ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: August 29, 2012

PROJECT ANALYST: Tanya S. Rupp
CON CHIEF: Craig R. Smith

PROJECT I.D. NUMBER: F-8826-12 / Hospice and Palliative Care of Iredell County, Inc. / Convert three hospice residential beds to three hospice inpatient beds for a total of 15 hospice inpatient beds and no hospice residential beds / Iredell County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

C

Hospice and Palliative Care of Iredell County, Inc. (**"HPCIC"**) operates a 15-bed hospice facility with 12 inpatient hospice beds and 3 residential hospice beds, located in Statesville, in Iredell County. The applicant proposes to convert its three hospice residential beds to three hospice inpatient beds, for a total of 15 hospice inpatient beds and no hospice residential beds upon completion of the project.

The 2012 State Medical Facilities Plan (SMFP) identifies a need determination for three new hospice inpatient beds in Iredell County. The applicant proposes to convert no more than three hospice residential beds to hospice inpatient beds. Thus, the application is conforming to the need determination in the 2012 SMFP.

Additionally, Policy GEN-3 of the 2012 SMFP is applicable to this review. Policy GEN-3: Basic Principles states:

> *"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the*

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

Maximize Healthcare Value

In Section III.3, pages 68 - 69, the applicant describes how the proposal maximizes healthcare value in Iredell County:

"The applicant is proposing a cost-effective approach to meet hospice inpatient needs in Iredell County. The proposed project involves conversion of existing hospice residential beds to hospice inpatient beds and highly flexible use of licensed beds. The project involves no construction or renovation. Because North Carolina Licensure guidelines permit a hospice facility to rotate designation of beds to prevent moving fragile patients, all beds were built to inpatient standards.

North Carolina licensure guidelines also permit inpatient beds to be used for both inpatient and residential care. When the facility has hospice beds licensed as residential, and the inpatient beds are being used at the licensed capacity, the facility can provide only residential care in the remaining beds. By increasing the number of flexible care beds from twelve to fifteen, the proposed project will allow HPCIC maximum care delivery flexibility.

The financial proformas in Tab 13, which is built on the utilization projected in Section IV, document that the project will be financially feasible. Increasing the number of flexible beds, in the face of current hospice inpatient demand that is sufficient to fill all fifteen GHH beds, will improve the financial viability of the entire HPCIC program. Thus, it clearly represents an effort to maximize health care value for the resources expended."

The applicant adequately demonstrates the proposed project will maximize health care value in Iredell County.

Promote Safety and Quality

In Section III.3, page 67, the applicant describes how the proposal will promote safety and quality in Iredell County:

"HPCIC is built on a strong quality/safety foundation. It was established in 1984 to make hospice care available to everyone in Iredell County and the surrounding communities. It is licensed by the State of North Carolina, certified for Medicare and Medicaid participation and accredited by an independent third party accrediting body, the Accreditation Commission for Health Care (ACHC). Each of these bodies requires programs that promote safety and quality. …

… Among the specific programs that help HPCIC promote safety and quality in the fifteen GHH beds and related services are:

- *Compliance with North Carolina Licensure and Medicare / Medicaid Conditions of Participation requirements for facility, staff and programs,*
- *Compliance with North Carolina Department of Environment and Natural Resources regulations including radiation protection,*
- *Compliance of the facility design and operation with the North Carolina Building Code, Occupational Safety and Health Administration, and Americans with Disabilities Act,*
- *Adherence to its own safety and quality policies and procedures,*
- *Hiring standards and employee credentialing review processes that assure appropriate licensure and current certification at the time of hiring and throughout the period of employment,*
- *Regular staff in-service programs provided by appropriate agency/staff, Quality assurance and performance improvement surveys for management, environment of care, administrative file, resident charting, resident care, medication record, activities, dining services, and employee files, and*
- *Regular licensing inspections."*

In Exhibit 2, the applicant provides copies of accreditation certificates. In Exhibit 16, the applicant provides a copy of HPCIC's policies and procedures with regard to safety and quality. The applicant adequately demonstrates how the proposal will promote safety and quality in the delivery of hospice services in Iredell County.

Promote Equitable Access

In Section III.3, page 68, the applicant describes how the proposal will promote equitable access to hospice services in Iredell County:

"The proposed project will make hospice inpatient services more accessible to residents in Iredell County and the surrounding communities. GHH

policies, tax-exempt status and financing structure permit it to make services available to all persons in need of hospice inpatient or residential care when beds are available. HPCIC does not discriminate on the basis of age, race, sex, religion, handicap, or ability to pay. Because of this, increasing inpatient capacity at GHH will increase access to all service area residents, including those with limited financial resources."

In Section VI.5, pages 123 – 124, the applicant describes how it will provide hospice services to those persons who are traditionally underserved or who have no means to pay for hospice services. The applicant adequately describes how the proposal will promote equitable access to hospice services in Iredell County. See also Criterion (13).

Projected Volumes Incorporate GEN-3 Concepts

The applicant adequately demonstrates the need for the proposal. The applicant demonstrates that projected volumes for the proposed hospice facility incorporate the basic principles in meeting the needs of patients to be served. See Criteria (3) and (5). Consequently, the application is consistent with Policy GEN-3. In summary, the applicant is conforming to the need determination in the 2012 SMFP and is consistent with Policy GEN-3. Therefore, the application is conforming to this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

C

Hospice and Palliative Care of Iredell County, Inc. (**"HPCIC"**) is a community-based, non-profit organization which provides palliative care to persons with terminal or life-threatening illnesses. HPCIC was established in Iredell County in 1984, and has provided hospice services to patients since then. In 2005, HPCIC established the Gordon Hospice House (**"GHH"**), a 15-bed hospice facility with 12 inpatient hospice beds and three residential hospice beds, to provide residential and inpatient hospice services to those patients whose care needs could not be met in the home. In this application, HPCIC proposes to convert three residential hospice beds to three inpatient hospice beds, for a total of 15 inpatient hospice beds and no residential hospice beds in the facility upon project completion.

Population to be Served

In Section III.12, page 75, the applicant projects that 87.8.0% of its population, or approximately 468 patients will reside in Iredell County; approximately 6.4%, or 34 of its patients will reside in Alexander and Davie Counties, and the remaining patients will reside in various counties, as shown in the table below from page 75:

COUNTY	# INPATIENTS	% INPATIENTS	# RESIDENTIAL PATIENTS	% RESIDENTIAL PATIENTS
Iredell	422	87.8%	46	88.3%
Alexander	11	2.2%	3	5.0%
Davie	18	3.7%	2	3.3%
Catawba	2	0.5%	1	1.7%
Rowan	8	1.7%	0	0.0%
Wilkes	8	1.7%	0	0.0%
Mecklenburg	6	1.2%	0	0.0%
Yadkin	5	1.0%	1	1.7%
Total	**481**	**100.0%**	**52**	**100.0%**

In Section III.13, page 76, the applicant states the projected population to be served is based on historical patient origin at the existing Gordon Hospice House for the most recent eight months prior to submission of this application, as shown in Section III.11, page 75. Furthermore, no change in patient origin is projected. The applicant adequately identified the population projected to be served.

Demonstration of Need

In Section III.1(a), page 42, the applicant states the 2012 SMFP indicates a need in Iredell County for three hospice inpatient beds, pursuant to an adjusted need determination petition submitted by HPCIC. The applicant states:

> *"It should be noted that the need in the 2012 SMFP was included in response to a special need petition filed by HPCIC. The petition was endorsed by community members and supported a track record of waiting lists and multiple days when the facility was occupied by 15 patients who qualified for General Inpatient level of care.*

In Section III.1(a), pages 42 – 44, the applicant provides data from the North Carolina Office of State Budget and Management (OSBM) to compare projected population growth in Iredell County and North Carolina, as shown in the following table:

Projected General Population Growth 2012 - 2015

AREA	2012	2013	2014	2015	2012 – 2015 CAGR	2012 – 2015 % CHANGE
Iredell County	165,460	168,136	170,813	173,489	1.59%	4.85%
Alexander Co.	37,644	37,807	37,956	38,088	0.39%	1.18%
North Carolina	9,886,725	10,035,382	10,184,132	10,331,630	1.48%	4.50%

Also on page 44, the applicant provides a table that illustrates projected population growth of the over 65 age group in Iredell County and North Carolina, as shown in the following table:

Projected Population Growth Over 65 Age Group, 2012 - 2015

AREA	2012	2013	2014	2015	2012 – 2015 CAGR	2012 – 2015 % CHANGE
Iredell County	22,416	23,442	24,332	25,221	4.01%	12.51%
Alexander Co.	6,178	6,450	6,672	6,886	3.68%	11.46%
North Carolina	1,356,133	1,416,175	1,471,500	1,525,643	4.00%	12.50%

The data shows that the general population in Iredell County is projected to increase by 4.85% from 2012 to 2015; and the over age 65 age group is projected to increase by 12.51%.

In addition, utilizing data from the Carolinas Center for Hospice and End of Life Care, the applicant shows on page 45 that the percent of hospice patients, ages 0 – 64 in North Carolina in 2010 was 18.2%. By contrast, the percentage of hospice patients over the age of 65 in North Carolina in 2010 was 81.8%. Thus, the percent of hospice patients over the age of 65 in North Carolina in 2010 was in excess of four times the percent of those patients under the age of 65. Furthermore, on pages 47 – 48, the applicant provides statistics from the Central Cancer Registry that shows the number of cancer patients in Iredell County increased by a Compound Annual Growth Rate (CAGR) of 5.9% from 2006 to 2011.

In Section III.1, pages 53 – 60, the applicant provides a ten-step methodology to demonstrate HPCIC's need for the three additional hospice inpatient beds. The methodology, which is similar to the methodology utilized in the 2012 SMFP to determine the need for hospice inpatient beds, is summarized below:

Step One

On page 54, the applicant states the first step in projecting utilization of the proposed hospice inpatient beds is to determine the Iredell County historical unduplicated hospice admissions rate for 2008 – 2011 and develop a *"trailing average,"* similar to the methodology used in the SMFP.

Step Two

Utilizing the trailing average from the 2012 SMFP methodology for hospice inpatient projections, which is 4.4%, the applicant projects unduplicated inpatient admission data for Iredell County hospice admissions through 2015, the third project year for the proposed project. On page 54, the applicant states use of the SMFP trailing average is conservative, since the actual average annual growth rate in Iredell County for inpatient hospice admissions for 2008 to 2011 was 10.9%.

Step Three

On page 55, utilizing data contained in the Iredell Hospice License Renewal Applications, the applicant determines the historical Iredell County hospice average length of stay (ALOS) per unduplicated admission, by dividing the number of actual days of care by the number of unduplicated admissions. See the following table, from page 55:

	2008	2009	2010	2011	TWO YEAR TRAILING AVERAGE GROWTH RATE
Admissions	605	649	674	795	
Days of Care	38,158	42,051	47,404	48,628	
ALOS	63.1	64.8	70.3	61.2	-2.2%

Step Four

In Step Four, the applicant projects Iredell County's hospice ALOS per unduplicated admission through the third project year, 2015. The applicant states:

> *"The 2012 SMFP identifies the statewide median hospice ALOS per admission as 80.45. As shown* [above], *the 2011 Iredell County hospice ALOS per admission is 61.2, a decline from prior years. Conservatively, the applicant projects that the Iredell County hospice ALOS per admission will stay constant through 2015 at the 2011 Iredell County level."*

It is worth noting that use of the 61.2 ALOS is lower than the average for the years utilized by the applicant in its calculations (2008 – 2011) [(63.1 + 64.8 + 70.3 + 61.2) / 4 = 64.85]. Therefore, the applicant's use of 61.2 for future projections is reasonable.

Step Five

Therefore, in Step Five, the applicant applies the ALOS from 2011 to the annual admissions, calculated in Step 2, to determine the Iredell County hospice days of care. See the following table, from page 56 of the application:

	2012	2013	2014	2015
Iredell County Resident Days of Care	50,769	53,032	55,356	57,803

The project analyst performed the same calculations and arrived at slightly different totals than are represented in the table; however the difference is likely the result of rounding. The analyst will use the totals arrived at by the applicant.

Step Six

On page 56, the applicant determines Iredell County's historical hospice inpatient days of care as a percent of total days of care (DOC), for the years 2008 through 2011, as illustrated in the following table:

	2008	2009	2010	2011
Total Hospice IP DOC Demanded	NA	3,262	3,560	3,898
Hospice Home Care DOC Plus Wait List	NA	42 942	48 334	49,610
Hospice IP DOC as Percent of Hospice DOC	NA	7.6%	7.4%	7.9%

The applicant states:

> *"Hospice inpatient days at GHH have been and continue to be constrained by capacity, even after opening three more beds in October 2011. In 2012 fiscal year to date through March, the days of general inpatient (GIP) patients in residential beds annualizes to demand for 185 more inpatient days."*

Step Seven

In Step seven, the applicant projects Iredell County hospice inpatient days of care as a percent of hospice days of care, based on historical data. The applicant assumes the percentage will remain at the level it was in FY 2010, at 7.4%. The applicant states:

> *"The 2012 SMFP assumes that hospice inpatient days of care will equal six percent of hospice days of care. The state average is constrained by lack of inpatient beds in many counties. As recently as the 2009 SMFP, hospice inpatient days of care were estimated to be 8.0 percent of hospice days of care, for all counties. Using the lowest of the last three years to project the future for Iredell County is conservative.*
>
> *As demonstrated in Step 6, Iredell County's demand for hospice inpatient days of care as a percentage of hospice days of care was 7.9 percent in 2011 and 7.4 percent in 2010."*

Step Eight

On page 59, the applicant determines HPCIC's inpatient days of care through 2015 by multiplying hospice days of care by the projected hospice inpatient days of care percentage. See the following table,

FISCAL YEAR	2012	2013	2014	2015
Iredell IP Days of Care	3,739	3,906	4,077	4,257

Step Nine

In this step, the applicant assumes an 85% target occupancy for HPCIC's hospice inpatient beds pursuant to the 2012 SMFP Hospice Inpatient Methodology. The applicant divides the total hospice inpatient days of care, from Step 8, by 365 (days per year), and by 85 percent (SMFP target occupancy). See the following table:

FISCAL YEAR	2012	2013	2014	2015
IP bed need, Iredell County Residents	12.1	12.6	13.1	13.7

Step Ten

The applicant states, on page 60, that it determines the number of hospice inpatient beds needed in Iredell County by dividing the total number of beds needed (step 8) by 84.6% (HPCIC historical Iredell County GHH residents).

FISCAL YEAR	2012	2013	2014	2015
IP bed need, Iredell County	14.2	14.9	15.6	16.2

Thus, the applicant projects a hospice inpatient bed need through the third project year. As stated in Section III.13, the applicant projects to serve Alexander County residents, consistent with its historical utilization. Therefore, the applicant states the number of beds projected, when considered with HPCIC's historical utilization, will be sufficient to serve hospice inpatient needs for both Iredell and Alexander County patients, as served.

On pages 60 – 61 the applicant assumes:

> *"According to data from 2012 Hospice Renewal applications, GHH provided 87 percent of the hospice inpatient days of care used by Alexander County residents. Alexander County used 341 total inpatient days. If Alexander County demand increased only in proportion to its total population increase, residents of Alexander County would need more than one hospice inpatient bed in Iredell County. The 2012 SMFP estimates that Alexander County will need three inpatient beds by 2015 (2012 SMFP page 350). Alexander County has no hospice inpatient beds.*
>
> …
>
> *By these estimates, Alexander County and Iredell County together will need 15 hospice inpatient beds by 2015. The Alexander County need is actually included in the out of area estimates ….*
>
> *Demand from residents of the other four counties adjacent to Iredell that have no hospice inpatient beds: Wilkes, Davie, Yadkin and Lincoln will represent the balance of the need for inpatient beds in Iredell County. Davie, Alexander and Yadkin Counties are very small and will have difficulty supporting inpatient beds. Residents of these counties are close to Iredell."*

The applicant's methodology with regard to the utilization projections is based on historical utilization at the GHH, population growth estimates in Iredell and Alexander Counties, and hospice utilization information from the Carolinas Center for Hospice and End of Life Care. Therefore, the applicant's projections are reasonable.

In addition, the performance standards set forth at 10A NCAC 14C .4003 require that an applicant proposing to develop hospice inpatient or hospice residential beds demonstrate:

> *"the average occupancy rate of the licensed hospice beds, for each level of care, in the facility is projected to be at least 50 percent for the last six months of the first operating year following completion of the project;*
>
> *the average occupancy rate for the licensed hospice beds, for each level of care, in the facility is projected to be at least 65 percent for the second operating year following completion of the project…."*

The project analyst reviewed the *Hospice Days of Care by Level of Care* tables in the *Hospice Data* and *Trends,* published by The Carolinas Center for Hospice and End of Life Care, for fiscal years 2007 through 2010, for Hospice and Palliative Care of Iredell County, Inc. See the following table prepared by the project analyst:

FISCAL YEAR	INPATIENT CARE DAYS	TOTAL DAYS OF CARE	AVERAGE INPATIENT DAILY CENSUS	# LICENSED HOSPICE INPATIENT BEDS
2007*	2,368	39,481	6.5	3
2008*	2,942	39,340	8.1	3
2009*	3,672	38,857	10.1	9
2010*	4,022	42,387	11.0	9
2011^	4,109	43,042	11.3	12♦

*Source: *Hospice Data and Trends, Fiscal Years 2007, 2008, 2009, 2010; State Medical Facilities Plans for fiscal years 2010, 2009, 2008, 2007.*
^Source: 2012 License Renewal Application
♦The number of licensed hospice inpatient beds increased from 9 to 12 on October 1, 2011.

The data shows the inpatient days of care and average daily census for Hospice and Palliative Care of Iredell County, Inc. has continued to increase since 2007. The Compound Annual Growth Rate (CAGR) for inpatient care days is 14.7%, and the average daily census for inpatient care has nearly doubled in four years, from 6.5 to 11.3.

The latest statistics available from the North Carolina State Office of Budget and Management project that the population of Iredell County will grow by 4.35% from July 2011 to July 2015. In addition, that same data base projects the population age 65+ to grow by 12.9% during the same time. Moreover, in Section III.1, pages 46 – 50, the applicant provides data to show the incidence in Iredell County of those diseases that would require a patient to seek hospice or palliative care is projected to increase as well. Furthermore, the applicant applied for and was granted an adjusted need determination in the 2012 SMFP for three additional hospice inpatient beds in Iredell County.

In summary, the applicant's projected utilization for hospice inpatient beds is reasonable, based on the assumptions and methodology stated in Sections III and IV of the application. The applicant adequately identifies the population to be served and adequately demonstrates the need the population has for the proposed services at the hospice facility. Furthermore,

the applicant's current occupancy, with an average daily census of 11.3 and 15 proposed inpatient beds will exceed the performance standard of 65% utilization required for the second year of operation, pursuant to 10A NCAC 14C .4003 [11.3 / 15 beds = 0.753]. Therefore, even if the inpatient hospice population was not projected to grow beyond its current number, the applicant would satisfy the performance standards required for the second year of occupancy following project completion. Consequently, the application is conforming to this criterion.

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

C

HPCIC operates a 15-bed hospice facility with 12 inpatient hospice beds and 3 residential hospice beds located in Statesville. The applicant proposes to convert three hospice residential beds to three hospice inpatient beds, for a total of 15 hospice inpatient beds and no hospice residential beds upon completion of the project. Therefore, the applicant proposes to reduce the number of hospice residential beds from 3 beds to 0 beds upon completion of the project. In Section III.1, page 52, the applicant states:

> *"GHH is able to provide hospice inpatient level care in beds licensed as "hospice residential" because all of its beds meet inpatient construction standards and are staffed to inpatient levels. However, because three beds are licensed as residential, HPCIC is only reimbursed at the residential rate for general inpatients in excess of 12 in the facility at any given time. HPCIC loses money when this occurs. As long as it can, HPCIC will continue to provide needed inpatient care, at residential payment rates, because of its commitment to the community. However, this pattern is not sustainable.* ***HPCIC*** *needs these residential beds licensed as "hospice inpatient," so that it can be reimbursed properly for the care it is providing.*
>
> *After converting the remaining three hospice residential beds to hospice inpatient beds, GHH will continue to support patients needing hospice residential care. At project completion, GHH will have fifteen hospice inpatient beds and no designated hospice residential beds. Inpatient hospice beds licensed as inpatient, either inpatient or residential care can be accommodated. Therefore, any patients who change to residential care status can receive residential care in any of the fifteen beds at GHH. This provides GHH with maximum care delivery flexibility."*

In Section III.6, page 71, the applicant states:

> *"GHH will have no licensed residential beds at completion of the project. Many residential days are the result of patients admitted as inpatients that temporarily*

improve and do not meet all of the Medicare or Medicaid clinical guidelines for inpatient hospice care. Yet, they are too unstable to move or discharge. Most stay at the residential level only a short time before again returning to inpatient status. GHH can use beds licensed for inpatient care for patients who need only residential level care. …

In addition, in Section III.7, page 72, the applicant states:

"The proposed project will not "eliminate" hospice residential services. The project will change the license designation by permitting GUI to convert three existing hospice residential beds to hospice inpatient beds, reducing the total number of licensed residential beds from three to zero.

However, when hospice beds are licensed as inpatient, both inpatient and residential care can be provided. Therefore, any patients needing hospice residential care can receive residential care in any of the fifteen beds at GHH. A person may remain in the same bed and be reimbursed at different levels of care. Because GHH is small, staffing does not change when patient designation changes."

In Section IV.1, page 78, the applicant provides a table showing that the historical utilization of HPCIC's three existing hospice residential beds has been declining for the most recent eight months prior to submission of the application. See the following table:

Residential Hospice Patients

MONTH	# PATIENTS	PATIENT DAYS OF CARE	# LICENSED BEDS	OCCUPANCY RATE
March 2012	3	26	3	28.0%
February 2012	6	33	3	37.9%
January 2012	6	39	3	41.9%
December 2011	5	28	3	30.1%
November 2011	7	66	3	73.3%
October 2011	12	99	3	106.5%
September 2011	14	158	6	87.8%
August 2011	29	71	6	38.2%
July 2011	34	130	6	69.9%
Total	**116**	**650**	**36**	**59.0%**
Average	**12.9**	**72.2**	**4**	**59.1%**

The applicant states:

"From March 22, 2011 to October 1, 2011, GHH operated with nine inpatient beds. During this time, GHH was licensed for nine inpatient beds and six residential beds. GHH opened six residential hospice beds on March 22, 2011. On October 1, 2011, GHH converted three residential beds to inpatient beds."

Although the number of residential care beds is being reduced, the data shows utilization of hospice residential care beds in Iredell County continues to decline. In addition, the

applicant documents that hospice residential patients can and will be served in hospice inpatient beds when necessary.

In summary, the applicant adequately demonstrates that the needs of the residential hospice care population will be met by Gordon Hospice House and area nursing homes. The reduction in the number of hospice residential care beds in GHH will not adversely affect access by medically underserved groups in Iredell County. See Criteria (3) and (13). The application is conforming to this criterion.

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

C

Hospice and Palliative Care of Iredell County, Inc., d/b/a Gordon Hospice House is currently licensed for 12 hospice inpatient beds and three hospice residential beds. The applicant proposes to convert its three hospice residential beds to three hospice inpatient beds, for a total of 15 hospice inpatient beds and no hospice residential beds upon completion of the project. The applicant states in Section III.14, pages 76 – 77, that it considered three alternatives in addition to the one represented in this application, which included: 1) Maintaining the status quo; 2) Developing three new hospice inpatient beds; and 3) Pursuing a joint venture with another hospice provider. The applicant adequately explains why it chose to convert its three hospice residential beds, rather than one of the other alternatives. Furthermore, the application is conforming to all other applicable statutory review criteria. See Criteria (1), (3), (3a), (5), (6), (7), (8), (12), (13), (14), (18a) and (20) for additional discussion. Therefore, the applicant adequately demonstrates that the selected proposal represented in its application is its least costly or most effective alternative to meet the identified need for hospice inpatient beds in Iredell County. Consequently, the application is conforming to this criterion and is approved subject to the following conditions:

1. **Hospice & Palliative Care of Iredell County, Inc. shall materially comply with all representations made in its certificate of need application.**

2. **Hospice & Palliative Care of Iredell County, Inc. shall convert three hospice residential beds to three hospice inpatient beds and shall be licensed for a total of 15 hospice inpatient beds and no hospice residential beds upon completion of this project.**

3. **Hospice & Palliative Care of Iredell County, Inc. shall acknowledge acceptance of and compliance with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

C

In Section VIII.1, page 143, the applicant projects that the total capital cost of the project will be $75,000; including $50,000 for consultant fees (Certificate of Need application) and $25,000 for contingency fees. In Section VIII.5, page 144; and Section VII.9, page 145, the applicant states the entire capital cost will be funded with the accumulated reserves of Hospice and Palliative Care of Iredell County, Inc. In Exhibit 25 the applicant provides a May 2, 2012 letter signed by Terri Phillips, President/CEO of Hospice and Palliative Care of Iredell County, Inc. that states:

> "*This letter is to confirm that cash reserves of Hospice and Palliative Care of Iredell County, Inc will be available to finance the fixed and working capital requirements of Hospice and Palliative Care of Iredell County, Inc. for the above referenced CON application, as necessary. As President/CEO, I have the authority to obligate up to $75,000 of Hospice and Palliative Care of Iredell County, Inc. cash reserves for the project. Please see the line item 'Cash' on the 2011 audited balance sheet for Hospice and Palliative Care of Iredell County, Inc. The amount of $75,000 is more than sufficient to cover the fixed and working capital requirements of Hospice and Palliative Care of Iredell County, Inc. and these funds are not committed to any other use*."

In Exhibit 26, the applicant provides the audited financial statements of Hospice and Palliative Care of Iredell County, Inc. for fiscal years ending September 30, 2010 and September 30, 2011. Those statements show that, as of September 30, 2011, HPCIC had $11,994,167 in total current assets, and $1,456,359 in cash and cash equivalents. Those statements also show that the applicant had total net assets (total assets less total liabilities) in the amount of $11,186,114.

In the pro forma statements of Operating Results and Retained Earnings, Form B, on pages 175 - 177; and the pro forma statements of Operating Expenses, Form C, on pages 179 – 187, the applicant projects that revenue will exceed expenses in the second and third operating years, as shown in the table below, prepared by the project analyst.

	PY 1 (FY 2013)	**PY2 (FY 2014)**	**PY 3 (FY 2015)**
Revenue	$2,983,663	$3,121,221	$3,267,204
Expenses	$3,031,660	$3,109,527	$3,190,135
Profit (loss)	($47,997)	$11,694	$77,069

In Section X.3, page 154, the applicant projects the following reimbursement rates and charges for the first three years of operation of the proposed hospice facility.

SOURCE OF PAYMENT BY TYPE OF CARE	**10/01/2012 – 09/30/2013**	**10/01/2013 – 09/30/2014**	**10/01/2014 – 09/30/2015**
Hospice Inpatient			
Private Pay	$607.30	$607.30	$607.30
Commercial Insurance	$780.00	$780.00	$780.00

Medicare	$619.51	$625.70	$631.95
Medicaid	$619.51	$625.70	$631.95
Respite Care (Medicare)	$153.36	$154.90	$156.44
Hospice Residential Care (Room & Board)			
Private Pay	$100.00	$100.00	$100.00
Commercial Insurance	$100.00	$100.00	$100.00
Hospice Home Care Rate (Medicare)	$138.50	$139.88	$141.28

In Section X.4, page 154, the applicant states:

> "*To remain conservative, HPCIC assumes no increase in per diem reimbursement rates for commercial insurance and self pay for the first three years of the project*."

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

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

C

Hospice and Palliative Care of Iredell County, Inc. currently operates Gordon Hospice House, a 15-bed hospice inpatient and residential care facility with 12 hospice inpatient beds and three hospice residential care beds. In this application HPCIC proposes to convert the three hospice residential care beds to three hospice inpatient hospice beds, for a total bed complement of 15 hospice inpatient beds upon project completion. The applicant applied for and was granted an adjusted need determination in the 2012 SMFP for the three hospice inpatient beds. The application is conforming to the three-bed need determination in the 2012 State Medical Facilities Plan. The applicant adequately demonstrates the need for the three additional hospice inpatient beds.

For the past twelve months, the applicant's average occupancy rate for the existing hospice inpatient beds was 93% [(4,109 inpatient care days / 365 days per year) / 12 inpatient beds = 0.9381]. The applicant reasonably projects that its occupancy will exceed 65% occupancy in the second operating year, the minimum required by the performance standards in 10A NCAC 14C .4003(a)(2). In fact, the applicant adequately demonstrates that its current occupancy exceeds the 65% occupancy rate that an applicant is required to project by the second operating year of a project, since its most recent occupancy was 93%. Moreover, if the applicant's current hospice inpatient bed complement were 15 beds, its occupancy would exceed the 65% minimum [(4,109 patient days / 365 days) / 15 beds = 0.75). In addition, of the eight counties that are roughly contiguous to Iredell (Wilkes, Yadkin, Davie, Rowan, Mecklenburg, Lincoln, and Catawba); only two currently have hospice inpatient facilities

(Catawba and Mecklenburg). Therefore, the applicant adequately demonstrates that the proposed project will not result in the unnecessary duplication of existing or approved hospice services in Iredell County, and the application is conforming to this criterion.

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

C

In Section VII, Table VII.1, on pages 131 – 132, the applicant provides proposed staffing for the facility in the second year following completion of the project. See the following table:

	HOSPICE INPATIENT	HOSPICE RESIDENTIAL	TOTAL FACILITY
Routine Services			
Registered Nurse	8.64	2.16	
LPNs	0.40	0.10	
CNAs (Aides)	9.20	2.30	
Other	0.80	0.20	
Dietary			
Cook	1.60	0.40	
Social Work Services			
Social Worker	1.00	0.25	
Housekeeping, Administrative Services			
Housekeepers	1.10	0.30	
Secretary	1.44	0.36	
Other (GHH Manager)	0.80	0.20	
Other (Chaplain)	0.32	0.08	
Total Positions	26.33	6.58	**32.91**

In Section VII.3, page 130, the applicant states:

> *"Total and projected FTEs are the same as total existing FTEs. Because GHH currently staffs all beds at inpatient levels, no new staff is projected at this time. To estimate FTEs by bed type, FTEs are allocated based on projected patient days."*

Thus, the applicant proposes no additional staffing as a result of the proposed project. In Section VII.5, page 137, the applicant projects the number of direct care staff. In Section VII.7, page 139, the applicant projects to provide 8.4 nursing hours per patient day (NHPPD) for inpatient services [36,628 nursing hours for inpatient beds / 4,366 hospice inpatient days of care = 8.38 NHPPD]. The applicant adequately demonstrates the availability of resources, including health manpower and management personnel, for the provision of the proposed hospice services. Therefore, the application is conforming to this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and

support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section II, pages 28 - 30, the applicant states that HPCIC currently provides all the necessary ancillary services, including nursing services, social work services, bereavement and counseling services, physician services, and pharmaceutical services. Exhibits 6 and 7 contain letters from existing area health care providers expressing their support for the project and their intention to continue working with and providing referral services to HPCIC. In Section V.2, page 116, the applicant states that HPCIC currently has transfer agreements with area healthcare providers, including Catawba Valley Medical Center, David Regional Medical Center, Iredell Memorial Hospital and Lake Norman Regional Medical Center. The applicant also states it has current transfer agreements with area skilled nursing facilities and assisted living facilities. The applicant states it projects the transfer agreements to continue following completion of this project. In Section V.3(c), page `117, the applicant states Dr. Charlotte Evans currently serves as Medical Director for the GHH and will continue in that role following project completion. In Exhibit 20 the applicant provides a May 2, 2012 letter signed by Dr. Evans expressing her intention to continue as the Medical Director for HPCIC and GHH. The applicant adequately demonstrates that necessary ancillary and support services will be available and that the proposed services will be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers: (i) would be available under a contract of at least 5 years duration; (ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO; (iii) would cost no more than if the services were provided by the HMO; and (iv)would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

NA

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

In Section VI.3, page 121, the applicant provides the historical payor mix during FY2011 for the existing HPCIC GHH facility, as shown in the table below.

PAYOR CATEGORY	HOSPICE INPATIENTS	HOSPICE INPATIENT DAYS OF CARE
Medicare	86.69%	86.07%
Medicaid	4.82%	7.20%
Commercial	6.23%	5.54%
Private Pay / Indigent	2.27%	1.18%
Total	**100.0%**	**100.0%**

The Division of Medical Assistance (DMA) maintains a website which offers information regarding the number of persons eligible for Medicaid assistance and estimates of the percentage of uninsured for each county in North Carolina. The following table illustrates those percentages as of June 2010 and CY2008-2009, respectively. The data in the table was obtained on August 14, 2012. More current data, particularly with regard to the estimated uninsured percentages, was not available.

	TOTAL # OF MEDICAID ELIGIBLES AS % OF TOTAL POPULATION	TOTAL # OF MEDICAID ELIGIBLES AGE 21 AND OLDER AS % OF TOTAL POPULATION	% UNINSURED CY 2008-2009 (ESTIMATE BY CECIL G. SHEPS CENTER)
Iredell	14.0%	5.5%	18.3%
Statewide	17.0%	6.7%	19.7%

The majority of Medicaid eligibles are children under the age of 21. This age group does not utilize the same health services at the same rate as older segments of the population, particularly the hospice services offered by the applicant.

The Office of State Budget & Management (OSBM) maintains a website which provides historical and projected population data for each county in North Carolina. In addition, data is available by age, race or gender. However, a direct comparison to the applicants' current payer mix would be of little value. The population data by age, race or gender does not include information on the number of elderly, minorities or women utilizing health services. Furthermore, OSBM's website does not include information on the number of handicapped persons.

Annual data provided by the Carolinas Center for Hospice and End of Life Care (CCH) reports the following payer mix for hospice patients served during FFY 2010 for both North Carolina and the US:

PAYER CATEGORY	% OF HOSPICE PATIENTS	% OF HOSPICE PATIENT DAYS OF CARE
Medicare	86.3%	91.6%
Medicaid	4.9%	3.4%
Private Insurance	5.9%	3.4%
Self pay / Other	2.8%	1.6%
Total	**100.0%**	**100.0%**

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

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

	% HOSPICE PATIENTS NC DATA 2010	% HOSPICE PATIENTS NATIONAL DATA 2010
Race		
White/Caucasian	80.5%	77.3%
Black/African American	15.4%	8.9%
Asian, Hawaiian, Other Pacific Islander	0.4%	2.5%
Another Race	2.7%	11.0%
American Indian or Alaskan Native	1.0%	0.3%
Ethnicity		

Hispanic or Latino Origin	0.7%	5.7%
Non-Hispanic or Latino Origin	99.3%	94.3%
Totals	100.0%	100.0%

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

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

In Section VI, pages 122 - 124, the applicant describes how HPCIC has and will provide hospice services to all patients, including the elderly, Medicare and Medicaid recipients, racial and ethnic minorities, women, handicapped persons, and other underserved persons. In Exhibit 9 the applicant provides a copy of the HPCIC admission policies and procedures. The applicant adequately demonstrates that medically underserved populations currently have adequate access to hospice services provided by HPCIC and GHH. Therefore, the application is conforming to this criterion.

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

C

In Section VI.10 page 126, the applicant states that there have been no such complaints filed against HPCIC. Therefore, the application is conforming to this criterion.

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

C

In Section VI.4, page 122, the applicant provides the projected payor mix for inpatient services for the second year of operation at HPCIC (FY 2014), as shown in the table below.

PAYER CATEGORY	HOSPICE INPATIENTS	HOSPICE PATIENT DAYS OF CARE
Medicare	90.1%	90.0%
Medicaid	6.3%	5.0%
Commercial Insurance	3.2%	4.0%
Private Pay and Indigent	0.5%	1.0%
Total	**100.0%**	**100.0%**

The projected payor mix is slightly higher than the statewide hospice payor mix provided in the FY 2011 annual report from The Carolinas Center for Hospice and End of Life Care. The applicant adequately demonstrates that medically underserved groups will be adequately served by the proposed hospice facility. Therefore, the application is conforming to this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Section VI.9, page 125, the applicant adequately demonstrates the range of means by which a person will have access to the hospice facility. In addition, in Exhibit 5, the applicant provides a copy of an existing working agreement between HPCIC and Genesis Health Care. Therefore, the application is conforming to this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

In Section V.1(b) and (c), pages 115 - 116, the applicant states:

> *"Currently, HPCIC has training agreements with Appalachian State University, Gardner-Webb University, Iredell / Statesville Schools, Mitchell Community College, the University of North Carolina at Greensboro, and Winston-Salem University."*

Exhibit 19 contains a copy of a training program affiliation agreement between HPCIC and Gardner-Webb University. The applicant adequately demonstrates that the facility will accommodate the clinical needs of health professional training programs in the area. Therefore, the application is conforming to this criterion.

(15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.
(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

See Sections II, III, V, VI and VII of the application. In particular, see Section V.7, page 120, in which the applicant discusses the impact of the proposed project as it relates to promoting cost-effectiveness, quality and access to hospice services in Iredell County. The information provided by the applicant in those sections is reasonable and credible and adequately demonstrates that the expected effects of the proposed hospice services on competition include a positive impact on cost-effectiveness, quality and access to hospice services in Iredell and Alexander Counties. This determination is based on the information contained in the application, and on the following:

- The applicant adequately demonstrates the need to convert three hospice residential beds into three hospice inpatient beds at the existing Gordon Hospice House hospice facility, and that it is a cost-effective alternative;
- The applicant has and will continue to provide quality services; and
- The applicant has and will continue to provide adequate access to medically underserved populations in its proposed service area.

Therefore, the application is conforming to this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

According to files in the Acute and Home Care Licensure and Certification Section in the Division of Health Service Regulation, no incidents have occurred at HPCIC within the eighteen months immediately preceding the date of the decision for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

C

The application is conforming to all applicable Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Care Facilities 10A NCAC 14C .4000. The specific criteria are discussed below.

10A NCAC 14C .4002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall complete the application form for Hospice Inpatient and Hospice Residential Care Services.

-C- The applicant used the correct application form.

(b) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall provide the following information:

(1) the projected annual number of hospice patients, admissions, deaths, and other discharges, <u>for each level of care</u> (i.e., respite care, hospice residential care and hospice inpatient care), to be served in the facility in each of the first three years following completion of the project and the methodology and assumptions used to make the projections;

-C- In Section IV.2, pages 80 - 81, and Section IV.3, pages 93 - 96, the applicant provides the projected number of hospice inpatient, residential and respite admissions, deaths, and other discharges to be served in HPCIC GHH in each of the first three years following completion of the project. See the following table, compiled by the project analyst form the data on pages 80 – 81, and 93 - 95:

	FY 2013 (OY 1)	FY 2014 (OY 2)	FY 2015 (OY 3)
Inpatient			
Number of Patients	451	471	492
Admissions	483	504	526
Deaths	410	428	447
Other Discharges	0	0	0
Respite			
Number of Patients	9	10	10
Admissions	9	10	10
Deaths	0	0	0

Other Discharges	0	0	0
Residential			
Number of Patients	50	52	54
Admissions	50	52	54
Deaths	12	13	14
Other Discharges	6	6	6

The methodology and assumptions used to develop the projections are provided in Section III.1 pages 53 - 64, and Section IV.2, pages 82 - 92. See Criterion (3) for discussion of reasonableness.

(2) the projected annual number of hospice patients, admissions, deaths, and other discharges for each level of care to be served by the applicant's licensed hospice agency in each of the first three years following completion of the project and the methodology and assumptions used to make the projections;

-C- In Section IV.4, page 102, the applicant projects the annual number of hospice patients, admissions, deaths, and other discharges for total hospice agency operations in each of the first three years following completion of the project, as shown in the table below. The methodology and assumptions used to develop the projections are provided in Section IV, pages 104 - 112. See Criterion (3) for discussion of reasonableness.

HPCIC Projected Utilization – Hospice Agency

	2013	2014	2015
Admissions – Unduplicated	840	877	915
Deaths	739	772	806
Discharges	77	81	84

*Source: Application, page 102

(3) the projected annual number of patient care days, for each level of care (i.e., respite care, hospice residential care and hospice inpatient care), to be provided in each of the first three years of operation following completion of the project and the methodology and assumptions used to make the projections;

-C- In Section IV.2, page 80, the applicant shows the projected annual number of patient care days for the inpatient, residential and respite levels of care to be provided in each of the first three years of operation, as shown in the table below. The methodology and assumptions used to develop the projections are provided in Section III.1, pages 56 - 63. See Criterion (3) for discussion.

HPCIC Projected Patient Care Days

CARE LEVEL	YEAR 1 FY2013	YEAR 2 FY2014	YEAR 3 FY2015
Inpatient (includes respite)	4,183	4,366	4,559
Residential	497	518	541
Total	4,680	4,884	5,100

(4) the projected average length of stay (ALOS) based on admissions to the applicant's facility, for each level of care, (i.e., respite care, hospice residential care and hospice inpatient care) and the methodology and assumptions used to make the projections;

-C- In Section II.2, page 23, the applicant provides the projected average length of stay (ALOS) for the inpatient, residential, and respite levels of care, as shown in the table below:

CARE LEVEL	YEAR 1 FY2013	YEAR 2 FY2014	YEAR 3 FY2015
Inpatient	8.66	8.66	8.66
Residential	10.0	10.0	10.0
Respite*	4.00	4.00	4.00

The methodology and assumptions used to develop the projections are provided in Section III.1, pages 54 - 56.

(5) the projected readmission rate, for each level of care, (i.e., respite care, hospice residential care and hospice inpatient care) and the methodology and assumptions used to make the projections;

-C- In Section II.2, page 24, the applicant projects a readmission rate only for the hospice inpatient care, as shown in the table below:

READMISSION LEVEL	YEAR 1 FY2013	YEAR 2 FY2014	YEAR 3 FY2015
Inpatient	5.0%	5.0%	5.0%
Residential	0.0%	0.0%	0.0%
Respite*	0.0%	0.0%	0.0%

The methodology and assumptions used to develop the projections are provided in Section IV.2, pages 80 - 92.

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

-C- In the Pro Forma Section of the application, the applicant provides the projected average cost per patient day by level of care, as shown in the table below. The applicant likewise provides the assumptions used to project average annual cost.

CARE LEVEL	YEAR 1 FY2013	YEAR 2 FY2014	YEAR 3 FY2015
Inpatient	$647.85	$636.55	$625.45
Residential	$647.85	$636.55	$625.45

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

-C- In Section II.2, page 25, the applicant states, *"HPCIC has established strong relationships with health care providers in the community and has enjoyed excellent referral patterns that are expected to continue following the completion of the project. … In addition to referrals from hospitals, HPCIC has established relationships with a number of physicians in the community. HPCIC fully expects all these relationships to continue following completion of the project"* In Exhibit 5, the applicant provides copies of existing referral agreements; and in Exhibits 6, and 7, the applicant provides copies of letters of support from area physicians and other healthcare providers.

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

-C- In Exhibit 6, the applicant provides letters of support from area healthcare providers which document the historical number of referrals made to HPCIC, and project future referrals. In Exhibit 35, the applicant provides a table that summarizes the historical and projected number of referrals to HPCIC.

(9) copies of the proposed contractual agreements, if the applicant is not a licensed hospice, with a licensed hospice or a licensed home care agency with a hospice designation on its license, for the provision of hospice services;

-NA- HPCIC is a licensed hospice.

(10) documentation of the projected number of patients to be referred for each payor type from the referring hospices, if the applicant is not a licensed hospice or if the applicant proposes to admit patients on a contractual basis; and

-NA- HPCIC is a licensed hospice.

(11) a copy of the admission policies, including the criteria that shall be used to select persons for admission to the hospice inpatient and residential care beds.

-C- Exhibit 9 contains copies of the applicant's admission policies.

10A NCAC 14C .4003 PERFORMANCE STANDARDS

(a) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall demonstrate that:

(1) the average occupancy rate of the licensed hospice beds, for each level of care, in the facility is projected to be at least 50 percent for the last six months of the first operating year following completion of the project;

-C- In Section IV.2(a), page 80, the applicant projects an average occupancy rate for the licensed beds for each level of care in excess of 50 percent for the last six months of the first operating year following completion of project.

(2) the average occupancy rate for the licensed hospice beds, for each level of care, in the facility is projected to be at least 65 percent for the second operating year following completion of the project; and

-C- In Section IV.2(a), page 80, the applicant projects an average occupancy rate for the licensed beds for each level of care in excess of 65 percent for the second operating year following completion of project.

(3) if the application is submitted to address the need for hospice residential care beds, each existing hospice residential care facility which is located in the hospice service area operated at an occupancy rate of at least 65 percent for the 12 month period reported on that facility's most recent Licensure Renewal Application Form.

-NA- The applicant does not propose to add hospice residential care beds.

(b) An applicant proposing to add hospice inpatient facility beds to an existing hospice inpatient facility shall document that the average occupancy of the licensed hospice inpatient facility beds in its existing facility was at least 65 percent for the nine months immediately preceding the submittal of the proposal.

-C- In Section IV.1, page 78, the applicant reports an average occupancy rate for the licensed hospice inpatient beds was 92.8% for the nine months immediately preceding the submittal of the proposal.

(c) An applicant proposing to add residential care beds to an existing hospice residential care facility shall document that the average occupancy of the licensed hospice residential care beds in its existing facility was at least 65 percent for the nine months immediately preceding the submittal of the proposal.

-NA- The applicant does not propose to add residential care beds to an existing facility.

10A NCAC 14C .4004 SUPPORT SERVICES

(a) An applicant proposing to develop a hospice inpatient facility beds or hospice residential care facility beds shall demonstrate that the following services will be provided directly by the applicant or by a contracted hospice to the patient and the patient's family or significant others:

(1) nursing services;

-C- In Section II.2, page 28, the applicant states, *"GHH will provide nursing services through nursing staff."* The applicant provides documentation that the services required in this rule are provided in Section II.3, page 37 and Section VII.2, page 133.

(2) social work services;

-C- In Section II.2, page 28, the applicant states, *"GHH will provide social work services through its social work staff."* The applicant provides documentation that the services required in this rule are provided in Section II.3, page 37 and Section VII.2, page 133.

(3) counseling services including dietary, spiritual, and family counseling;

-C- In Section II.2, page 29, the applicant states, *"GHH will provide dietary counseling through its dietary consultant. GHH will provide spiritual and family counseling services through chaplains."* The applicant provides documentation that the services required in this rule are provided in Section II.3, page 37 and Section VII.2, page 133.

(4) bereavement counseling services;

-C- In Section II.2, page 29, the applicant states, *"GHH will provide bereavement counseling through its chaplains."* The applicant provides documentation that the services required in this rule are provided in Section II.3, page 37 and Section VII.2, page 133.

(5) volunteer services;

-C- In Section II.2, page 29, the applicant states, *"GHH will provide volunteer services through its volunteer coordinator and volunteer staff."* The applicant provides documentation that the services required in this rule are provided in Section II.3, page 37 and Section VII.2, page 133.

(6) physician services; and

-C- In Section II.2, page 29, the applicant states, *"GHH will provide physician services through its Medical Director."* The applicant provides documentation that the services required in this rule are provided in Section II.3, page 37 and Section VII.2, page 133.

(7) medical supplies.

-C- In Section II.2, page 29, the applicant states, *"GHH will provide medical supplies through Neil Medical."* The applicant provides documentation that medical services required in this rule will be provided in Section II.3, page 37.

(b) An applicant shall demonstrate that the nursing services listed in Paragraph (a) of this Rule will be available 24 hours a day, seven days a week.

-C- In Section II.3, page 29, the applicant states, *"GHH will have nursing staff available 24 hours a day, 7 days a week."* In Section VII.4, page 135, the applicant provides a staffing table that shows nursing services will be available 24 hours a day, seven days a week.

(c) An applicant proposing to develop a hospice inpatient facility or a hospice residential care facility shall provide documentation that pharmaceutical services will be provided directly by the facility or by contract.

-C- In Section II.3, page 30, the applicant states *"GHH will provide pharmaceutical services through Family Pharmacy of Statesville."* In supplemental information provided to the Agency, the applicant provides a copy of the existing pharmaceutical agreement.

(d) For each of the services listed in Paragraphs (a) and (c) of this Rule which are proposed to be provided by contract, the applicant shall provide a copy of a letter from the proposed provider which expresses its interest in working with the proposed facility.

-C- In Section II.2, page 30, the applicant states the copies of the letters of the proposed services are provided in a CON application submitted less than 12 months prior to the submittal of this application, and the agreements *"automatically renew and remain in force."*

10A NCAC 14C .4005 STAFFING AND STAFF TRAINING

(a) An applicant proposing to develop a hospice inpatient facility beds or hospice residential care facility beds shall document that staffing will be provided in a manner consistent with G.S. 131E, Article 10.

-C- In Section II.2, page 30, the applicant states that the staffing will comply with the requirements of 131E, Article 10. In Section VII, the applicant provides staffing information.

(b) The applicant shall demonstrate that:

(1) the staffing pattern will be consistent with licensure requirements as specified in 10A NCAC 13K, Hospice Licensing Rules;

-C- In Section II.2, page 30, the applicant states, *"Please see Section VII for staffing information. The staffing pattern will be consistent with 10A NCAC 13K of the hospice licensing rules."*

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

-C- In Section II.2, page 31, applicant states, *"Training for all staff will meet the requirements as specified in 10A NCAC 13K .0400, hospice licensing rules.* In Exhibit 10 the applicant provides a copy of HPCIC's staff training policies.

10A NCAC 14C .4006 FACILITY

An applicant proposing to develop new hospice inpatient facility beds or new hospice residential care facility beds shall document:

(1) that a home-like setting shall be provided in the facility;

-C- In Section II.2, pages 31 – 33, the applicant describes how the facility will provide a home-like setting for its patients. The applicant provides photos to support its statements on pages 32 and 33.

(2) that the services will be provided in conformity with applicable state and local laws and regulations pertaining to zoning, physical environment, water supply, waste disposal and other relevant health and safety requirements; and

-C- In Section II.2, page 34, the applicant states that HPCIC's existing services are and will be provided in conformity with applicable state and local laws and regulations pertaining to zoning, physical environment, water supply, waste disposal and other relevant health and

safety requirements. In Exhibit 12 the applicant provides a letter signed by the CEO of HPCIC that confirms the services will be provided in conformity with the requirements of this rule.

(3) for new facilities, the location of the site on which the services are to be operated. If the site is neither owned by nor under option to the applicant, the applicant must provide a written commitment to pursue acquiring the site if and when the approval is granted, must specify a secondary site on which the services could be operated if acquisition efforts relative to the primary site ultimately fail, and must demonstrate that the primary and secondary sites are available for acquisition.

-NA- HPCIC is not proposing a new facility in this application.