



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor  
MANDY COHEN, MD, MPH • Secretary  
MARK PAYNE • Director, Division of Health Service Regulation

**RESPONSE REQUIRED**

January 29, 2019

Wanda Coley  
6752 Parker Farm Drive  
Suite 210  
Wilmington, NC 28405

**Conditional Approval**

Project ID #: J-11615-18  
Facility: Well Care Home Health  
Project Description: Develop a new Medicare-certified home health agency in Wake County pursuant to the Need Determination in the 2018 State Medical Facilities Plan  
County: Wake  
FID #: 180512

Approved Capital Expenditure: \$100,000  
Conditions of Approval: See Attachment A  
Approved Timetable: See Attachment B  
Last Date to Appeal: February 28, 2019  
Required State Agency Findings: Will be mailed within five business days after the date of this letter

Dear Ms. Coley:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency) has conditionally approved the above referenced certificate of need application. This decision was made after review of the application or applications if the review was competitive, consideration of the Certificate of Need Law and regulations promulgated thereunder, the State Medical Facilities Plan, written comments if any, responses to comments if any, and other publicly applicable information.

The conditional approval is valid only for the approved capital expenditure shown above. If a cost overrun occurs that exceeds the approved capital expenditure amount, a new certificate of need may be required based on N.C. Gen. Stat. §131E-176(16)(e).

The applicant shall not proceed with the construction, offering or development of this project until the certificate of need is issued. Furthermore, the Agency shall not issue the certificate of need until all applicable conditions of approval have been met pursuant to N.C. Gen. Stat. §131E-187(a). **Response to the conditions in Attachment A should be submitted to the Agency no later than 35 days from the date of the decision. Failure to respond within this time period may result in the Agency making a determination not to issue a certificate of need for the project referenced above.**

The timetable for completion of the project is the timetable outlined in the certificate of need application, unless an adjustment has been made by the Agency because the review period was extended. The approved timetable for this project is found in Attachment B.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

HEALTHCARE PLANNING AND CERTIFICATE OF NEED SECTION

LOCATION: 809 Ruggles Drive, Edgerton Building, Raleigh, NC 27603  
MAILING ADDRESS: 2704 Mail Service Center, Raleigh, NC 27699-2704  
www.ncdhhs.gov/dhsr • TEL: 919-855-3873

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

The Certificate of Need law provides that any affected person has thirty (30) days after the date of the decision to file a petition for a contested case on this approval. Further, if you are aggrieved by any of the conditions you may file a petition for a contested case hearing in accordance with N.C. Gen. Stat. §150B, Article 3. This petition must be filed with the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, North Carolina 27699-6714 within thirty (30) days of the date of this decision. Effective October 1, 2009, OAH requires a filing fee with submittal of petitions for contested cases. Please direct all questions regarding this fee to the OAH Clerk's Office (919-431-3000).

N.C. Gen. Stat. §150B-23 provides that a party filing a petition must also serve a copy of the petition on all parties to the petition. Therefore, if you file a petition for a contested case hearing, you must serve a copy of the petition on the Department of Health and Human Services by mailing a copy of your petition to:

Lisa G. Corbett  
Department of Health and Human Services,  
Office of Legal Affairs,  
Adams Building – Room 154  
2001 Mail Service Center  
Raleigh, North Carolina, 27699-2001


It is requested that a copy of the petition also be served on the Agency.

The certificate of need will not be issued before the completion of thirty day appeal period which ends on the date shown above. If a contested case petition is filed with OAH within the thirty day appeal period, the certificate will not be issued until the appeal is resolved.

If the decision is appealed, the timetable set forth in this letter will be adjusted accordingly before the certificate of need is issued. Please contact this office if any clarification of this decision is required.

Please refer to the Project ID # and Facility ID # (FID) in all correspondence.

Sincerely,

  
Bernetta Thorne-Williams  
Project Analyst

  
Lisa Pittman  
Assistant Chief

Enclosures:

Attachment A: Conditions of Approval  
Attachment B: Approved Timetable

cc: Acute & Home Care Licensure & Certification Section, DHSR  
Melinda Boyette, Administrative Assistant, Healthcare Planning, DHSR

**Attachment A**  
**Conditions of Approval**

- 1. Well Care Home Health of the Southern Triangle, Inc., d/b/a/ Well Care Home Health shall materially comply with all representations made in the certificate of need application.**
- 2. Pursuant to the need determination identified in the 2018 State Medical Facilities Plan, Well Care Home Health of the Southern Triangle, Inc., d/b/a/ Well Care Home Health shall develop no more than one Medicare-certified home health care agency in Wake County.**
- 3. Upon completion of the project, Well Care Health, LLC shall be licensed for no more than two Medicare-certified home health care agencies in Wake County.**
- 4. No later than three months after the last day of each of the first three full years of operation following initiation of the services authorized by this certificate of need, Well Care Home Health of the Southern Triangle, Inc., d/b/a/ Well Care Home Health shall submit, on the form provided by the Healthcare Planning and Certificate of Need Section, an annual report containing the:**
  - a. Payor mix for the services authorized in this certificate of need.**
  - b. Utilization of the services authorized in this certificate of need.**
  - c. Revenues and operating costs for the services authorized in this certificate of need.**
  - d. Average gross revenue per unit of service.**
  - e. Average net revenue per unit of service.**
  - f. Average operating cost per unit of service.**
- 5. Well Care Home Health of the Southern Triangle, Inc., d/b/a/ Well Care Home Health shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Agency in writing prior to issuance of the certificate of need.**



**Attachment B**  
**Approved Timetable**

1. Services Offered \_\_\_\_\_ May 4, 2019

