NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

GEORGIA CORPORATIONS DIVISION

GEORGIA SECRETARY OF STATE
BRIAN P. KEMP

HOME (/)

BUSINESS SEARCH

BUSINESS INFORMATION

Business Name:	**Hospice of the South, Inc.**	Control Number:	**18101225**
Business Type:	**Domestic Nonprofit Corporation**	Business Status:	**Active/Compliance**
NAICS Code:	**Any legal purpose**	NAICS Sub Code:	
Principal Office Address:	**4411 Oakwood Drive, Chattanooga, TN, 37416, USA**	Date of Formation / Registration Date:	**8/16/2018**
State of Formation:	**Georgia**	Last Annual Registration Year:	**NONE**

REGISTERED AGENT INFORMATION

Registered Agent Name:	**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

Report a Problem?

NELSON MULLINS

NELSON MULLINS RILEY & SCARBOROUGH LLP
ATTORNEYS AND COUNSELORS AT LAW

Denise M. Gunter
T 336.774.3322 F 336.774.3372
denise.gunter@nelsonmullins.com

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.

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

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[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.

Enclosures

Exhibit A

State of North 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 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 **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.

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.

***Please note*: 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

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

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:

PRIMARY: **Good Shepherd Home Health and Hospice Agency**

Agency Mailing Address: (If materials are to be mailed to another address list here)
125 Medical Park Lane
Suite HMurphy, NC ~~28903~~ 28906

Agency Site Address: 125 Medical Park Lane, Suite H
Murphy, NC ~~28903~~ 28906
County: Cherokee
Telephone: (828)837-~~4260~~ 1197 Fax: (828)837-~~4860~~ 9503
Agency E-Mail:(Required) jyonce@murphymedical.org
Web Site :(If applicable) _____

Administrator/Director: Julie Younce

Title: Home Care Manager

Name of the person to contact for any questions regarding this form:

Name: Teresa West **Telephone:** 828-837-1197

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, OT, ST; Hospice Home Services, and Companion, Sitter, and Respite Services

1) Under this home care license number, are you directly providing Home Medical Equipment/Durable Medical Equipment? ____ Yes ✓ No
2) Do you also have a medical equipment permit issued by the NC Board of Pharmacy? ____ Yes ✓ No

If "yes," please provide the permit number: _____

Hours:

Indicate the hours that the agency is regularly open for business each day:
[Example: 9 am – 5 pm. Use "O" if not open]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8am - 4pm	8am - 4pm	8am - 4pm	8am - 4pm	8am - 4pm	

Nursing:

Full-time Equivalents (FTE)

	R.N.	L.P.N.	Aides
Number:	2.39	115	156

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
✓	TJC (The Joint Commission)	12/04/2018	
	DNV (Det Norske Veritas)		
	CHAP (Community Home Association Program)	- -	
	ACHC (Accreditation Commission for Health Care, Inc.)	- -	
	Other: TJC	- -	

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

Home Care Agency Applicants:

1. Are you a Medicare Certified Home Health agency? ✓ Yes ____ No If yes, what is your Medicare provider number? 347014
2. This agency is a Home Health Agency. ✓ Yes ____ No.
   If 'Yes', please check one: Parent ✓ Branch __ Sub-unit __
3. Is this agency owned or operated by a Continuing Care Retirement Center (CCRC)? ____ Yes ✓ No

Hospice Applicants:

1. If Medicare certified, what is your hospice provider number? 341554
2. For Medicare certified hospices do you operate more than one office under this provider number? If yes please list each license operating under this Medicare number.
   HC0275 HC0318
3. Has this site been issued a Certificate of Need to provide hospice services? ✓ Yes ____ No.
4. Do you have an agreement to operate Hospice licensed inpatient beds or hospice residential beds in another facility? If so, list facility.

Nursing Pool Applicants:

All nursing pool applicants must attach a copy of the agency's current general and professional liability insurance policy (binder acceptable). The document must show that the applicant is insured against loss, damage, and expense related to a death or injury claim resulting from negligence or malpractice in the provision of health care by the nursing pool and its employees.

Ownership Disclosure: (Please fill in any blanks and make changes where necessary).

1. What is the name of the legal entity with ownership responsibility and liability? If this is a Corporation, complete the exact wording of the corporate name as on file with the NC Secretary of State (Corporate Office). If this is a Unit of Government, the name of the governmental unit that has the ownership responsibility and liability for services offered.

Owner:	Murphy Pos-Acute and Wellness, LLC
National Provider Identifier (NPI):	1588020770
Street/Box:	4130 U.S. Hwy. 64 E
City:	Murphy State: NC Zip: 28906
Telephone:	(828)835-7502 Fax: (___) _____
Senior Officer:	James M. Stevenson

a. Legal entity is: ___ For Profit X Not For Profit

b. Legal entity is ___ Corporation X Limited Liability Company ___ Partnership

___ Proprietorship ___ Limited Liability Partnership ___ Government Unit

Corporation:

a. What is the exact wording of the corporate name on file with the NC Secretary of State?

Murphy Post-Acute and Wellness, LLC

b. In what state was the corporation originally established? NC

c. Address and Telephone number of the corporation:

41 30 US Hwy 64 East
Murphy, NC 28906

d. List names and addresses of ALL officers and any other persons with a controlling interest of 5% or more.

Name	Title	Percent of Stock
James M. Stevenson	President	N/A
Toni Lovingood	Secretary	N/A

(Attach additional sheets as needed)

Government Unit:

a. Name of the governmental unit that has the **ownership responsibility and liability** for the services offered:

b. Title of the official in charge of the governmental unit:

c. Check which best describes the type of governmental unit:

City ___ County ___ State ___ Authority ___ Health Dept ___ DSS ___

Other (Please specify):

Multiple Facilities:

a. Is this facility part of a multiple facility/agency system in North Carolina? ✓ Yes ___ No
(A multiple facility system is defined as two or more facilities under the same management or ownership).

b. If 'Yes' above, are medical records in a centralized location? ✓ Yes ___ No

c. If 'Yes', please specify location.

Name	Location	License #
Murphy Post-Acute and Wellness, LLC	125 Medical Park Lane, Ste H Murphy, NC 28906	HC0318

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 Post-Acute and Wellness, LLC	6950 Hwy 64 West, Brasstown, NC 28902	#CO275

(Attach additional sheets as needed)

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.

g. Is your agency managed by another entity? ✓ Yes ___ No

h. If 'Yes', please specify the name of entity. Murphy Medical Center, Inc.

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.

Signature: Julie Yonce RN-BC **Date:** 11/2017

PRINT NAME OF APPROVING OFFICIAL Julie Yonce RN-BC Home Care Manager

Please be advised, the license fee must accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, prior 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 Official Use Only
License # HC0318
FID # 953772
PC _____ Date _____

HOME CARE AGENCY N/A

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 completed for each site.

A. Identification:

License No: 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: 125 Medical Park Lane; Suite H

Murphy, NC 28903

County: Cherokee

B. Reporting Period

Data is requested for the twelve-month period beginning on July, August, September or October 1, 2016, and ending after the twelve-month period, but no later than September 30, 2017. If your agency or facility was not open for this entire twelve-month period, please specify the time period covered in this report.

Your reporting period:

Starts _____**, 2016 and Ends** **September 30, 2017** *

** Change date if different from September 30*

AUTHENTICATING SIGNATURE: I certify the information submitted in this Annual Utilization Data is accurate.

Typed Name: _____ **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.
- 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

Copy and attach additional page if needed.

D. Staff

N/A

- Report data in Table below.

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

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 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.
	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		
Nurse Director or Supervisors		
Other Administrative Staff		
Nursing (RN, LPN)		
Occupational Therapist		
Physical Therapist		
Speech Therapist		
Social Worker		
In -Home Aide		
Companion, Sitter, Respite Staff		
Respiratory Therapist		
Respiratory Practitioner		
Other (Specify)		

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

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~~ 28906

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:**

CONTACT NAME: Name of the person to contact for any questions regarding this form.

Print Name: Teresa West **Telephone:** 828-837-1197

E-Mail: twest@murphymedical.org **Fax:** 828-837-9503

CEO/DIRECTOR SIGNATURE: I certify the information submitted herewith in this data supplement is accurate.

Print Name: Julie Yonce, RN-BC **Title:** Home Care Manager

Signature: Julie Yonce RN BC **Date:** 11/21/17

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.**

Number of Home Health Clients by Age by County of Residence

County of Residence	Number of Unduplicated Clients								Total Visits by County
	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total Number of Clients	
Clay		3	22	17	31	29	24	126	2004

Copy and attach additional page(s) as needed.

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	Number of Unduplicated Clients							
	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total

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 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). 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*:		
	126	2004

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

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:

From 10/2016 **To** 09/2017
Month/Year **Month/Year**

a.	**Number of Medicare Episodes**	=	94
b.	**Average Number of Medicare episodes per beneficiary**	=	1.27
c.	**Average Number of Medicare Visits per Episode (all disciplines)**	=	14.03
d.	**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 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 = 20/40 = 1/2 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.

Home Health Services Reporting

SECTION E Staff - Home Health (continued)

2017 Home Health Staffing Data (Table E)

Staff Discipline	Total Staff	FTES	Total Clients	Total Visits	Average Cost Per Visit
Administrator	1.0	.50			
Nurse Director/Supervisors	1.0	.50			
Other Administrative Staff	1.0	.50			
Nursing (RN, LPN)	2.0	2.54	142	778	129.42
Occupational Therapy	.50	.38	39	257	118.82
Physical Therapy	2.0	1.05	106	842	118.82
Speech Therapy	.25	.10	5	6	118.82
Social Worker	.25	.20	3	3	170.62
Home Health Aide	1.0	.55	12	117	31.28
Nutrition					
Totals	9.0	6.32	307	2004	

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).

Total Staff: 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).

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 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 **all** 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 **not** 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

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

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

Please read all directions for each section carefully.

SECTION A Identification and Contact Information

License No:	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~~ 28906
County:	Cherokee
Agency Phone #:	(828)837-~~4260~~ 1197
Agency Fax #:	(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:**

_____

CONTACT NAME: Name of the person to contact for any questions regarding this form.

Print Name: Teresa West **Telephone:** 828-837-1197

E-Mail: twest@murphymedical.org **Fax:** 828-837-9503

CEO/DIRECTOR SIGNATURE: I certify the information submitted herewith in this data supplement is accurate.

Print Name: Julie Yonce, RN-BC **Title:** Home Care Manager

Signature: Julie Yonce RN-BC **Date:** 11/21/17

SECTION B Program Demographics

1. **AGENCY TYPE (Select one based on Medicare 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)**
   (If zero, explanation required) _____

3. **MEDICARE CERTIFICATION**
   Is this facility Medicare certified? ☑ Yes or ☐ No **(Required)**
   Medicare Provider Number: 34 -- 1554 (Example Medicare Provider Number: 34-5113)

4. **ACCREDITATION STATUS**
   Accredited by:
   - ☐ ACHC
   - ☐ CHAP
   - ☑ TJC
   - ☐ DNV
   - ☐ Other
   - ☐ Not accredited

5. **TAX STATUS (Select one)**
   - ☑ Voluntary (not for profit)
   - ☐ Proprietary (for profit)
   - ☐ Government

SECTION C Patient Volume

1. **AVERAGE DAILY CENSUS AND LENGTH OF STAY:** Please review the definitions carefully before completing the following questions. (**NOTE**: 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 died/discharged patients for FY2017 by the total number of patients that died/discharged in FY2017 (**NOTE**: Use total days of care from admission to death or other discharge, even if the admission is outside the reporting period).

   b. **Median Length of Stay (MLOS)** 20
   The midpoint for all died/discharged patients for FY2017 (same populations as for ALOS, above). Half of the patients have a LOS longer than the median and half of the patients have a LOS shorter than the median. Calculate the MLOS by arranging the LOS scores for all patients from lowest to highest (1, 2, 3, . .). Find the score that falls in the exact middle of the list. This is the median length of stay.

   c. **Average Daily Census (ADC)** 3.25
   ADC is computed as follows: Take all patient days for the reporting period and divide by the number of days in that period.

   d. **Total Number of Deaths** 29
   Must agree with the total number of deaths in sections D, E, and I.

   Number of Patients Who Died in ≤ 7 days (stays of 7 days or fewer) 6
   {Include the number of deaths for patients who died for the reporting period with stays of 7 days or fewer.}

   Number of Patients Who Died in ≥180 days (stays of 180 days or more) 2
   {Include the number of deaths for all patients who died for the reporting period with stays of 180 or more consecutive days.}

SECTION C Patient Volume (continued)

2. LEVEL OF CARE AND PAY SOURCE:

- Include all patients who received services in FY2017. Do not 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	1	1				1
Private Insurance	4	73				73
Self Pay *						
Other **						
Total	32	1173	0	15	0	1188

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

** 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).*

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.

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 **your hospice** for all patients who died or 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 New (Unduplicated) Admissions	Number of Deaths	Number of Live Discharges	Patient Days for Patients Who Died or Were Discharged
ICD-10-CM Codes	Categories				
A00-B99	Infectious and Parasitic Diseases	1		1	16
C00-D49	Neoplasms	6	9		271
D50-D99	Diseases of The Blood and Blood-Forming Organs	1	1		4
E00-E99	Endocrine, Nutritional and Metabolic Diseases, And Immunity Disorders	2	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	1		20
I00-I99	Diseases of The Circulatory System	8	5		176
J00-J99	Diseases of The Respiratory System	4	3	1	165
K00-K99	Diseases of The Digestive System				
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	2	2	1	155
Q00-Q99	Congenital Anomalies				
S00-T99	Injury and Poisoning, Classification of External Causes of Injury and Poisoning				
	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
1	**Nursing – Direct Clinical** 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
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**	.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, 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).	.50
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 **all** 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.**

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. *Do not include chaplains, bereavement staff, or volunteer coordinators.*	71
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	35
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 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 Caseload
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 Worker caseloads.	9
Hospice Aide	5
Chaplain - Include only those patients who receive visits in determining chaplain caseload.	9
Volunteer Coordinator - Include only those patients who are assigned a volunteer in determining volunteer coordinator caseload.	7
Medical Director - Include only those patients whom the medical director is the attending physician in determining caseload.	9

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.	Female	15
b.	Male	12
	Total	27 (Required)

2. AGE
Use patient's age on the first day of admission in FY2017

a.	< 1	
b.	1 - 4	
c.	5 - 14	
d.	15 - 20	
e.	21 - 24	
f.	25 - 34	
g.	35 - 64	2
h.	65 - 74	4
i.	75 - 84	10
j.	85 +	11
	Total	27 (Required)

3. ETHNICITY all patients should be categorized as Hispanic or non-Hispanic, and further categorized by Race below (as defined by U.S. Census Bureau)

a.	Hispanic	
b.	Non-Hispanic	27
	Total (must equal Race total)	27 (Required)

4. RACE

a.	American Indian or Alaskan Native	
b.	Asian	
c.	Black or African American	
d.	Hawaiian or Other Pacific Islander	
e.	White	27
f.	Some other race or races	
	Total (must equal Ethnicity total)	27 (Required)

NOTE: Number of Admissions must 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 **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.			
All Hospice Volunteers - Sum of (1-3) above.	6	162.25	

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 **not** 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.	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 Services Include all individuals enrolled for bereavement, including those served through support groups and camps.	29	3	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.

2018 Hospice Data Supplement Reporting for:
Good Shepherd Home Health and Hospice Agency ♣ Cherokee County

License No: **HC0318**
Facility ID: **953772**

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.

A	B	C	D	E	F	G	H	I	Sum (F-I)
County of Primary Residence	Number of New (Unduplicated) Admissions	Number of Deaths	Number of Non-Death Discharges	Number of Patients Served	Routine Home Care Days	Inpatient Care Days	Respite Care Days	Continuous Care Days	Total Days of Care
Clay	27	29	3	32	1173	0	15	0	1188
Grand Total	27	29	3	32	1173	0	15	0	1188

SECTION J Inpatient and Residential Information N/A

Completion of this entire Section is required. Please provide the following information for FY2017.

1. **Facility Name:** _____

2. **Number of Licensed Inpatient Beds:** _____
   Number of Licensed Residential Beds: _____

3. **Where is the facility located? (Select one)**
   - ☐ On campus of Freestanding Hospice
   - ☐ in Hospital
   - ☐ in Nursing Home
   - ☐ other (please specify): _____

4. **Did the facility open during FY2017?** ☐ **Yes or** ☐ **No**

   If yes, please note the date the facility was licensed: _____

   If yes, please note the date the facility was Medicare certified: _____

5. **Did the facility add beds during FY2017?** ☐ **Yes or** ☐ **No**

   If yes, please note how many beds were added: _____

   If yes, please note the date the beds were licensed: _____

6. **Did the facility convert any residential beds to inpatient beds during FY2017?** ☐ **Yes or** ☐ **No**

   If yes, please note how many beds were converted: _____

   If yes, please note the date the beds were licensed: _____

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 **and/or** 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.

   County of Primary Residence: List all inpatient and residential clients served. Report admitted patients by county of primary residence. Count each inpatient client **only** once. Count each residential client **only** once.
   Direct Admits: These are defined as patients with no prior hospice care.
   Transfers In: These are defined as existing hospice patients coming from the home, hospital, nursing facility, assisted living and independent living.
   Total Days of Care: If the patient was admitted before the reporting period, include **only** the days of care that occurred during FY2017. **Do not include respite days.**
   Total Deaths: Include **only** those deaths that occurred during FY2017.

Hospice Inpatient Facility Patients					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
Grand Total							

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.

	Staffing by Discipline	Facility FTEs	
		Inpatient	Residential
1	**Nursing – Direct Clinical** 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.*		
2	**Social Services** Include medical social services staff as defined by CMS for the cost report. Do not include bereavement counselors.		
3	**Hospice Aides**		
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.		

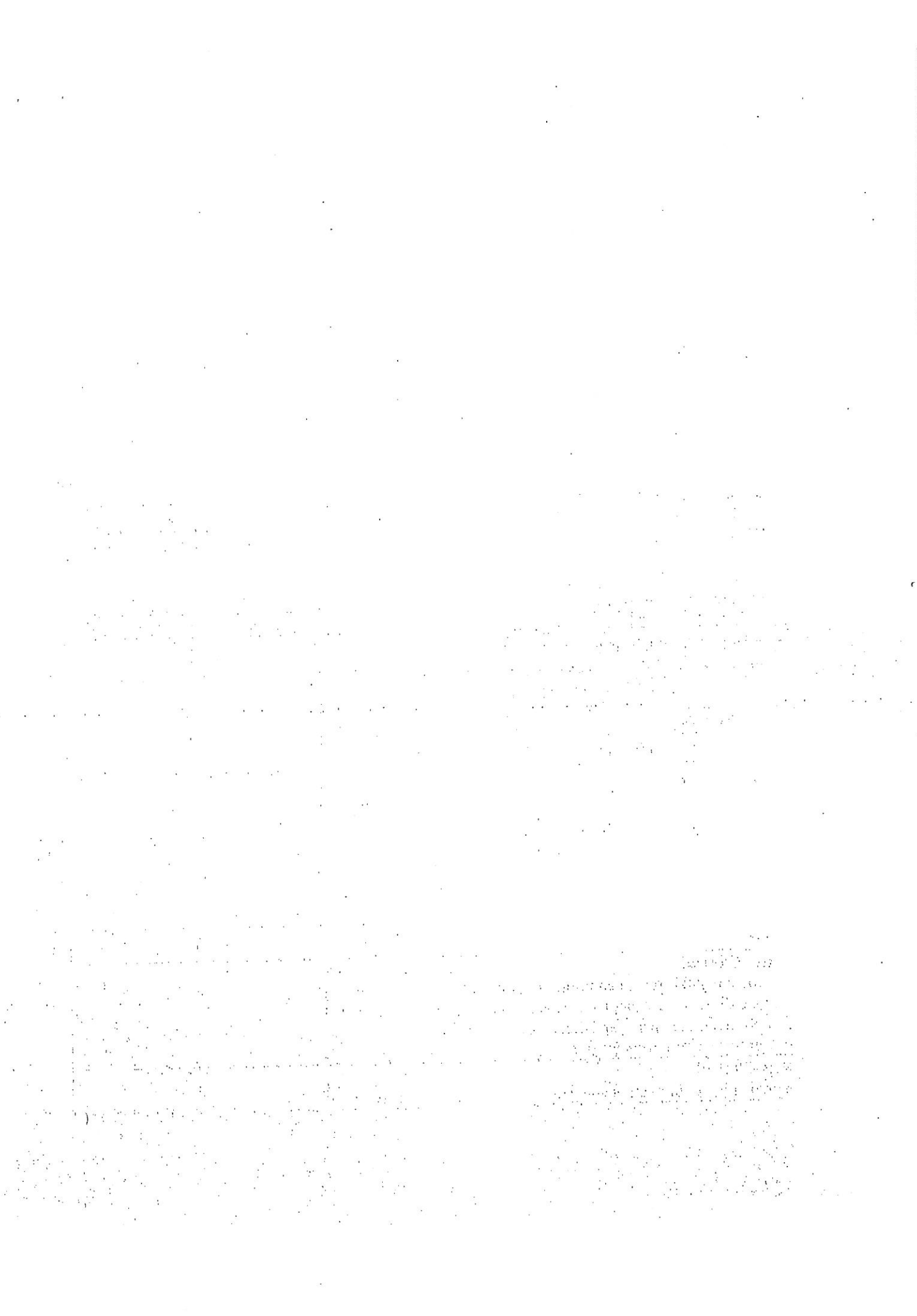

Exhibit B

State of North 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 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 -- 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 **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.

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.

***Please note*: 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

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 Official Use Only
License # HC0275
FID # 953771
PC _____ Date _____

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:

PRIMARY: **Good Shepherd Home Health and Hospice Agency**

Agency Mailing Address: (If materials are to be mailed to another address list here)
125 Medical Park Lane
Suite HMurphy, NC 28906

Agency Site Address: 6950 HWY 64 West
Brasstown, NC 28902

County: Clay
Telephone: (828)837-~~1197~~ 4260 Fax: (828)837-4860
Agency E-Mail:(Required) jyonce@murphymedical.org
Web Site :(If applicable) _____

Administrator/Director: Julie Yonce

Title: Home Care Manager

Name of the person to contact for any questions regarding this form:

Name: Teresa West **Telephone:** 828-837-1197

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, OT, ST; Hospice Home Services, and Companion, Sitter, and Respite Services

1) Under this home care license number, are you directly providing Home Medical Equipment/Durable Medical Equipment? ____ Yes ✓ No
2) Do you also have a medical equipment permit issued by the NC Board of Pharmacy? ____ Yes ✓ No

If "yes," please provide the permit number: _____

Hours:

Indicate the hours that the agency is regularly open for business each day:
[Example: 9 am – 5 pm. Use "O" if not open]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8Am-4PM	8AM-4PM	8Am-4PM	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
✓	TJC (The Joint Commission)	12/04/2018	
	DNV (Det Norske Veritas)		
	CHAP (Community Home Association Program)	- -	
	ACHC (Accreditation Commission for Health Care, Inc.)	- -	
	Other: TJC	- -	

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

Home Care Agency Applicants:

1. Are you a Medicare Certified Home Health agency? ✓ Yes ____ No If yes, what is your Medicare provider number? 347014
2. This agency is a Home Health Agency. ✓ Yes ____ No.
   If 'Yes', please check one: Parent __ Branch ✓ Sub-unit __
3. Is this agency owned or operated by a Continuing Care Retirement Center (CCRC)? ____ Yes ✓ No

Hospice Applicants:

1. If Medicare certified, what is your hospice provider number? 34-1554
2. For Medicare certified hospices do you operate more than one office under this provider number? If yes please list each license operating under this Medicare number.
   HC0275 HC0318
3. Has this site been issued a Certificate of Need to provide hospice services? ✓ Yes ____ No.
4. Do you have an agreement to operate Hospice licensed inpatient beds or hospice residential beds in another facility? If so, list facility.

Nursing Pool Applicants:

All nursing pool applicants must attach a copy of the agency's current general and professional liability and malpractice insurance policy (binder acceptable). The document must show that the applicant is insured against loss, damage, and expense related to a death or injury claim resulting from negligence or malpractice in the provision of health care by the nursing pool and its employees.

Ownership Disclosure: (Please fill in any blanks and make changes where necessary).

1. What is the name of the legal entity with ownership responsibility and liability? If this is a Corporation, complete the exact wording of the corporate name as on file with the NC Secretary of State (Corporate Office). If this is a Unit of Government, the name of the governmental unit that has the ownership responsibility and liability for services offered.

Owner: Murphy Post-Acute and Wellness, LLc
National Provider Identifier (NPI): 1588020770
Street/Box: 4130 U.S. Hwy. 64 E
City: Murphy State: NC Zip: 28906
Telephone: (828)835-7502 Fax: (___) _____
Senior Officer: James M. Stevenson

a. Legal entity is: ___ For Profit X Not For Profit
b. Legal entity is ___ Corporation X Limited Liability Company ___ Partnership
___ Proprietorship ___ Limited Liability Partnership ___ Government Unit

Corporation:

a. What is the exact wording of the corporate name on file with the NC Secretary of State?

Murphy Post-Acute and Wellness, LLC

b. In what state was the corporation originally established? NC

c. Address and Telephone number of the corporation:

4130 US Hwy 64 East
Murphy, NC 28906

d. List names and addresses of ALL officers and any other persons with a controlling interest of 5% or more.

Name	Title	Percent of Stock
James M Stevenson	President	N/A
Toni Lovingood	Secretary	N/A

(Attach additional sheets as needed)

Government Unit:

a. Name of the governmental unit that has the **ownership responsibility and liability** for the services offered:

b. Title of the official in charge of the governmental unit: _____

c. Check which best describes the type of governmental unit:

City ___ County ___ State ___ Authority ___ Health Dept ___ DSS ___

Other (Please specify): _____

Multiple Facilities:

a. Is this facility part of a multiple facility/agency system in North Carolina? ✓ Yes ___ No
(A multiple facility system is defined as two or more facilities under the same management or ownership).

b. If 'Yes' above, are medical records in a centralized location? ✓ Yes ___ No

c. If 'Yes', please specify location.

Name	Location	License #
Murphy Post-Acute and Wellness, LLC	125 Medical Park Lane, Ste H Murphy, NC 28906	AC0318

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 Post-Acute and Wellness, LLC	6950 Hwy 64 W, Brasstown, NC 28902	HC0275

(Attach additional sheets as needed)

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.

g. Is your agency managed by another entity? ✓ Yes ___ No

h. If 'Yes', please specify the name of entity. Murphy Medical Center, Inc

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.

Signature: Julie Yonce, RN-BC **Date:** 11/2/17

PRINT NAME OF APPROVING OFFICIAL Julie Yonce, RN-BC Home Care Manager

Please be advised, the license fee must accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, prior 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 Official Use Only
License # HC0275
FID # 953771
PC _____ Date _____

HOME CARE AGENCY N/A

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 completed for each site.

A. Identification:

License No: 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: 6950 HWY 64 West
Brasstown, NC 28902

County: Clay

B. Reporting Period

Data is requested for the twelve-month period beginning on July, August, September or October 1, 2016, and ending after the twelve-month period, but no later than September 30, 2017. If your agency or facility was not open for this entire twelve-month period, please specify the time period covered in this report.

Your reporting period:
Starts _____, **2016 and Ends** **September 30, 2017** *
** Change date if different from September 30*

AUTHENTICATING SIGNATURE: I certify the information submitted in this Annual Utilization Data is accurate.

Typed Name: _____ **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.
- 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

Copy and attach additional page if needed.

D. Staff N/A

- Report data in Table below.

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

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 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.
	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		
Nurse Director or Supervisors		
Other Administrative Staff		
Nursing (RN, LPN)		
Occupational Therapist		
Physical Therapist		
Speech Therapist		
Social Worker		
In -Home Aide		
Companion, Sitter, Respite Staff		
Respiratory Therapist		
Respiratory Practitioner		
Other (Specify)		

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 # HC0275
FID # 953771
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

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~~ 4200

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:**

_____

CONTACT NAME: Name of the person to contact for any questions regarding this form.

Print Name: Teresa West **Telephone:** 828-837-1197

E-Mail: twest@murphymedical.org **Fax:** 828-837-9503

CEO/DIRECTOR SIGNATURE: I certify the information submitted herewith in this data supplement is accurate.

Print Name: Julie Vance, RN-BC **Title:** Home Care Manager

Signature: Julie Vance RN BC **Date:** 11/21/17

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.**

Number of Home Health Clients by Age by County of Residence

County of Residence	Number of Unduplicated Clients								Total Visits by County
	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total Number of Clients	
Cherokee	2	5	57	43	143	137	78	465	7736
Graham		5	11	4	11	13	1	45	797
Macon			1		1	2		4	45
								514	8578

Copy and attach additional page(s) as needed.

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	Number of Unduplicated Clients							
	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total

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 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). 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	1	6
Specify any other below*:		
	514	8578

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

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:

From 10/2016 **To** 09/2017
Month/Year **Month/Year**

a.	**Number of Medicare Episodes**	=	444
b.	**Average Number of Medicare episodes per beneficiary**	=	1.25
c.	**Average Number of Medicare Visits per Episode (all disciplines)**	=	13.22
d.	**For Medicare – the Percent of Lupus**	=	.09

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 = 20/40 = 1/2 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.

Home Health Services Reporting

SECTION E Staff - Home Health (continued)

2017 Home Health Staffing Data (Table E)

Staff Discipline	Total Staff	FTES	Total Clients	Total Visits	Average Cost Per Visit
Administrator	1.0	.50			
Nurse Director/Supervisors	1.0	.50			
Other Administrative Staff	1.0	1.0			
Nursing (RN, LPN)	8.0	7.59	584	3484	129.42
Occupational Therapy	2.0	2.15	173	1120	118.82
Physical Therapy	4.0	4.87	399	3402	118.82
Speech Therapy	.75	.10	16	44	118.82
Social Worker	.25	.25	21	22	170.52
Home Health Aide	1.50	1.64	58	506	31.28
Nutrition					
Totals	19.50	18.60	1251	8578	

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).

Total Staff: 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).

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 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
OVERVIEW

HC0275

There are a total of twelve sections in this data supplement form on 14 pages. Please answer **all** 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 **not** 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

For Official Use Only
License # HC0275
FID #: 953771
PC _____ Date _____

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

Please read all directions for each section carefully.

SECTION A Identification and Contact Information

License No:	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 #:	(828)837-~~1197~~ 4260
Agency Fax #:	(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:**

_____

CONTACT NAME: Name of the person to contact for any questions regarding this form.

Print Name: Teresa West **Telephone:** 828-837-1197

E-Mail: twest@murphymedical.org **Fax:** 828-837-9503

CEO/DIRECTOR SIGNATURE: I certify the information submitted herewith in this data supplement is accurate.

Print Name: Julie Yonce, RN-BC **Title:** Home Care Manager

Signature: Julie Yonce RN BC **Date:** 11/21/17

SECTION B Program Demographics

1. **AGENCY TYPE (Select one based on Medicare Cost Report Status)**
   - ☑ Freestanding
   - ☐ Hospital Based
   - ☐ Home Health Based (dually certified)
   - ☐ Nursing Home Based

2. **CENSUS ON 9/30/2017:** 7 **(Only this license number)**
   (If zero, explanation required) _____

3. **MEDICARE CERTIFICATION**
   Is this facility Medicare certified? ☑ Yes or ☐ No **(Required)**
   Medicare Provider Number: 34 -- 1554 (Example Medicare Provider Number: 34-5113)

4. **ACCREDITATION STATUS**
   Accredited by:
   - ☐ ACHC ☐ DNV
   - ☐ CHAP ☐ Other
   - ☑ TJC ☐ Not accredited

5. **TAX STATUS (Select one)**
   - ☑ Voluntary (not for profit)
   - ☐ Proprietary (for profit)
   - ☐ Government

SECTION C Patient Volume

1. **AVERAGE DAILY CENSUS AND LENGTH OF STAY:** Please review the definitions carefully before completing the following questions. (**NOTE**: For FY2017 count multiple admissions and discharges for the same patient as discrete events).
   - a. **Average Length of Stay (ALOS)** 49
     Divide the total days of care provided to died/discharged patients for FY2017 by the total number of patients that died/discharged in FY2017 (**NOTE**: Use total days of care from admission to death or other discharge, even if the admission is outside the reporting period).
   - b. **Median Length of Stay (MLOS)** 18
     The midpoint for all died/discharged patients for FY2017 (same populations as for ALOS, above). Half of the patients have a LOS longer than the median and half of the patients have a LOS shorter than the median. Calculate the MLOS by arranging the LOS scores for all patients from lowest to highest (1, 2, 3, . . .). Find the score that falls in the exact middle of the list. This is the median length of stay.
   - c. **Average Daily Census (ADC)** 10.24
     ADC is computed as follows: Take all patient days for the reporting period and divide by the number of days in that period.
   - d. **Total Number of Deaths** 61
     Must agree with the total number of deaths in sections D, E, and I.

     Number of Patients Who Died in ≤ 7 days (stays of 7 days or fewer) 17
     {Include the number of deaths for patients who died for the reporting period with stays of 7 days or fewer.}

     Number of Patients Who Died in ≥180 days (stays of 180 days or more) 5
     {Include the number of deaths for all patients who died for the reporting period with stays of 180 or more consecutive days.}

SECTION C Patient Volume (continued)

2. LEVEL OF CARE AND PAY SOURCE:

- Include all patients who received services in FY2017. Do not 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 *	1	58		3		61
Other **						
Total	74	3723		21		3744

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

** 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).*

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.

Location 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	61

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 **your hospice** for all patients who died or 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 New (Unduplicated) Admissions	Number of Deaths	Number of Live Discharges	Patient Days for Patients Who Died or Were Discharged
ICD-10-CM Codes	Categories				
A00-B99	Infectious and Parasitic Diseases	1		1	57
C00-D49	Neoplasms	29	27	4	1496
D50-D99	Diseases of The Blood and Blood-Forming Organs				
E00-E99	Endocrine, Nutritional and Metabolic Diseases, And Immunity Disorders	1	1		17
F01-F99	Mental, Behavioral and Neurodevelopmental Disorders				
G00-G99, H00-H99	Diseases of The Nervous System and Sense Organs	9	8		253
I00-I99	Diseases of The Circulatory System	15	12	1	475
J00-J99	Diseases of The Respiratory System	9	9	1	423
K00-K99	Diseases of The Digestive System	4	3	1	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		13
S00-T99	Injury and Poisoning, Classification of External Causes of Injury and Poisoning				
	All Others				
	TOTAL	69	61	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.

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
1	**Nursing – Direct Clinical** 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.	.53
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**	.31
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.	
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).	.50
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

2. VISITS BY DISCIPLINE

Please provide the following information for FY2017. Count **all** 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.**

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.	964
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. *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 include volunteers or bereavement staff.*	12

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 Caseload
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 Worker caseloads.	24
Hospice Aide	5
Chaplain - Include only those patients who receive visits in determining chaplain caseload.	24
Volunteer Coordinator - Include only those patients who are assigned a volunteer in determining volunteer coordinator caseload.	14
Medical Director - Include only those patients whom the medical director is the 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.	Female	41
b.	Male	28
	Total	69 **(Required)**

2. AGE
Use patient's age on the first day of admission in FY2017

a.	< 1	
b.	1 - 4	
c.	5 - 14	
d.	15 - 20	
e.	21 - 24	
f.	25 - 34	
g.	35 - 64	13
h.	65 - 74	17
i.	75 - 84	21
j.	85 +	18
	Total	69 **(Required)**

3. ETHNICITY all patients should be categorized as Hispanic or non-Hispanic, and further categorized by Race below (as defined by U.S. Census Bureau)

a.	Hispanic	
b.	Non-Hispanic	69
	Total (must equal Race total)	69 **(Required)**

4. RACE

a.	American Indian or Alaskan Native	1
b.	Asian	
c.	Black or African American	1
d.	Hawaiian or Other Pacific Islander	
e.	White	67
f.	Some other race or races	
	Total (must equal Ethnicity total)	69 **(Required)**

NOTE: Number of Admissions must 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 **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).	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.			
All Hospice Volunteers - Sum of (1-3) above.	9	215.09	

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 **not** 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	102	3	105
Total Number of Mailings to the Bereaved	91	3	94
Total Number of Individuals Who Received Bereavement Services Include all individuals enrolled for bereavement, including those served through support groups and camps.	68	3	71

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.

2018 Hospice Data Supplement Reporting for: License No: **HC0275**

Good Shepherd Home Health and Hospice Agency ♣ Clay County 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.

A	B	C	D	E	F	G	H	I	Sum (F-I)
County of Primary Residence	Number of New (Unduplicated) Admissions	Number of Deaths	Number of Non-Death Discharges	Number of Patients Served	Routine Home Care Days	Inpatient Care Days	Respite Care Days	Continuous Care Days	Total Days of Care
Cherokee	66	59	6	70	3656		21		3677
Graham	3	2	2	4	67		0		67
Macon	0	0	0	0	0		0		0
Grand Total	69	61	8	74	3723	0	21	0	3744

SECTION J Inpatient and Residential Information N/A

Completion of this entire Section is required. Please provide the following information for FY2017.

1. **Facility Name:** _____

2. **Number of Licensed Inpatient Beds:** _____
   Number of Licensed Residential Beds: _____

3. **Where is the facility located? (Select one)**
   - ☐ On campus of Freestanding Hospice
   - ☐ in Hospital
   - ☐ in Nursing Home
   - ☐ other (please specify): _____

4. **Did the facility open during FY2017? ☐ Yes or ☐ No**

   If yes, please note the date the facility was licensed: _____

   If yes, please note the date the facility was Medicare certified: _____

5. **Did the facility add beds during FY2017? ☐ Yes or ☐ No**

   If yes, please note how many beds were added: _____

   If yes, please note the date the beds were licensed: _____

6. **Did the facility convert any residential beds to inpatient beds during FY2017? ☐ Yes or ☐ No**

   If yes, please note how many beds were converted: _____

   If yes, please note the date the beds were licensed: _____

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 **and/or** 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.

   County of Primary Residence: List all inpatient and residential clients served. Report admitted patients by county of primary residence. Count each inpatient client **only** once. Count each residential client **only** once.
   Direct Admits: These are defined as patients with no prior hospice care.
   Transfers In: These are defined as existing hospice patients coming from the home, hospital, nursing facility, assisted living and independent living.
   Total Days of Care: If the patient was admitted before the reporting period, include **only** the days of care that occurred during FY2017. **Do not include respite days.**
   Total Deaths: Include **only** those deaths that occurred during FY2017.

Hospice Inpatient Facility Patients					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
Grand Total							

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.

	Staffing by Discipline	Facility FTEs	
		Inpatient	Residential
1	**Nursing – Direct Clinical** 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.*		
2	**Social Services** Include medical social services staff as defined by CMS for the cost report. Do not include bereavement counselors.		
3	**Hospice Aides**		
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.		

Exhibit C

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

Craig R. Smith, Project Analyst

Terri M. Muchmore

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

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

3. Agency Director

Thomas J. Taaffe

4. Geographic Area to be Served

Cherokee and Clay Counties

5. Services to be Offered

a.	Physician -	Theresa Heavner, MD, Volunteer Director
b.	Nursing -	Staff
c.	Medical Social Service -	Staff; Mary K. Thompson, MSW
d.	Counseling Service -	Rev. Frank Hamilton, Volunteer Chaplain
e.	Nutrition -	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
l.	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