ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: July 29, 2013

PROJECT ANALYST: Michael McKillip
TEAM LEADER: Lisa Pittman

PROJECT I.D. NUMBER: F-10132-13 / Hospice & Palliative Care Charlotte Region d/b/a Levine & Dickson Hospice House / Add six hospice inpatient beds to the existing facility for a total of 22 hospice inpatient beds / Mecklenburg County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

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

C

The applicant, Hospice & Palliative Care Charlotte Region **[HPCCR]**, proposes to add six hospice inpatient beds for a total of 22 hospice inpatient beds by constructing a 6,000 square foot addition to its existing facility, the Levine & Dickson Hospice House **[LDHH]**, which is located in Huntersville.

The 2013 State Medical Facilities Plan (SMFP) identifies a need determination for six additional hospice inpatient beds for Mecklenburg County. The applicant proposes to develop no more than six additional hospice inpatient beds. Thus, the application is conforming to the need determination in the 2013 SMFP.

Additionally, Policy GEN-3 of the 2013 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."*

Policy GEN-3 – In Section III.3, pages 53-54, HPCCR describes how it believes the project conforms with Policy GEN-3. HPCCR describes how its proposal will promote safety and quality in Section II.4, pages 42-44, Exhibit 15, and Section III.3, page 54. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will promote safety and quality.

HPCCR describes how its proposal will promote equitable access in Section VI, pages 85-90. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will promote equitable access.

HPCCR describes how its proposal will maximize health care value for resources expended in Section III.3, page 53, Section III.1, pages 46-52, Section IV, pages 64-79, Section X, pages 110-115, and the pro forma financial statements. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will maximize health care value for resources expended.

HPCCR adequately demonstrates how its proposal will promote safety and quality, equitable access and maximize health care value for resources expended. Therefore, the application is consistent with Policy GEN-3.

Additionally, Policy GEN-4 of the 2013 SMFP is applicable to this review. Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities states:

> *"Any person proposing a capital expenditure greater than $2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178 shall include in its certificate of need application a written statement describing the project's plan to assure improved energy efficiency and water conservation.*
>
> *In approving a certificate of need proposing an expenditure greater than $5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178, the Certificate of Need Section shall impose a condition requiring the applicant to develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4.*

Any person awarded a certificate of need for a project or an exemption from review pursuant to G.S. 131E-184 are required to submit a plan for energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of the Division of Health Service Regulation. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4. The plan shall not adversely affect patient or resident health, safety or infection control."

In Section III.3, page 54, the applicant states:

"The design of the 6-bed addition includes energy efficiency and water conservation includes [sic] *the following items:*

- *Fluorescent lighting is used throughout the center to contain costs*
- *Insulated glass is used throughout the center*
- *Roof overhangs provide for solar control*
- *Gas heating is used to minimize heating costs*
- *Individual patient room heat pump controls*
- *The common areas utilizes a variable volume air system to prioritize energy needs and efficiency*
- *Low flow shower heads and low flow toilets for water conservation"*

The applicant adequately demonstrates that it will assure improved energy efficiency and water conservation in the proposed addition of six hospice inpatient beds to the existing facility. Therefore, the application is consistent with Policy GEN-4.

In summary, the application is conforming to the need determination in the 2013 SMFP, and is consistent with Policy GEN-3 and Policy GEN-4. 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

HPCCR proposes to add six hospice inpatient beds for a total of 22 hospice inpatient beds at Levine & Dickson Hospice House (LDHH), its Huntersville hospice inpatient facility. The 6,000 square foot addition to LDHH will include six private patient rooms, a nursing station, conference room, and family waiting room.

Population to be Served

In Section III.11, the applicant provides projected patient origin for LDHH's hospice inpatient services in the first two years of operation, as shown in the table below.

County	# of Patients as Percent of Total
Mecklenburg	80.5%
Iredell	5.8%
Gaston	4.9%
Cabarrus	2.7%
Other	6.2%
TOTAL	**100.0%**

On page 62 of the application, the applicant states projected patient origin is based on *"LDHH actual* [May 10, 2013] *patient origin adjusted for opening of Lincoln County Hospice House."* The applicant adequately identified the population proposed to be served.

Need for the Project

In Section III.1(a) of the application, the applicant describes the factors supporting the need for the proposed project, including, the need determination in the 2013 State Medical Facilities Plan (page 46), the requirements of Federal and State regulations (page 46), historical utilization of hospice services by Mecklenburg county residents (pages 47-49), the projected growth in Mecklenburg County population, particularly in the older population segments (page 50), and the historical utilization of LDHH's existing hospice inpatient beds (page 51).

In Section IV.1, page 65, the applicant provides a table showing the projected quarterly utilization for LDHH's hospice inpatient beds through the first two years of operation (FY2016-FY2017) for the proposed project, which is summarized below:

LDHH's Hospice Inpatient Bed Utilization

Fiscal Year	Patient Beds	Patient Days	Occupancy Percent
1st Quarter – FY2016	22	1,447	71.49%
2nd Quarter – FY2016	22	1,415	71.46%
3rd Quarter – FY2016	22	1,431	71.48%
4th Quarter – FY2016	22	1,447	71.49%
Total FY2016	22	5,740	71.48%
1st Quarter – FY2017	22	1,519	75.05%
2nd Quarter – FY2017	22	1,486	75.05%
3rd Quarter – FY2017	22	1,502	75.02%
4th Quarter – FY2017	22	1,519	75.05%
Total FY2017	22	6,026	75.04%

As indicated in the above table, the applicant projects it will provide 2,878 patient days of care in the 22 hospice inpatient beds at LDHH in the last six months of the first operating year of the

proposed project (FY2016), which is equivalent to an average occupancy rate of 71.5 percent [2,878 patient days / (22 beds X 183 available beds days) = 71.5%], which exceeds the minimum utilization standard of 50 percent required in 10A NCAC 14C .4003(a)(1). Also, the applicant projects it will provide 6,026 patient days of care in the 22 hospice inpatient beds at LDHH in the second operating year of the proposed project (FY2017), which is equivalent to an average occupancy rate of 75 percent [6,026 patient days / (22 beds X 365 available beds days) = 75%], which exceeds the minimum utilization standard of 65 percent required in 10A NCAC 14C .4003(a)(2).

In Section IV.2, pages 68-69, the applicant describes the assumptions and methodology used to project the number of hospice inpatient days to be provided at LDHH during the first two years of operation as follows:

> *"LDHH had experienced a* [sic] *8.7% increase in the number of Mecklenburg County patients that it served between 2010 and 2011. LDHH experienced a decrease in patients served in 2012 due to changes related to the Affordable Care Act; however, this decline is not continuing in 2013. Annualized volumes through April 2013 show LDHH serving over 650 inpatients and over 5,300 days of care. As such, LDHH is projecting a lower percentage increase of 5.0% per year in the number of Mecklenburg County patients it serves through 2018. … LDHH hospice inpatients originating from other counties total 135 patients or 24.2% of total hospice inpatients in 2012. However, annualized volumes through April 2013 show LDHH serving over 160 inpatients from other counties and states; HPCCR assumes a 5.0% annual increase through FY2018. Additionally, LDHH will experience a 1-year decrease of 49 inpatients in FY2016 due to the operation of its proposed Lincoln County Hospice House. … LDHH has experienced an increase in the average length of stay of its hospice inpatients. HPCCR had been able to decrease the LDHH ALOS from* [sic] *to 7.73 days in 2012. However, ALOS has increase* [sic] *in annualized 2013 to 8.11 days; HPCCR projects that the ALOS will remain constant at 8.11 days. … HPCCR multiplied the total admits (C) by the ALOS (D) to project the LDHH total days of care. … HPCCR divided the LDHH total days of care (E) by 365 days (or 366 depending on leap year) to calculate the average daily census. … HPCCR divided the LDHH average occupancy rate (F) by 22 beds to calculate the occupancy rate."*

On September 25, 2012 (Project I.D. # F-8824-12), the applicant was approved to convert four hospice residential beds to hospice inpatient beds, increasing LDHH's licensed capacity from 12 to 16 hospice inpatient beds. Project I.D. # F-8824-12 was completed in April 2013. In this application, the applicant proposes to add six hospice inpatient beds for a total of 22 beds. On page 68, the applicant provides a table showing the historical and projected utilization of the hospice inpatient beds at LDHH, which is summarized below:

LDHH's Hospice Inpatient Bed Utilization

Fiscal Years	Mecklenburg County	Other Counties	Total Admits	ALOS	Total Days	Average Daily	Occupancy Rate*

	Admits (A)	Admits (B)	(C)	(D)	of Care (E)	Census (F)	(G)
2010 – Actual	390	131	521	7.83	4,082	11.18	101.7%
2011 – Actual	424	135	559	7.75	4,332	11.87	98.9%
2012 – Actual	414	120	534	7.73	4,128	11.28	94.0%
2013 - Projected	492	162	654	8.11	5,301	14.52	101.3%
2014 – Projected	517	170	687	8.11	5,566	15.25	95.3%
2015 – Projected	542	179	721	8.11	5,844	16.01	100.1%
2016 – PY 1	570	139	708	8.11	5,739	15.68	71.3%
2017 – PY 2	598	145	743	8.11	6,026	16.51	75.0%
2018 – PY 3	628	153	781	8.11	6,328	17.34	78.8%

*The applicant's occupancy rate for FY2010-FY2012 is based on a licensed capacity of 12 hospice inpatient beds. From mid-FY2013 through FY2015, following completion of Project I.D. # F-8824-12, the applicant's occupancy rate is based on a licensed capacity of 16 hospice inpatient beds. Beginning in Project Year 1 (PY 1), the applicant's occupancy rate is based on a licensed capacity of 22 hospice inpatient beds [12 + 4 + 6 = 22].

As shown in the table above, LDHH's existing hospice inpatient beds have operated at between 94 and 102 percent of capacity in the last three operating years. In Section IV.1, page 64, the applicant reports that its average occupancy rate over the past nine months (August 2012 – April 2013) was 96 percent of capacity. Based on annualized year-to-date utilization through April 2013, the applicant projects it will serve more than 650 admissions in FY2013. The applicant projects five percent annual increases in admissions from FY2014 through FY2018 (Project Year 3), which the applicant states is supported by the historical growth in hospice deaths for Mecklenburg County from FY2007 to FY2011 (See table on page 66), as well as the historical utilization of LDHH's existing hospice inpatient beds. Exhibits 19 and 25 of the application contain letters from physicians expressing support for the proposed project. The projected utilization of the hospice inpatient beds at LDHH is based on reasonable, credible and supported assumptions. LDHH adequately demonstrates the need for six additional hospice inpatient beds.

Access

The applicant projects 78.9% of its patients will be covered by Medicare (66.7%) and Medicaid (12.2%). The applicant demonstrates adequate access for medically underserved groups to the proposed services.

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

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income

persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

NA

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

CA

In Section III.13, page 63, the applicant describes the alternatives considered, including maintaining the status quo and developing a freestanding hospice house.

- The applicant states it rejected the status quo alternative due to the need to increase capacity to meet the current and projected need for hospice inpatient services.
- The applicant considered the alternative of developing a freestanding hospice house, but rejected it because of the higher construction costs and a history of opposition by local homeowners to the development of a new hospice house.

The applicant adequately demonstrated that the proposal is its least costly or most effective alternative to meet the need.

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

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

1. **Hospice & Palliative Care Charlotte Region d/b/a Levine & Dickson Hospice House shall materially comply with all representations made in the certificate of need application.**

2. **Hospice & Palliative Care Charlotte Region d/b/a Levine & Dickson Hospice House shall develop no more than six additional hospice inpatient beds for a total of not more than 22 hospice inpatient beds upon completion of the project.**

3. **Hospice & Palliative Care Charlotte Region d/b/a Levine & Dickson Hospice House shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure in Section VIII of the application and that would otherwise require a certificate of need.**

4. **Hospice & Palliative Care Charlotte Region d/b/a Levine & Dickson Hospice House shall acknowledge acceptance of and agree to comply with all conditions**

stated herein to the Certificate of Need Section, in writing prior to issuance of the certificate of need.

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

C

In Section VIII.1, the applicant projects its capital cost for the project to be $2,025,000, as shown in the table below.

Project Capital Costs	
Construction Contract	$1,800,000
Furniture & Equipment	$58,000
Consulting Fees	$167,000
TOTAL	**$2,025,000**

Exhibit 12 contains a letter from a registered architect, which certifies that the total construction costs are estimated to be $1,800,000, which is consistent with the costs reported by the applicant in Section VIII.1, page 100.

In Section VIII.5, the applicant states the capital cost will be financed with $1 million raised in a public campaign and $1.025 million in accumulated reserves of HPCCR. In Sections IX.1 and IX.2, the applicant projects no start-up or initial operating expenses. In Exhibit 21 of the application, the applicant provides a letter signed by the President and Chief Executive Officer for HPCCR, which states

> *"Hospice & Palliative Care Charlotte Region (HPCCR) will obligate and commit $1,025,000 from Cash and cash equivalents and $1,000,000 from fundraising activities to fund the capital costs associated with the Levine & Dickson Hospice House (LDHH) expansion project.*
>
> *HPCCR has an outstanding record in raising funds for both the operation of the hospice program and the construction/development of inpatient hospice facilities. As examples, HPCCR raised nearly $10.8 million on a $10.0 million goal for the construction of LDHH and has raised over $1.0 million in the last year for the development of the LDHH at Southminster facility."*

Furthermore, In Section VIII.6, page 102, the applicant provides a table showing that HPCCR has received an average of $1.6 million annually in charitable donations ("*community support*") every year since FY2007. The applicant states those funds *"can be used to fund both operations and capital expenditures."*

Exhibit 22 of the application contains audited financial statements for HPCCR for the year ended December 31, 2012, which documents that HPCCR had $4 million in cash and $16.4 million in total current assets as of December 31, 2012. The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the proposal.

In pro forma financial statements for HPCCR's hospice services (Form C), the applicant projects income will meet or exceed expenses in each of the first three operating years, as shown below:

Hospice & Palliative Care Charlotte Region

	FY2016 Year 1	FY2017 Year 2	FY2018 Year 3
Total Income	$4,253,125	$4,382,884	$4,593,152
Total Expenses	$4,253,125	$4,360,012	$4,461,007
Net Income (Loss)*	$0	$22,872	$132,145

*The applicant projects an operating loss of $70,065 in Year 1, but also projects charitable donations in an equal amount, thereby eliminating the projected operating loss.

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

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

C

HPCCR proposes to add six hospice inpatient beds to its existing LDHH facility for a total of 22 hospice inpatient beds upon project completion. The following table summarizes the utilization of the existing and approved licensed hospice inpatient beds in Mecklenburg County:

FY2012 Mecklenburg County Hospice Inpatient Bed Utilization

Facility	Licensed Hospice Inpatient	Approved Hospice Inpatient	Total Hospice Inpatient	Occupancy Percent*

	Beds	Beds	Beds	
Levine & Dickson Hospice House (LDHH)	12	4	16	94.0%
LDHH at Southminster**	10	0	10	94.4%
Novant Presbyterian Hospital	8	10	18	74.0%
Novant Health Matthews Medical Center	0	3	3	NA
Totals	30	17	47	

*Occupancy percentages for LDHH and LDHH at Southminster are from Section IV.1, page 68 and page 70, respectively. Occupancy percentage for Novant Presbyterian Hospital (Harris Hospice Unit) is based on data reported in the hospital's *2013 Hospital License Renewal Application* form.
**Projected FY2013.

In Section IV.1, page 64, the applicant reports that the average occupancy rate for its existing hospice inpatient beds at LDHH over the past nine months (August 2012 – April 2013) was 96 percent of capacity. In Project I.D. #F-8677-11, HPCCR was approved to develop a new 10-bed hospice inpatient facility, Levine & Dickson Hospice House at Southminster (LDHH at Southminster). The project was completed and became operational in December 2012. In Section IV.2, page 70 of the application, the applicant projects LDHH at Southminster will operate at an average occupancy rate of 94.4 percent in FY2013, based on its year-to-date utilization.

Presbyterian Hospital-Harris Hospice Unit is an 8-bed hospice inpatient unit located at Novant Presbyterian Hospital in Charlotte. In FY2012, Novant Presbyterian Hospital reported 2,162 patient days in their 8 hospice inpatient beds, which is equivalent to an average occupancy rate of 74 percent of capacity [2,162 patient days of care / 2,920 available bed days = 0.74]. Also, on November 22, 2011, Novant Presbyterian Hospital was approved (Project I.D. # F-8686-11) to develop 10 additional hospice inpatient beds for a total of 18 beds upon project completion. The project is currently under development.

On September 25, 2012, Novant Health Matthews Medical Center was approved (Project I.D. # F-8832-12) to develop 3 new hospice inpatient beds for a total of 3 beds upon project completion. The project is currently under development.

Therefore, based on the most recent utilization data available, the three existing hospice inpatient facilities in Mecklenburg County were operating at occupancy rates above the performance standards required in 10A NCAC 14C .4003.

On page 68, the applicant provides a table showing the historical and projected utilization of the hospice inpatient beds at LDHH, which is summarized below:

LDHH's Hospice Inpatient Bed Utilization

Fiscal Years	Mecklenburg County Admits	Other Counties Admits	Total Admits	ALOS	Total Days of Care	Average Daily Census	Occupancy Rate*

	(A)	(B)	(C)	(D)	(E)	(F)	(G)
2010 – Actual	390	131	521	7.83	4,082	11.18	101.7%
2011 – Actual	424	135	559	7.75	4,332	11.87	98.91%
2012 – Actual	414	120	534	7.73	4,128	11.28	93.98%
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2014 – Projected	517	170	687	8.11	5,566	15.25	95.3%
2015 – Projected	542	179	721	8.11	5,844	16.01	100.1%
2016 – PY 1	570	139	708	8.11	5,739	15.68	71.3%
2017 – PY 2	598	145	743	8.11	6,026	16.51	75.0%
2018 – PY 3	628	153	781	8.11	6,328	17.34	78.8%

*The applicant's occupancy rate for FY2010-FY2012 is based on a licensed capacity of 12 hospice inpatient beds. From mid-FY2013 through FY2015, following completion of Project I.D. # F-8824-12, the applicant's occupancy rate is based on a licensed capacity of 16 hospice inpatient beds. Beginning in Project Year 1 (PY 1), the applicant's occupancy rate is based on a licensed capacity of 22 hospice inpatient beds [12 + 4 + 6 = 22].

As shown in the table above, LDHH's existing hospice inpatient beds have operated at between 94 and 102 percent of capacity in the last three operating years. HPCCR adequately demonstrated the need to develop six additional hospice inpatient beds, given the high historical utilization of its existing beds and the projected growth in utilization of hospice services by the residents of Mecklenburg County. Consequently, the applicant adequately demonstrates the proposed project would not result in the unnecessary duplication of existing or approved health service capabilities or facilities in the applicant's service area. Therefore, the application is conforming with 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.1, pages 93-96, the applicant provides the current and proposed staffing for LDHH, as shown in the table below.

LDHH Staffing	Current FTEs	Proposed FTEs
Nurse Practitioner	0.40	0.40
Charge Nurse	2.90	2.90
Nurse	12.75	16.00
Nurse – PRN	1.62	1.55

Nursing Assistant	12.94	17.20
Dietary	2.79	2.79
Social Worker	1.12	1.12
Housekeeper	1.12	1.62
Maintenance	1.50	1.50
Associate Medical Director	0.80	0.80
Administrator	1.00	1.00
Sr. Administrative Assistant	2.50	2.50
Chaplain	0.75	1.00
Total	**42.19**	**50.38**

The applicant states the proposed project will result in the addition of 3.25 FTE registered nurse, 4.26 FTE nursing assistant, 0.5 FTE housekeeper, and 0.25 FTE chaplain positions.

In Section VII.4, page 97, the applicant projects the number of direct care staff. The applicant projects that a minimum of eight staff members will be on duty at all times, including four registered nurses and four nursing assistants per shift.

In Section VII.5, page 97, the applicant states that nurses will work 12.5 hours per shift (2 shifts) and nursing assistants will 12.25 hours per shift. In Section VII.7, page 98, the applicant projects to provide 6.1 nursing hours per patient day (NHPPD) for hospice inpatient services [(100 RN hours per day X 365 days = 36,500 RN hours) / 6,026 inpatient days of care = 6.1 NHPPD)].

In Section VII.9, page 99, the applicant describes the availability of employees to fill the proposed positions. In Section V.3, page 82, the applicant identifies Robert Smith, M.D. as the Medical Director for LDHH. Exhibits 19 and 25 of the application contain copies of letters from physicians expressing support for the proposed project. The applicant adequately demonstrates the availability of sufficient health manpower and management personnel to provide the proposed services. Therefore, the application is conforming to this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section II.3, pages 32-37, the applicant states that all of the necessary ancillary and support services for the proposed services are currently provided at LDHH. In Section V.2, page 81, the applicant states,

> *"HPCCR does not establish transfer agreements with health care providers. HPCCR either treats the patient in the acute care facility (hospital) or the patient becomes a patient at LDHH through an arranged transfer by the patient's family and/or local*

ambulance services. … HPCCR has written contracts to provide services to patients and residents of the previously identified facilities."

On page 81, the applicant provides a list of facilities with which LDHH has contract agreements, and Exhibit 18 of the application contains a copy of several contract agreements. Exhibits 19 and 25 contain copies of letters from physicians expressing support for the proposed project. The applicant adequately demonstrates that necessary ancillary and support services will be available and that the proposed project will be coordinated with the existing health care system. Therefore, the application is conforming with this criterion.

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

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;
(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
(iii) would cost no more than if the services were provided by the HMO; and
(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

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

C

In Section XI.7, the applicant states the proposed addition will be 6,000 square feet. Exhibit 12 contains a letter from a registered architect, which certifies that the total construction costs are

estimated to be $1,800,000, which is consistent with the costs reported by the applicant in Section VIII.1, page 100. In Section III.3, page 54, the applicant states that applicable energy savings features will be incorporated into the plans. The applicant adequately demonstrates that the cost, design and means of construction represent the most reasonable alternative for the project it proposes, and that the construction costs will not unduly increase costs and charges for health services. See Criterion (5) for discussion of costs and charges, which is incorporated hereby as if set forth fully herein. Therefore, the application is conforming to this criterion.

(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 86, the applicant provides the payer mix during FY2012 for the hospice inpatient services at LDHH, as shown in the table below.

LDHH Hospice Inpatient Services Payer Category	Patient Days as % of Total
Medicare	66.7%
Medicaid	12.2%
Commercial	20.2%
Private Pay	0.9%
Total	**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. More current data, particularly with regard to the estimated uninsured percentages, was not available.

County	Total # of Medicaid Eligibles as % of Total Population June 2010	Total # of Medicaid Eligibles Age 21 and older as % of Total Population June 2010	% Uninsured CY2008-2009 (Estimate by Cecil G. Sheps Center)
Mecklenburg	15%	5.1%	20.1%
Statewide	**17%**	**6.7%**	**19.7%**

The majority of Medicaid eligibles are children under the age of 21. This age group does not utilize the same health services at the same rate as older segments of the population, particularly the hospice inpatient services proposed in this application.

Moreover, the number of persons eligible for Medicaid assistance may be greater than the number of Medicaid eligibles who actually utilize health services. The DMA website includes information regarding dental services which illustrates this point. For dental services only, DMA provides a comparison of the number of persons eligible for dental services with the number actually receiving services. The statewide percentage of persons eligible to receive dental services who actually received dental services was 48.6% for those age 20 and younger and 31.6% for those age 21 and older. Similar information is not provided on the website for other types of services covered by Medicaid. However, it is reasonable to assume that the percentage of those actually receiving other types of health services covered by Medicaid is less than the percentage that is eligible for those services.

The Office of State Budget & Management (OSBM) maintains a website which provides historical and projected population data for each county in North Carolina. In addition, data is available by age, race or gender. However, a direct comparison to the applicant's 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 reports that hospice patients in North Carolina had the following payor mix during 2011.

NC Hospice Patients by Payor Mix

Payor	Patient Days	Patient Count
Hospice Medicare	91.6%	86.3%
Hospice Private Insurance	3.4%	5.9%
Hospice Medicaid	3.4%	4.9%
Self Pay	1.2%	2.2%
Other	0.4%	0.6%
Total	**100.0%**	**100.0%**

Source: Carolinas Center for Hospice and End of Life Care

The following table shows North Carolina and national hospice patients by race and ethnicity.

Hospice Patients by Race and Ethnicity

	% of Hospice Patients 2011 NC Data	% of Hospice Patients 2010 NC Data	% of Hospice Patients 2010 National Data
Race:			
White/ Caucasian	80.1%	80.5%	77.3%
Black/ African American	13.6%	15.4%	8.9%
Other Race	2.5%	2.7%	11.0%
American Indian or Alaskan Native	1.0%	1.0%	0.3%
Asian, Hawaiian, Other Pacific Islander	2.7%	0.4%	2.5%
Total	**100.0%**	**100.0%**	**100.0%**
Ethnicity:			
Hispanic or Latino Origin	1.0%	0.7%	5.7%
Non-Hispanic or Latino Origin	99.0%	99.3%	94.3%
Total	**100.0%**	**100.0%**	**100.0%**

Source: Carolinas Center for Hospice and End of Life Care

The table below illustrates North Carolina and national hospice patients by age groups, which indicates more than 80% of the patients are age 65+ and thus Medicare eligible.

Hospice Patients by Age Categories

Age Category	% of Hospice Patients 2011 NC Data	% of Hospice Patients 2010 NC Data	% of Hospice Patients 2010 National Data
0-34	0.8%	0.8%	1.3%
35-64	16.5%	17.4%	16.1%
65-74	18.2%	18.4%	15.9%
75+	64.5%	63.4%	66.8%
Total	**100.0%**	**100.0%**	**100.0%**

Source: Carolinas Center for Hospice and End of Life Care

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

In Section VI.5, page 88, the applicant describes the manner in which its services are made accessible by minorities and handicapped persons to programs receiving federal assistance. In Section VI.10, page 90, the applicant states that no civil rights complaints have been filed against HPCCR or LDHH in last five years. 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 87, the applicant provides the projected payer mix for the second year of operation (FY2017) for the hospice inpatient services at LDHH, as shown in the table below.

LDHH Hospice Inpatient Services Payer Category	**Patient Days as % of Total**
Medicare	66.7%
Medicaid	12.2%
Commercial	20.2%
Private Pay	0.9%
Total	**100.0%**

The applicant demonstrates that medically underserved populations will have adequate access to the proposed services. Therefore, the application is conforming to this criterion.

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

C

In Section VI.9(a), page 90, the applicant describes the range of means by which a person will have access to its services. The information provided is reasonable and credible and supports a finding of conformity to this criterion.

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

C

In Section V.1, page 80, the applicant states HPCCR has established relationships with area health professional training programs. Exhibit 17 contains a copies HPCCR's training

program affiliation agreements with several programs, including Central Piedmont Community College, Gardner-Webb University, University of North Carolina-Charlotte, University of North Carolina-Chapel Hill, and Western Carolina University. The information provided in Section V.1 is reasonable and credible and supports a finding of conformity to this criterion.

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

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

C

HPCCR proposes to add six hospice inpatient beds to its existing LDHH facility for a total of 22 hospice inpatient beds upon project completion. In addition to LDHH, HPCCR operates another 10-bed hospice inpatient facility in south Charlotte, LDHH at Southminster. There is currently one other provider of licensed hospice inpatient beds in the applicant's proposed service area; Novant Presbyterian Hospital-Harris Hospice Unit is an 8-bed hospice inpatient unit located in Charlotte. Novant Presbyterian Hospital-Harris Hospice Unit has been approved to add 10 hospice inpatient beds for a total of 18 beds upon completion. The project is currently under development. Also, Novant Health Matthews Medical Center has been approved to develop three hospice inpatient beds. That project is also currently under development.

In Section V.7, page 84, the applicant discusses the impact of the proposed project on competition in the service area as it relates to promoting cost-effectiveness, quality and access. The applicant states

> *"Admissions criteria have a positive impact on cost-effectiveness, overall quality of care and access to the under-served patient in the community.*
>
> *Currently, HPCCR:*
>
> - *Facilitates discharge planning for hospitalized patients that need inpatient care that can be provided in the hospice setting.*
> - *Provides needed services for patients whose death is imminent, but for whom home or nursing care is not feasible.*
> - *Provides for the growing needs of the elderly population.*

- *Provides intermittent inpatient care needed by home-managed patients (i.e. pain management).*
- *Provides the only specialized pediatric, home-based, hospice and palliative care program.*

In summary, as the region's population gets older, patients need access to an inpatient hospice facility that can provide the best quality care (for both patients and families) and a cost effective alternative to institutional settings. LDHH offers a unique approach that best meets the needs of the patients and can offer families many resources, such as bereavement counseling services that are not typically provided by other healthcare providers."

See also Sections II, III, V, VI and VII where the applicant discusses the impact of the project on cost-effectiveness, quality and access.

The information provided by the applicant in those sections is reasonable and credible and adequately demonstrates that the expected effects of the proposal on competition in the service area include a positive impact on cost-effectiveness, quality and access to the proposed services. This determination is based on the information in the application and the following analysis:

- The applicant adequately demonstrates the need to develop six additional hospice inpatient beds and that it is a cost-effective alternative;
- The applicant adequately demonstrates that it will continue to provide quality services; and
- The applicant demonstrates that it will continue to provide adequate access to medically underserved populations.

The application is conforming to this criterion.

(19) Repealed effective July 1, 1987.

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

C

HPCCR and LDHH are certified by CMS for Medicare and Medicaid participation, and licensed by the NC Department of Health and Human Services. According to files in the Acute and Home Care Licensure and Certification Section in the Division of Health Service Regulation, no incidents have occurred at HPCCR or LDHH 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

HPCCR proposes to add six hospice inpatient beds to its existing facility for a total of 22 hospice inpatient beds upon project completion. Therefore, the Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Care Facilities 10A NCAC 14C .4000 are applicable to this review. The application is conforming to all applicable Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Care Facilities. 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, for each level of care (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 II.2, page 20, the applicant provides the projected number of hospice inpatient, residential and respite admissions, deaths, and other discharges to be served in LDHH 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.2(b), pages 66-76.

LDHH Projections by Level of Care

Level of Care	FY2016	FY2017	FY2018
Inpatient			
Patients	708	743	781
Admissions	708	743	781
Deaths	576	604	635
Discharges	111	117	123

Residential			
Patients	33	33	33
Admissions	33	33	33
Deaths	23	23	23
Discharges	10	10	10
Respite			
Patients	52	52	52
Admissions	52	52	52
Deaths	0	0	0
Discharges	52	52	52

(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- On page 21 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. The methodology and assumptions used to develop the projections are provided in Section IV.2(b), pages 66-76, and Section IV.4(a), page 77.

HPCCR Total Hospice Operations

Level of Care	Year 1 FY2016	Year 2 FY2017	Year 3 FY2018
Home Care			
Patients	2,640	2,664	2,689
Admissions	2,640	2,664	2,689
Deaths	2,402	2,424	2,447
Discharges	237	240	242
Inpatient			
Patients	1,113	1,148	1,186
Admissions	1,113	1,148	1,186
Deaths	905	934	964
Discharges	152	157	162
Residential			
Patients	33	33	33
Admissions	33	33	33
Deaths	33	33	33

Discharges	14	14	14
Respite			
Patients	52	52	52
Admissions	52	52	52
Deaths	0	0	0
Discharges	52	52	52

(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 II.2, page 22, the applicant provides a table showing 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 summarized below. The methodology and assumptions used to develop the projections are provided on pages 66-76.

LDHH Projected Patient Care Days

Care Level	Year 1 FY2016	Year 2 FY2017	Year 3 FY2018
Inpatient	5,739	6,026	6,328
Residential	493	493	493
Respite	244	244	244

(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 22 and Section IV, pages 66-70, the applicant provides the projected average length of stay (ALOS) for the inpatient, residential care and respite levels of care, as shown in the table below:

LDHH Average Length of Stay

Care Level	Year 1 FY2016	Year 2 FY2017	Year 3 FY2018
Inpatient	8.1	8.1	8.1
Residential	14.9	14.9	14.9
Respite	4.7	4.7	4.7

The methodology and assumptions used to develop the projections are provided in Section IV.2(b), pages 68-74.

(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 23, the applicant states it anticipates no readmissions.

(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 Section II.2, page 23, and in Form C, applicant provides the projected average annual cost per patient care day for the inpatient, residential care and respite levels of care for each of the first three operating years following completion of the project, as shown below. The methodology and assumptions are provided in Form C.

Care Level	Year 1 FY2016	Year 2 FY2017	Year 3 FY2018
Inpatient	$668.87	$655.98	$641.95
Residential	$509.64	$501.00	$491.13
Respite	$668.87	$655.98	$641.95

(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 23, the applicant states:

"HPCCR has established working relationships with many sources of referrals because it is the operator of an existing inpatient hospice facility in Mecklenburg County, LDDH, and because it is the largest provider of hospice services in Mecklenberg County, nearly 64% of total hospice days of care are provided by HPCCR. Please refer to Exhibit 25 for letters of support."

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

-C- In Section II.2, page 24, the applicant states:

"HPCCR has working relationships with all of the referral physicians identified in Exhibit 25, as well as with local hospitals and nursing homes. HPCCR's referral network is anticipated to continue referring over 500 patients per year to the LDHH, as the benefits of hospice care become more prevalent in Mecklenburg County, these physicians and HPCCR executives believe that inpatient hospice care will increase in utilization."

(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- HPCCR 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- HPCCR 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 7 contains a copy of HPCCR's *"Admissions Criteria"* policy.

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 II.2, page 25, the applicant states:

"HPCCR proposes to provide 2,878 inpatient hospice days of care during the last six months of the first operating year, which results in an occupancy rate of 71.5% [(2,878 days of care / (22 beds X 183 days)].

HPCCR proposes to provide 3,247 hospice days of care (inpatient, respite, and residential care) during the last six months of the first operating year, which results in an occupancy rate of 80.7 percent [(3,247 days of care / (22 beds X 183 days)]."

(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 II.2, page 25, the applicant states:

"HPCCR proposes to provide 6,026 inpatient hospice days of care during the second operating year, which results in an occupancy rate of 75.0 percent [(6,026 days of care / (22 beds X 365 days)].

HPCCR proposes to provide 6,763 hospice day of care (inpatient, respite, and residential care) during the second operating year, which results in an occupancy rate of 84.2 percent [(6,763 days of care / (22 beds X 365 days)]."

(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- The applicant states *"LDHH provided 3,140 inpatient hospice days of care during the last nine months, which results in an average occupancy rate of 95.5 percent [(3,140 days of care / (12 beds X 274 days)]*.

(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;
(2) social work services;
(3) counseling services including dietary, spiritual, and family counseling;
(4) bereavement counseling services;
(5) volunteer services;
(6) physician services; and
(7) medical supplies.

-C- Exhibit 8 contains a letter from the President and CEO of HPCCR documenting that the hospice services required by this rule will be provided.

(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 VII.4, page 97, the applicant shows that at least 4.0 FTE registered nurses and 4.0 FTE nursing assistants will work each shift during the 24 hour period. In Section II.2, page

27, the applicant states that nursing services will be available 24 hours a day, seven days a week for the provision of direct patient care.

(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.2, page 27, the applicant states that Hospice Pharmacia will supply medications to LDHH and the inpatient hospice staff will administer medications per physicians' orders. Exhibit 9 contains a copy of the agreement between HPCCR and Hospice Pharmacia.

(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 27, the applicant states that all services listed above are provided through HPCCR (Exhibit 8) and Hospice Pharmacia (Exhibit 9).

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 28, 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 29, the applicant states:

"As identified in the 10A NCAC 13K staffing requirements and in the Section VII Staffing Table, LDHH continues to:

- *Staff a registered nurse 24 hours per day who will supervise all nursing services,*
- *Assure a minimum of two staff members will be on duty at all times,*
- *Assure all staff will be trained to meet the needs of the terminally ill and their families as discussed in the respective job descriptions,*
- *Assure all nurse aides will be supervised by a registered nurse, and*
- *Assure interdisciplinary teams will be available as required by the patient's plan of care."*

In addition, the proposed staffing shown in Table VII.2, pages 95-96, reflects that the above services will be provided.

(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 30, applicant states:

> *"All LDHH staff will receive orientation, in-service training, and competency testing as provided through HPCCR job descriptions and policies and procedures. Policies and procedures are developed to meet the requirements of 10A NCAC 13K Rules."*

In addition, Exhibit 10 contains copies of HPCCR's "*Orientation Process, Competency/Licensure and Supervision"* policies. Exhibit 11 contains copies of job descriptions.

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, page 31, the applicant states that the existing LDHH facility was designed as a home-like setting, and that the proposed addition will be similarly designed.

(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, page 31, the applicant states that LDHH's existing services are 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.

(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- HPCCR is not proposing a new facility in this application.