Yr 2	Routine	Inpatient	Respite	Cont. Care (hourly)
Gentiva Hospice	Charges	$159.00	$708.00	$165.00	$39.00
	Costs	$132.00	$315.00	$169.00	$42.00
GVDHD	Charges	$164.85	$695.45	$164.85	$41.21
	Costs	$96.27	$747.46	$175.44	$52.53
Continuum	Charges	$139.59	$625.78	$147.87	$33.94
	Costs	$125.78	$369.61	$179.39	$26.56

Per Diem charges.

The applicants' projected charges for Medicare are used, as Medicare is the predominant payor source for all three applicants. **Continuum** projects the lowest charges for all four levels of care in PY2. Therefore, **Continuum** is the most effective alternative with regard to charges for all four levels of hospice care. **GVDHD** projects the lowest cost for routine home care. **Gentiva Hospice** projects the lowest cost for inpatient care and for respite care. **Continuum** projects the lowest cost for continuous care. **Gentiva Hospice** projects that over 95% of its days of care provided to hospice patients will be routine home care days. **GVDHD** projects that over 94% of its days of care provided to hospice patients will be routine home care days. **Continuum** projects that over 92% of its days of care provided to hospice patients will be routine home care days. Therefore, **Gentiva Hospice** is the most effective applicant with regard to projected routine home care days for hospice patients. However, **GVDHD** did not propose sufficient staffing to provide the projected number of nursing assistant visits. Thus, the costs are understated. Additionally, both **Gentiva Hospice**'s and **Continuum**'s projected costs are based on unsupported and unreliable projected utilization. Therefore, projected costs for **Gentiva Hospice** and **Continuum** are also unreliable.

Net Revenue per Visit

Net revenue per visit is calculated by dividing the PY2 projected net revenue by the PY2 projected number of projected visits. The following table illustrates the projected net revenue per patient in PY2 for all three applicants.

	Net Revenue (PY2)	Projected Visits (PY2)	Net Revenue per Visit
Gentiva Hospice	$1,693,567	4,947	$342.34
GVDHD	$1,930,185	11,003	$175.42
Continuum	$1,830,445	*14,324	$127.78

*Totals on page 100 vs. page 143 differ slightly, perhaps due to rounding.

Gentiva Hospice projects the highest net revenue per patient visit. **Continuum** projects the lowest net revenue per visit. However, all three applicants fail to demonstrate that their stated net revenue per patient visit is based on reasonable and supported projections.

Net Revenue per Patient

Net revenue per patient is calculated by dividing the PY2 projected net revenue by the projected number of PY2 unduplicated patients provided in Section IV of the applications. The following table illustrates the projected net revenue per patient.

NET REVENUE PER PATIENT PY2			
	Net Revenue	**Projected Patients**	**Net Revenue per Patient**
Gentiva Hospice	$1,693,567	163	$10,389.98
GVDHD	$1,930,185	219	$8,813.63
Continuum	$1,830,445	169	$10,831.03

Continuum projects the highest net revenue per patient. **GVDHD** projects the lowest net revenue per patient. However, all three applicants fail to demonstrate that their stated net revenue per patient is based on reasonable and supported projections.

Administrative Cost per Visit

The average administrative cost per visit is calculated by dividing the total administrative expenses, projected in Form B Pro Formas, by the total number of visits projected in Section IV, as shown in the table below.

ADMINISTRATIVE COST PER VISIT PY2			
	Adm. Costs	**Projected Visits**	**Adm. Cost per Visit**
Gentiva Hospice	$214,732	4,947	$43.41
GVDHD	$172,021	11,003	$15.63
Continuum	$181,550	14,324	$12.67

Continuum projects the lowest administrative cost per patient visit. However, all three applicants fail to demonstrate that their stated administrative cost per visit is based on reasonable and supported projections.

Salaries for Direct Care Staff (RN, CNA, SW)

In recruitment and retention of personnel, salaries are a significant factor. The applicants provide the following information in Section VII for PY2. The project analyst compared the proposed salaries for these key direct-care staff as shown below in the table.

SALARIES – DIRECT CARE STAFF PY2			
	RN*	**CNA**	**Social Worker**
Gentiva Hospice	$64,056	$25,500	$61,812
GVDHD	$60,752	$27,422	$56,599
Continuum	$63,038	$26,791	$47,278

*Direct Care Provider

Gentiva Hospice projects the highest salary for nurses and **GVDHD** projects the lowest salary for nurses. Therefore, **Gentiva Hospice** is the most effective alternative with regard to nursing salaries. **GVDHD** is the least effective alternative with regard to nursing salaries.

GVDHD projects the highest salary for nursing assistants and **Gentiva Hospice** projects the lowest salary for nursing assistants. Therefore, **GVDHD** is the most effective alternative with regard to nursing assistant salaries. **Gentiva Hospice** is the least effective alternative with regard to nursing assistant salaries.

Gentiva Hospice projects the highest salary for social workers and **Continuum** projects the lowest salary for social workers. Therefore, **Gentiva Hospice** is the most effective alternative with regard to social worker salaries. **Continuum** is the least effective alternative with regard to social worker salaries.

Management Personnel

The applicants provide the following information in Section VII. Table VII.6b, for PY2.

HOSPICE AGENCY MANAGEMENT PERSONNEL PY2									
	Administrator / Ex. Director	**FTE**	**Patient-Family Care Coord/Manager**	**FTE**	**Dir of Nursing**	**Hospice Rep**	**FTE**	**Ad-missions Coord**	**FTE**
Gentiva Hospice	$86,802	1.0	$69,258	1.0	-	$61,812	1.0	$43,962	1.0
GVDHD	$75,458	.6	-	-	-	-	-	-	
Continuum	$75,120	1.0	$75,120	.5	-	-	-	-	

Gentiva Hospice proposes 4.0 FTEs, **Continuum** proposes 1.5 FTEs and **GVDHD** proposes .60 FTE for the administrative/management functions of the hospice agency. Additionally, **Gentiva Hospice** proposes a larger salary for the Administrator/Executive Director position and will commit more resources toward the administrative/management functions of the hospice agency. Thus, **Gentiva Hospice** is the most effective applicant with regard to proposed management personnel.

Demonstration of Adequate Staffing for the Proposed Service

The Project Analyst calculates the required staffing for each applicant based on their stated assumptions provided in Section VII. **Gentiva Hospice and Continuum** propose sufficient staffing for the projected visits. **GVDHD** under projects RN's by 0.14 FTE for the second operating year, based on their stated assumptions provided in Section VII. Therefore, **Gentiva Hospice and Continuum** are equally effective alternatives with regard to adequate staffing. **GVDHD** is the least effective alternative.

Volunteer Services

Gentiva Hospice and **Continuum** both propose one FTE to coordinate volunteer services. **GVDHD** proposes .50 FTE to coordinate volunteer services. Each applicant proposes to recruit hospice volunteers for their respective agency. However, **Gentiva Hospice** does not project any hours for volunteer staff in its application (See Section IV, pages 86-93). **Continuum** is the most effective alternatives with regard to staffing for the coordination of volunteer services.

Visits per Patient

RN/LPN Visits (Table IV.6) ALOS IV.5 or 6						
	# Patients Yr 2	Projected Visits	Average Visits/ Patient	ALOS	# Weeks/ LOS	Average Visits/ Patient/Week
Gentiva Hospice	163	3,235	19.8	64.8	9.3	2.1
GVDHD	219	4,047	18.5	60.0	8.6	2.2
Continuum*	169	5,156	30.5	75	10.7	2.9

*Includes LPN. Section VII, page 130.

CNA/Aide Visits						
	# Patients Yr 2	Projected Visits	Average Visits/ Patient	ALOS	# Weeks/ LOS	Average Visits/ Patient/Week
Gentiva Hospice*	163	3,629	22.3	64.8	9.3	2.4
GVDHD **	219	3,650	16.7	60.0	8.6	1.9
Continuum***	169	5,647	33.4	75	10.7	3.1

*CNA performs duties of hospice aide and homemaker. Section VII, page 119. ** CNA performs duties of hospice aide and homemaker.
*** CNA performs duties of hospice aide and homemaker. Section VII, page 130.

SW Visits						
	# Patients Yr 2	Projected Visits	Average Visits/ Patient	ALOS	# Weeks/ LOS	Average Visits/ Patient/Week
Gentiva Hospice	163	902	5.5	64.8	9.3	0.6
GVDHD	219	1,124	5.1	60.0	8.6	0.6
Continuum	169	1,434	8.5	75	10.7	0.8

Clergy Visits						
	#	Projected	Average	ALO	# Weeks/	Average Visits/

	Patients Yr 2	Visits	Visits/ Patient	S	LOS	Patient/Week
Gentiva Hospice	163	464	2.8	64.8	9.3	0.3
GVDHD	219	538	2.5	60.0	8.6	0.3
Continuum	169	726	4.3	75	10.7	0.4

Continuum projects to provide more nursing visits per patient per week. **Continuum** is providing 59% its nursing hours with LPNs instead of RNs and is the most effective applicant with regard to projected nursing visits per patient. **GVDHD** projects the second highest nursing visits per patient per week. However, **GVDHD** does not appear to project enough RN FTEs to supervise the nursing staff. **Continuum** projects to provide 3.1 CNA/aide visits per patient per week, which is more than the other two applicants. Therefore, **Continuum** is the most effective applicant with regard to projected CNA/aide visits per patient. **Continuum** projects to provide 0.8 social work visits and 0.4 clergy visits per patient per week, which are more than the other two applicants. Therefore, **Continuum** is the most effective applicant with regard to projected social work and clergy visits per patient. Thus, **Continuum** is the most effective applicant with regard to overall projected visits per patient.

Provision of Ancillary and Support Services

Gentiva Hospice and **Continuum** propose to provide physical, occupational, and speech therapies through a contractual arrangement. **GVDHD** will directly provide physical therapy, but proposes to contract for occupational and speech therapies. **Gentiva Hospice** and **GVDHD** propose to directly provide dietary counseling. **GVDHD** states that it will contract for in-depth dietary counseling services. **Continuum** proposes to contract for dietary counseling services. All three applicants propose to directly provide home health aid, homemaker and continuous care. All three applicants propose to contract with providers for medical equipment. However, **Continuum** is the least effective alternative for the provision of medical equipment to hospice home care patients as the applicant does not provide a letter of intent from a provider of medical equipment.

All applicants have agreements or letters of intent to contract for hospice inpatient and respite care. **Gentiva Hospice** has support letters with Wake County providers and no Granville County providers for inpatient and respite services. **GVDHD** has letters of intent to contract for inpatient and respite services with providers in Granville, Vance and Wake counties. **Continuum** has letters of intent to contract for inpatient and respite services with providers in Granville and Vance counties. **GVDHD** is the most effective alternative with regard to letters of intent for potential contracts with Granville County and providers in other counties for hospice inpatient and respite services.

CONCLUSION

All three applicants are individually conforming to the need determination in the 2013 SMFP for one hospice home care agency in Granville County. N.C.G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of hospice home care agencies

that can be approved by the Certificate of Need Section. However, the Certificate of Need Section determined that none of the applications submitted is the most effective alternative proposed in this review for the development of one additional hospice home care agency in Granville County, and thus no application is approved.