



DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

July 19, 2017

Lindsay B. Smith
557 Brookdale Drive
Statesville, NC 28677

No Review

Record #: 2321
Facility Name: Iredell Memorial Hospital, Incorporated
FID #: 933284
Business Name: Iredell Memorial Hospital, Incorporated
Business #: 1032
Project Description: Change 2 rooms on Skilled Nursing Floor from Double Occupancy to Single Occupancy. Current number of Nursing Facility beds to remain the same at 48.
County: Iredell

Dear Ms. Smith:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency) received your letter of July 6, 2017 regarding the above referenced proposal. Based on the CON law **in effect on the date of this response to your request**, the proposal described in your correspondence is not governed by, and therefore, does not currently require a certificate of need. However, please note that if the CON law is subsequently amended such that the above referenced proposal would require a certificate of need, this determination does not authorize you to proceed to develop the above referenced proposal when the new law becomes effective.

It should be noted that this determination is binding only for the facts represented in your correspondence. Consequently, if changes are made in the project or in the facts provided in your correspondence referenced above, a new determination as to whether a certificate of need is required would need to be made by this office. Changes in a project include, but are not limited to: (1) increases in the capital cost; (2) acquisition of medical equipment not included in the original cost estimate; (3) modifications in the design of the project; (4) change in location; and (5) any increase in the number of square feet to be constructed.

HEALTHCARE PLANNING AND CERTIFICATE OF NEED SECTION

WWW.NCDHHS.GOV

TELEPHONE 919-855-3873

LOCATION: EDGERTON BUILDING • 809 RUGGLES DRIVE • RALEIGH, NC 27603

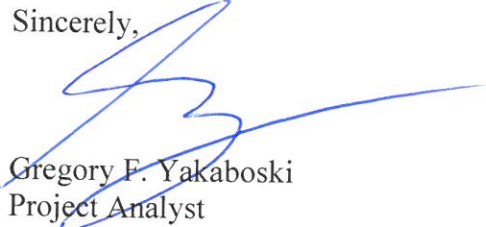
MAILING ADDRESS: 2704 MAIL SERVICE CENTER • RALEIGH, NC 27699-2704

AN EQUAL OPPORTUNITY/ AFFIRMATIVE ACTION EMPLOYER

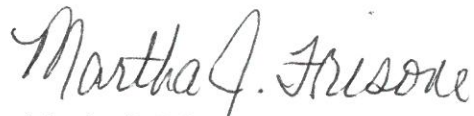


Please contact this office if you have any questions. Also, in all future correspondence you should reference the Facility ID # (FID) if the facility is licensed.

Sincerely,



Gregory F. Yakaboski
Project Analyst



Martha J. Frisone
Chief, Healthcare Planning and Certificate of Need

cc: Construction Section, DHSR
Acute and Home Care Licensure and Certification Section, DHSR
Nursing Home Licensure and Certification Section, DHSR
Paige Bennett, Assistant Chief, Healthcare Planning, DHSR



July 05, 2017

Healthcare Planning and Certificate of Need
Attn: Ms. Martha Frisone, Chief
2704 Mail Service Center
Raleigh, North Carolina 27699-2704



Dear Sir or Madam:

The purpose of this letter is to request a re-designation of 2 rooms on our Skilled Nursing Floor located inside Iredell Memorial Hospital, located at 557 Brookdale Drive, Statesville, North Carolina 28677. License #H0164. We do not seek to add or subtract from our total bed capacity of 48.

Our intent is to withdraw double occupancy from Rooms 147 & 153 and make these single occupancy rooms. We would like to propose to restore Rooms 133 & 166 back into our room mix as single occupancy rooms which would leave our bed capacity at 48. Please note, these rooms are physically the same as all the other single occupancy rooms on 1 West and they were included in our previous licensed bed count back in October 2013. We have not altered these rooms in anyway so they would continue to meet SNF criteria under Nursing Home Licensure.

These changes are reflected in the attached floor plan to this letter. Again, our licensed bed occupancy would remain at 48 beds, 29 licensed single occupancy beds on 1 West and 19 single occupancy beds on 2 West. There are no changes being requested for 2 West at this time.

The effective date for this proposal is July 10, 2017. Iredell Memorial Hospital's fiscal operating year is October 01, 2017 – September 30, 2018. If you should have any questions regarding this proposal, please feel free to contact me at (704)873-5661 ext. 3451.

Sincerely,

A handwritten signature in black ink that reads "Lindsay B. Smith, NHA".

Lindsay B. Smith, NHA
Skilled Nursing Administrator
Iredell Memorial Hospital

Enclosures

CURRENT

BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: REDELL MEMORIAL HBSNF TOWN: STATESVILLE NC PROVIDER NUMBER: 345300

If change in beds or room numbers the effective date of the change: _____

1 WEST

Room Number	# of Beds within Room	CHECK ONLY ONE				Room Number	# of Beds within Room	CHECK ONLY ONE			
		Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only			Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only
134	1	X				105	1	X			
135	1	X									
136	1	X									
137	1	X									
138	1	X									
139	1	X									
140	1	X									
141	1	X									
142	1	X									
143	1	X									
144	1	X									
145	1	X									
146	1	X									
147	2	X									
148	1	X									
149	1	X									
150	1	X									
151	1	X									
153	2	X									
158	1	X									
159	1	X									
160	1	X									
161	1	X									
162	1	X									
163	1	X									
164	1	X									

INSTRUCTIONS: Complete and mail to appropriate Regional Office of the Division of Health Service Regulation, NC Department of Human & Human Services. Total the beds for the different classifications (Medicare, Medicaid, etc.) at the bottom of the continuation sheet. The administrator must sign and date the form on the back since copies of these forms are sent to the appropriate certifying agency(ies) for reimbursement purposes.

*Identify type of beds (Nursing or Adult Care Home) NURSING

NEW PROPOSAL

BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: REDELL MEMORIAL HBSNF

TOWN: STATESVILLE, NC

PROVIDER NUMBER: 345306

I WEST

If change in beds or room numbers the effective date of the change: July 10, 2017

Room Number	# of Beds within Room	CHECK ONLY ONE				Room Number	# of Beds within Room	CHECK ONLY ONE			
		Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only			Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only
133	1	X				164	1	X			
134	1	X				165	1	X			
135	1	X				166	1	X			
136	1	X									
137	1	X									
138	1	X									
139	1	X									
140	1	X									
141	1	X									
142	1	X									
143	1	X									
144	1	X									
145	1	X									
146	1	X									
147	1	X									
148	1	X									
149	1	X									
150	1	X									
151	1	X									
153	1	X									
158	1	X									
159	1	X									
160	1	X									
161	1	X									
162	1	X									
163	1	X									

INSTRUCTIONS: Complete and mail to appropriate Regional Office of the Division of Health Service Regulation, NC Department of Human & Human Services. Total the beds for the different classifications (Medicare, Medicaid, etc.) at the bottom of the continuation sheet. The administrator must sign and date the form on the back since copies of these forms are sent to the appropriate certifying agency(ies) for reimbursement purposes.

*Identify type of beds (Nursing or Adult Care Home) NURSING

NO CHANGES ON 2 WEST

BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: IREDELL MEMORIAL HBSNF TOWN: STATESVILLE, NC PROVIDER NUMBER: 345306

If change in beds or room numbers the effective date of the change: N/A.

2 WEST

Room Number	CHECK ONLY ONE				CHECK ONLY ONE							
	# of Beds within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only	Room Number	# of Beds within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only	
237	1	X										
238	1	X										
239	1	X										
240	1	X										
241	1	X										
242	1	X										
243	1	X										
244	1	X										
245	1	X										
246	1	X										
254	1	X										
255	1	X										
256	1	X										
257	1	X										
258	1	X										
259	1	X										
260	1	X										
261	1	X										
262	1	X										

TOTAL

Medicare/Medicaid = 48 (Beds)
 Medicare Only = _____ (Beds)

Medicaid Only = _____ (Beds)
 Licensed Only = _____ (Beds)

FOR YOUR INFORMATION: Adult Care Home beds cannot be certified in Medicare nor Medicaid

*Identify type of beds (Nursing or Adult Care Home) NURSING

Administrator's Signature: Quincy B. Smith NHA

Date: 06/20/17

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
NURSING HOME LICENSURE AND CERTIFICATION SECTION
2711 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2711
TELEPHONE: (919) 855-4520

FOR OFFICIAL USE ONLY
Computer Number _____
Bed Change _____
Effective Date _____
Fee Received _____
Check No: _____
Amount: _____

2017

NURSING HOME APPLICATION – BED CHANGES
(Including Adult Care Home Beds in Combination Facilities)

LEGAL IDENTITY OF APPLICANT:

IREDELL MEMORIAL HOSPITAL
{Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.}

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMARY: _____
Other: _____

If the above names are **NOT IDENTICAL** to the names on the current license, please check reason for the change:

Change of Ownership/Licensee Facility Name Change
 Other (Specify): CHANGE IN BEDS

NORTH CAROLINA LICENSE NUMBER: H0164

FACILITY MAILING ADDRESS:

Street/P O Box: _____
City: _____ State: _____ Zip: _____ - _____
(Ex. 27626 - 0530)

FACILITY SITE:

Street: 557 BROOKDALE DRIVE
City: STATESVILLE County: IREDELL
Telephone: (704) 873-5661
Fax: (704) 878-7294

PATIENT SERVICES

1. Is the facility now to be a "Combination Facility", thereby incorporating licensed ACH beds? 1. YES ___ NO
If "Yes", indicate which rules the facility chooses to apply to the operation of
these ACH beds. Nursing Home Licensure 48 ACH Licensure 0
(Complete checklist if using both sets of rules.)

APPLICATION TO INCREASE LICENSED NURSING HOME BEDS

2. NUMBER OF BEDS BY TYPE (*Must complete required data supplement form)

- a. **Nursing Beds (NF)** (TOTAL) a. 48
- 1. General Nursing Facility Beds 1. 48
 - 2. *Alzheimer's Special Care Unit Resident Beds 2. 0
 - 3. Ventilator Dependent Resident Beds 3. 0
 - 4. Traumatic Brain Injury Beds 4. 0
- Are you equipped to accommodate bariatric residents? Y N
- b. **Adult Care Home (ACH)** (TOTAL) b. 0
- 1. General Adult Care Home Beds 1. 0
 - 2. *Alzheimer's Special Care Unit Beds 2. 0
- Are you equipped to accommodate bariatric residents? Y NA
- c. **TOTAL LICENSED BEDS** (TOTAL a & b) c. 48

LICENSE FEE

A non-refundable per bed license fee is required for the number of beds added to the facility's licensed capacity and must accompany this application prior to the issuance of a nursing home license. Payment for the license fee should be in the form of check, certified check or money order and must be made payable to: "The Division of Health Service Regulation." Payment should include the facility's license number and be submitted with this license application.

License Fee Calculation:

a. Total number of <u>additional</u> Licensed beds. (must match number of additional beds approved by CON)	0
b. Multiply by per bed fee	x \$17.50
c. Total per bed fee (1a "x, multiply by" 1b)	\$ 0.

This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The license fee is non-refundable. The legislation (SB-622, Session Law 2005-276) prohibits a license from being issued if the annual fee has not been paid.

The undersigned submits this application for licensure for the year 2016 {subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission} and certifies the accuracy of this information.

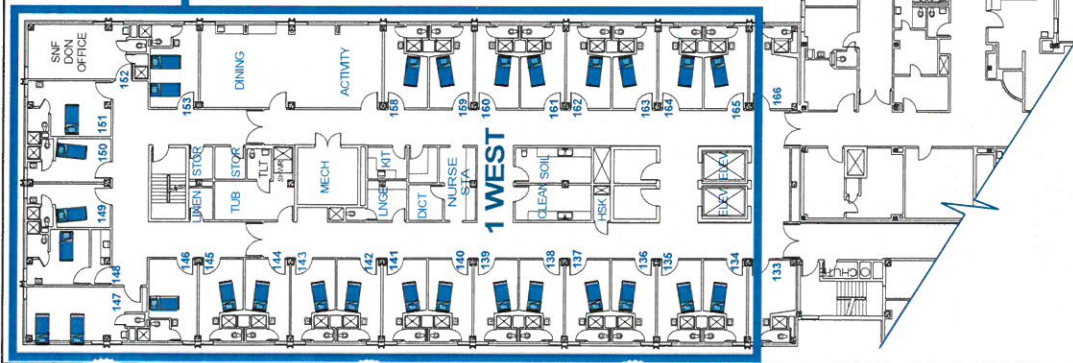
Lindsay B. Smith, NHA
Name of Chief Administrative Officer
or Authorized Official

LINDSAY B. SMITH
(Written Signature)

Title: Nursing Home Administrator

Date: 6/20/17

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services."



**1 WEST WING
29 SKILLED BEDS
PRESENT LOCATIONS**

FIRST FLOOR PRESENT BEDS LOCATION
LOCATION SNF BED = 1 = 29

IHS PRESENT TOTAL LICENSED BEDS

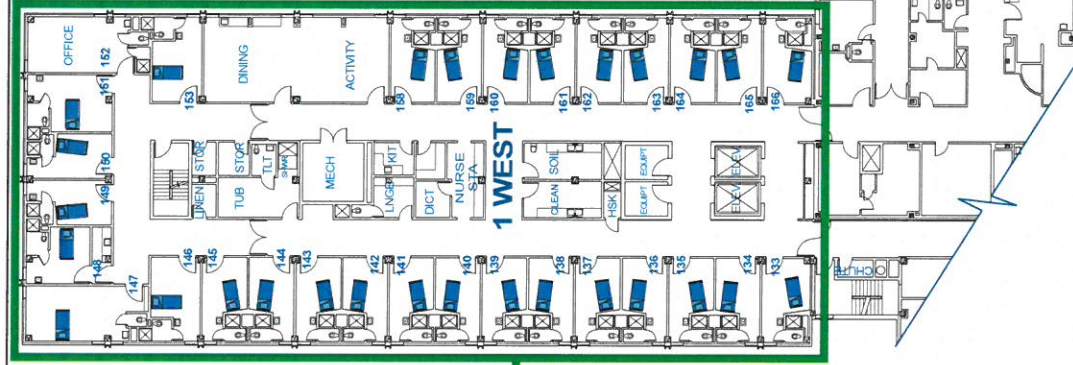
SNF BEDS
GROUND FLOOR = 00
FIRST FLOOR = 29
SECOND FLOOR = 19
THIRD FLOOR = 00
FOURTH FLOOR = 00
FIFTH FLOOR = 00
TOTAL = 48

**1 WEST WING
29 SKILLED BEDS
PROPOSED LOCATIONS**

FIRST FLOOR PROPOSED BEDS LOCATION
LOCATION SNF BED = 1 = 29

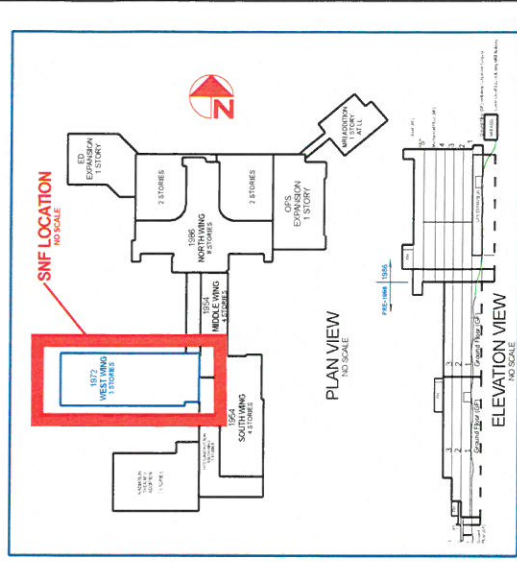
IHS PRESENT TOTAL LICENSED BEDS

SNF BEDS
GROUND FLOOR = 00
FIRST FLOOR = 29
SECOND FLOOR = 19
THIRD FLOOR = 00
FOURTH FLOOR = 00
FIFTH FLOOR = 00
TOTAL = 48



FIRST FLOOR BEDS PRESENT LOCATIONS

FIRST FLOOR BEDS PROPOSED LOCATIONS



PROPOSED SNF BEDS RELOCATION - FIRST FLOOR - WEST	
IREDELL MEMORIAL HOSPITAL	
557 Brookdale Drive, Statesville, N.C. 28677	
PROJ #	FID # 933284
Last Revision: 06/15/2017	
Drawn By: Scott Graham, PE	

Scale: 3/32" = 1' 0"