ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: July 29, 2013
PROJECT ANALYST: Celia C. Inman
TEAM LEADER: Lisa Pittman

PROJECT I.D. NUMBER: F-10136-13 / Hospice & Palliative Care Charlotte Region d/b/a Lincoln County Hospice House / Develop a new hospice unit with six hospice inpatient beds / Lincoln 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 develop a new hospice facility with six hospice inpatient beds to be located in Denver, Lincoln County, North Carolina. The proposed new facility name is Lincoln County Hospice House (LCHH). The 2013 State Medical Facilities Plan (SMFP) identifies a need determination for six new hospice inpatient beds in Lincoln County. The proposed project is consistent with the 2013 SMFP need determination and is the only application received by the Certificate of Need Section in response to the six inpatient hospice bed need determination in the 2013 SMFP.

Additionally, Policies GEN-3: BASIC PRINCIPLES and GEN-4: ENERGY EFFICIENCY AND SUSTAINABILITY FOR HEALTH SERVICE FACILITIES of the 2013 SMFP are applicable to this review.

Policy GEN-3: BASIC PRINCIPLES on page 42 of the 2013 SMFP 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, page 54, the applicant states the following regarding how the proposal promotes healthcare value:

"Promote Cost Effective Approaches

HPCCR proposes to develop 6 inpatient hospice beds. With the rising demand for inpatient services that are driven by a growing community, and aging population and an expanding physician referral base, HPCCR believes that any hospice patients who may benefit from the care at an inpatient hospice facility should have access to those services; the development if LCHH will open up capacity to Lincoln County hospice patients. This proposed project will not hinder any existing providers' ability to compete.

Choice helps promote competition and competition helps promote better alternatives for the patients. HPCCR will complement the needs and ever growing demands of the patients, staff, and physicians within the service area. This project will promote an [sic] *community-based inpatient hospice facility that will be open to all patients within the service area."*

The applicant adequately demonstrates that the proposed project will maximize health care value.

Promote Safety and Quality

In Section III.3, page 55, the applicant states the following with regard to how the proposal will promote safety and quality:

"Encourage Quality Health Care Services

The aging population and the demands from the baby boomer generation continue to force the provision of care services into a 'consumerism' mentality. Today's patients demand better care, better access to information, better outcomes, more

patient (consumer) focus from the provider and their physician, and more economical options for health care services. HPCCR will address these demands in an ever growing segment of the heath care delivery system: inpatient hospice services.

The 6-bed, inpatient hospice facility will be designed to be homelike; a friendlier, relaxed, and less intimidating environment to the patient. The patients and their families will have a facility that is easily accessible and easy to find. A freestanding inpatient hospice facility lessens the anxiety associated with end-of-life issues.

HPCCR offers an extensive continuum of care, recognized for its innovation and excellence (NHPCO award winner). HPCCR is recognized as a NHPCO "Quality Partner" and provides the leadership to encourage quality care."

Staff Orientation and Competence Policies and Procedures are included in Exhibit 10. Quality Assessment and Performance Improvement Policies are included in Exhibit 15.

The applicant adequately demonstrates that the proposed project will promote safety and quality.

Promote Equitable Access

In Section III.3, page 54-55, the applicant states the following with regard to how the proposal will promote equitable access:

"Expand Health Care Services to the Medically Underserved

Low income persons needing hospice services will have access to the facility. As an existing North Carolina health care provider, HPCCR has provided hospice services to Lincoln and surrounding counties for over 30 years. HPCCR remains committed to providing care for the uninsured, under-insured, and charity care patients.

All persons, including patients covered by Medicare, Medicaid, Commercial Insurance, Self-Pay (including self-pay, indigent, charity care), and any others will have access to appropriate services. HPCCR will render appropriate medical care to all persons in need of hospice care regardless of their ability to pay."

In Section VI.5, page 84, the applicant further discusses promoting equitable access:

"HPCCR participates in the Medicare and Medicaid program and otherwise provides care to the elderly. HPCCR will continue to make available services to low-income persons needing care.

…

HPCCR's Admission Criteria Policy guarantees equal access to hospice services for members of all racial, ethnic and religious minority groups.

…

HPCCR does not discriminate on the basis of gender as stated in the Admission Criteria Policy.

…

LDHH conforms to the North Carolina State Building Code, the National Fire Protection Association 101 Life Safety Code, the Rules and Statutes applying to the Licensing of Hospices in North Carolina, ANSI Standards for Handicapped Access, and any other requirement of federal, state, and local bodies.

…

HPCCR is and will continue to be accessible to all persons, including the medically indigent and terminally ill children.

…

HPCCR will continue to be available to all in need of care, without discrimination."

The applicant provides its Admission Criteria Policy in Exhibit 7 and the Special Financial Consideration Policy can be found on pages 649-650 of Exhibit 20. The applicant adequately demonstrates that medically underserved groups will have equitable access to the proposed services. See also Criterion (13).

Projected Volumes Incorporate GEN-3 Concepts

The applicant adequately demonstrates the need for the project. 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.

Policy GEN-4: ENERGY EFFICIENCY AND SUSTAINABILITY FOR HEALTH SERVICE FACILITIES, on page 43 of the 2013 SMFP, 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 of 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, beginning on page 55, the applicant addresses Policy GEN-4 and the facility's plan for energy efficiency and water conservation. The applicant states the facility design includes energy efficient and water conservation as criteria of design and further states:

"Energy efficiency and water conservation includes 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* [sic] *a variable volume air system to prioritize energy needs and efficiency*
- *Low-flow showerheads and low-flow toilets will be used for water conservation."*

The applicant adequately demonstrates the proposal includes a plan to assure improved energy efficiency and water conservation. Therefore, the application is consistent with Policy GEN-4.

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

The applicant, HPCCR, proposes to develop a new hospice inpatient unit with six hospice inpatient beds to be located in Denver, Lincoln County. The applicant plans to construct an 8,700 square foot building to accommodate the six-bed hospice inpatient unit which will be known as Lincoln County Hospice House (LCHH). HPCCR operates Hospice & Palliative Care Lincoln County (HPCLC), the only licensed hospice agency in Lincoln County, serving 360 hospice patients in 2012.

HPCCR also owns and operates two inpatient hospice facilities in Mecklenburg County. The Levine & Dickson House (LDHH), an existing 16-bed hospice inpatient facility is in Huntersville and LDHH at Southminster, a 10-bed hospice inpatient unit is in Charlotte.

Population to be Served

In supplemental information submitted by the applicant during the expedited review of this project, the applicant states:

> *"The SMFP defined inpatient hospice bed service area is Lincoln County; however, the service area for the LCHH will also include Catawba and Gaston counties, as all three counties are currently served by LDHH, HPCCR's inpatient hospice facility in Mecklenburg County."*

In Section III.11, page 62, the applicant provides patient origin which includes patients from Lincoln, Catawba and Gaston Counties in the first two operating years.

Projected Patient Origin Year One
FY 2016

	Inpatient Patients		Residential Patients	
County	**Projected # Patients**	**Percent of Patients**	**Projected # Patients**	**Percent of Patients**
Lincoln	132	86.8%	6	85.7%
Catawba	15	9.9%	1	14.3%
Gaston	5	3.3%	0	0.0%
TOTAL	152	100.0%	7	100.0%

Projected Patient Origin Year Two
FY 2017

	Inpatient Patients		Residential Patients	
County	**Projected # Patients**	**Percent of Patients**	**Projected # Patients**	**Percent of Patients**
Lincoln	159	86.9%	6	85.7%
Catawba	18	9.8%	1	14.3%
Gaston	6	3.3%	0	0.0%
TOTAL	183	100.0%	7	100.0%

Furthermore, on page 68, the applicant states:

> *"In FY2013 HPCCR is on target to serve 45 patients from Gaston and Catawba counties at LDHH and HPCCR projects that 20 patients will transfer to the LCHH in the first year of operation. The number of Iredell County hospice patients receiving care in the LCHH will be equal to 24 patients in FY2017 and in FY2018 or approximately 13.0% of inpatients."*

In the supplemental information submitted, the applicant confirmed that Iredell County should not have been referenced above. The applicant is projecting 24 patients from Gaston and Catawba counties in FY2017 and FY2018. HPCCR expects these patients to transfer from LDHH to LCHH.

The applicant adequately identified the population projected to be served by the proposed facility.

Demonstration of Need

In Section III.1, page 45, the applicant states:

> *"HPCCR utilized the following information to determine to submit a CON application for the development of a six (6) bed inpatient hospice facility in Lincoln County:*
>
> - *2013 State Medical Facilities Plan*
> - *Federal and State Regulations*
> - *Hospice Home Care Utilization*
> - *Mecklenberg County Demographics*
> - *Palliative Medicine Deaths*
> - *Inpatient Hospice Bed Statistical Need*
> - *County Hospice Utilization Comparison"*

In Section III.1, page 45, the applicant states that the 2013 SMFP, utilizing the most current inpatient hospice bed need methodology, determined a need for six inpatient hospice beds in Lincoln County.

In Section III.1(b), page 46, the applicant states, *"Lincoln County has experienced an 84.2 percent growth in hospice days of care from 15,310 days of care in 2005 to 28,200 days of care in 2012."* In Exhibit 16, the applicant provides copies of annual Hospice Data Supplements showing Lincoln County hospice home care utilization growth from 2005 through 2011, as shown in the table below.

Lincoln County	**2005**	**2011**	**Change**	**% increase**
Hospice Days of Care	15,310	28,200	12,890	84.19%
Hospice Deaths	140	240	100	71.43%

As the table above illustrates, both hospice days of care and deaths have increased significantly. In 2011, Lincoln County hospice patients were served by 11 hospice programs, six more than in 2005. HPCLC is the only hospice service provider located in Lincoln County.

In Section III.1, page 49, the applicant provides data from the NC Office of State Budget and Management for population growth in Lincoln County from 2010 through 2013, as shown in the table below.

Population Age Group	**2010**	**2013**	**2018**	**2010- 2013 % Change**	**2013-2018 % Change**
Under 18	18,418	18,005	17,619	-2.24%	-2.14%
18 -44	26,295	26,251	25,810	-0.17%	-1.68%
45-64	23,244	23,909	25,087	2.86%	4.93%
65+	10,440	12,129	14,437	16.18%	19.03%
Total All ages	**78,397**	**80,294**	**82,953**	**2.42%**	**3.31%**
% Under 18	23.49%	22.42%	21.24%		
% 18 -44	33.54%	32.69%	31.11%		
% 45-64	29.65%	29.78%	30.24%		
% 65+	13.32%	15.11%	17.40%		

Source: Data from NC OSBM, by county, by age group, last updated January 2013

As illustrated in the table above, the population in Lincoln County is projected to grow by 3.3% between 2013 and 2018. However, the population ages 45- 64 is projected to grow 4.9% from 2013 to 2018 to become 30.2% of Lincoln County's total population in 2018. Additionally, the population ages 65 and older is projected to grow 19% from 2013 to 2018 to become 17% of Lincoln County total population in 2018. In supplemental information, the applicant states, *"Based on FY2012 HPCCR-Lincoln County data, hospice patients who are 65 years old and older represent 80.9 percent of hospice admissions."*

On page 50, the applicant states:

"HPCCR has developed an extensive palliative medicine consultation service over the past ten years. The HPCCR Palliative Medicine Program cared for 2,739 patients in 2010 and 3,316 patients in 2011, and 3,452 patients in 2012, of which 719 in 2010 and 865 in 2011, and 936 in 2012 transitioned to hospice care. Most of these deaths occurred in a hospital setting due to lack of capacity in a home-like setting, such as the proposed LCHH."

In regard to the statistical need for the proposed project, the applicant states on pages 50-52 that the 2013 State Medical Facilities Plan contains a need determination for 6 hospice inpatient beds in Lincoln County. Also, the applicant provides statistics for deaths, hospice deaths, and hospice inpatients deaths for Lincoln County and its contiguous counties.

2010 Comparison of Hospice Services

	2010	Hospice		Inpatient Hospice		Hospice as % of Total		Inpatient Hospice as % of Total	
County	**Deaths**	**Admits**	**Deaths**	**Admits**	**Deaths**	**Admits**	**Deaths**	**Admits**	**Deaths**
Catawba	1,561	853	789	407	400	54.6%	50.5%	26.1%	25.6%
Cleveland	1,075	573	550	197	168	53.3%	51.2%	18.3%	15.6%
Gaston	2,071	1095	967	307	232	52.9%	46.7%	14.8%	11.2%
Iredell	1,343	674	607	279	243	50.2%	45.2%	20.8%	18.1%
Lincoln	673	266	213	69	47	39.5%	31.6%	10.3%	7.0%
Mecklenburg	5,060	2654	2,316	873	605	52.5%	45.8%	17.3%	12.0%
Totals	11,783	6,115	5,442	2,132	1,695	51.9%	46.2%	18.1%	14.4%

Source: Applicant: 2012 License Applications and Hospice Supplemental Reports

2011 Comparison of Hospice Services

	2011	Hospice		Inpatient Hospice		Hospice as % of Total		Inpatient Hospice as % of Total	
County	**Deaths**	**Admits**	**Deaths**	**Admits**	**Deaths**	**Admits**	**Deaths**	**Admits**	**Deaths**
Catawba	1,485	969	884	476	462	65.3%	59.5%	32.1%	31.1%
Cleveland	1,065	543	508	247	200	51.0%	47.7%	23.2%	18.8%
Gaston	2,081	1017	919	311	256	48.9%	44.2%	14.9%	12.3%
Iredell	1,438	796	659	325	317	55.4%	45.8%	22.6%	22.0%
Lincoln	715	305	240	55	41	42.7%	33.6%	7.7%	5.7%
Mecklenburg	5,134	2662	2,449	885	659	51.9%	47.7%	17.2%	12.8%
Totals	11,918	6,292	5,659	2,299	1,935	52.8%	47.5%	19.3%	16.2%

Source: Applicant: 2013 License Applications and Hospice Supplemental Reports

On page 51, the applicant states:

"All five adjacent counties have inpatient hospice facilities and three counties have multiple inpatient hospice facilities. Although more than ten hospice programs serve patients from Lincoln County, without an inpatient hospice

facility the percentage of county deaths served by hospice is much lower in Lincoln County; in fact, the five counties with inpatient hospice facilities have served over 44 percent of the county's deaths, while less than 34 percent of Lincoln County resident deaths are served by hospice. More telling is the comparison of inpatient hospice care. The five counties with inpatient hospice care all care for over 10 percent of the county's deaths, while in 2011, less than 6.0 percent of Lincoln County deaths were served in an inpatient hospice. When comparing Lincoln County deaths to the other two rural counties, Cleveland and Iredell Counties, both of those counties in 2011 served over 18.0 percent of their county's deaths."

On page 52, the applicant states:

"The comparisons clearly indicate that the presence of an inpatient hospice facility not only increases the number and percentage of county deaths served by inpatient hospice services, but also increase the utilization of hospice care in general.

It is based on these comparisons that HPCCR expects to increase hospice and inpatient hospice care in Lincoln County and make the operation of an inpatient hospice feasible in Lincoln County."

Lincoln County Hospice Service Utilization Projections

In Section IV.2(a), page 65 and supplemental information, the applicant provides the projected utilization for the first two fiscal years by level of care as summarized in the table below.

Projected Quarterly Utilization

	Patient Days				Beds	Occupancy Rate	
Quarter	Inpatient	Respite	Residential	Total Days	Total	Inpatient Days	Total Days
1st	261	7	26	294	6	47.28%	53.31%
2nd	279	7	26	312	6	51.67%	57.73%
3rd	333	7	26	366	6	60.99%	67.03%
4th	362	7	26	395	6	65.58%	71.61%
Total 2016	1,235	28	104	1,367	6	56.37%	62.41%
5th	373	7	26	406	6	67.64%	73.67%
6th	365	7	26	398	6	67.64%	73.70%
7th	369	7	26	402	6	67.64%	73.68%
8th	373	7	26	406	6	67.64%	73.67%
Total 2017	1,480	28	104	1,612	6	67.64%	73.68%

On page 66, the applicant provides the following table illustrating historical and projected Lincoln County Hospice Services from FY2007 – FY2018.

Historical and Projected Lincoln County Hospice Services

		Historical					Projected						
		FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
A	Population	73,633	75,759	77,097	78,406	78,877	79,267	79,630	79,995	80,358	80,722	81,087	81,451
B	County Deaths	637	697	691	673	715	721	725	728	731	735	738	741
C	Death % of Pop	0.87%	0.92%	0.90%	0.86%	0.91%	0.91%	0.91%	0.91%	0.91%	0.91%	0.91%	0.91%
D	Days of Care	21,693	21,699	23,219	27,361	28,200	28,952	29,704	30,455	31,207	31,959	32,711	33,463
E	Hospice Deaths	222	216	246	213	240	254	270	286	303	321	340	361
F	Annual Increase Hospice Deaths*		-2.7%	13.9%	-13.4%	12.7%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%

Source: Days of Care, Deaths: NC Hospice Licensure Data Supplements

* Projected increase in hospice deaths at 6% is half the increase in hospice deaths between 2010 and 2011. The Compound Annual Growth Rate 2007 - 2011 is 1.97%.

The methodology and assumptions used to project Lincoln County Hospice Service Utilization provided in Section IV, pages 66-76 are outlined below.

Methodology:

Step A) Population – The applicant used 2007-2018 NC Office of State Budget and Management population estimates and projections.

Steps B and C) County Deaths as a Percent of Population - The applicant calculated Lincoln County annual deaths and found deaths averaged 0.91% of the population for FY2007-FY2011. The applicant projected Lincoln County deaths forward through 2018 at 0.91% of the projected population.

Step D) Days of Care – Lincoln County hospice days of care increased 30% from FY2007-FY2011. The 2013 SMFP projects 31,959 hospice days of care in 2016 for Lincoln County. The applicant projects a 3% average increase for FY2011-FY2014 and a 2% average increase annually for FY2015-FY2018.

Steps E and F) Hospice Deaths - The applicant recorded the number of Lincoln County hospice deaths for FY2007-FY2011 and calculated the annual increase in hospice deaths during that period. As the table above shows, FY2011 increased by 12.7% over 2010. On page 67, the applicant states, *"However, in projecting conservative hospice deaths, HPCCR used less than 50% of the annual death rate increase from FY2011 or 6.0% to project the number of Lincoln County hospice deaths through 2018."* The applicant projects hospice deaths forward, increasing 6% annually for a total of 361 hospice deaths in FY2018.

However, the annual increase in hospice deaths for FY2007-FY2011 was inconsistent, a decrease in some years and increase in others, with the Compound Annual Growth Rate (CAGR) being only 1.97%. One questions whether using a 6% annual increase in projecting hospice deaths is reasonable when the CAGR FY2007-FY2011 is only 1.97%. The following table demonstrates the difference in the projections using the two percentages.

	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Lincoln County Hospice Deaths 2011	240							
Projected Hospice Deaths @ 6%		254	270	286	303	321	340	361
Projected Hospice Deaths @ 1.97%		245	250	254	259	265	270	275
Difference in Projected Hospice Deaths		10	20	31	44	57	71	86
Hospice Deaths as % of Total Deaths @ 6%	33.6%	35.3%	37.2%	39.3%	41.4%	43.7%	46.1%	48.7%
Hospice Deaths as % of Total Deaths @ 1.97%	33.6%	33.9%	34.4%	35.0%	35.5%	36.0%	36.6%	37.1%

As the table above shows, there is a 30% difference in the projected number of hospice deaths by 2018. However, a comparison of Lincoln County hospice utilization with the hospice utilization of its contiguous counties shows that the 6% annual increase in projected hospice deaths brings Lincoln County hospice deaths as a percent of total deaths in line with Lincoln County's neighboring counties which provide inpatient hospice services.

County	FY2010	FY2011
Catawba	50.5%	59.5%
Cleveland	51.2%	47.7%
Gaston	46.7%	44.2%
Iredell	45.2%	45.8%
Mecklenburg	45.8%	47.7%
Average	47.9%	49.0%

The above comparison supports the use of a 6% increase as a reasonable assumption.

Inpatient Utilization Projections

The following table, from information provided in Section IV, page 68 of the application and the applicant's supplemental, clarifying information, reflects LCHH's projected inpatient days of care.

LCHH Inpatient Days of Care

		Projected		
		FY2016	FY2017	FY2018
A	Lincoln County	132	159	163
B	Other County	20	24	24
	Total Inpatients	152	183	187
C	ALOS per pg 22	8.11	8.11	8.11
D	Total Days of Care	1,235	1,481	1,517
E	Average Daily Census	3.4	4.1	4.2
F	Occupancy Rate	56.4%	67.6%	69.3%

The methodology and assumptions used to project LCHH inpatient utilization are provided on pages 68-69 and in the applicant's supplemental data, and outlined below.

Step A) Lincoln County Inpatients - The applicant projects inpatient hospice patients equal to 18% (735 * 18% = 132) of Lincoln County deaths in 2016, increasing to 22% (741 * 22% = 163) of Lincoln County total deaths in 2018. The applicant reviewed historical utilization for LDHH and noted that LDHH is on target to serve 39 Lincoln County patients in 2013. The applicant projects 29 will transfer to LCHH in the first year of operation. The applicant states, "*This percentage of county deaths will place Lincoln County in the range of adjacent rural inpatient hospice facilities.*"

Calculation for Step A (Supplemental Data)

	Projected		
	FY2016	**FY2017**	**FY2018**
Lincoln County Deaths	735	738	741
Inpatient Hospice Deaths %	18.0%	21.5%	22.0%
LCHH Deaths	132	159	163

The table on page 52 of the application shows Cleveland and Iredell counties serving hospice inpatient deaths at 18.8% and 22.0%, respectively, as a percent of total county deaths.

Step B) Other County Inpatients - The applicant reviewed historical utilization for LDHH patients originating from Gaston and Catawba counties and noted that LDHH is on target to serve 45 patients in 2013. The applicant projects 20 patients will transfer from LDHH to LCHH the first year of operation, increasing to 24 in the second two years.

Step C) Average Length of Stay (ALOS) – Based on historical ALOS for LDHH, the applicant projects an average length of stay of 8.11 days.

Step D) Total Days of Care - The applicant projected LCHH total days of care by multiplying total hospice inpatient admits (A+B) by the projected ALOS.

Step E) Average Daily Census - The applicant projected the average daily census by dividing the LCHH total days of care (D) by 365 (366 for leap year) days. (1,234 total days of care in FY2016 / 365 = 3.38 average daily census).

Step F) The applicant projected the occupancy rate by dividing the LCHH average daily census (E) by six beds.

In Section IV, page 70, the applicant provides the following table illustrating the projected LCHH Residential utilization.

Projected LCHH Residential Days of Care

	FY2016	FY2017	FY2018
Lincoln County Patient Admits	6	6	6
Other County Patient Admits	1	1	1
ALOS	14.9	14.9	14.9
Total Days of Care	104	104	104

Based on HPCCR experience, the applicant states it projects six patients from Lincoln County will be admitted to LCHH for residential care, rather than inpatient care in each of the first three years of operation. HPCCR expects one patient from outside Lincoln County will be admitted for residential care each year. ALOS of 14.9 is projected based on the average length of stay for residential patients at LDHH.

In Section IV, page 71, the applicant provides the following table illustrating the projected LCHH hospice respite patient utilization.

Projected LCHH Respite Days of Care

	FY2016	FY2017	FY2018
Lincoln County Patient Admits	6	6	6
ALOS	4.7	4.7	4.7
Total Days of Care	28	28	28

Based on HPCCR experience, the applicant states it projects six patients from Lincoln County will be admitted to LCHH for respite care, rather than inpatient care in each of the first three years of operation. ALOS of 4.7 is projected based on the average length of stay for respite patients at LDHH.

In Section II.2, page 20 and Section IV.2(b), page 72, and in supplemental data, the applicant provides a summary of LCHH inpatient, residential and respite care utilization for years FY2016 – FY2018, as illustrated in the table below.

LCHH Projected Hospice Utilization

Level of Care	FY2016	FY2017	FY2018
Inpatient			
Patients	152	183	187
Admissions	152	183	187
Deaths	124	148	152
Discharges	21	25	26
Residential			
Patients	21	21	22
Transfers	14	14	15
Admissions	7	7	7
Deaths	15	15	16
Discharges	6	6	6
Respite			
Patients	6	6	6
Admissions	6	6	6
Deaths	0	0	0
Discharges	6	6	6

In Section IV.4(a), page 74 and in clarifying supplemental data, the applicant provides the historical and projected utilization for FY2011 through FY2018 for its hospice agency office in Lincoln County, as shown in the table below. The table in Section II.2, page 21 should reflect the same corrected numbers from the supplemental data for the first three years following completion of the project (FY2016-FY2018).

HPCLC Projected Utilization Hospice Agency Office Excluding LCHH

		FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
A	Admits	259	267	275	284	293	302	320	330
B	Deaths	216	230	237	244	252	260	275	284
C	Discharges	43	37	38	39	41	42	44	46

The methodology and assumptions used to project HPCLC hospice agency admissions, deaths and discharges are provided on page 74 of the application and in the supplemental data, and are outlined below.

Step A) Admits - The applicant states HPCCR has experienced a one-year, 3.1% increase in unduplicated hospice program admissions from FY2010 to FY2011. The applicant used FY2012 267 unduplicated admissions as a base and projected an annual increase of 3.1% per year with an increase to 6% for FY2017, reflecting ramp up of the inpatient program.

Step B) Deaths - The applicant projected deaths based on HPCCR's two-year average death rate of 86.1% for years FY2010 – FY2011 and assumed the rate would remain constant through FY2018.

Step C) Discharges - The applicant projected discharges by subtracting projected deaths from projected admissions.

In Section IV.4(b), page 75, HPCCR provides the following from the 2013 License Application for Hospice: the current number of patients who are residents of nursing homes, the total number of nursing home days of care, ALOS and place of death as shown in the table below.

HPCCR Lincoln Office Nursing Home Data

	FY2012
Nursing Home Patients	86
Nursing Home Patient Days of Care	7,589
ALOS	88.2
Place of Death	58

Source: 2013 Hospice License Renewal Application

In Section IV.4(c), page 76, the applicant provides the historical and projected number of patients who are residents of nursing homes and the total projected nursing home days of care, ALOS and place of death as shown in the table below.

HPCCR Lincoln Office Nursing Home Data

	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2014**	**FY2015**	**FY2016**	**FY2017**	**FY2018**
Nursing Home Patients	95	86	99	101	102	104	105	107	109
Nursing Home Patient Days of Care	9,495	7,589	8,438	8,569	8,702	8,836	8,973	9,113	9,254
ALOS	99.9	88.2	85.2	85.2	85.2	85.2	85.2	85.2	85.2
Place of Death	61	58	61	68	69	70	71	72	73

The methodology and assumptions used to project utilization illustrated above are outlined below.

Step A) Nursing Home Patients - The applicant states HPCLC is expected to serve 99 nursing home patients in FY2012 and projects that nursing home patients will increase 1.6% annually through FY2018. In supplemental data, the applicant states that it projects a 1.6% increase as a conservative alternative to the 16.4% increase in FY2012 over FY2011 [(99-86)/86 = 16.4%].

Steps B and C) ALOS and Days of Care - The applicant has experienced a decrease in nursing home patients' ALOS occurred from FY2010 through FY2012. The applicant assumes the ALOS will remain at the FY2012 level, 85.2 days, through FY2018. (Patients X ALOS = Patient Days of Care).

Step D) Place of Death - In FY2011, HPCCR experienced a death rate of 67.4% for its hospice patients dying in a nursing home (58 projected deaths in nursing home / 86 nursing home patients = 0.674 = 67.4%). The applicant assumes the rate will remain relatively constant through FY2018.

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's projected utilization is reasonable based on the assumptions and methodology provided in the application and supplemental data. The applicant adequately identifies the population it proposes to serve and adequately demonstrates the need to develop the proposed hospice inpatient facility. Additionally, the applicant adequately demonstrates the projected utilization will exceed the performance standards as stated in 10A NCAC 14C .4003. 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.

C

In Section III.13, page 63, the applicant discusses the alternatives considered prior to the submission of this application, which include:

1) Maintain the Status Quo – The applicant states:

> *"As the primary provider of both home hospice and inpatient hospice care to Lincoln County patients, HPCCR determined that it is not reasonable to maintain the status quo."*

2) Develop an Inpatient Hospice Facility within an Existing Health Service Facility – The applicant states:

> *"HPCCR considered developing an inpatient hospice unit within an existing health service facility, but could not identify an existing facility that could accommodate the proposed 6-bed inpatient hospice facility. Most existing health service facilities within Lincoln County are assisted living and nursing home facilities where their residents can already receive hospice care. HPCCR does not consider developing an inpatient*

hospice unit within an existing health service facility to be a feasible alternative."

3) Construct a Freestanding Hospice House – The applicant states:

"HPCCR considers constructing a new freestanding hospice house to be the best solution to initiate inpatient hospice services in Lincoln County. The proposed inpatient hospice facility will be rightly sized and constructed and as such can be developed for under $3.0 million, not including the purchase of land."

Absence of an inpatient hospice facility in Lincoln County appears to foster far lower hospice utilization for Lincoln County than that of its adjacent counties with inpatient hospice facilities. 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 Lincoln County Hospice House shall materially comply with all representations made in its certificate of need application and supplemental information provided. In those instances where representations conflict, Hospice & Palliative Care Charlotte Region d/b/a Lincoln County Hospice House shall materially comply with the last made representations.**

2. **Hospice & Palliative Care Charlotte Region d/b/a Lincoln County Hospice House shall develop a 6-bed hospice inpatient facility and shall be licensed for a total of 6 hospice inpatient beds upon completion of this project.**

3. **Hospice & Palliative Care Charlotte Region d/b/a Lincoln County Hospice House shall acknowledge acceptance 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.

In Section VIII.1, page 96, the applicant projects that the total capital cost of the project will be $3,462,600 as shown in the table below.

Project Capital Costs

Land Purchase	$500,000
Construction Contract	$2,610,000
Equipment/Furniture	$113,800
Architect & Engineering Fees	$208,800
Consultant Fees	$30,000
Total Capital Cost	**$3,462,600**

Exhibit 12 contains a letter from the architect which states that total estimated construction costs are $2,610,000, which is consistent with the information in Section VIII.

In Section IX.1-4, pages 102-103, the applicant states start-up and initial operating expenses required for the project will total $155,983 and that the source of the working capital will be $155,983 from HPCCR's unrestricted cash. Exhibit 21 contains a letter from the President and CEO of HPCCR which states:

> *"Hospice & Palliative Care Charlotte Region (HPCCR) will obligate and commit $2,462,600 from cash and cash equivalents and $1,000,000 from fundraising activities to fund the capital costs associated with the development of the 6-bed Lincoln County Hospice House (LCHH) 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.*
> …
>
> *Hospice & Palliative Care Charlotte Region will obligate and commit $155,983 from cash and cash equivalents to fund the working capital associated with the start-up and initial operating expenses of the 6-bed LCHH project.*
>
> …
>
> *HPCCR projects the need for annual donations to cover hospice house expenses in the future. Annual donations total over $1.6 million per year."*

Exhibit 22 contains the financial statements for HPCCR for the years ending December 31, 2012 and 2011. As of December 31, 2012, HPCCR had cash and cash equivalents of $4,006,872, total current assets of $16,483,791 and total net assets of $27,111,279 (total assets – total liabilities).

The applicant provided pro forma financial statements for the first three years of the project. The applicant projects revenues will exceed operating expenses in the second and third operating years of the project, as illustrated in the table below. The applicant states it will use annual donations to offset the first year's operating loss.

Lincoln County Hospice House

6- Bed Inpatient Hospice Facility with Inpatient, Residential and Respite Days	Project Year 1	Project Year 2	Project Year 3
Projected # of days	1,367	1,613	1,649
Projected Average Charge	$ 599	$ 606	$ 607
Gross Patient Revenue	$ 819,140	$ 977,424	$ 1,000,588
Deductions from Gross Patient Revenue	$ 44,233	$ 52,781	$ 54,031
Net Patient Revenue	$ 774,907	$ 924,643	$ 946,557
Total Expenses	$ 900,960	$ 1,003,627	$ 1,023,900
Other Revenues – Physician Offset	$ 75,680	$ 89,229	$ 91,212
Net Income (Loss)*	$ 0	$ 10,245	$ 13,869

*The applicant projects an operating loss of $50,373 in Year 1, but also projects charitable donations in an equal amount, thereby eliminating the projected operation loss.

The assumptions used by the applicant in preparation of the pro forma financial statements (as revised in the supplemental data) are reasonable, including projected utilization, costs and charges. The service is profitable in years two and three. Per HPCCR President & CEO in the letter in Exhibit 21, any operating loss in year one will be offset by annual donations which total more than $1.6 million per year. See Section X.3 for patient per diem reimbursement rates. These rates were held constant and based on LDHH historical rates. See the pro forma in Section 13 for the assumptions regarding costs and charges. See Criterion (3) for discussion regarding projected utilization which is incorporated hereby as if fully set forth herein. The applicant adequately demonstrates that the financial feasibility of the proposal is based upon reasonable projections of costs and charges, and 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

The applicant proposes to construct and operate a six-bed hospice inpatient facility, pursuant to a need determination for 6 hospice inpatient beds in the 2013 SMFP. HPCCR currently operates a hospice home agency in Lincoln County (HPCLC) and has provided the county with hospice services for 30 years. HPCLC is the only in-county hospice agency providing hospice services to Lincoln County patients.

As discussed in Criterion (3), Lincoln County resident's use rate of hospice services is far lower than its neighboring counties. The applicant provides data on pages 51-52 of the application documenting that in FY2010 and FY2011, Lincoln County hospice deaths as a percent of total county deaths were 31.6% and 33.6%, respectively when the average for its five neighboring counties was 47.9% and 49%, respectively. The difference in the percent of inpatient hospice deaths served is even greater, with Lincoln County's 2011 percentage of 5.7% compared to the five-county average of 19.4%. The

five surrounding counties all provide in-county inpatient hospice units. The applicant states,

> *"The comparisons clearly indicate that the presence of an inpatient hospice facility not only increases the number and percentage of county deaths served by inpatient hospice services, but also increases the utilization of hospice care in general."*

Therefore, the applicant adequately demonstrates that the proposal will not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, 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 Table VII.2, pages 91-92, the applicant provides the proposed staffing for the proposed hospice inpatient facility in the second operating year, as shown in the table below.

	Annual Salary	**FTEs**
Routine Services		
Nurse Practitioner	$86,997	0.25
Nurse	$54,140	4.40
Nursing Assistant	$30,762	4.30
Social Work Services		
Social Worker	$46,953	0.50
Administrative		
Associate Medical Director	$178,479	0.20
Administrator	$82,977	1.00
Sr. Administrative Assistant	$34,519	1.00
Other Staff		
Cooks, Housekeeping, Maintenance	$26,290	3.05
Total Positions/Hours/FTEs		**14.70**

On page 93, the applicant projects the number of direct care staff. The applicant projects that a minimum of two staff members will be on duty at all times, including at least one registered nurse and one assistant per shift.

The applicant states that nurses will work 12.5 hours per shift (2 shifts) and nursing assistants will work 12.25 hours per shift. In the second year of operation, the applicant projects to provide 6.2 nursing hours per patient day (NHPPD) for inpatient services [(25 RN hours per day X 365 days = 9,125 RN hours) / 1,481 inpatient patient days of care = 6.16 NHPPD)].

The NHPPD in the second year of operation, serving a total of 1,613 inpatient, residential and respite days of care is 5.7 [(25 RN hours per day X 365 days = 9,125 RN hours) / 1,613 total patient days of care = 5.66 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 with 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.2, page 27, the applicant states that HPCCR provides all the listed hospice services in 10A NCAC 14C .4004(a). Exhibit 8 contains a letter from the President and CEO of HPCCR which states that HPCCR has provided hospice services to Lincoln County for more than 30 years and that HPCCR provides the following services: nursing, social work, counseling, bereavement, volunteer, physician and medical supply services.

Exhibit 14 contains copies of agreements between HPCCR and suppliers of durable medical equipment, and medical gases. Exhibit 9 contains HPCCR's agreement with Hospice Pharmacia for pharmaceuticals. Exhibit 25 contains letters of support from area physicians, hospitals and organizations, including Carolinas Health Care System, Caromont Cancer Center and others. Exhibit 18 contains service agreements between HPCCR and existing healthcare providers. In Section II, page 23, the applicant states the following regarding established relationships for referrals:

> *"HPCCR has established working relationships with many sources of referrals because it is the operator of an existing hospice program in Lincoln County and because it is the largest provider of hospice services in Lincoln County, nearly 69% of total hospice visits are provided by HPCCR."*

In supplemental information provided by the applicant, the applicant states that the following top 10 referral sources accounted for 362 referrals in FY2012.

- Carolinas Medical Center – Lincoln
- Brian Center of Lincolnton
- Gaston Memorial Hospital
- Cardinal Health Care & Rehab
- Lincoln Nursing Center
- Cammy Benton, MD
- Carolinas Medical Center

- Kindred Nursing and Rehabilitation – Lincoln
- Rober Reid, Jr., MD
- Health House

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 conforms 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.

C

The applicant proposes to build a new inpatient hospice facility. In Section XI.7, pages 122-124, the applicant states the proposed facility will have 8,700 square feet of space. On page 124, the applicant states that the construction cost is estimated to be $300 per

square foot. Exhibit 12 contains a letter from the architect verifying the estimated construction contract costs of $2,610,000, which is consistent with the information provided by the applicant in Section VIII.1, page 96. A line drawing of the proposed hospice inpatient facility is provided in Exhibit 12. In Section X.9, page 110, the applicant describes methods that will be used to maintain energy efficiency and contain the costs of utilities at the proposed hospice facility, which include energy conservation through the use of fluorescent lighting, insulated glass, gas heating, individual patient room heat pump controls, and a variable volume air system in common areas. Low-flow showerheads and toilets will be used for water conservation. See Criterion (5) for discussion of costs and charges which is hereby incorporated as if set forth fully herein.

The applicant adequately demonstrates that the cost and design of the facility are reasonable, and that the construction costs will not unduly increase the costs of the proposed services and that applicable energy saving features have been incorporated into the construction plans. Therefore, the application is conforming with 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.1, page 85, the applicant provides the payor mix for HPCCR-Lincoln County Office hospice patients and days of care provided by their certified hospice home care agency during the previous licensure year, as shown in the table below.

Hospice & Palliative Care Lincoln County

Payor	Hospice Patients	Hospice Days of Care
Medicare	88.9%	93.0%
Medicaid	3.9%	3.4%
Commercial	5.3%	2.7%
Private Pay	1.9%	0.9%
Total	**100.0%**	**100.0%**

In Section VI.5, page 84, the applicant states:

"HPCCR participates in the Medicare and Medicaid program and other wise provides care to the elderly. HPCCR will continue to make available services to low-income persons needing care.

HPCCR's Admission Criteria Policy guarantees equal access to hospice services for members of all racial, ethnic and religious minority groups.

HPCCR does not discriminate on the basis of gender as stated in the Admission Criteria Policy.

LDHH [sic] *will conform to the North Carolina State Building Code, the National Fire Protection Association 101 Life Safety Code, the Rules and statutes applying to the Licensing of Hospices in North Carolina, ANSI Standards for Handicapped Access, and any of the requirements of federal, state and local bodies.*

HPCCR is and will continue to be accessible to all persons, including the medically indigent and terminally ill children."

Exhibit 7 contains a copy of the Admission Criteria Policy. Exhibit 20 contains a copy of the Special Financial Consideration Policy.

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 for Lincoln County and statewide.

	2011 Total # of Medicaid Eligibles as % of Total Population *	**2011 Total # of Medicaid Eligibles Age 21 and older as % of Total Population ***	**2008-09 % Uninsured (Estimate by Cecil G. Sheps Center) ***
Lincoln County	15%	6.2%	19.0%
Statewide	17%	6.7%	19.7%

* More current data, particularly with regard to the estimated uninsured percentages, was not available.

The majority of Medicaid eligibles are children under the age of 21. This age group would not typically utilize the health services proposed in this application, particularly the services offered by hospice inpatient facilities.

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 payor 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 have adequate access to existing services; 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 86, the applicant states that there have been no such complaints filed against HPCCR or LDHH. 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 83, the applicant provides the projected payor mix for inpatient services for the second year of operation (FY2017) at the proposed new facility, as shown in the table below.

LCHH Projected Payor Mix Year 2

Payor	Hospice Inpatients and Days of Care	Hospice Residential Patients and Days of Care
Medicare	66.7%	84.8%
Medicaid	12.2%	10.7%
Commercial	20.2%	4.5%
Private Pay and Indigent	0.9%	0.0%
Total	**100.0%**	**100.0%**

The projected payor mix above shows 80% to 95% of total days of care are expected to be paid by Medicare or Medicaid. This is consistent with the statewide hospice payor mix of combined Medicare/Medicaid of over 90% provided in the FY11 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 with 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 86, the applicant states:

> *"Access to all hospice services requires a physician referral and certificate of eligibility. A HPCCR patient's plan of care will include admission to the LCHH. The interdisciplinary team, including physician and medical director, makes the decisions regarding the care plan. A person seeking admission to the LCHH will have to be referred by their attending physician and fulfill admission criteria for the inpatient hospice facility.*
>
> *HPCCR staff will provide ongoing public information about the LCHH including admission requirements. Admissions to the inpatient hospice*

facility are transfers from home, hospitals, nursing homes and other hospices."

Exhibit 7 contains a copy of the Admission Criteria Policy.

The applicant adequately demonstrates the range of means by which a person will have access to the proposed hospice facility; 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(c), page 77, the applicant states:

"HPCCR, which includes LDHH and will include LCHH, offers an opportunity to educate health science students, especially medical students, medical residents, and nursing students, in palliative care, pain and symptom management, as well as the basic concepts of a hospice program."

Exhibit 17 contains copies of training program affiliation agreements between HPCCR and Central Piedmont Community College, Gardner-Webb University, University of North Carolina at Chapel Hill, University of North Carolina at Greensboro, and Western Carolina 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

The applicant, HPCCR, proposes to develop a new hospice inpatient unit with six hospice inpatient beds to be located in Denver, Lincoln County, NC. The applicant plans

to construct an 8,700 square foot building to accommodate the six-bed hospice inpatient unit which will be known as Lincoln County Hospice House.

HPCCR operates HPCLC, the only licensed hospice agency in Lincoln County, which served 360 hospice patients in 2012.

In Section III.3, page 54, the applicant discusses how the proposed project and any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access of underserved groups to the proposed services. The applicant states that the development of LCHH will provide access to inpatient services for Lincoln County hospice patients. The applicant further states,

> *"Choice helps promote competition and competition helps promote better alternatives for the patients. HPCCR will complement the needs and ever growing demands of the patients, staff, and physicians within the service area. This project will promote an* [sic] *community-based inpatient hospice facility that will be open to all patients within the service area."*

In Section V.7, page 81, the applicant summarizes its expected impact on hospice patients, stating,

> *"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. The LCHH will offer 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."*

Quality is discussed in Section II.4, pages 41-43; and Section III.3, page 55. Exhibit 15 contains a copy of HPCCR's Quality Assessment Performance Improvement Plan. Access for underserved groups is discussed in Section III.3, page 54, Section V.7, page 81 and Section VI, pages 83-84.

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 a 6-bed inpatient hospice in Lincoln County 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.

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

HPCCR proposes to develop a six-bed inpatient hospice facility (Lincoln County Hospice House) in Lincoln County. HPCCR currently owns and operates Hospice & Palliative Care Lincoln County, the only hospice agency located in Lincoln County. According to the Acute and Home Care Licensure and Certification Section, DHSR, no incidents occurred within the eighteen months immediately preceding the date of this 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, 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 and in supplemental data, the applicant provides the projected number of hospice inpatient, residential and respite admissions, deaths, and other discharges to be served in LCHH in each of the first three years following completion of the project as shown in the tables below. The methodology and assumptions used to develop the projections are provided in Section IV.2(b), pages 66-75. See Criterion 3 for the discussion on methodology and assumptions, which is incorporated hereby as if set forth fully herein.

LCHH Projected Patients by Level of Care

Level of Care	FY2016	FY2017	FY2018
Inpatient			
Patients	152	183	187
Admissions	152	183	187
Deaths	124	148	152
Discharges	21	25	26
Residential			
Patients	21	21	22
Transfers	14	14	15
Admissions	7	7	7
Deaths	15	15	16
Discharges	6	6	6
Respite			
Patients	6	6	6
Admissions	6	6	6
Deaths	0	0	0
Discharges	6	6	6

(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 II.2, page 21 and in supplemental data, 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, pages 65-76. See Criterion 3 for the discussion on methodology and assumptions, which is incorporated hereby as if set forth fully herein.

HPCCR Total Lincoln County Hospice Operations

Level of Care	Year 1 FY2016	Year 2 FY2017	Year 3 FY2018
Home Care			
Patients	302	320	330
Admissions	302	320	330
Deaths	260	275	284
Discharges	42	44	46
Inpatient			
Patients	152	183	187
Admissions	152	183	187
Deaths	124	148	152
Discharges	21	25	26
Residential			
Patients	21	21	22
Transfers	14	14	15
Admissions	7	7	7
Deaths	15	15	16
Discharges	6	6	6
Respite			
Patients	6	6	6
Admissions	6	6	6
Deaths	0	0	0
Discharges	6	6	6

(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 and IV.2, pages 68, 70 and 71, the applicant shows projected annual number of patient care days for Inpatient, Residential and Respite levels of care, respectively, as shown in the table below. The methodology and assumptions used to develop the projections are provided in Section IV.2, pages 66-72. See Criterion 3 for the discussion on methodology and assumptions, which is incorporated hereby as if set forth fully herein.

LCHH Projected Patient Care Days

Care Level	Year 1 FY2016	Year 2 FY2017	Year 3 FY2018
Inpatient	1,235	1,481	1,517
Residential	104	104	104
Respite	28	28	28

(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.2, pages 68, 70 and 71, the applicant provides the projected average length of stay (ALOS) for the Inpatient, Residential and Respite levels of care, respectively, as shown in the table below:

LCHH Projected 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, pages 66-72. See Criterion 3 for the discussion on methodology and assumptions, which is incorporated hereby as if set forth fully herein.

(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 provides information indicating they anticipate 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, the applicant provides the projected average cost per patient day by level of care. In Form C, the applicant provides the projected average annual cost per patient care day, for the Inpatient, Residential and Respite levels of care for each of the first three operating years following completion of the project, as shown below. The assumptions are provided in the pro forma statements and assumptions in Section XIII.

Care Level	Year 1 FY2016	Year 2 FY2017	Year 3 FY2018
Inpatient	$673.15	$632.39	$630.84
Residential	$488.23	$474.53	$473.57
Respite	$673.15	$632.39	$630.84

(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, page 23, the applicant states:

> *"HPCCR has established working relationships with many sources of referrals because it is the operator an existing hospice program in Lincoln County and because it is the largest provider of hospice services in Lincoln County, nearly 69% of total hospice visits 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, 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 refer over 200 patients per year to the HPCCR, as the benefits of hospice care become more prevalent in Lincoln County, these physicians and HPCCR executives believe that inpatient hospice care will increase in utilization."*

In supplemental information provided by the applicant, the applicant states that the following top 10 referral sources accounted for 362 referrals in FY2012.

- Carolinas Medical Center – Lincoln
- Brian Center of Lincolnton
- Gaston Memorial Hospital
- Cardinal Health Care & Rehab
- Lincoln Nursing Center
- Cammy Benton, MD
- Carolinas Medical Center
- Kindred Nursing and Rehabilitation – Lincoln
- Rober Reid, Jr., MD
- Health House

Therefore, the application is conforming to this rule.

(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 the 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 IV.2, page 65, the applicant shows that in the last six months of the first operating year, the average occupancy rate for inpatient and for inpatient, residential and respite levels of care combined is projected to be at least 50 percent, as shown in the following table.

LCHH Projected Quarterly Utilization Year One

	Patient Days				# of Beds	Occupancy Rate	
Quarter	Inpatient	Respite*	Residential*	Total	Total	Inpatient	Total
1st	261	7	26	294	6	47.67%	53.70%
2nd	279	7	26	312	6	50.96%	56.99%
3rd	333	7	26	366	6	60.82%	66.85%
4th	362	7	26	395	6	66.12%	72.15%
Total FY2016	1,235	28	104	1,367	6	56.39%	62.42%

*Residential and Respite patients will be served in Inpatient beds. Patient Days = Admits x ALOS

(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- Data provided by the applicant in Section IV.2, page 65 of the application and in the table below shows the average occupancy rate for the licensed hospice beds is projected to be at least 65% for the second operating year following completion of the project.

LCHH Projected Quarterly Utilization Year Two

	Patient Days				# of Beds	Occupancy Rate	
Quarter	Inpatient	Respite*	Residential*	Total	Total	Inpatient	Total
5th	373	7	26	406	6	68.13%	74.16%
6th	365	7	26	398	6	66.67%	72.69%
7th	369	7	26	402	6	67.40%	73.42%
8th	373	7	26	406	6	68.13%	74.16%
Total FY2017	1,480	28	104	1612	6	67.58%	73.61%

*Residential and Respite patients will be served in Inpatient beds. Patient Days = Admits x ALOS

(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.

-NA- The applicant is not proposing to add hospice inpatient beds to an existing hospice inpatient facility.

(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 the rule will be provided by HPCCR.

(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 93, the applicant shows that 2.0 RNs and 2.0 CNAs will work each 24 hour period, divided between the day, evening and night shifts. 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. The applicant also states LCHH will have on-call services.

(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 LCHH patients 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 the staffing of the inpatient hospice facility will comply with the requirements of N.C.G.S. 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 LCHH will staff consistent with licensure requirements in 10A NCAC 13K. The applicant further states that as shown in the staffing table in Section VII, it will:

- 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.

(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 LCHH 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 policies related to the Orientation Process, Competency/Licensure and Supervision Policies, and Staff Education and Training. Exhibit 11 contains copies of position 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 Exhibit 12, the applicant provides a letter from the project architect stating that LCHH inpatient facility will be designed in a home-like setting.

(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- The applicant provides a letter from the project architect in Exhibit 12 which states that

LCHH services will conform 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.

-C- Exhibit 23 contains a letter of intent from HPCCR President & CEO to acquire the primary or secondary site if the application is approved. The same exhibit contains a letter from a Lincoln County realtor stating the properties are available and properly zoned.