

ROY COOPER • Governor MANDY COHEN, MD, MPH . Secretary

MARK PAYNE • Director, Division of Health Service Regulation

October 19, 2018

Denise M. Gunter 380 Knollwood Street, Suite 530 Winston-Salem, NC 27103

Exempt from Review - Acquisition of Facility

Record #:

2732

Facility Name:

Good Shepherd Home Health and Hospice Agency

Type of Facility:

Hospice Home Care agency (once licensed separately)

Acquisition by:

Hospital of the South, Inc.

Business #:

2921

County:

Cherokee

Dear Ms. Gunter:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency) determined that based on your representations, the above referenced proposal is exempt from certificate of need (CON) review in accordance with N.C. Gen. Stat. §131E-184(a)(8). Therefore, the above referenced business may proceed to acquire the hospice office of the health service facility identified above without first obtaining a CON. The Agency's determination is limited to the question of whether or not the above referenced business would have to obtain a CON if the current owners of the health service facility do in fact sell it to the business listed above. Note that pursuant to N.C. Gen. Stat. §131E-181(b): "A recipient of a certificate of need, or any person who may subsequently acquire, in any manner whatsoever permitted by law, the service for which that certificate of need was issued, is required to materially comply with the representations made in its application for that certificate of need."

In the event that the business listed above does acquire the facility, you should contact the Agency's Acute and Home Care Licensure and Certification Section to obtain instructions for changing ownership of the existing facility.

It should be noted that this Agency's position is based solely on the facts represented by you and that any change in facts as represented would require further consideration by this Agency and a separate determination regarding whether or not a certificate of need would be required. If you have any questions concerning this matter, please feel free to contact this office.

Sincerely.

Ena Lightbourne

Project Analyst

Martha J. Frisone

Chief, Healthcare Planning and Certificate of Need Section

cc:

Acute and Home Care Licensure and Certification Section, DHSR

Melinda Boyette, Administrative Assistant, Healthcare Planning, DHSR

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION HEALTHCARE PLANNING AND CERTIFICATE OF NEED SECTION

> LOCATION: 809 Ruggles Drive, Edgerton Building, Raleigh, NC 27603 MAILING ADDRESS: 2701 Mail Service Center, Raleigh, NC 27699-2701 www.ncdhhs.gov/dhsr/ • TEL: 919-855-3750 • FAX: 919-733-2757



GEORGIA SECRETARY OF STATE BRIAN P. KEMP

HOME (/)

BUSINESS SEARCH

BUSINESS INFORMATION

Hospice of the South, **Business Name:**

Control Number: 18101225

Domestic Nonprofit Business Type:

Corporation

Business Status: Active/Compliance

NAICS Code: Any legal purpose

NAICS Sub Code:

4411 Oakwood Drive, Principal Office Address:

Chattanooga, TN, 37416, USA

Date of Formation / 8/16/2018 Registration Date:

State of Formation: Georgia

Last Annual

NONE Registration Year:

REGISTERED AGENT INFORMATION

Registered Agent PARANET CORPORATION SERVICES, INC.

Physical Address: 3675 CRESTWOOD PARKWAY, SUITE 350, Duluth, GA, 30096, USA

County: Gwinnett

Back

Filing History

Name History

Return to Business Search

Office of the Georgia Secretary of State Attn: 2 MLK, Jr. Dr. Suite 313, Floyd West Tower Atlanta, GA 30334-1530, Phone: (404) 656-2817 Toll-free: (844) 753-7825, WEBSITE: http://www.sos.ga.gov/ © 2015 PCC Technology Group. All Rights Reserved. Version 4.7.1 Report a Problem?



Denise M. Gunter T 336.774.3322 F 336.774.3372 denise.gunter@nelsonmullins.com NELSON MULLINS RILEY & SCARBOROUGH LLP ATTORNEYS AND COUNSELORS AT LAW

380 Knollwood Street | Suite 530 Winston-Salem, NC 27103 T 336.774.3300 F 336.774.3299 nelsonmullins.com

October 3, 2018

Hand Delivered

Martha J. Frisone, Chief North Carolina Department of Health and Human Services Division of Health Service Regulation Healthcare Planning and Certificate of Need Section 809 Ruggles Drive Raleigh, North Carolina 27603



Re:

Notice of Exempt Acquisition

Good Shepherd Home Health and Hospice Agency, Inc. Murphy, North Carolina and Brasstown, North Carolina

Cherokee County and Clay County

Health Service Area I

FID# 953771

License # HC0275 and HC0318

Dear Ms. Frisone:

Pursuant to N.C. Gen. Stat. § 131E-184(a)(8), I am writing on behalf of Hospice of the South, Inc. ("HOS")¹ to provide prior written notice of the acquisition of the existing hospice office of Good Shepherd Home Health and Hospice Agency ("Good Shepherd") located at 125 Medical Park Lane, Suite H, Murphy, North Carolina (the "Transaction"). Good Shepherd also has an office in Clay County, North Carolina located at 6950 Highway 64 West, Brasstown, North Carolina. See Exhibits A and B for the respective licenses for these offices.

The Seller is Murphy Post-Acute and Wellness, LLC, an affiliate of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System ("Erlanger"). Please note that Erlanger has submitted a Material Compliance Determination Letter related to

¹ HOS is a Georgia non-profit corporation that is an affiliate of Hospice of Chattanooga in Chattanooga, Tennessee.

Martha J. Frisone October 3, 2018 Page 2

the Transaction, dated October 3, 2018. HOS understands that a different buyer will acquire Good Shepherd's home health office, so the acquisition of the home health office is not part of the Transaction described in this letter.² Good Shepherd began operations in 1991 before in-home hospice services were specifically regulated under the CON Law. See Exhibit C for the no review correspondence.

N.C. Gen. Stat. § 131E-184(a)(8) provides that the following is exempt upon prior written notice to the CON Section:

To acquire an existing health service facility, including equipment owned by the health service facility at the time of acquisition. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of this subdivision.

N.C. Gen. Stat. § 131E-184(a)(8).

N.C. Gen. Stat. § 131E-176(9b) defines "health service facility" to include a hospice office. The Transaction will facilitate the continued provision of hospice services to residents of far western North Carolina.

HOS anticipates that the transaction will close on or about November 1, 2018. We therefore would appreciate the CON Section's written confirmation before November 1 that the above-described transaction is exempt from CON review.

If you need further information, please let me know.

Thank you for your time and consideration.

Sincerely,

Denise M. Gunter

² Hospice and home health appear on both the HC0275 and HC0318 licenses. The parties intend to separate these licenses at closing, and will work with the Acute and Home Care Licensure and Certification Section to separate the two licenses, so that home health is on one license, and hospice is on another license. On October 3, 2018, Erlanger submitted a material compliance letter to the CON Section concerning the separation of these licenses.

Martha J. Frisone October 3, 2018 Page 3

Enclosures

State of Aurth Carolina Department of Health and Human Services Division of Health Service Regulation

Effective January 01, 2018, this license is issued to Murphy Post-Acute and Wellness, LLC

to operate an agency known as

Good Shepherd Home Health and Hospice Agency

located at 125 Medical Park Lane; Suite H
City of Murphy, North Carolina.

This license is issued subject to the statutes of the

State of North Carolina, is not transferable and shall expire

midnight December 31, 2018.

Facility ID: 953772

License Number: HC0318

Home Care Services: Nursing Care, Infusion Nursing, In-home Aide, Medical Social Services, Physical Therapy, Occupational Therapy, Speech Therapy, Hospice Services, Companion, Sitter, Respite This agency is authorized to provide Medicare-certified home health services.

Authorized, by:

Secretary, N.C. Department of Health and

Human Services



Director, Division of Health Service Regulation



DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER GOVERNOR MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

MEMORANDUM

TO:

Good Shepherd Home Health and Hospice Agency -- Murphy

FROM:

Azzie Y. Conley, RN, Section Chief

Cindy H. Deporter, MSSW, Acting Assistant Section Chief

SUBJECT:

2018 Home Care / Home Health / Hospice Agency License Renewal Application

PLEASE READ CAREFULLY

Enclosed is your 2018 License Renewal Application. Please complete this application and return <u>no later than</u> <u>December 1, 2017</u> to the address below. Mail to the attention of Cindy Deporter.

Mailing Address

Acute and Home Care Licensure and Certification Section 1205 Umstead Drive 2712 Mail Service Center Raleigh, NC 27699-2712

Overnight Address (UPS and FedEx Only)

Acute and Home Care
Licensure and Certification Section
1205 Umstead Drive
Raleigh, NC 27603

Data on file with the Division indicates that your agency is a Home Care Agency providing Home Health and Hospice Services (HC/HHA/Hospice). Your annual licensure fee, as authorized by Sections 41.2(a) – 41.2(i) of Session Law 2005-622, is \$510.00. This amount is comprised of a base fee of \$510.00 -- no additional fee.

Payment should be in the form of check, money order or certified check and must be payable to "NC-DHSR." Payment should include the facility's license number and be submitted with your license renewal application. A separate check is required for each licensed entity.

Your completed license renewal application and the license renewal fee must be received by December 1, 2017 to ensure your license is renewed with an effective date of January 1, 2018. Failure to possess a valid license may compromise your facility's ability to operate and/or adversely impact its funding sources.

ACUTE AND HOME CARE LICENSURE AND CERTIFICATION SECTION

HTTP://WWW.NCDHHS.GOV/DHSR/
TEL: (919) 855-4620 • FAX: (919) 715-3073
LOCATION: 1205 UMSTEAD DRIVE • LINEBERGER BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 1205 UMSTEAD DRIVE • 2712 MAIL SERVICE CENTER • RALEIGH, NC 27699-2712
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Good Shepherd Home Health and Hospice Agency -- Murphy
2018 Home Care / Home Health / Hospice Agency License Renewal Application
Page 2

PLEASE NOTE -- No requests for agency director change, change of ownership, geographic service area expansion, additional services or deletion of a service(s) will be handled as part of the licensure renewal process. Please provide the above in a separate request in writing.

A portion of this application contains preprinted information from our data systems, based on your last HC/HHA/Hospice license renewal application or the most recent information that has been reported to this office. If any of this preprinted- information has changed, mark through the incorrect information with a RED pen and write in the correct information. Prior to amending the legal entity, please contact this office for further instructions. Please review the "ownership disclosure" section carefully to verify its accuracy. Complete all areas of this application and return by the date specified above, along with the annual licensure fee. PLEASE, DO NOT RETYPE THE APPLICATION, and be sure to retain a second copy of the application for your records. If you have any questions about the preprinted information contained in this application, please feel free to call our staff at (919) 855-4620.

National Provider Identifier (NPI). Please provide your NPI number in the space indicated on the license renewal application. If you need to obtain an NPI, have questions or need additional information regarding the NPI number contact 1-800-465-3203 (NPI Toll-Free) or visit the website http://www.ncdhhs.gov/dma/NPI/index.htm.

Data Supplement Information: Collected for the purpose of composing data tables and calculating need determinations for additional healthcare services detailed in the annual North Carolina State Medical Facilities Plan. If you have any questions about the data supplement or how to complete it, please contact Healthcare Planning at (919) 855-3865.

<u>Please note</u>: Non-Medicare certified Home Care Agencies who state on their application they are accredited by ACHC, TJC, DNV, or CHAPS, must verify their accreditation by submitting their full accreditation report at the time of license renewal.

Questions on license renewal applications should be addressed to:

Cindy Deporter

(919) 855-4557

Email: Cindy.Deporter@dhhs.nc.gov

Anita M. Laumann

(919) 855-4636

Email: Anita.Laumann@dhhs.nc.gov

For Official Use Only North Carolina Department of Health and Human Services License # HC0318 Division of Health Service Regulation FID# 953772 Acute and Home Care Licensure and Certification Section Date PC Regular Mail: 1205 Umstead Drive 2712 Mail Service Center Raleigh, North Carolina 27699-2712 Overnight UPS and FedEx only: 1205 Umstead Drive Raleigh, North Carolina 27603 Total License Fee: Telephone: (919) 855-4620 Fax: (919) 715-8476 LICENSE RENEWAL APPLICATION FOR HOME CARE, NURSING POOL, AND HOSPICE A separate application is to be completed for each site from which home care (including home health), nursing pool, or hospice services are offered. Separate legal entities operated out of the same office must submit separate applications. Legal Identity of Applicant: Owner/Corporate Identity: Murphy Post-Acute and Wellness, LLC (Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.) Agency Name/Doing Business As (D/B/A) - Name(s) under which the facility or services are advertised or presented to the public: Good Shepherd Home Health and Hospice Agency PRIMARY: (If materials are to be mailed to another address list here) Agency Mailing Address: 125 Medical Park Lane Suite HMurphy, NC 28903 - 28904 125 Medical Park Lane, Suite H Agency Site Address: Murphy, NC 28903 28906 Cherokee County: Telephone: (828)837-4260 MQ 7 Fax: (828)837-4860 9503 Agency E-Mail: (Required) Wonce & Marphy Medical orq Web Site (If applicable) Julie Younce Administrator/Director: Home Care Manager Title: Name of the person to contact for any questions regarding this form: Telephone: 828-837-1197 Name: PERSON NOST

E-Mail: jyonce@murphymedical.org

Licensure Categories Licensed For (Check All That Apply)

- 1. X Home Care Agency (G.S. 131E-138)
- 2. ___ Nursing Pool (G.S. 131E-154,3)
- 3. X Hospice Services (G.S. 131E-200)

Scope of Services:

DHSR licenses Home Care agencies for a Scope of Services: Nursing Care, Infusion Nursing Services, In-Home Aide, Medical Social Services, Physical Therapy, Occupational Therapy, Speech Therapy, and Clinical Respiratory Services (including Pulmonary or Ventilation if provided separately from routine nursing practice). Any agency adding a new service category as outlined in G.S. 131E-136(3)(a)-(f) shall notify the Department in writing at least 30 days prior to the provision of that service to any clients. YOU MAY NOT ADD SERVICES ON THIS APPLICATION.

Below are the services you are currently licensed to provide:

Home Care Services: Nursing Care, Infusion Nursing, In-home Aide, Medical Social Services, PT,

			•	ompanion, Sitte		ervices	, ,
1)	Home M	edical Equipmen	nt/Durable Medic			Yes	No No
2)	Do you a Pharmac			rmit issued by the		Yes	No No
	If "yes,"	please provide th	ne permit numbe	r:		_	. *
Hou	rs:			e e e	a a		
				pen for business e	each day:	. 0	
[Exa	mple: 9 a	m – 5 pm. Use Monday	"O" if not open] Tuesday	Wednesday	Thursday	Friday	Saturday
			8 am - 4 pm	8pm-4pm	8pm-4PM	8pm-4pm	
	sing:			***			
Full-	-time Equi	valents (FTE)	r e		* (***		
			DN	IDN	Aides		

Number: Accreditation Information:

If home care licensure is being requested on the basis of deemed status as an accredited agency, attach a complete copy of accrediting organization's inspection report (or findings) together with its decision, if surveyed within the last 12 months. Licensure based upon deemed status cannot be completed without full disclosure.

Accredited	Accrediting Organization	Expiration Date	*Deemed Status
V	TJC (The Joint Commission)	12/04/2018	
	DNV (Det Norske Veritas)	1. 1. 127,000 . 1.1.	$\mathcal{A}^{T}\mathcal{A}^{A}_{+} = \mathcal{A}^{T}\mathcal{B}^{A}_{+}$
	CHAP (Community Home Association	75 (Table 1997)	erang kalangan sa Nagara
(1)	Program)		The state of the state of
	ACHC (Accreditation Commission for Health	1 m T	1
* B.	Care, Inc.)	and the second	1 1
	Other: TJC	T = · -	

^{*}Please provide a copy of your letter if you are deemed

DHSR-4029 REV 08/2017

H	ome Care Agency Appl	icants:	v		
1.	Are you a Medicare Ce provider number? 3470		ency? Yes No If y	es, what is y	our Medicare
	■ 1.83 10 4001-2019/2019/2019 = 12 00.31 1				
2.	This agency is a Home	Health Agency.	YesNo.		The second secon
	If 'Yes', please check of	one: Parent 🖊 Bran	ch_Sub-unit_		
3.	Is this agency owned or	operated by a Continui	ng Care Retirement Center (Co	CRC)?	Yes No
ш,	ospice Applicants:				
1.	If Medicare certified, w	hat is your hospice prov	ider number? <u>341554</u>		
2	For Medicare certified	hospices do you operate	more than one office under th	is provider n	number? If yes
	please list each license	operating under this Me	dicare number.	•	
	HCD275 HCD3	Ŕ		1 *	
3	Has this site been issue	d a Certificate of Need t	o provide hospice services? _	✓ Yes _	No:
4.	Do you have an agreem	ent to operate Hospice l	icensed inpatient beds or hosp	ice residenti	al beds in another
	facility? If so, list facili				
					Security March
Nr	rsing Pool Applicants:	(Marie Andrea Andrea) (1967) Marie Andrea (1967)		1. 1. 1. 1.	
		must attach a copy of the	ne agency's current general and	l professiona	al liability
ins	surance policy (binder ac	ceptable). The documer	nt must show that the applican	is insured a	gainst loss,
daı	mage, and expense relate	d to a death or injury cl	aim resulting from negligence	or malpracti	ce in the provision
	health care by the nursin				
Ov	wnership Disclosure: (Please fill in any blanks	and make changes where nece	essary).	
				19 70	
1.	What is the name of the	legal entity with owner	ship responsibility and liabilit	y/ II this is	a Corporation,
			me as on file with the NC Seco		
d.			ne of the governmental unit th	at has the ov	viterstrib
	responsibility and liabil	ity for services offered.			
. :	Owner:	Murphy Pos-Acute an	d Wellness, LLC		
	National Provider	Carlos SADA			one na veneral po especial de la comoción de la co
	Identifier (NPI):	1688020770			
	Street/Box:	4130 U.S. Hwy. 64 E	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ote manifest granders To de Domesta Bland	
	City:	CONTRACTOR AND AND THE PART OF A PAR	te: NC Zip: 28906		
74	Telephone: Senior Officer	(828)835-7502 Fax James M. Stevenson			
	Semon Officer,	MUMINES IVI. BIEVENSON,			
	a. Legal entity is:	For Profit	X Not For Profit	The state of the s	general Mikhila (2006) Naka pagwani Jawa (2006)
33	b. Legal entity is	Corporation	X Limited Liability	Part	nership
			Company		
		Proprietorship	Limited Liability	Gov	ernment Unit
			Partnership		

Corporation:	•	
a. What is the exact wording of the corpo	orate name on file with the NC Secretary of	State?
Murphy Post- Houte and	Wellness, LLC	
o. In what state was the corporation original	nally established? NC	
c. Address and Telephone number of the 41 30 US Hwy 64 Ea	.6t	
Murphy, NC 28906		
d. List names and addresses of ALL office	cers and any other persons with a controlling	
Name	Title	Percent of Stock
James M. Stevenson	President	NA
Toni Loving od	Secretary	IN/A
		<u> </u>
Government Unit:	Attach additional sheets as needed) the ownership responsibility and liability	y for the services offered
Government Unit: a. Name of the governmental unit that has b. Title of the official in charge of the gove. c. Check which best describes the type of	the ownership responsibility and liability remmental unit:	
Government Unit: a. Name of the governmental unit that has b. Title of the official in charge of the gov c. Check which best describes the type of City County State	the ownership responsibility and liability rernmental unit: governmental unit: e Authority Health Dept	
Government Unit: a. Name of the governmental unit that has b. Title of the official in charge of the gov c. Check which best describes the type of City County State Other (Please specify): Multiple Facilities: a. Is this facility part of a multiple facility	rernmental unit: governmental unit: a Authority Health Dept y/agency system in North Carolina? Y wo or more facilities under the same manage	DSS
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Government Unit: a. Name of the governmental unit that has b. Title of the official in charge of the gov c. Check which best describes the type of City County State Other (Please specify): Multiple Facilities: a. Is this facility part of a multiple facility (A multiple facility system is defined as to b. If 'Yes' above, are medical records in c. If 'Yes', please specify location.	rernmental unit: governmental unit: a Authority Health Dept y/agency system in North Carolina? Y wo or more facilities under the same manage	DSS Tes No ement or ownership).

d. If yes above, list name(s) of other facilities licensed in North Carolina by the Division of Health Service Regulation.

Name	Location				License #
Murphy Past Acute and Nell	1856 HC 6950 4	11/64 West B	rasstoren WC	28902	HC0275
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(Attach additional sheets as needed)

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e.	Is your agency owned, in whole or in part, or operated by a hospital? Yes No
f.	If 'Yes', please specify the name of entity. Murphy Medical Center, Inc.
	그 그는 이 시간에 가게 살아 가꾸는 것이 없는데 그런 그렇게 되었다. 그는 그는 그를 하는데 그리고 하는데 사람들이 되었다. 그는 그를 하는데 그를 하는데 그를 하는데 되었다.
g.	Is your agency managed by another entity? Yes No
h	If 'Yes', please specify the name of entity. Murphy Medical Center, Inc.
	WALL LOSS OF THE PROPERTY OF T

This application must be completed and submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2018 home care agency license.

AUTHENTICATING SIGNATURE: The undersigned submits application for the year 2018 in accordance with North Carolina General Statutes G.S. 131E-138, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13J), and certifies the accuracy of this information.

	1 1 1 1	And the second second				1. 1.	
Signature: \lambda	Acres Mese	Market Cheer	Y P	<i>T</i>	Dai	0	The contract of
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alle Physician in California	·	新的 公司和1995年	2007 人名埃尔 354 五				

<u>Please be advised</u>, the license fee <u>must</u> accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, <u>prior</u> to the issuance of a home care agency license.

North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section Regular Mail: 1205 Umstead Drive 2712 Mail Service Center Raleigh, North Carolina 27699-2712 Overnight UPS and FedEx only: 1205 Umstead Drive Raleigh, North Carolina 27603

Telephone: (919) 855-4620 Fax: (919) 715-8476

For Of	ficial	Use Only	
License	# HC	C0318	
FID#	9537	772	
PC		Date	

HOME CA	RE AGENCY
2018 Annual	Utilization Data

(Reporting 2017 Fiscal Year Data)

To be completed by agencies without a certificate of need or authorization to provide Medicare certified home health services.

A separate form should be co	mpleted for each site.
A. Identification:	
License No: <u>HC0318</u>	*
Legal Identity of Applicant: Murphy Post-Acute	and Wellness, LLC
Agency d/b/a: Good Shepherd Hon	ne Health and Hospice Agency
Agency Site Address: 125 Medical Park Lar	e; Suite H
Murphy, NC 28903	
County: Cherokee	ရည္ခ်ေရာက္သည္ လုတ္လာလုံးလုံးသည့္ မင္း မရက္က မင္းရုိက္ လုတ္သည္
	The state of the s
B. Reporting Period	
Data is requested for the twelve-month period beging 2016, and ending after the twelve-month period, but or facility was not open for this entire twelve-month period.	it no later than September 30, 2017. If your agency
Your reporting period:	
Starts, 20	116 and Ends September 30, 2017 * * Change date if different from September 30
	The second of th
AUTHENTICATING SIGNATURE: I certify the information	on submitted in this Annual Utilization Data is
accurate.	
Typed Name:	Title: Tenning Title:
Signature:	Date:

C. Client Residence

N/A

Instructions:

• Report numbers of persons who received home care services including companion, sitter and respite services by county of residence for each age category shown.

License No: HC0318

Facility ID: 953772

• Use each client's age on the first day of service during the reporting period. This is an unduplicated count. Clients may be counted only once during the reporting period regardless of the number of times admitted.

Number of Clients by Age and by County of Residence DO NOT USE OTHER AGE GROUPS

County of Residence	0-17	18-40	41-59	60-64	65-74	75-84	85+	All Ages
			45					
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		The property of the same						nt sette och et ette och sette nota (och sette)

Copy and attach additional page if needed.

Page 2

D. Staff

N/A

· Report data in Table below.

<u>Total Staff</u> means the total number of employees by discipline, including contract staff, who are involved with the agency's home care services.

License No: HC0318

Facility ID: 953772

<u>Total Clients</u> means the total number of clients seen by each staff discipline during the reporting period. If the client is seen by more than one discipline, include the related clients under each discipline. Include companion, sitter, homemaker and respite services. If a client is reopened to the same discipline later in the year, count only once.

Examples	Mrs. Brown was admitted on four different occasions to the home care agency. She received nursing services on each admission. Count Mrs. Brown as one (1) client under nursing.
3	Mrs. Smith was admitted on four (4) different occasions to the home care agency. She received
A 2	nursing on 2 admissions, aide services on 3 admissions and physical therapy on 1 admission.
b _i	Count Mrs. Smith as 1 client under nursing, 1 client under in-home aide services and 1 client under physical therapy.

If the RN supervisor and Agency Administrator are the same person please report the position in only one category and use the category in which the most time is utilized.

Staff Discipline	Total Staff	Total Clients 12-Month Report Period
Administrator		
Nurse Director or Supervisors		Land Land Control of C
Other Administrative Staff		
Nursing (RN, LPN)		Commence and Part And Stewnssical House Stewarts (
Occupational Therapist		
Physical Therapist	•	
Speech Therapist		
Social Worker		
In -Home Aide		
Companion, Sitter, Respite Staff		
Respiratory Therapist		
Respiratory Practitioner	······································	A Carrier and American American
Other (Specify)		

DHSR-4029 REV 08/2017

North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section

Regular Mail: 1205 Umstead Drive 2712 Mail Service Center

Raleigh, North Carolina 27699-2712

Overnight Mail Only: 1205 Umstead Drive

Raleigh, North Carolina 27603

Telephone: (919) 855-4620Fax: (919) 715-8476

For Official Use Only
License # HC0318
FID # 953772
PC _____ Date _____

HOME HEALTH AGENCY

2018 Annual Data Supplement to License Application

(Reporting 2017 Fiscal Year Data)

Includes Home Health and Home Care data to be reported by Medicare certified agencies.

A separate form to be completed for each site.

SECTION A Identification	SECT	ION A	Iden	tification	ı
--------------------------	------	-------	------	------------	---

License Number:

HC0318

Legal Identity of Applicant:

Murphy Post-Acute and Wellness, LLC

Agency d/b/a:

Good Shepherd Home Health and Hospice Agency

Agency Site Address:

Street: 125 Medical Park Lane; Suite H

City: Murphy State: NC Zip: 28903 28904

County:

Cherokee

Agency Phone Number:

(828)837-4260 1197

Agency Fax Number:

(828)837-4860 9503

Reporting Period October 1, 2016-September 30, 2017

□ July 1, 2016 - June 30, 2017

 If your agency or facility was not open for an entire twelve-month period, please specify the time period covered in this data supplement in the space provided below:

	specify the time	periou covered in	tuis data suppieme	ent in the space i	oroviaca deiow:
Book Jagar <mark>a</mark> process swi	Salah mendahan di		19 18 18 18 18 18 18 18 18 18 18 18 18 18	(SP ZZ) proproproproproproproproproproproproprop	Managara paga
CONTACTN	AME: Name of t	he person to contact	for any questions r	egarding this form	n.
Print Name:	Teresa West		Telepho	ne: 828-837	-11917
E-Mail: 1126	t@marphym	edical org	Fax	828-837-0	7503
CEOMIDE C	DOD CLONATU	RE: I certify the int			
	LOK SIGNATUL	supplement is acc		ea nerewill in L	us gata
Print Name: _	Julie Yonce	RN-BC		Home Core	Manager
是"阿勒斯特"的。				会自 <i>与</i> 设备数据的扩展	J
Signature:	Julie yer	se Pa Be	Date:	1112111	Control of the contro

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

Home Health Services Reporting

SECTION B Client Residence (Part-time Intermittent Home Health)

Instructions:

Report data related to clients who are receiving Part-time Intermittent Home Health services through your Medicare certified agency regardless of payer source.

These are services provided on a per visit basis (Nursing, PT, OT, ST, MSW and IN-HOME AIDE [HOME HEALTH AIDE]).

Report any other types of services such as Medicaid CAP and PCS in-home aide or private duty nursing on the next page.

• Report number of clients by county of residence for each age category shown. Use each client's age on the first day of services during the reporting period.

This is an unduplicated count. Clients may be counted only once during the reporting period regardless of the number of times admitted.

Do not use other age groups.

Report number of Part-time/Intermittent Home Health visits (all payor sources) by county during the reporting period.

lumber of H			Num	oer of Unc	luplicated	Clients			Total
County of Residence	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total Number of Clients	Visits by County
							044		0
Clay		3	22	17	31	29	24	126	200
1									ton Weeds or the same and same
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*				,· .		Six 16		1 . 1 .	

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

Home Care (Non Part-time Intermittent Home Health) Services Reporting N/A SECTION C Client Residence (Home Care)

Instructions:

- Report numbers of clients who received Home Care (Non Part-Time Intermittent Home Health) Services by county of residence for each age category shown.
- Use each client's age on the first day of service during the reporting period. This is an unduplicated count. Clients may be counted only once during the reporting period regardless of the number of times admitted.
- Do not report clients reported on the previous page.
- Do not use other age groups.

Number of Home Care Clients by Age by County of Residence

County of								
Residence	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total
			20.67					
				1876 A				*
Andrew Sand				and the second				
					Yang Yang Yang Yang			
			1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1					
		To the Section	1 No. 1					
		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1			instance visites			

Copy and attach additional page(s) as needed.

Home Health Services Reporting

SECTION D Clients/Visits by Payer Source for your Designated Reporting Period

Instructions:

* Report data related to clients who are receiving <u>PART-TIME INTERMITTENT HOME HEALTH</u> * services through your Medicare certified agency <u>regardless of payer source</u>.

* These are services provided on a <u>per visit</u> basis: Nursing, PT, OT, ST, MSW and In-Home Aide (Home Health Aide). This includes patient services reimbursed by Medicare, Medicaid, private insurance, etc.

* Clients admitted twice during the reporting period and reimbursed by the same payer should be counted only once.

* Clients admitted once during the reporting period, for whom payment was obtained from two sources, should be reported twice, once for each payment source.

* Do not provide data here related to clients on page 3 of this report.

Examples	Mrs. Brown was admitted on four different occasions to the home health agency. Medicare was the only payor for each admission. Therefore, Mrs. Brown would be reported as one Medicare client, but the number of visits would include all visits from the four admissions.
	Mrs. Smith was admitted once to the home health agency, but received services paid for by both Medicare and Medicaid. Mrs. Smith would be reported as one Medicare client and one Medicaid client. Her visits should reflect the number of visits paid by each of the payers.
	Mr. Jones was admitted to the home health agency on six different occasions during this reporting period. Three admissions were under Medicare and three were under Medicaid. Mr. Jones would be reported as one Medicare client and one Medicaid client. His visits should reflect the number of visits paid by each of the payers.

Payment Source	Number of Clients	Number of Visits
Medicare	72	1254
Medicare HMO	13	172
Medicaid	15	200
Medicaid HMO		
Private Insurance	24	335
Private Insurance HMO		
Indigent Non-Pay	2	43
Specify any other below*:		
		1
		2.1
	;	
	126	200

*May include Self-pay, Worker's Comp, VA/Tricare, Etc.

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

SECTION D. Clients/Visits by Payor Source for your Designated Reporting Period (continued)

1. The following information may either be collected off your system or requested by you from the Centers for Medicare and Medicaid Services (CMS) or Palmetto Government Benefits Administrators (PGBA). It is expected that your system data will be more up-to-date.

Please specify the 12-month reporting period, by month and year, of the following information:

Fron	n 10/2016 To 09/2017	
	Month/Year Month/Year	
a. N	Number of Medicare Episodes =	94
b. A	Average Number of Medicare episodes per beneficiary =	1,27
c. A	Average Number of Medicare Visits per Episode (all disciplines) =	14,03
d. I	For Medicare – the Percent of Lupus =	0,14

Home Health Services Reporting

SECTION E Staff - Home Health

Report data in Table E related to clients who are receiving part-time intermittent home health services through your Medicare certified agency <u>regardless of payer source</u>. These are services provided on a <u>per visit</u> basis: Nursing, PT, OT, ST, MSW and In-Home Aide, (Home Health Aide).

<u>Total Staff</u>: Means the total number of employees by discipline, including contract staff, who are involved with the agency's home health services.

<u>FTEs</u> (Full-Time Equivalents): Means total number of hours per week regularly worked, by discipline, divided by 40. Do not include homemaker, sitter or In-Home Aide Level I (Home Management).

Examples

The administrator works 20 hrs./wk. in your home care program and 20 hrs./wk. in a non-home care program. FTE = 20/40 = 1/2 FTE

15 nurses work a combined total of 400 hours a week. FTE = 400/40 = 10 FTE's

<u>Total Clients</u>: Means the total number of clients seen by each staff discipline during the reporting period. If the client is seen by more than one discipline, include the related client visits under each. Do not report visits if only for the purpose of supervising other staff. <u>Do not include homemaker, sitter or In-Home Aide Level I</u> (<u>Home Management</u>). If a client is reopened to the same discipline later in the year, count the client only once.

Examples

Mrs. Brown was admitted on four different occasions to the home care agency. She received nursing services on each admission. Count Mrs. Brown as one client under nursing, but report all the visits she received related to nursing.

Mrs. Smith was admitted on four different occasions to the home care agency. She received nursing on two admissions, aide services on three admissions and physical therapy on one admission. Count Mrs. Smith as one client under nursing, one client under in-home aide services and one client under physical therapy, but report all the visit she received related to each discipline.

<u>Total Visits</u>: These are direct care visits provided to the client by home health staff members, or by others under contract with the home health agency for which <u>you bill</u>. (If you are providing contract staffing services to another home health agency, do not include these visits. These visits should be reported by the agency who is billing for the clients' services.)

Average Cost Per Visit: Means the total cost for each staff discipline divided by the total number of visits by that discipline. Use your most recent cost report as filed.

License No: HC0318

Facility ID: 953772

License No: <u>HC0318</u> Facility ID: 953772

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

Home Health Services Reporting

SECTION E Staff - Home Health (continued)

2017 Home Health Staffing Data (Table E)

Staff	Total	FTES	Total Clients	Total Visits	Average Cost Per Visit
Discipline	Staff		Chems	V 15115	1 (1) 151
Administrator	1,0	150			Tolky 20 September
Nurse Director/Supervisors	1.0	,50			
Other Administrative Staff	1,0	150			
Nursing (RN, LPN)					
	2.0	2,54	142	778	129.42
Occupational Therapy	,60	, 38	39	251	118.87
Physical Therapy	2,0	1.05	104	842	118.89
Speech Therapy	1,25	110	5	6	118.85
Social Worker	25	120	3	3	170.50
Home Health Aide	1.0	,55	Ja	117	31,28
Nutrition	costina di Gilina di Li		territoria (1964) Servicio (1966) Espaino (1964)		magang magang karang magang magan
Totals	90	4.32	307	2004	

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

Home Care (Non Part-time Intermittent Home Health) Services Reporting N/A SECTION F Staff - Home Care

Report data in Table F related to clients who are receiving continuous hours of services through your home care agency (Non part-time intermittent home health).

<u>Total Staff</u>: Means the total number of employees by discipline, including contract staff, who are involved with the agency's **home care** services (Non Medicare-certified/non part-time intermittent home health).

<u>Total Clients</u>: Means the total number of clients seen by each staff discipline during the reporting period. If the client is seen by more than one discipline, include the related clients under each discipline. Do not include homemaker, sitter or In-Home Aide Level I (Home Management).

Examples	Mrs. Brown was admitted on four different occasions to the home care agency. She received nursing services on each
•	admission. Count Mrs. Brown as one client under nursing.
	Mrs. Smith was admitted on four different occasions to the home care agency. She received nursing on two admissions, aide services on three admissions and physical therapy on one admission. Count Mrs. Smith as one client
	under nursing, one client under in-home aide services and one client under physical therapy.

2017 Home Care Staffing Data (Table F)

Staff Discipline	Total Staff	Total Clients (12 Month Reporting Period)
Administrator		
Nurse/Director Supervisors		
Other Administrative Staff		
Nursing (RN, LPN)		
Occupational Therapist		¥
Physical Therapist		
Physical Therapy Assistant		
Speech Therapist		
Social Worker		
In-home Aide	·	
Respiratory Therapist		
Respiratory Practitioner		
Other (Specify)		
Total		

2018 HOSPICE DATA SUPPLEMENT HC0318 OVERVIEW

There are a total of twelve sections in this data supplement form on 14 pages. Please answer <u>all</u> of the questions in the designated location on each page that applies to this licensed agency.

Please be sure to double check all calculated totals throughout this document; to include all row totals and column totals. Also, please double check to make sure all section totals that are required to match another section total match before submitting this form to DHSR.

Section A collects information regarding this particular hospice agency. Select one of two choices for your facility's reporting period.

DHSR Healthcare Planning staff will contact the person who is listed under the <u>Contact Name</u> if the form is submitted <u>incomplete</u> or if there are any questions regarding data contained on the form.

Section E collects data for FY2017 based only on patient principle/primary diagnosis (use ICD-10-CM Code list provided) regardless of payment source. Do <u>not</u> include patients carried over from FY2016.

Section G is patient demographics for new, unduplicated admissions.

Section I collects the number of patients by county of the patient's primary residence in FY2017 for this licensed agency.

Section J collects information on the number of licensed inpatient and residential beds for this licensed agency, if applicable.

Section K collects, by county of primary residence, inpatient and residential patient information for this licensed agency, if applicable. Total days of inpatient care days do not include respite days.

Section L collects inpatient and residential staffing information for FY2017 for this licensed agency, if applicable

If you have questions, please call Healthcare Planning at (919) 855-3865 or email us at DHSR.SMFP.Hospice-Inventory@dhhs.nc.gov.

North Carolina Department of Health and Human Services Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section Regular Mail: 1205 Umstead Drive
2712 Mail Service Center
Raleigh, North Carolina 27699-2712
Overnight UPS and FedEx only: 1205 Umstead Drive
Raleigh, North Carolina 27603

Telephone: (919) 855-4620 Fax: (919) 715-8476

License No:

Legal Identity of Applicant:

License # HC0318	
FID #: 953772	
PC Date	

Hospice Agency

2018 Annual Data Supplement to Licensure Application (Reporting 2017 Fiscal Year Data)

Murphy Post-Acute and Wellness, LLC

Please read all directions for each section carefully.

SECTION A Identification and Contact Information

Agency d/b/a:	Good Shepherd Home Health and Hospice Agency
Agency Site Address:	Street: 125 Medical Park Lane; Suite H
	City: Murphy State: NC Zip: 28903 28906
County:	Cherokee
Agency Phone #:	(828)837 -4260 119 ⁴ 1
Agency Fax #:	(828)837-4860 9503
	☑ October 1, 2016 – September 30, 2017 □ July 1, 2016 – June 30, 2017
If your agency or facility vertime period covered in this.	vas not open for an entire twelve-month period, please specify the data supplement in the space provided below:
CONTACT NAME: Name of the per	son to contact for any questions regarding this form:
Print Name: Teresa West	Telephone: <u>828-837-1197</u>
E-Mail: twest@ murphymed.	
	I certify the information submitted herewith in this data supplement
Print Name: Julie Yonce	생생님도 없이 많아 하는 것이 되었다. 그는 이렇게 되었다면 하셨다면 하셨다면 어떻게 하셨다면 하셨다.
Signature: Hospice Data Supplement REV 08/2017	PE Date: WAW

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

SECTION B Program Demographics	e
1. AGENCY TYPE (Select one based on Medicare	e Cost Report Status)
Freestanding	
☐ Hospital Based	
☐ Home Health Based (dually certified)	
☐ Nursing Home Based	
2 CENSUS ON 9/30/2017: 3 (Only this	license number)
2. CENSUS ON 9/30/2017: 3 (Only this (If zero, explanation required)	nemse number)
(II 2010, Capitalanous Isaganous)	
3. MEDICARE CERTIFICATION	
Is this facility Medicare certified? Yes or No	o (Required)
Medicare Provider Number: 34 1554 (Exa	ample Medicare Provider Number: 34-5113)
가게 있다면 마이트에서 다른 것이다. 원립과 대한민국의 대한 대학교 이 마음을 보고 하는데 다른	. TAX STATUS (Select one)
Accredited by	
□ ACHC □ DNV	Voluntary (not for profit)
☐ CHAP ☐ Öther	☐ Proprietary (for profit)
☑ TIC □ Not accredited	☐ Government
SECTION C Patient Volume	
1. AVERAGE DAILY CENSUS AND LENGTH	OF STAY: Please review the definitions carefully
before completing the following questions. (NOT	E: For FY2017 count multiple admissions and
discharges for the same patient as discrete events)	
a. Average Length of Stay (ALOS)	36
Divide the total days of care provided to dicurdisc	al days of care from admission to death or other discharge
even if the admission is outside the reporting perio	od).
b Median Length of Stay (MLOS)	$\mathcal{A}o$
The midpoint for all died/discharged patients for I	Y2017 (same populations as for ALOS, above). Half of the
patients have a LOS longer than the median and	I half of the patients have a LOS shorter than the median for all patients from lowest to highest (1, 2, 3,). Find the
score that falls in the exact middle of the list. This	s is the median length of stay.
c Average Daily Census (ADC)	A. 25 Annie 18 Annie
ADC is computed as follows: Take all patient day	ys for the reporting period and divide by the number of days
in that period	29
d. Total Number of Deaths	The state of the s
" <u>Must</u> agree with the total number of deaths in sec	(tons D , Γ , and Ω)
Number of Patients Who Died in ≤7 days (stays)	of 7 days or fewer)
{Include the number of deaths for patients who d	ied for the reporting period with stays of 7, days or
fewer)	
Number of Patients Who Died in ≥180 days (stay	s of 180 days of more)
Include the number of deaths for all patients who	o died for the reporting period with stays of 180 or
more <u>consecutive</u> days.}	

SECTION C Patient Volume (continued)

2. LEVEL OF CARE AND PAY SOURCE:

- Include all patients who received services in FY2017. Do <u>not</u> count re-admissions within the same payment source.
- Patients who change primary pay source during this time should be reported for each pay source with the number of days of care recorded for each pay source (count each day only once even if there is more than one pay source on any given day).
- The number of patients served may be higher than the actual number of patients served due to a change in pay source.

Hospice Payment Source	Number of Patients Served	(a) Days of Routine Home Care	(b) Days of Inpatient Care	(c) Days of Respite Care	(d) Days of Continuous Care	Sum of (a thru d) Total Patient Care Days
Hospice Medicare	27	1099		15		1114
Hospice Medicaid						
Private Insurance	4	73				7.3
Self Pay *	,				3.4	
Other **					e transcript	
Total	32	1173	Ø	15	Ø	1188

NOTE: Total Days of Care should agree to Total Days of Care in Section I.

SECTION D Number of Unduplicated Admissions and Deaths by Location

Please report the number of new admissions and deaths in each location during FY2017. For admissions, use location on the first day of care. Patients can start in one location and finish at another location.

New Unduplicated Admissions:

Only include patients admitted to your hospice for the first time during FY2017. Count each patient only one time. This means patients who were admitted multiple times during FY2017 are counted only once. Do not include patients carried over from FY2016.

Deaths:

Include all patients who died during FY2017 regardless of date of admission

^{*} Self Pay included charity/indigent care and foundation help; does NOT include any commercial or government 3rd party payer.

^{**} Other Payment Sources (to be used rarely) may include but are not limited to VA, Workers Comp, Home Health Benefit (only for non-Medicare Certified agencies).

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

Location of Care	Number of New Unduplicated Admissions	Number of Deaths
(1) Home - Private residence of either the patient or the caregiver	19	22
(2) Nursing Facility - A licensed long term care facility providing nursing and supportive services	8	7
(3) Hospice Unit - An inpatient unit (one or more beds) operated by a hospice, and located in a facility operated by another entity (includes hospital, nursing home, and other).		
(4) Hospital - An acute care facility not operated by the hospice (may be a floating or scattered bed contract).		
(5) Free Standing Hospice Inpatient Facility or Residence - An inpatient facility and/or residence operated entirely by a hospice.		
(6) Residential Care Setting - A residential care facility that is not run by the hospice (assisted living, boarding home, rest home, shelter, etc.)		
Totals (Sum 1-6)	27	29

NOTE: Number of Admissions must match the Number of Admissions in Sections E, G and I.

Number of Deaths must match the Number of Deaths in Sections C, E and I.

SECTION E Number of Patients by Principle/Primary Diagnosis

Please provide data for FY2017, regardless of payment source. Data provided should be based only on patient principle/primary diagnosis. The revised list in the table consists of ICD-10-CM Codes Categories.

New (Unduplicated) Admissions:

Only include patients admitted to your hospice for the first time during FY2017. Count each patient only one time. This means patients who were admitted multiple times in FY2016 are counted only once. **Do not include patients carried over from FY2016.**

Deaths:

Include all patients who died in FY2017, regardless of date of admission.

Live Discharges:

Include all live discharges that occurred during FY2017, regardless of when the admission occurred. Count multiple discharges for the same patient as discrete events. (Example: A patient discharges alive, is later readmitted and discharges alive again. The patient is counted as 2 separate discharges.)

Patient Days:

Include the total number of days services were provided by <u>your hospice</u> for all patients who died or were discharged in FY2017. Count <u>all</u> days of service in FY2017 for each patient. For patients who had multiple episodes of care, count all days in each episode.

Page 4

	Rrinciple Primary Diagnosis	Namber of	Number	Number.	Patient Days for Patients
(CD:10 a) CM:Codes	Categories	k(Undupicated)/ Admissions	of Deaths	Discharges	MhoDled or Mere Discharged
A00-B99	Infectious and Parasitic Diseases				276
C00-D49	Neoplasms	6	9		211
D50-D99	Diseases of The Blood and Blood-Forming Organs				9
E00-E99	Endocrine, Nutritional and Metabolic Diseases, And Immunity Disorders	3	3		19
F01-F99	Mental, Behavioral and Neurodevelopmental Disorders	2	5		146
G00-G99, H00-H99	Diseases of The Nervous System and Sense Organs		1		20
100-199	Diseases of The Circulatory System	8	5		176
J00-J99	Diseases of The Respiratory System	. 4	3		/65
K00-K99	Diseases of The Digestive System				
L00-L99	Diseases of The Skin and Subcutaneous Tissue			11	
M00-M99	Diseases of The Musculoskeletal System and Connective Tissue				
N00-N99	Diseases of The Genitourinary System	4	- 2		155
Q00-Q99	Congenital Anomalies				
S00-T99	Injury and Poisoning, Classification of External Causes of Injury and Poisoning	, A			
	All Others TOTAL	27	29	3	977

NOTE: Number of Admissions must equal Sections D, G and I. Number of Deaths must equal Sections C, D and I.

SECTION F Productivity and Cost of Care

:Complete this section using the following definitions.

Direct Care:

Includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care as distinct from supervision of other staff or program activities.

FTE

One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs.

Calculations:

- Total FTEs: Divide paid hours by 2080 (may include up to 2 decimal points). Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried and contract staff.
- On-call FTEs: First, calculate total payments made for on-call nursing staff. Next, calculate the average salary of a full-time nurse providing direct patient care. Then divide the total payments for on-call by the average nursing salary.
- Home Hospice FTEs: Includes all staff involved in delivery of hospice care to patients in all settings (home, hospital, nursing home, etc.): Do not include inpatient staff when completing this section.

1. STAFFING BY DISCIPLINE - FY2017

	Staffing by Discipline	Total Home Hospice FTEs
100	Nursing - Direct Clinical	
1	Include RNs and LPNs. Include on-call and after hours care. Do not include supervisors or other clinical administrators unless a portion of their time is spent in direct care.	195
2	Nurse Practitioner Include nurses with an advanced degree who function and are licensed as a Nurse Practitioner.	
3	Social Services Include medical social services staff as defined by CMS for the cost report. Do not include chaplains, bereavement staff or volunteer coordinators.	.41
4	Hospice Aides	.18
34,7 55	Physicians - Paid	
	Include medical directors and other physicians providing direct	
5	care to patients and participating in clinical support. Exclude	NAME OF THE PARTY
***	volunteer physicians.	
6	Physicians - Volunteer	. 23
7	Chaplains	144
8	Other Clinical Include any paid staff in addition to those captured above who provide direct care to patients or families. Include therapists and dietitians. Do not include volunteers.	
9	Clinical (add rows 1 – 8) Includes all direct care time (above 8 rows). This is the total of Nursing-Direct clinical, NP, Social Services, Aides, Physicians, of Chaplains & Other Clinical.	
10	Nursing - Indirect Clinical Include nurses with clinical background, but who do not provide direct care (intake staff, educators, quality improvement, managers, liaison nurses, etc).	150
11	Bereavement Include all paid staff providing bereavement services, including pre-death grief support. Do not include volunteers.	144
12	Non-Clinical Include all administrative and general staff.	,50
13	Total (add rows 9-12) Include all staff time. This is the total of Clinical, Indirect Clinical, Bereavement and Non-Clinical.	3.65

2. VISITS BY DISCIPLINE

Please provide the following information for FY2017. Count <u>all</u> visits, regardless of setting (hospital, nursing home, residential facility, etc.). If you own/operate a hospice, inpatient or residential facility – <u>do not include visits to your facility here.</u>

Discipline	Total Visits
Nursing	
Include visits made by RNs and LPNs. Include visits made by a Nurse Practitioner or a	
Clinical Nurse Specialist if the visit was a nursing visit (i.e., the NP was not serving as an	
attending physician or performing a visit in compliance with the face-to-face encounter	
regulation). Include on-call and after hours care visits.	412
Nurse Practitioners	
Include visits made by Nurse Practitioners when they are serving as an attending physician	
or performing a visit in compliance with the face-to-face encounter regulation.	
Social Services	,
Include visits made by medical social services staff as defined by CMS for the cost report.	. 11
Do not include chaplains, bereavement staff, or volunteer coordinators.	7//
Hospice Aides	205
Physicians – Paid	
Include visits made by medical directors and other physicians providing direct care to	
patient. Exclude volunteer physicians.	
Physicians - Volunteer	. 7
Chaplains	3.5
Other Clinical	
Include any paid staff in addition to those captured above who make visits as part of direct	are:
care to patients or families. Include therapists, nurse practitioners, and dieticians. Do not	
include volunteers or bereavement staff.	

3. CASELOADS

Caseload is the preferred number of patients for which a staff member has responsibility or to which she/he is assigned at a time. Enter a single number for FY2017. Do not enter a range.

Discipline	Average Casel	oad
Primary Nurse/Nurse Case Manager - RN with primary responsibility for the patient's care.	, , ,	9
Social Worker - Social Worker with medical social services duties, as defined		
by CMS. Include only those patients who receive visits in determining Social	: 7	Δ
Worker caseloads.	to state and	4
Hospice Aide		5
Chaplain - Include only those patients who receive visits in determining chaplain		0
caseload.	Marian Commence	7
Volunteer Coordinator - Include only those patients who are assigned a		1
volunteer in determining volunteer coordinator caseload.		
Medical Director - Include only those patients whom the medical director is the	Ware Section	01
attending physician in determining caseload.	. ;	

SECTION G Patient Demographics for New (Unduplicated) Admissions

Only include patients admitted for the first time during FY2017. Patients who are admitted multiple times are counted only once.

1. GENDER	3.	. E	THNICITY all patients should be categorized or non-Hispanic, and further categories.	as Hispanic orized by
		· ·	Race below (as defined by U.S. Cen	sus Bureau)
a. Female	15	a.	Hispanic	
b. Male	<u> 12</u>	ъ.	Non-Hispanic	27
			Total (must equal Race total)	27
	0.0			(Required)
Total	(Required)			¥I
	(Kedunea)			
100		i i i Ma	ACE	
2. AGE Use patient's age of	the state of the s	л.		
admission in FY20				
			T. T Alcolon Nativo	
a. <1		a.	American Indian or Alaskan Native	1 - 1 - 1 - 1
b 1-4		⊮\b	Asian	
c. 5-14		¢	Black or African American	
d. 15 - 20		ď	Hawaiian or Other Pacific Islander	
e: 21 - 24		i e	White	27
f, 25 - 34		\mathbf{f}	Some other race or races	
	7		Total (must equal Ethnicity total)	21
g. 35 - 64				(Required)
h. 65 - 74	4			
1. 75 - 84	10			
TO COM				
j. 85 +	17	CANAL COMPANY COMPANY		
Total	21			
i Ulai	(Required)			

NOTE: Number of Admissions <u>must</u> agree to the number of admissions in Sections D, E and I.

License No. HC0318

Facility ID: 953772

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

SECTION H Processes of Care

1. DIRECT PATIENT CARE VOLUNTEERS

Provide the following information during FY2017.

Do not include volunteer medical director hours when entering responses in this section. Medical director's volunteer hours should be entered in Section F: Productivity and Cost of Care.

Number of Volunteers:

The number of volunteers should be an unduplicated count, with no individuals included in more than one category, even if they engaged in more than one type of volunteer service. Some volunteers participate in multiple types of activities, such as spending time with patients and assisting with fundraising mailings. If any of the activities performed by a volunteer involved direct contact with patients or families, the volunteer should be counted in the direct care category, regardless of the proportion of time spent providing direct care.

Volunteer Hours:

For those volunteers who contributed hours in more than one volunteer service category, provide the number of hours for each category.

Volunteers	Number	Hours	Visits
(1) Direct Patient Care Volunteers – Defined as volunteers who provide services through direct contact with patients and families, such as spending time with patients or making calls to patients and families as part of a weekend "tuck-in" program (do not include phone calls as a visit).	5	109.14	28
(2) Clinical Support Volunteers - Report the number/hours for volunteers who provide patient care and clinical support. These volunteers are combined with Direct Patient Care Volunteers, to meet the Medicare Condition of Participation regarding 5% volunteer hours. Medicare interpretive guidelines			
define administrative volunteers in this context as supporting patient care activities (e.g., clerical duties), rather than general support (e.g., fundraising).	1	53.11	
(3) General Support Volunteers - Report the number and the hours for volunteers who provide general support, such as those who help with fundraising and members of the board of directors. These volunteers do not contribute to the 5% Medicare requirement.	707		
All Hospice Volunteers - Sum of (1-3) above.	6	162,27	

2. BEREAVEMENT SERVICES

Provide the following information for FY2017.

- In calculating responses for the questions below, include all bereavement clients who received services during FY2017, both those currently on bereavement rolls and those who were discharged from bereavement services.
- Information entered under Community Members should include bereavement services provided to
 individuals in the community who were <u>not</u> associated with a family member or friend admitted to
 hospice.

the state of the s			
Bereavement Services	Hospicë Family Members	Community Members	Total
Total Number of Contacts by Visit		•	5, e.s.
Include any face-to-face one-to-one contact with individuals, regardless of setting. Do not include support group or camp			
services.	32	3	35
Total Number of Contacts by Phone Call	44	3	47
Total Number of Mailings to the Bereaved	39	3	42
Total Number of Individuals Who Received Bereavement			To Flanck, Since
Services	7.4		
Include all individuals enrolled for bereavement, including those	00		
served through support groups and camps.	29	5	L 32-

SECTION I Patient Volume (Required)

PATIENTS SERVED BY COUNTY OF PRIMARY RESIDENCE:

Please complete the following information (for FY2017) for each patient this agency served by county of the patient's primary residence.

Column

- A. County of Primary Residence: List patients by county of primary residence.
- B. Number of New (Unduplicated) Admissions: Only include patients admitted to your hospice for the first time during FY2017. Count each patient only one time. This means patients who were admitted multiple times in FY2017 are counted only once. **Do not include patients** carried over from FY2016. Total number of unduplicated admissions must equal the total admissions in Sections D, E and G.
- C. Number of Deaths: include all deaths that occurred during the FY2017.
- D. Number of Non-Death Discharges: Live discharges that occurred in FY2017.
- E. Number of Patients Served: Includes carryover patients from prior year, new admissions and re-admissions. Patients admitted multiple times in FY2017 are counted only once:
- F-I. Days of Care: Totals must agree to the Days of Care totals in Section C, 2. This includes all Days of Care in FY2017 regardless of when the admission occurred.

> Good Shepherd Home Health and Hospice Agency . Cherokee County 2018 Hospice Data Supplement Reporting for.

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

SECTION I Patient Volume (Required)

PATTENTS SERVED BY COUNTY OF PRIMARY RESIDENCE:

Please complete the following information (for FY2017) for each patient this agency served by county of the patient's primary residence. Make additional copies of this sheet if additional space is needed and attach.

Sum (F.P.) Total Days of Care												1/87
Confinuous												Ø
function Respite Care Care Days 3 \(\empty{M} \)												15
G. Imaticut Care Days											_	N N
F. Routine Bome Care Days												6111
Number of Routine Patients Bome Care Served Days 33 13												32
D. Nomber of Non Death Discharges											,	3
Number of Deaths												6
B. Number of New (Orduplicated) Admissions			9	-						:		27
ry Residence					1	5.5						Grand Total
County of Prima	Yar.				(1) (2)				V.			

SECTION J Inpatient and Residential Information N/A

Completion of this entire Section is required. Ple	ase provide the following in	itormation for FY2017.
	w.2	
1 Facility Names	025	
1. Facility Name:		
		1 to 5.
2. Number of Licensed Inpatient Beds:		
Number of Licensed Residential Beds:		1 19-19
		i an an le tres et le serie. La companya de la c
3. Where is the facility located? (Select one)		
☐ On campus of Freestanding Hospice		
in Hospital		
in Nursing Home	20 20 20 20 E	edge of the garden
other (please specify):	<u> </u>	والمعارب والمعارب
A Section of the sect		the first of the control of the cont
4. Did the facility open during FY2017? □ Y	Zogram [] Na	
4. Did the facility open during F 1 2017:	ES 01 1110	
If yes, please note the date the facility was lic	censed:	
If yes, please note the date the facility was M	edicare certified:	
	er i de jaron de la servición de la company de la comp	
5. Did the facility add beds during FY20172	E Vosor C No	
5. Did the facility and beds during F 1 201//4	M. I.OS.OI (LITTO	
If yes, please note how many beds were adde	d:	
If yes, please note the date the beds were lice	ensed:	
	artari altresa e arti di Maria della colori della colori della colori della colori di solori di solori di solo Ristrato di colori d	an in a saidh a' cheann a' tha a' chuir a bha an tail a saidh an tail a saidh an tail a saidh an tail a' chean Tail a chuir a cheann an taill a tail a cheann a tail a saidh a cheann a tail a cheann a tail a saidh a cheann
6. Did the facility convert any residential bed inpatient beds during FY2017? Yes or		
If yes, please note how many beds were conv	verted:	
If yes, please note the date the beds were lice	, достига в в в в в в в в в в в в в в в в в в в	

License No: HC0318 Facility ID: 953772

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

SECTION K Inpatient and Residential Patient Information



1. Hospice Facility Patients: Only freestanding hospice inpatient facilities operated by a licensed hospice or hospice inpatient units with a Certificate of Need for hospice beds <u>and/or</u> freestanding hospice residences operated by a licensed hospice should complete this table. The purpose of this table is to collect bed utilization data. Include all patients admitted in the facility even if the care was provided under contract to another hospice.

<u>County of Primary Residence</u>: List all inpatient and residential clients served. Report admitted patients by county of primary residence. Count each inpatient client <u>only</u> once. Count each residential client <u>only</u> once.

Direct Admits: These are defined as patients with no prior hospice care.

<u>Transfers In</u>: These are defined as existing hospice patients coming from the home, hospital, nursing facility, assisted living and independent living.

<u>Total Days of Care</u>: If the patient was admitted before the reporting period, include <u>only</u> the days of care that occurred during FY2017. Do not include respite days.

Total Deaths: Include only those deaths that occurred during FY2017.

Hospice]	nnatient	Facility Pat	tients		Hospice	Residence Pa	tients.
	Direct Admits	Transfer from Hospice Home Care	Total Days of Inpatient Care (Do Not Count Respite Days)	Total Number of Deaths	Total Number of Patients Admitted	Total Days of Residential Care	Total Number of Deaths
		٠	1	1,15,	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10 H	1
				1. 16 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A 5	-3.5-3433	
- 71					EXTRANSPORT	18 1 18 18 18 18 18 18 18 18 18 18 18 18	£ 5 00 5 1
<u>. 1925 Maria de Maria Maria de la compansión de la compa</u>	. 1.4. <u>%</u>	7. 2 (d. inse	per training and		<u> Alder Maker (1987)</u> Alder Maker (1987)	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	<u> </u>
	\$ 14 A CO. 1			3 1. 1 1 80 18 5 5 3 7 18	20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		March 1
<u>, 1. 8. j. s. 201, t. M. 1. 22</u>	11		1 1 1 1 1 1 1 1 1		學學為於 數學的效率	表表的数字数3.4°	
Lange to the state of the state	Mary V			St. St.			Carle Co.
<u> </u>							
and a supplied to the supplied of the supplied	W			1,114			137.57
Grand Total	21			-1	the family of		1,5 ;.

SECTION L Inpatient and Residential Staffing Information N/A

1. Facility Staffing by Discipline - Staffing Information for FY2017

Complete this section using the following definitions and calculation instructions:

Direct Care: Includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care as distinct from supervision of other staff or program activities.

FTE: One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs.

Calculations: Total FTEs: Divide paid hours by 2080 (can include up to 2 decimal points). Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried and contract staff.

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	Server receive nexistant	Facilit	TO STATE OF THE PROPERTY OF THE PARTY OF THE
	Staffing by Discipline	Inpatient	Residential
	Nursing - Direct Clinical		VINZ NE
1	Include DNR and I PNs. Include on-call and after hours care.		
	Do not include supervisors or other clinical administrators unless a portion of their time is spent in direct care.		
	Carial Corriges		
2	Include medical social services staff as defined by CMS for the cost report. Do not include bereavement counselors.		
-	Service of the servic	The State of the S	
3	Hospice Aides	1,1	
	Physicians—Paid		
4	Include medical directors and other physicians providing direct		
N 84	care to patients and participating in clinical support. Exclude		
P. SA	volunteer physicians.	W. D. N. W. W. W. W.	MONTH STATE
5	Physicians - Volunteer	Year To THE TOWN	
6	Chaplains	300000000000000000000000000000000000000	
	11 17 (4) The 20 (4) (4) (4) (4) (4) (4) (4) (4) (4) (4)	XXXXXXXXX	Part America
	Other Clinical Include any paid staff in addition to those captured above who		
1 7	provide direct care to patients or families. Include nurse		
] '	practitioners, therapists, and dietitians. Do not include		
	volunteers or bereavement staff.		and the second
	Non-Clinical		
8	include all administrative and general staff or contract staff.		
F			$\mathcal{L}_{\mathcal{L}} = \mathcal{L}_{\mathcal{L}} \times \mathcal{L}_{\mathcal{L}} \times \mathcal{L}_{\mathcal{L}} \times \mathcal{L}_{\mathcal{L}} \times \mathcal{L}_{\mathcal{L}} \times \mathcal{L}_{\mathcal{L}}$

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State of Aurth Carolina Department of Health and Human Services Division of Health Service Regulation

Effective January 01, 2018, this license is issued to Murphy Post-Acute and Wellness, LLC

to operate an agency known as

Good Shepherd Home Health and Hospice Agency

located at 6950 HWY 64 West City of Brasstown, North Carolina.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall expire midnight December 31, 2018.

Facility ID: 953771

License Number: HC0275

Home Care Services: Nursing Care, Infusion Nursing, In-home Alde, Medical Social Services, Physical Therapy, Occupational Therapy, Speech Therapy, Hospice Services, Companion, Sitter, Respite This agency is authorized to provide Medicare-certified home health services.

Authorized, by:

Secretary, N.C. Department of Health and

Human Services



Director, Division of Health Service Regulation



DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER GOVERNOR MANDY COHEN, MD, MPH SECRETARY

> MARK PAYNE DIRECTOR

MEMORANDUM

TO:

Good Shepherd Home Health and Hospice Agency -- Brasstown

FROM:

Azzie Y. Conley, RN, Section Chief

Cindy H. Deporter, MSSW, Acting Assistant Section Chief

SUBJECT:

2018 Home Care / Home Health / Hospice Agency License Renewal Application

PLEASE READ CAREFULLY

Enclosed is your 2018 License Renewal Application. Please complete this application and return no later than December 1, 2017 to the address below. Mail to the attention of Cindy Deporter.

Mailing Address

Acute and Home Care
Licensure and Certification Section
1205 Umstead Drive
2712 Mail Service Center
Raleigh, NC 27699-2712

Overnight Address (UPS and FedEx Only)

Acute and Home Care Licensure and Certification Section 1205 Umstead Drive Raleigh, NC 27603

Data on file with the Division indicates that your agency is a <u>Home Care Agency providing Home Health and Hospice Services (HC/HHA/Hospice)</u>. Your annual licensure fee, as authorized by Sections 41.2(a) – 41.2(i) of Session Law 2005-622, is <u>\$510.00</u>. This amount is comprised of a base fee of <u>\$510.00</u> -- no additional fee.

Payment should be in the form of check, money order or certified check and must be payable to "NC-DHSR." Payment should include the facility's license number and be submitted with your license renewal application. A separate check is required for each licensed entity.

Your completed license renewal application and the license renewal fee must be received by December 1, 2017 to ensure your license is renewed with an effective date of January 1, 2018. Failure to possess a valid license may compromise your facility's ability to operate and/or adversely impact its funding sources.

ACUTE AND HOME CARE LICENSURE AND CERTIFICATION SECTION

HTTP://WWW.NCDHHS.GOV/DHSR/ TEL: (919) 855-4620 • FAX: (919) 715-3073 STEAD DRIVE • LINERERGER BUILDING • RALE

LOCATION: 1205 UMSTEAD DRIVE • LINEBERGER BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 1205 UMSTEAD DRIVE • 2712 MAIL SERVICE CENTER • RALEIGH, NC 27699-2712
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Good Shepherd Home Health and Hospice Agency -- Brasstown
2018 Home Care / Home Health / Hospice Agency License Renewal Application
Page 2

PLEASE NOTE -- No requests for agency director change, change of ownership, geographic service area expansion, additional services or deletion of a service(s) will be handled as part of the licensure renewal process. Please provide the above in a separate request in writing.

A portion of this application contains preprinted information from our data systems, based on your last HC/HHA/Hospice license renewal application or the most recent information that has been reported to this office. If any of this preprinted- information has changed, mark through the incorrect information with a RED pen and write in the correct information. Prior to amending the legal entity, please contact this office for further instructions. Please review the "ownership disclosure" section carefully to verify its accuracy. Complete all areas of this application and return by the date specified above, along with the annual licensure fee. PLEASE, DO NOT RETYPE THE APPLICATION, and be sure to retain a second copy of the application for your records. If you have any questions about the preprinted information contained in this application, please feel free to call our staff at (919) 855-4620.

National Provider Identifier (NPI). Please provide your NPI number in the space indicated on the license renewal application. If you need to obtain an NPI, have questions or need additional information regarding the NPI number contact 1-800-465-3203 (NPI Toll-Free) or visit the website http://www.ncdhhs.gov/dma/NPI/index.htm.

Data Supplement Information: Collected for the purpose of composing data tables and calculating need determinations for additional healthcare services detailed in the annual North Carolina State Medical Facilities Plan. If you have any questions about the data supplement or how to complete it, please contact Healthcare Planning at (919) 855-3865.

<u>Please note</u>: Non-Medicare certified Home Care Agencies who state on their application they are accredited by ACHC, TJC, DNV, or CHAPS, must verify their accreditation by submitting their full accreditation report at the time of license renewal.

Questions on license renewal applications should be addressed to:

Cindy Deporter

(919) 855-4557

Email: Cindy.Deporter@dhhs.nc.gov

Anita M. Laumann

(919) 855-4636

Email: Anita.Laumann@dhhs.nc.gov

For Official Use Only North Carolina Department of Health and Human Services License # HC0275 Division of Health Service Regulation FID# 953771 Acute and Home Care Licensure and Certification Section PC Regular Mail: 1205 Umstead Drive 2712 Mail Service Center Raleigh, North Carolina 27699-2712 Overnight UPS and FedEx only: 1205 Umstead Drive Raleigh, North Carolina 27603 Telephone: (919) 855-4620 Fax: (919) 715-8476 Total License Fee: \$510.00 2018 LICENSE RENEWAL APPLICATION FOR HOME CARE, NURSING POOL, AND HOSPICE A separate application is to be completed for each site from which home care (including home health), nursing pool, or hospice services are offered. Separate legal entities operated out of the same office must submit separate applications. Legal Identity of Applicant: Owner/Corporate Identity, Murphy Post-Acute and Wellness, LLC (Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.) Agency Name/Doing Business As (D/B/A) - Name(s) under which the facility or services are advertised or presented to the public: Good Shepherd Home Health and Hospice Agency PRIMARY: (If materials are to be mailed to another address list here) Agency Mailing Address: 11) 125 Medical Park Lane Suite HMurphy, NC 28906 6950 HWY 64 West Agency Site Address: Brasstown, NC 28902 County: Clay Telephone: (828)837-4197-4260 Fax: (828)837-4860 Agency E-Mail (Required) Nonce @ Murphymedical org Web Site :(If applicable) Administrator/Director: Julie Yonce Home Care Manager Title: Name of the person to contact for any questions regarding this form: Telephone: 828-831-1191 Name: Cocsa E-Mail: jyonce@murphymedical.org

Licensure Categories Licensed For: (Check All That Apply)

1. X Home Care Agency (G.S. 131B-138)

Nursing Pool (G.S. 131E-1543)
 X Hospice Services (G.S. 131E-200)

License No: HC0275 Facility ID: 953771

Scope of Services:

DHSR licenses Home Care agencies for a Scope of Services: Nursing Care, Infusion Nursing Services, In-Home Aide, Medical Social Services, Physical Therapy, Occupational Therapy, Speech Therapy, and Clinical Respiratory Services (including Pulmonary or Ventilation if provided separately from routine nursing practice). Any agency adding a new service category as outlined in G.S. 131E-136(3)(a)-(f) shall notify the Department in writing at least 30 days prior to the provision of that service to any clients. YOU MAY NOT ADD SERVICES ON THIS APPLICATION.

Below are the services you are currently licensed to provide:

1)	Under this home care license number, are you directly providing
	Home Medical Equipment/Durable Medical Equipment? Yes
2)	Do you also have a medical equipment permit issued by the NC Board of
,	Pharmacy? Yes V
	If "yes," please provide the permit number:
Hot	urs:

Tryantaer 3 a	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Han I Tom	8pm-4pm	8AM - 4PM	8 Am - 4 Pm.	8AM-4PM	8AM-4PM	

Nursing:

Full-time Equivalents (FTE)

	R.N.	L.P.N.	Aides
Number:	7.61	1.85	1.45

Accreditation Information:

If home care licensure is being requested on the basis of deemed status as an accredited agency, attach a complete copy of accrediting organization's inspection report (or findings) together with its decision, if surveyed within the last 12 months. Licensure based upon deemed status cannot be completed without full disclosure.

Accredited	Accrediting Organization	Expiration Date	*Deemed Status
<u> </u>	TJC (The Joint Commission)	12/04/2018	
			\$P\$《我的关键》。
1 %	CHAP (Community Home Association Program)		Part of the Spirit Spir
	ACHC (Accreditation Commission for Health Care, Inc.)		ar distalled and mi
	Other: TJC	<u> </u>	<u> </u>

^{*}Please provide a copy of your letter if you are deemed

License No	: HC0275
Facility II	

provider number? 347	<u>014</u>	
2. This agency is a Home	Health Agency. Yes No.	
If 'Yes', please check	one: Parent Branch / Sub-unit	
3. Is this agency owned c	or operated by a Continuing Care Retirement Ce	nter (CCRC)?YesNo
Hospice Applicants; 1. If Medicare certified, v	what is your hospice provider number? <u>34-7</u>	<u>554</u>
2 For Medicare certified please list each license 社C0275 社C1	hospices do you operate more than one office u operating under this Medicare number.	nder this provider number? If yes
3 Has this site been issue	ed a Certificate of Need to provide hospice servi	ces? Yes No.
	nent to operate Hospice licensed inpatient beds	
insurance policy (binder addamage, and expense relat of health care by the nursin Ownership Disclosure:	s must attach a copy of the agency's current gen acceptable). The lowument must show that the aged to a death or injury claim resulting from negling pool and its employees. (Please fill in any blanks and make changes who	oplicant is insured against loss, igence or malpractice in the provision or necessary).
All nursing pool applicants insurance policy (binder addamage, and expense relat of health care by the nursis Ownership Disclosure: 1. What is the name of the complete the exact wo Office). If this is a Uni	smust attach a copy of the agency's current gen occeptable). The flownment must show that the ap ed to a death or injury claim resulting from negl ng pool and its employees.	oplicant is incured against loss, igence or malpractice in the provision re necessary). Liability? If this is a Corporation, if Secretary of State (Corporate).
All nursing pool applicants insurance policy (binder addamage, and expense relat of health care by the nursis Ownership Disclosure: 1. What is the name of the complete the exact wo Office). If this is a University and liability and liability and liability.	smust attach a copy of the agency's current gen acceptable). The the unent must show that the agency and the death or injury claim resulting from negling pool and its employees. (Please fill in any blanks and make changes who e legal entity with ownership responsibility and rding of the corporate name as on file with the late of Government, the name of the governmental	oplicant is incured against loss, igence or malpractice in the provision re necessary). Itability? If this is a Corporation, if Secretary of State (Corporate).
All nursing pool applicants insurance policy (binder addamage, and expense relat of health care by the nursis Ownership Disclosure: 1. What is the name of the complete the exact wo Office). If this is a Unitersponsibility and liability and liability. The liability and liability. The liability and liability a	smust attach a copy of the agency's current gen acceptable). The the unent must show that the aged to a death or injury claim resulting from negling pool and its employees. (Please fill in any blanks and make changes who e legal entity with ownership responsibility and rding of the corporate name as on file with the Nt of Government, the name of the governmental lity for services offered.	oplicant is incured against loss; igence or malpractice in the provision are necessary). Liability? If this is a Corporation, IC Secretary of State (Corporate unit that has the ownership.
All nursing pool applicants insurance policy (binder addamage, and expense relat of health care by the nursis Ownership Disclosure: 1. What is the name of the complete the exact wo Office). If this is a Unit responsibility and liability and liability and liability and liability. Street/Box: City: Telephone: Senior Officer.	smust attach a copy of the agency's current gen acceptable). The theorem must show that the agency and to a death or injury claim resulting from negling pool and its employees. (Please fill in any blanks and make changes who e legal entity with ownership responsibility and rding of the corporate name as on file with the Notice of Government, the name of the governmental lity for services offered. Murphy Post-Acute and Wellness, LLc	oplicant is incured against loss; igence or malpractice in the provision are necessary). liability? If this is a Corporation, it is secretary of State (Corporate unit that has the ownership.
All nursing peol applicants insurance policy (binder addamage, and expense relat of health care by the nursin Ownership Disclosure: 1. What is the name of the complete the exact woo Office): If this is a Unit responsibility and liability a	smust attach a copy of the agency's current gen acceptable). The threament must show that the agency and to a death or injury claim resulting from negling pool and its employees. (Please fill in any blanks and make changes who e legal entity with ownership responsibility and rding of the corporate name as on file with the N tof Government, the name of the governmental lity for services offered. Murphy Post-Acute and Wellness, LLc Murphy Post-Acute and Wellness, LLc Murphy Stacute and Wellness, LLc Murphy State: NC Zip: 28906 (828)835-7502 Fax:) James M. Stevenson For Profit X Not For Profit Liab	oplicant is insured against loss; igence or malpractice in the provision are necessary). Liability? If this is a Corporation, it Secretary of State (Corporate unit that has the ownership. Ofit Lity:Partnership
All nursing pool applicants insurance policy (binder addamage, and expense relat of health care by the nursis Ownership Disclosure: 1. What is the name of the complete the exact wo Office). If this is a Unit responsibility and liability and liability and liability and liability. Street/Box: City: Telephone: Senior Officer.	smust attach a copy of the agency's current gen acceptable). The theorem must show that the agency and to a death or injury claim resulting from negling pool and its employees. (Please fill in any blanks and make changes who e legal entity with ownership responsibility and rding of the corporate name as on file with the Notice of Government, the name of the governmental lity for services offered. Murphy Post-Acute and Wellness, LLc	oplicant is incured against loss; igence or malpractice in the provision are necessary). Liability? If this is a Corporation, IC Secretary of State (Corporate unit that has the ownership. Ofit Partnership

License # Location AC0318

License No: HC0275

d. If yes above,	Lat nama(a)	of other	facilities	licensed in	North	Carolina	by the	Divis	sion	of Health	Service
d. If yes above,	nst name(s)	or onici	Idellities	110011000 111		-5.3.3	•				
Regulation.			¥		*					20	

Vame	Location		License #
Juply Post-Acute and Wellness LU	1050 Auro 104 W Boasstown	NC 28902	HC0275
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		1	
		71 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	(Attach additional sheets as needed		
Is your agency owned, in whole o	r in part, or operated by a hospital	? ✓ Yes	No
is your agency owned, in whole o	i in part, or operated by a mosperim	Λ	
If 'Yes', please specify the name	of entity. Muchy Medical (enter Inc.	
The state of the s			Nativity (1997)

This application must be completed and submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2018 home care agency license.

i please specify the name of entity. Murphy Medical Center, Inc

AUTHENTICATING SIGNATURE: The undersigned submits application for the year 2018 in accordance with North Carolina General Statutes G.S. 131E-138, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13J), and certifies the accuracy of this information.

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	(A) 100	State of the state		Mark Mark Comment	中一年中华(2018年)	17. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19	
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PRINT NAME OF APPROVING OFFIC	mar Ard	10 /M	ce KIN	TO C	tome car	e i i kwika	<u>qeq</u>
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2. "一个,这个人的一个,我们就是这个人。"		 Addresses 			A Santa Santa Santa Santa	Section of the sectio	Address and revenience in the

Please be advised, the license fee <u>must</u> accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, <u>prior</u> to the issuance of a home care agency license.

North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section Regular Mail: 1205 Umstead Drive 2712 Mail Service Center Raleigh, North Carolina 27699-2712 Overnight UPS and FedEx only: 1205 Umstead Drive Raleigh, North Carolina 27603

For Of	ficial U	se Only	1	
License	# HC0	275		
FID#	95377	l		
PC		Date _		

Telephone:	(919) 855-4620	Fax: (919)	715-8476	
		****	HOME CARE AGENCY	N/A
			2018 Annual Utilization Data	19

(Reporting 2017 Fiscal Year Data)

To be completed by agencies without a certificate of need or authorization to provide Medicare certified home health services.

ı	1	negicare certified floi				t se
*	A sepai	rate form should be	completed for	each site.		18
A.	Identification: License No:	HC0275				
	Legal Identity of Applicant:	Murphy Post-Acu	te and Wellnes	ss, LLC		
	Agency d/b/a:	Good Shepherd H	7.0 0			
(d West	Agency Site Address:	6950 HWY 64 Wes	st H, J()	Sea, pleasing po	NAMO NOME LE VI	tilly J
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В.	Reporting Period	8 2	n 10	er er	- E	
energy or a	Data is requested for the two 2016, and ending after the two or facility was not open for the report.	welve-month period.	but no later th	ian September 30,	, 2017. If your ag	gency
* ***	Your reporting period: Starts		, 2016 and E	Ends Septer	mber 30, 2017	*
					ifferent from Septem	SPACE SAPE
AUT accu	HENTICATING SIGNATURE rate.	: I certify the informa	ation submitted	in this Annual Uti	ilization Data is	
Тур	ed Name:			Title:	安林(四)	n
	ature:			Date:	unida Principalisa Notae Principalisa (notae	

DHSR-4029 REV 08/2017

NIA Client Residence C.

Instructions:

Report numbers of persons who received home care services including companion, sitter and respite services by county of residence for each age category shown.

License No: HC0275

Facility ID: 953771

Use each client's age on the first day of service during the reporting period. This is an unduplicated count. Clients may be counted only once during the reporting period regardless of the number of times admitted.

Number of Clients by Age and by County of Residence DO NOT USE OTHER AGE GROUPS

County of Residence	0-17	18-40	41-59	60-64	65-74	75-84	⊹8 5 +	All Ages
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	And Andrews							
	Parinetal							
		WA TANK YES						

Copy and attach additional page if needed

D. Staff N/A

• Report data in Table below.

<u>Total Staff</u> means the total number of employees by discipline, including contract staff, who are involved with the agency's home care services.

<u>Total Clients</u> means the total number of clients seen by each staff discipline during the reporting period. If the client is seen by more than one discipline, include the related clients under each discipline. Include companion, sitter, homemaker and respite services. If a client is reopened to the same discipline later in the year, count only once.

Examples	Mrs. Brown was admitted on four different occasions to the home care agency. She received nursing services on each admission. Count Mrs. Brown as one (1) client under nursing.
** (c)	Mrs. Smith was admitted on four (4) different occasions to the home care agency. She received nursing on 2 admissions, aide services on 3 admissions and physical therapy on 1 admission. Count Mrs. Smith as 1 client under nursing, 1 client under in-home aide services and 1 client under physical therapy.

If the RN supervisor and Agency Administrator are the same person please report the position in only one category and use the category in which the most time is utilized.

Staff Discipline	Total Staff	Total Clients 12-Month Report Period
Administrator	W 300	
Nurse Director or Supervisors		
Other Administrative Staff		
Nursing (RN, LPN)	,	
Occupational Therapist		1.00
Physical Therapist		
Speech Therapist		5 9
Social Worker		
In -Home Aide		
Companion, Sitter, Respite Staff		
Respiratory Therapist		1
Respiratory Practitioner		
Other (Specify)	r de	

License No: HC0275

Facility ID: 953771

North Carolina Department of Health and Human Services Division of Health Service Regulation

Acute and Home Care Licensure and Certification Section

Regular Mail: 1205 Umstead Drive 2712 Mail Service Center Raleigh, North Carolina 27699-2712

Overnight Mail Only: 1205 Umstead Drive

Raleigh, North Carolina 27603

Telephone: (919) 855-4620Fax: (919) 715-8476

For Of	ficia	al Use Only	7	
License	#	HC0275		
FID#	95	3771	70	
PC		Date_		

HOME HEALTH AGENCY

2018 Annual Data Supplement to License Application

(Reporting 2017 Fiscal Year Data)

Includes Home Health and Home Care data to be reported by Medicare certified agencies.

A separate form to be completed for each site.

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- 11 II	D 1-14 /-4	H A 10-0		

License Number:

HC0275

Legal Identity of Applicant:

Murphy Post-Acute and Wellness, LLC

Agency d/b/a:

Good Shepherd Home Health and Hospice Agency

Agency Site Address:

Street: 6950 HWY 64 West

City: Brasstown State: NC Zip: 28902

County:

Clay

Agency Phone Number:

(828)837-1197 42(10

Agency Fax Number:

(828)837-4860

Reporting Period October 1, 2016-September 30, 2017

□ July 1, 2016 - June 30, 2017

 If your agency or facility was not open for an entire twelve-month period, please specify the time period covered in this data supplement in the space provided below:

				Transfer of the second
CONTACT NAME: Name o	f the person to contact i	for any questions reg	arding this form.	
Print Name: Tecesa We	st	Telephon	e: 828-837-11	97
E-Mail: texst@murphy	medical org	Eax	R28-837-95	<i>70</i> З
CEO/DIRECTOR SIGNAT		ormation submitted	herewith in this	s data
The state of the s	supplement is acc	urate.	Home Care 1	And real factors
Print Name: Jijje Von	ce, KN-bc		COLLEGE WAS TO LIKE THE Y	1 (a) xalg ex
Signature: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	one In Bc	Date:	1((2(11))	

Home Health Services Reporting

SECTION B Client Residence (Part-time Intermittent Home Health)

Instructions:

- Report data related to clients who are receiving <u>Part-time Intermittent Home Health</u> services through your Medicare certified agency <u>regardless of payer source</u>.
- These are services provided on a per visit basis (Nursing, PT, OT, ST, MSW and IN-HOME AIDE [HOME HEALTH AIDE]).
- Report any other types of services such as Medicaid CAP and PCS in-home aide or private duty nursing on the next page.
- Report <u>number of clients</u> by county of residence for each age category shown. Use each client's age on the first day of services during the reporting period.
- This is an unduplicated count. Clients may be counted only once during the reporting period regardless of the number of times admitted.
- Do not use other age groups.
- Report number of Part-time/Intermittent Home Health visits (all payor sources) by county during the reporting period.

Number of Home Health Clients by Age by County of Residence

Mumber of A	Number of Unduplicated Clients								
County of Residence	0-17	18-40	Numi 41-59	60-64	65-74	75-84	85+	Total Number of Clients	Total Visits by County
	· · ·				· .:				All .
Cherokee	. 2	5	. 57	43	143	137	78	465	7736
Graham		5	11	4	11	13		45	797
Macon			j	, .	1.	<u></u>		4	45
			,						
								514	8578

Home Care (Non Part-time Intermittent Home Health) Services Reporting N/A SECTION C Client Residence (Home Care)

Instructions:

- Report numbers of clients who received Home Care (Non Part-Time Intermittent Home Health) Services by county of residence for each age category shown.
- Use each client's age on the first day of service during the reporting period. This is an unduplicated count. Clients may be counted only once during the reporting period regardless of the number of times admitted.
- Do not report clients reported on the previous page.
- Do not use other age groups.

Number of Home Care Clients by Age by County of Residence 1947年中国国际公司的国际管理等的联络

County of	Number of Unduplicated Clients								
Residence	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total	
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		7.4	15 m/m/24 m/m/m/m/m/m/m/m/m/m/m/m/m/m/m/m/m/m/m/						
	Twister Na selv			-60M ₁₀ - 50M		A STATE OF THE STA			
	3.00								
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Copy and attach additional page(s) as needed.

License No: HC0275

Facility ID: 953771

Home Health Services Reporting

SECTION D Clients/Visits by Payer Source for your Designated Reporting Period

Instructions:

- * Report data related to clients who are receiving <u>PART-TIME INTERMITTENT HOME HEALTH</u> * services through your Medicare certified agency <u>regardless of payer source</u>.
- * These are services provided on a <u>per visit</u> basis: Nursing, PT, OT, ST, MSW and In-Home Aide (Home Health Aide). This includes patient services reimbursed by Medicare, Medicaid, private insurance, etc.
- * Clients admitted twice during the reporting period and reimbursed by the same payer should be counted only once.
- * Clients admitted once during the reporting period, for whom payment was obtained from two sources, should be reported twice, once for each payment source.
- * Do not provide data here related to clients on page 3 of this report.

Examples	Mrs. Brown was admitted on four different occasions to the home health agency. Medicare was the only payor for each admission. Therefore, Mrs. Brown would be reported as one Medicare client, but the number of visits would include all visits from the four admissions.
	Mrs. Smith was admitted once to the home health agency, but received services paid for by both Medicare and Medicaid. Mrs. Smith would be reported as one Medicare client and one Medicaid client. Her visits should reflect the number of visits paid by each of the payers.
	Mr. Jones was admitted to the home health agency on six different occasions during this reporting period. Three admissions were under Medicare and three were under Medicaid. Mr. Jones would be reported as one Medicare client and one Medicaid client. His visits should reflect the number of visits paid by each of the payers.

Payment Source	Number of Clients	Number of Visits		
Medicare	275	4955		
Medicare HMO	94	1845		
Medicaid	66	923		
Medicaid HMO				
Private Insurance	78	849		
Private Insurance HMO				
Indigent Non-Pay		6		
Specify any other below*:				
W 1	514	8578		

*May include Self-pay, Worker's Comp, VA/Tricare, Etc.

License No: <u>HC0275</u> Facility ID: 953771

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

SECTION D. <u>Clients/Visits by Payor Source for your Designated Reporting Period</u> (continued)

1. The following information may either be collected off your system or requested by you from the Centers for Medicare and Medicaid Services (CMS) or Palmetto Government Benefits Administrators (PGBA). It is expected that your system data will be more up-to-date.

Please specify the 12-month reporting period, by month and year, of the following information:

From $\frac{10/2016}{Month/Year}$ To $\frac{09/2017}{Month/Year}$

a. Number of Medicare Episodes = 444

b. Average Number of Medicare episodes per beneficiary = $\frac{1.25}{}$

c. Average Number of Medicare Visits per Episode (all disciplines) = 13.22

d. For Medicare – the Percent of Lupus = .09

Good Shepherd Home Health and Hospice Agency * Clay County

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

Home Health Services Reporting

SECTION E Staff - Home Health

Report data in Table E related to clients who are receiving part-time intermittent home health services through your Medicare certified agency regardless of payer source. These are services provided on a per visit basis: Nursing, PT, OT, ST, MSW and In-Home Aide, (Home Health Aide).

Total Staff: Means the total number of employees by discipline, including contract staff, who are involved with the agency's home health services.

FTEs (Full-Time Equivalents): Means total number of hours per week regularly worked, by discipline, divided by 40. Do not include homemaker, sitter or In-Home Aide Level I (Home Management).

Examples

The administrator works 20 hrs./wk. in your home care program and 20 hrs./wk. in a non-home care program. FTE =

15 nurses work a combined total of 400 hours a week. FTE = 400/40 = 10 FTE's

Total Clients: Means the total number of clients seen by each staff discipline during the reporting period. If the client is seen by more than one discipline, include the related client visits under each. Do not report visits if only for the purpose of supervising other staff. Do not include homemaker, sitter or In-Home Aide Level I (Home Management). If a client is reopened to the same discipline later in the year, count the client only once.

Examples

Mrs. Brown was admitted on four different occasions to the home care agency. She received nursing services on each admission. Count Mrs. Brown as one client under nursing, but report all the visits she received related to nursing.

Mrs. Smith was admitted on four different occasions to the home care agency. She received nursing on two admissions, aide services on three admissions and physical therapy on one admission. Count Mrs. Smith as one client under nursing, one client under in home aide services and one client under physical therapy, but report all the visit she received related to each discipline.

Total Visits: These are direct care visits provided to the client by home health staff members, or by others under contract with the home health agency for which you bill. (If you are providing contract staffing services to another home health agency, do not include these visits. These visits should be reported by the agency who is billing for the clients' services.)

Average Cost Per Visit: Means the total cost for each staff discipline divided by the total number of visits by that discipline. Use your most recent cost report as filed.

License No: HC0275
Facility ID: 953771

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

Home Health Services Reporting

SECTION E Staff - Home Health (continued)

2017 Home Health Staffing Data (Table E)

Stoff Total Total Total Average Cost						
Staff	Total Staff	FTES	Total Clients	Total Visits	Per Visit	
Discipline	Stair		NAME OF THE OWNER OWNER OF THE OWNER	ATTENDED TO		
Administrator	1.0	160		1		
Nurse Director/Supervisors	1.0	,50		10000	Marketing Sales	
Other Administrative Staff	1.0	1.0,				
Nursing (RN, LPN)	8.0	7.59	584	3484	129.42	
Occupational Therapy	20	2.15	173	11.20	11882	
Occupational ringapy	3.4	011				
Physical Therapy	40	4.87	399	3402	118.82	
Speech Therapy	175	.10	16	44	118.82	
Social Worker	,25	,25	21	22	170.50	
Home Health Aide	1.50	1.64	58	506	31,28	
Nutrition	garantiga karan	e de la companya de l		30.50		
Totals	19.50	18,60	1251	8578		

License No: HC0275
Facility ID: 953771

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865

Home Care (Non Part-time Intermittent Home Health) Services Reporting N/A SECTION F Staff - Home Care

Report data in Table F related to clients who are receiving continuous hours of services through your home care agency (Non part-time intermittent home health).

<u>Total Staff</u>: Means the total number of employees by discipline, including contract staff, who are involved with the agency's **home care** services (Non Medicare-certified/non part-time intermittent home health).

<u>Total Clients</u>: Means the total number of clients seen by each staff discipline during the reporting period. If the client is seen by more than one discipline, include the related clients under each discipline. Do not include homemaker, sitter or In-Home Aide Level I (Home Management).

Examples	Mrs. Brown was admitted on four different occasions to the home care agency. She received nursing services on each
	admission. Count Mrs. Brown as one client under nursing.
	Mrs. Smith was admitted on four different occasions to the home care agency. She received nursing on two admissions, aide services on three admissions and physical therapy on one admission. Count Mrs. Smith as one client
	under nursing, one client under in-home aide services and one client under physical therapy.

2017 Home Care Staffing Data (Table F)

Staff	Total	Total Clients
Discipline	Staff	(12 Month Reporting Period)
Administrator		
Nurse/Director Supervisors		Toward Committee of the
Other Administrative Staff		
Nursing (RN, LPN)		
Occupational Therapist		
Physical Therapist		
Physical Therapy Assistant		
Speech Therapist		
Social Worker		
In-home Aide	·	
Respiratory Therapist		
Respiratory Practitioner		
Other (Specify)		<u> </u>
Total		

2018 HOSPICE DATA SUPPLEMENT OVERVIEW HC 02.75

There are a total of twelve sections in this data supplement form on 14 pages. Please answer <u>all</u> of the questions in the designated location on each page that applies to this licensed agency.

Please be sure to double check all calculated totals throughout this document; to include all row totals and column totals. Also, please double check to make sure all section totals that are required to match another section total match before submitting this form to DHSR.

Section A collects information regarding this particular hospice agency. Select one of two choices for your facility's reporting period.

DHSR Healthcare Planning staff will contact the person who is listed under the **Contact Name** if the form is submitted **incomplete** or if there are any questions regarding data contained on the form.

Section E collects data for FY2017 based only on patient principle/primary diagnosis (use ICD-10-CM Code list provided) regardless of payment source. Do <u>not</u> include patients carried over from FY2016.

Section G is patient demographies for new, unduplicated admissions.

Section I collects the number of patients by county of the patient's primary residence in FY2017 for this licensed agency.

Section I collects information on the number of licensed inpatient and residential beds for this licensed agency, if applicable.

Section K collects, by county of primary residence, inpatient and residential patient information for this licensed agency, if applicable. Total days of inpatient care days do not include respite days.

Section L collects inpatient and residential staffing information for FY2017 for this licensed agency, if applicable.

If you have questions, please call Healthcare Planning at (919) 855-3865 or email us at DHSR.SMFP.Hospice-Inventory@dhhs.nc.gov.

North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section Regular Mail: 1205 Umstead Drive 2712 Mail Service Center Raleigh, North Carolina 27699-2712 Overnight UPS and FedEx only: 1205 Umstead Drive

Telephone: (919) 855-4620 Fax: (919) 715-8476

Legal Identity of Applicant:

Raleigh, North Carolina 27603

License No:

Agency d/b/a:

For Of	ficial Use (Only	
License	# HC0275	i	
FID#:	953771		
PC		Date	

Hospice Agency

2018 Annual Data Supplement to Licensure Application

(Reporting 2017 Fiscal Year Data)

Murphy Post-Acute and Wellness, LLC

Good Shepherd Home Health and Hospice Agency

Please read all directions for each section carefully.

SECTION A Identification and Contact Information

HC0275

Agency Site Address:	Street: 6950 HWY 64 West	A	
County:	City: Brasstown State: NC	Zip: 28902	
Agency Phone #: Agency Fax #:	(828)837- 1197 4みんり (828)837-4860		
REPORTING PERIOD:	 ✓ October 1, 2016 – Septem □ July 1, 2016 – June 30, 20 	100 (ACC) - ACC -	i i i i i i i i i i i i i i i i i i i
time period covered in this CONTACT NAME: Name of the period Name: Teresa West	Teleph	provided below:	specify the
E-Mail: twest@murphy med CEO/DIRECTOR SIGNATURE:		र प्राप्त कर सर्वाद्रम् । तस्य विश्वतिक स्व	supplement
	s accurate. RN-BC Title:	Home Care Manages	

License No: <u>HC0275</u> Facility ID: 953771

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

SECTION B P	rogram Demographic	<u>es</u> .	* 1		8
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3. MEDICARE C	ERTIFICATION				
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4. ACCREDITAT		5. TAX S	TATUS (Select on	<u>e</u>)	
Accredited □ ACHC □ CHAP ☑ TIC	□ DNV □ Other	\	Voluntary (not fo Proprietary (for p Government	r profit) rofit)	
SECTION C 1			and the second s		
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{Include th fewer:} Number of {Include th	Patients Who Died in ≤ 7 days a number of deaths for patiet Patients Who Died in ≥180 cenumber of deaths for all pacutive days.}	nts who died for the	lays or more)	<i>5</i>	

License No: <u>HC0275</u> Facility ID: 953771

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

SECTION C Patient Volume (continued)

2. LEVEL OF CARE AND PAY SOURCE:

- Include all patients who received services in FY2017. Do <u>not</u> count re-admissions within the same payment source.
- Patients who change primary pay source during this time should be reported for each pay source with the number of days of care recorded for each pay source (count each day only once even if there is more than one pay source on any given day).
- The number of patients served may be higher than the actual number of patients served due to a change in pay source.

Hospice Payment Source	Number of Patients Served	(a) Days of Routine Home Care	(b) Days of Inpatient Care	(c) Days of Respite Care	(d) Days of Continuous Care	Sum of (a thru d) Total Patient Care Days
Hospice Medicare	67	3353		18		3371
Hospice Medicaid	2	183				183
Private Insurance	4	129				129
Self Pay *		58		3		61
Other **					<u> </u>	
Total	74	3723		. 21		3744

NOTE: Total Days of Care should agree to Total Days of Care in Section I.

SECTION D Number of Unduplicated Admissions and Deaths by Location

Please report the number of new admissions and deaths in each location during FY2017. For admissions, use location on the first day of care. Patients can start in one location and finish at another location.

New Unduplicated Admissions:

Only include patients admitted to your hospice for the first time during FY2017. Count each patient only one time. This means patients who were admitted multiple times during FY2017 are counted only once. Do not include patients carried over from FY2016.

Deaths:

Include all patients who died during FY2017 regardless of date of admission.

^{*} Self Pay included charity/indigent care and foundation help; does NOT include any commercial or government 3rd party payer.

^{**} Other Payment Sources (to be used rarely) may include but are not limited to VA, Workers Comp, Home Health Benefit (only for non-Medicare Certified agencies).

Löcation of Care	Number of New Unduplicated Admissions	Number of Deaths
(1) Home - Private residence of either the patient or the caregiver	59	52
(2) Nursing Facility - A licensed long term care facility providing nursing and supportive services	10	9
(3) Hospice Unit - An inpatient unit (one or more beds) operated by a hospice, and located in a facility operated by another entity (includes hospital, nursing home, and other).		
(4) Hospital - An acute care facility not operated by the hospice (may be a floating or scattered bed contract).		
(5) Free Standing Hospice Inpatient Facility or Residence - An inpatient facility and/or residence operated entirely by a hospice.		
(6) Residential Care Setting - A residential care facility that is not run by the hospice (assisted living, boarding home, rest home, shelter, etc.)		
Totals (Sum 1 – 6)	69	1: 6/1

NOTE: Number of Admissions must match the Number of Admissions in Sections E, G and I. Number of Deaths must match the Number of Deaths in Sections C, E and I.

SECTION E Number of Patients by Principle/Primary Diagnosis

Please provide data for FY2017, regardless of payment source. Data provided should be based only on patient principle/primary diagnosis. The revised list in the table consists of ICD-10-CM Codes Categories.

New (Unduplicated) Admissions:

Only include patients admitted to your hospice for the first time during FY 2017. Count each patient only one time. This means patients who were admitted multiple times in FY2016 are counted only once. Do not include patients carried over from FY2016. <u>Deaths</u>;

Include all patients who died in FY2017, regardless of date of admission

Live Discharges:

Include all live discharges that occurred during FY2017; regardless of when the admission occurred. Count multiple discharges for the same patient as discrete events. (Example! A patient discharges alive, is later readmitted and discharges alive again. The patient is counted as 2 separate discharges.)

Patient Days:

Include the total number of days services were provided by your hospice for all patients who died on were discharged in FY2017, Count all days of service in FY2017 for each patient. For patients who had multiple episodes of care, count all days in each episode.

	Principle/Primary/Diagnosis	Number of		Number	Patient Days
HGD:10- CM-Codes	Categories	New (Unduplicated) Admissions	Desilla	OLLIVA Discusives	Who Died or Wese Discharged
A00-B99	Infectious and Parasitic Diseases				51
C00-D49	Neoplasms	29	27	4	1496
D50-D99	Diseases of The Blood and Blood-Forming Organs	· ·	4.30		
E00-E99	Endocrine, Nutritional and Metabolic Diseases, And Immunity Disorders		1		17
F01-F99	Mental, Behavioral and Neurodevelopmental Disorders				1
G00-G99, H00-H99	Diseases of The Nervous System and Sense Organs	9	8		273
100-199	Diseases of The Circulatory System	15	12		475
J00-J99	Diseases of The Respiratory System	9	9	/	423
K00-K99	Diseases of The Digestive System	4	3		. 56
L00-L99	Diseases of The Skin and Subcutaneous Tissue		·		
M00-M99	Diseases of The Musculoskeletal System and Connective Tissue				
N00-N99	Diseases of The Genitourinary System				
Q00-Q99	Congenital Anomalies	1	1		1.3
S00-T99	Injury and Poisoning, Classification of External Causes of Injury and Poisoning				
	All Others				0.00
	TOTAL	49	41	. 8	2830

NOTE: Number of Admissions must equal Sections D, G and I. Number of Deaths must equal Sections C, D and I.

SECTION F Productivity and Cost of Care

Complete this section using the following definitions.

Direct Care:

Includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care as distinct from supervision of other staff or program activities.

FTE:

One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs. Charles and the second

Calculations:

- <u>Total FTEs</u>: Divide paid hours by 2080 (may include up to 2 decimal points). Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried and contract staff.
- On-call FTEs: First, calculate total payments made for on-call nursing staff. Next, calculate the average salary of a full-time nurse providing direct patient care. Then divide the total payments for on-call by the average nursing salary.
- Home Hospice FTEs: Includes all staff involved in delivery of hospice care to patients in all settings (home, hospital, nursing home, etc.). Do not include inpatient staff when completing this section.

1. STAFFING BY DISCIPLINE - FY2017

	Staffing by Discipline	Total Home Hospice FTEs
	Nursing – Direct Clinical	
1	Include RNs and LPNs. Include on-call and after hours care. Do not include supervisors or other clinical administrators unless a portion of their time is spent in direct care.	1.26
2	Nurse Practitioner Include nurses with an advanced degree who function and are licensed as a Nurse Practitioner.	
3	Social Services Include medical social services staff as defined by CMS for the cost report. Do not include chaplains, bereavement staff or volunteer coordinators.	153
4	Hospice Aides	,39
5	Physicians – Paid Include medical directors and other physicians providing direct care to patients and participating in clinical support. Exclude volunteer physicians.	
6	Physicians - Volunteer	.3/
7	Chaplains	,58
8	Other Clinical Include any paid staff in addition to those captured above who provide direct care to patients or families. Include therapists and dietitians. Do not include volunteers.	
9	Clinical (add rows 1 - 8) Includes all direct care time (above 8 rows). This is the total of Nursing Direct clinical, NP, Social Services, Aides, Physicians, Chaplains & Other Clinical.	enting
10	Nursing — Indirect Clinical Include nurses with clinical background, but who do not provide direct eare (intake staff; educators, quality improvement, managers, liaison nurses, etc).	150
11	Bereavement. Include all paid staff providing bereavement services, including pre-death grief support. Do not include volunteers.	.58
12	Non-Clinical Include all administrative and general staff.	,50
13	Total (add rows 9-12) Include all staff time. This is the total of Clinical, Indirect Clinical, Bereavement and Non-Clinical.	4.65
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Good Shepherd Home Health and Hospice Agency * Clay County

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

2. VISITS BY DISCIPLINE

Please provide the following information for FY2017. Count <u>all</u> visits, regardless of setting (hospital, nursing home, residential facility, etc.). If you own/operate a hospice, inpatient or residential facility — do not include visits to your facility here.

	T 11 11 11 11 11 11 11 11 11 11 11 11 11
Discipline	Total Visits
Nursing	
Include visits made by RNs and LPNs. Include visits made by a Nurse Practitioner or a	
Clinical Nurse Specialist if the visit was a nursing visit (i.e., the NP was not serving as an	
attending physician or performing a visit in compliance with the face-to-face encounter	0.11
regulation). Include on-call and after hours care visits.	764
Nurse Practitioners	
Include visits made by Nurse Practitioners when they are serving as an attending physician	
or performing a visit in compliance with the face-to-face encounter regulation.	
Social Services	
Include visits made by medical social services staff as defined by CMS for the cost report.	2.0
Do not include chaplains, bereavement staff, or volunteer coordinators.	222
Hospice Aides	610
Physicians - Paid	
Include visits made by medical directors and other physicians providing direct care to	
patient. Exclude volunteer physicians.	
Physicians - Volunteer	14
Chaplains	77
Other Clinical	
Include any paid staff in addition to those captured above who make visits as part of direct	
care to patients or families. Include therapists, nurse practitioners, and dieticians. Do not	12
include volunteers or bereavement staff.	10

3. CASELOADS

Caseload is the preferred number of patients for which a staff member has responsibility or to which she/he is assigned at a time. Enter a single number for FY2017. Do not enter a range.

Discipline	Average C	aseload
Primary Nurse/Nurse Case Manager - RN with primary responsibility for the patient's care.		24
Social Worker - Social Worker with medical social services duties, as defined		
by CMS. Include only those patients who receive visits in determining Social		- 11
Worker caseloads.	<u> </u>	24
Hospice Aide	<u> </u>	
Chaplain - Include only those patients who receive visits in determining chaplain		/
caseload.	1. 1. 1. 1. 1. 1.	24
Volunteer Coordinator - Include only those patients who are assigned a	Y., 1	11
volunteer in determining volunteer coordinator caseload.	11 72 11	14
Medical Director - Include only those patients whom the medical director is the .		0:11
attending physician in determining caseload.		24

SECTION G Patient Demographics for New (Unduplicated) Admissions

Only include patients admitted for the first time during FY2017. Patients who are admitted multiple times are counted only once.

1.	GENDER	a * 3	3. ET	HNICITY all patients should be categor	ized as Hispanic
			ga koje, vili Plomjej 1. do	or non-Hispanic, and further of Race below (as defined by U.S.	Census Bureau)
	a. Female	41	a.	Hispanic	
	b. Male	28	b.	Non-Hispanic	69
9			in the first of the control of the c	Total (must equal Race total)	69
		10			(Required)
	Total	(Required)		열성하시다 가면 그 그	
	(4)	(Acedanica)			
2.	AGE		4. RA	CE.	
	Use patient's a admission in F	ge on the first day of			
	admission in F	12017			
	a. <1		a	American Indian or Alaskan Native	
	b. 1-4		- b:	Asian	(3)
• 4	c. 5-14		c.	Black or African American	
Ja 1	d. 15 - 20		ď	Hawaiian or Other Pacific Islander	
	e. 21 - 24		, i e,	White	61
	f. 25 - 34		f .	Some other race of races	
	g. 35 - 64	13		Total (must equal Ethnicity total)	69
	h. 65 - 74	11			(Required)
	75.01	21			
a jed Politika	i, 75 - 84	And the State of t			
	j. 85+	18			
	Total	69			
		(Required)	的信观域的系统		Y KONDONEZ Y

NOTE: Number of Admissions <u>must</u> agree to the number of admissions in Sections D, E and I.

SECTION H Processes of Care

1. DIRECT PATIENT CARE VOLUNTEERS

Provide the following information during FY2017.

Do <u>not</u> include volunteer medical director hours when entering responses in this section. Medical director's volunteer hours should be entered in Section F: Productivity and Cost of Care.

Number of Volunteers:

The number of volunteers should be an unduplicated count, with no individuals included in more than one category, even if they engaged in more than one type of volunteer service. Some volunteers participate in multiple types of activities, such as spending time with patients and assisting with fundraising mailings. If any of the activities performed by a volunteer involved direct contact with patients or families, the volunteer should be counted in the direct care category, regardless of the proportion of time spent providing direct care.

Volunteer Hours:

For those volunteers who contributed hours in more than one volunteer service category, provide the number of hours for each category.

Volunteers	Number	Hours	Visits
(1) Direct Patient Care Volunteers – Defined as volunteers who provide services through direct contact with patients and families, such as spending time with patients or making calls to patients and families as part of a weekend "tuck-in" program (do not include phone calls as a visit).	8	144.69	37
(2) Clinical Support Volunteers - Report the number/hours for volunteers who provide patient care and clinical support. These volunteers are combined with Direct Patient Care Volunteers, to meet the Medicare Condition of Participation regarding 5% volunteer hours. Medicare interpretive guidelines define administrative volunteers in this context as supporting patient care			
activities (e.g., clerical duties), rather than general support (e.g., fundraising).	1	70.40	
(3) General Support Volunteers - Report the number and the hours for volunteers who provide general support, such as those who help with fundraising and members of the board of directors. These volunteers do not contribute to the 5% Medicare requirement.			year part
All Hospice Volunteers - Sum of (1-3) above.	9	215,09	

Good Shepherd Home Health and Hospice Agency * Clay County

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2. BEREAVEMENT SERVICES

Provide the following information for FY2017.

- In calculating responses for the questions below, include all bereavement clients who received services during FY2017, both those currently on bereavement rolls and those who were discharged from bereavement services.
- Information entered under Community Members should include bereavement services provided to individuals in the community who were <u>not</u> associated with a family member or friend admitted to hospice.

Bereavement Services	Hospice Family Members	Community Members	Total
Total Number of Contacts by Visit Include any face-to-face one-to-one contact with individuals, regardless of setting. Do not include support group or camp services.	74	3)	77
Total Number of Contacts by Phone Call	100	7	94
Total Number of Mailings to the Bereaved Total Number of Individuals Who Received Bereavement Services			
Include all individuals enrolled for bereavement, including those served through support groups and camps.	48	3	7/

SECTION I Patient Volume (Required)

PATIENTS SERVED BY COUNTY OF PRIMARY RESIDENCE;

Please complete the following information (for FY2017) for each patient this agency served by county of the patient's primary residence.

Column

- A. County of Primary Residence: List patients by county of primary residence:
- B. Number of New (Unduplicated) Admissions: Only include patients admitted to your hospice for the first time during FY2017. Count each patient only one time. This means patients who were admitted multiple times in FY2017 are counted only once. Do not include patients carried over from FY2016. Total number of unduplicated admissions must equal the total admissions in Sections D. E and G.
- C. Number of Deaths: Include all deaths that occurred during the FY2017.
- D. Number of Non-Death Discharges: Live discharges that occurred in FY2017.
- E. Number of Patients Served: Includes carryover patients from prior year, new admissions and re-admissions. Patients admitted multiple times in FY2017 are counted only once.
- F-I. Days of Care: Totals must agree to the Days of Care totals in Section C, 2: This includes all Days of Care in FY2017 regardless of when the admission occurred

License No: <u>HC0275</u> Facility ID: **953771**

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

SECTION I Patient Volume (Required)

PATIENTS SERVED BY COUNTY OF PRIMARY RESIDENCE:

Please complete the following information (for FY2017) for each patient this agency served by county of the patient's primary residence. Make additional copies of this sheet if additional space is needed and attach.

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Facility ID: 953771

For questions, contact the Division of Health Service Regulation - Healthcare Planning at (919) 855-3865.

SECTION J Inpatient and Residential Information N/A

Completion of this entire Section is required. Please provide the follo	wing information for	r FY2017.
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	8 (8)	
1. Facility Name:		
2. Number of Licensed Inpatient Beds:		
Number of Licensed Residential Beds:		
and the state of t	$c = (d - a_{n-1}) - (a - b_{n-1}) - (b - b_{n-1})$	A
3. Where is the facility located? (Select one)		
On campus of Freestanding Hospice		
in Hospital		Alaryia da
☐ in Nursing Home		
other (please specify):	mark and the second	
- Owas (product of the control of th		
4. Did the facility open during FY2017? ☐ Yes or ☐ No		and the second second
If yes, please note the date the facility was licensed:		
		in Comme
If yes, please note the date the facility was Medicare certified:		
Tryon, proudo note the date the racing was reported to		是是各种的
5. Did the facility add beds during FY2017? ☐ Yes or ☐ No		in the process of the section
If yes, please note how many beds were added:		
in yest pieaso note now many beds were added.		
If yes, please note the date the beds were licensed:		
and the second of the second o		
		Mark Company
6. Did the facility convert any residential beds to	The State of the S	A VERNOUS AND SOUTH
inpatient beds during FY2017? ☐ Yes or ☐ No		
If yes, please note how many beds were converted:		主制成的特色
A 1003, pacing note now many pour work converted.	Transper algebraiche de de de	
If yes, please note the date the beds were licensed:		titat omalikaj div

SECTION K Inpatient and Residential Patient Information N/A

1. Hospice Facility Patients: Only freestanding hospice inpatient facilities operated by a licensed hospice or hospice inpatient units with a Certificate of Need for hospice beds <u>and/or</u> freestanding hospice residences operated by a licensed hospice should complete this table. The purpose of this table is to collect bed utilization data. Include all patients admitted in the facility even if the care was provided under contract to another hospice.

<u>County of Primary Residence</u>: List all inpatient and residential clients served. Report admitted patients by county of primary residence. Count each inpatient client <u>only</u> once. Count each residential client <u>only</u> once.

Direct Admits: These are defined as patients with no prior hospice care.

<u>Transfers In:</u> These are defined as existing hospice patients coming from the home, hospital, nursing facility, assisted living and independent living.

<u>Total Days of Care</u>: If the patient was admitted before the reporting period, include <u>only</u> the days of care that occurred during FY2017. **Do not include respite days.**

Total Deaths: Include only those deaths that occurred during FY2017.

Hospice I	Hospice Residence Patients						
County of Primary Residence	Direct Admits	Transfer from Hospice Home Care	Total Days of Inpatient Care (Do Not Count Respite Days)	Total Number of Deaths	Total Number of Patients Admitted	Total Days of Residential Care	Total Number of Deaths
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SECTION L Inpatient and Residential Staffing Information

1. Facility Staffing by Discipline - Staffing Information for FY2017

Complete this section using the following definitions and calculation instructions:

Direct Care: Includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care as distinct from supervision of other staff or program activities.

FTE: One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs.

Calculations: Total FTEs: Divide paid hours by 2080 (can include up to 2 decimal points). Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried and contract staff.

0.0			
	Staffing by Discipline	Facility Inpatient	/ FTEs Residential
	Nursing - Direct Clinical	SATE PILINGERING AND TOPIC	na v nezonagaja sujej teorica. Goj
1	Include RNs and LPNs. Include on-call and after hours care. Do not include supervisors of other clinical administrators unless a portion of their time is spent in direct care.		
2	Social Services. Include medical social services staff as defined by CMS for the cost report. Do not include bereavement counselors.		
3	Hospice Aides	in the state of th	Walter Part Constraint
4	Physicians — Paid Include medical directors and other physicians providing direct care to patients and participating in clinical support. Exclude volunteer physicians.		
5	Physicians - Volunteer		
6	Chaplains		
7	Other Clinical Include any paid staff in addition to those captured above who provide direct care to patients or families. Include nurse practitioners, therapists, and dietitians. Do not include volunteers or bereavement staff.		
8	Non-Clinical Include all administrative and general staff or contract staff.		

License No: HC0275

Facility ID: 953771

GOOD SHEPHARD HOME HEALTH AGENCY POST OFFICE BOX 465 HAYESVILLE, NORTH CAROLINA 28904

THOMAS J. TAAFFE EXECUTIVE DIRECTOR

TELEPHONE (704) 389-6311

March 4, 1991

Mr. Craig Smith Project Analyst Certificate of Need Section Division of Facility Services STATE OF NORTH CAROLINA 701 Barbour Drive Raleigh, North Carolina 27603

RE: INTENT TO PROVIDE HOSPICE CARE

Dear Mr. Smith:

Good Shepherd Home Health Agency plans to begin providing Medicare certified in-home hospice services in May, 1991, within our current service area of Clay and Cherokee Counties. For patients requiring institutional care, we expect to negotiate an agreement with our local hospitals!

Although we anticipate some initial capital outlay, it should be minimal. Additional office equipment and furnishings should not exceed \$7,500. When fully implemented, we project an average census of 12-15 patients.

Because the core staff will come from our current employees, we do not anticipate significant increases in operating costs, however, as the program develops, we have budgeted an additional 1½ F.T.E. nurses to meet the service demands. This will increase operating costs approximately \$40,000 annually.

I hope this information is sufficient for your office to make a favorable determination for the purposes of CON requirements. Please feel free to call if you have further questions.

Sincerely,

GOOD SHEPHERD HOME HEALTH AGENCY

Thomas J. Taaffe Executive Director

TJT:jgk





North Carolina Department of Human Resources

Division of Facility Services

701 Barbour Drive • Raleigh, N. C. 27603-2008

Courier Number 53-11-13

James G. Martin, Governor David T. Flaherty, Secretary John M. Syria, Director Telephone (919)733-6360

April 8, 1991

Thomas J. Taaffe Executive Director Good Shephard Home Health Agency P. O. Box 465 Hayesville, NC 28904

RE: No Review/Provision of Hospice Care in Clay and Cherokee Counties

Dear Mr. Taaffe:

In response to your letter of March 4, 1991 the above referenced proposal does not represent a new institutional health service within the meaning of N.C.G.S. 131E-176(16) and, therefore, you may proceed to offer, develop or establish the above referenced project without a Certificate of Need. However, you may need to contact the Licensure Section and the Construction Section of the Division of Facility Services to determine if they have any special requirements for the proposed project.

It should be noted that this Agency's position is based solely on the facts represented by you and that any change in facts as represented would require further consideration by this Agency and a separate determination. If you have any questions concerning this matter, please feel free to contact me.

Sincerely.

Craig R. Smith, Project Analyst

Jerri M. Muchmore, Assistant Chief

Terri M. Muchmore, Assistant Chief Certificate of Need Section

TMM: CRS: jms

cc: Licensure Section
Construction Section
Certification Section
Dan Butler, BC/BS of North Carolina





North Carolina Department of Human Resources

Division of Facility Services

701 Barbour Drive • Raleigh, N. C. 27603-2008

Courier Number 53-11-13

James G. Martin, Governor David T. Flaherty, Secretary

John M. Syria, Director Telephone

Writer's Direct No. (919) 733-2786

May 1, 1991

Mr. Thomas J. Taaffe, Executive Director Good Shepherd Home Health Agency Post Office Box 465 Hayesville, North Carolina 28904

Dear Mr. Taaffe:

I am in receipt of a copy of a no-review letter from the Certificate of Need Section of the Division of Facility Services approving the addition of hospice services to your home health agency. If you plan to proceed, please write me outlining your plans and timeframes. We will issue a new license reflecting the addition of that service once we agree that the licensure requirements have been met.

I will look forward to working with you to that end.

Sincerely,

Louise Campbell Zapata, R.N., M.S.P.H.

Nurse Consultant

Health Care Facilities Branch

LCZ:cr

GOOD SHEPHARD HOME HEALTH AGENCY POST OFFICE BOX 465 HAYESVILLE, NORTH CAROLINA 28904

THOMAS J. TAAFFE EXECUTIVE DIRECTOR

TELEPHONE (704) 389-6311

May 10, 1991

Ms. Louise Campbell Zapata, RN, MSPH Nurse Consultant Health Care Facilities NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES 701 Barbour Drive Raleigh, North Carolina 27603

RE: HOSPICE LICENSURE

Dear Ms. Zapata:

Thank you for your recent letter regarding our desire to add hospice services at this agency. Indeed, we have received a no-review letter from Mr. Smith's office. Our plan for implementation is proceeding at an encouraging pace--although a bit slower than anticipated. We hope to be reviewed for Medicare Certification during the month of July, 1991.

In preparation for hospice, we have already taken many steps to assure compliance with state and federal guidelines. I trust that the following information will be sufficient to allow you to issue a revised license to Good Shepherd.

Background

Good Shepherd Home Health Agency has been operating as a comprehensive home care agency for over 35 years. We have been Medicare Certified since the mid-60's and, of course, licensed by North Carolina for the appropriate duration. Our Advisory and Governing Boards have voted to extend our services to the community as a certified hospice.

1. Name of Applicant

Good Shepherd Home Health Agency, Inc. Post Office Box 465 Hayesville, North Carolina 28904 North Carolina License No. 772

2. Boards

Advisory Members:

Joseph El-Khouri Arthur Murray

Leroy Ripper Betty Schopp Daniel Stroup, M.D.

Esther Hyatt

Governing Members:

Bishop John F. Donoghue, DD

Rev. Monsignor John J. McSweeney, VG Rev. Monsignor Joseph S. Showfety, VG Ms. Louise Campbell Zapata May 10, 1991 Page Two

3. Agency Director

Thomas J. Taaffe

4. Geographic Area to be Served

Cherokee and Clay Counties

5. Services to be Offered

a. Physician b. Nursing c. Medical Social Service c. Mursing Service e. Nutrition
Theresa Heavner, MD, Volunteer Director
Staff
Staff
Rev. Frank Hamilton, Volunteer Chaplain
By arrangement

f. Physical Therapy - Staff g. Speech Therapy - Staff h. Homemaker/HHA - Staff

i. Medical Supplies - By arrangement

j. Inpatient/Respite Care - By arrangement with local hospitals (being negotiated)

k. Volunteers (multiple disciplines) - 34 individuals have completed 7-week training course

 Agency Coordinator of Hospice Care - Ruth Kraushaar, RN

As mentioned above, we are hopeful that all pieces will be in place soon. It is our desire to provide this needed—but presently absent—service in our 2-county area. Your assistance and positive consideration is appreciated.

Please do not hesitate to call if you have additional questions.

Sincerely,

GOOD SHEPHERD HOME HEALTH AGENCY

Thomas J. Taaffe Executive Director

TJT: jgk