COMPETITIVE COMMENTS ON MECKLENBURG COUNTY

2021 MEDICARE-CERTIFIED HOME HEALTH AGENCY NEED DETERMINATION

SUBMITTED BY WELL CARE TPM, INC. / PROJECT ID F-012071-21

Well Care TPM, Inc. (Well Care) proposes to develop a home health agency in Mecklenburg County (Project ID No. F-012071-21). Four additional applications were submitted in response to the need determination in the 2021 State Medical Facilities Plan ("SMFP") for one new Medicare-certified home health agency in Mecklenburg County:

These comments are submitted by Well Care in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to address the representations in the applications, including a comparative analysis and a discussion of the most significant issues regarding the applicants' conformity with the statutory and regulatory review criteria ("the Criteria") in N.C. Gen. Stat. §131E-183(a) and (b). Other non-conformities in the competing applications may exist. Nothing in these Comments is intended to amend the Well Care Application and nothing contained here should be considered an amendment to the Well Care Application as submitted.

COMMENTS REGARDING COMPARATIVE REVIEW

The Healthcare Planning and Certificate of Need Section developed a list of suggested comparative factors for competitive batch reviews. The following factors are suggested for all reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Historical Utilization
- Geographic Accessibility (Location within the Service Area)
- Access by Service Area
- Access by Underserved Groups: Charity Care
- Access by Underserved Groups: Medicaid
- Access by Underserved Groups: Medicare
- Competition (Access to a New or Alternate Provider)
- Projected Average Net Revenue per Patient, Procedure, Case, or Visit
- Projected Average Total Operating Cost per Patient, Procedure, Case, or Visit

The following additional factor is suggested for home health proposals:

- Average Number of Visits per Patient

Project Analysts have the discretion to apply additional factors based on the type of proposal.

Conformity to CON Review Criteria

Five CON applications have been submitted seeking one home health agency in Mecklenburg County. Based on the 2021 SMFP's need determination for one additional home health agency, only one application can be approved. Only applicants demonstrating conformity with all applicable Criteria can be approved, and only the application submitted by Well Care demonstrates conformity to all Criteria:

Conformity of Competing Applications

Applicant	Project I.D.	Conforming/ Non-Conforming
BAYADA Home Health	F-012053-21	No
Aldersgate Home Health	F-012058-21	No
PHC Home Health	F-012061-21	No
Well Care TPM, Inc.	**F-012071-21**	**Yes**
PruittHealth @ Home – Home Health	F-012072-21	No

The Well Care application for a new home health agency is based on reasonable and supported volume projections and adequate projections of cost and revenues. As discussed below, the competing applications contain errors and flaws which result in one or more non-conformities with statutory and regulatory review Criteria. Therefore, Well Care is the most effective alternative regarding conformity with the review criteria.

Scope of Services

Each of the five applications proposes developing a Medicare-certified home health agency in Mecklenburg County providing services, including skilled nursing, home health aide, therapy services, and medical social work services. Therefore, the applications are all equally effective alternatives concerning this comparative.

Historical Utilization

Three applicants provided home health services in Mecklenburg County during FFY2019 (either directly or via affiliate entity). The following table illustrates the historical utilization of the respective providers as provided in the Proposed 2021 SMFP representing FY2019 reported utilization.

Home Health Offices Serving Mecklenburg County Home Health Patients
Proposed 2021 SMFP Based on FY2019 Data

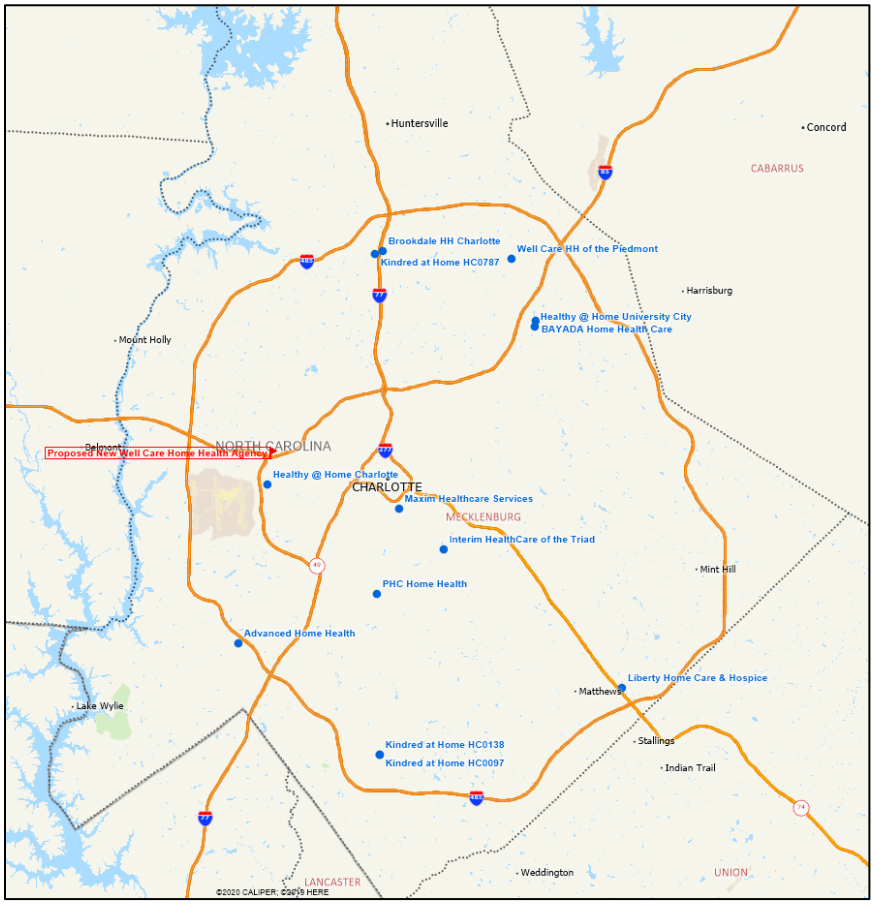
	Medicare-Certified Home Health Agency in Mecklenburg County	Medicare-Certified Home Health Agency in NC	Medicare-Certified Home Health Office Outside NC
BAYADA	Yes	Yes	Yes
Aldersgate	No	No	No
PHC	Yes	Yes	No
Well Care	Yes	Yes	No
PruittHealth	No	Yes	Yes

Except for Aldersgate, each applicant has experience providing Medicare-certified home health services, either in North Carolina or outside of North Carolina. Therefore, Bayada, PHC, Well Care, and PruittHealth are equally effective alternatives with respect to this comparative factor, and Aldersgate is the least effective alternative regarding historical utilization.

Geographic Accessibility (Location within the Service Area)

The 2021 SMFP identifies the need for one Medicare-certified home health agency in Mecklenburg County. There are currently thirteen Medicare-certified home health agencies located throughout Mecklenburg County. The following table and map summarize their addresses and geographic locations within the county.

Agency	Address	City	Zip Code	Geography Within County
Advanced Home Health	2520 Whitehall Park Drive	Charlotte	28273	Southwest
Healthy @ Home Charlotte	5040 Airport Center Parkway	Charlotte	28209	West
Healthy @ Home University City	101 East W.T. Harris Blvd	Charlotte	28262	Northeast
BAYADA Home Health Care	8801 JM Keynes Drive	Charlotte	28262	Northeast
Brookdale HH Charlotte	9300 Harris Corners Parkway	Charlotte	28269	North
Interim HealthCare of the Triad	330 Billingsley Road	Charlotte	28211	Central
Kindred at Home HC0138	11111 Carmel Commons Blvd	Charlotte	28226	South
Kindred at Home HC0787	9009 Perimeter Woods Drive	Charlotte	28216	North
Kindred at Home HC0097	11111 Carmel Commons Blvd	Charlotte	28226	South
Liberty Home Care & Hospice	2015 Moore Road	Matthews	28105	Southeast
Maxim Healthcare Services	1300 Baxter Street	Charlotte	28204	Central
PHC Home Health	1515 Mockingbird Lane	Charlotte	28209	South
Well Care HH of the Piedmont	11020 David Taylor Drive	Charlotte	28262	Northeast



Since a home health agency serves patients in their place of residence, the geographic location of the home health office is not a determinative factor. Therefore, the applications are equally effective with respect to geography.

Access By Service Area Residents

On page 217, the 2021 SMFP states, "*A Medicare-certified home health agency or office's service area is the county in which the agency or office is located. Each of the 100 counties in the state is a separate service area*." Therefore, for the purpose of this review, Mecklenburg County is the service area. Facilities may also serve residents of counties not included in their service area.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

	Total # of New (Unserved) Mecklenburg County Residents Served	Total # of New (Unduplicated) Patients Served	Mecklenburg County Residents Served as a % of Total New Patients Served
WellCare	**752**	**818**	**91.9%**
Bayada	1,342	1,863	72.0%
PHC	599	1,007	59.5%
PruittHealth	786	889	88.4%
Aldersgate	550	550	100.0%
Family First	159	316	50.3%

As shown in the table above, BAYADA, PHC, and PruittHealth, in that order, project to serve the highest total number of Mecklenburg County residents. However, as discussed separately in these comments, neither BAYADA, PHC, nor PruittHealth conform to all applicable statutory and regulatory criteria, and therefore BAYADA, PHC, and PruittHealth are not approvable. After PruittHealth, **Well Care** projects to serve the highest total number of Mecklenburg County residents. After Aldersgate, Well Care projects to serve the highest percentage of Mecklenburg County residents as a percentage of total new patients served. As described later in this document, the Aldersgate application does not conform to all applicable statutory and regulatory criteria and therefore is not approvable. Therefore, **Well Care** is the most effective alternative, and the remaining applications are less effective with respect to access by service area residents.

Access By Underserved Groups

Underserved groups are defined in G.S. 131E-183(a)(13) as follows:

"*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 access by underserved groups, applications are compared with respect to three underserved groups: charity care patients (i.e., medically indigent or low-income persons), Medicare patients, and Medicaid patients. Access by each group is treated as a separate factor.

The Agency may use one or more of the following metrics to compare the applications:

- Total charity care, Medicare or Medicaid admissions
- Charity care, Medicare or Medicaid admissions as a percentage of total admissions
- Total charity care, Medicare or Medicaid dollars
- Charity care, Medicare or Medicaid dollars as a percentage of total gross or net revenues

The above metrics the Agency uses are determined by whether or not the applications included in the review provide data that can be compared as presented above and whether or not such a comparison would be of value in evaluating the alternative factors.

Projected Charity Care

The following table compares projected charity care in the third full fiscal year following project completion for all the applicants as a percentage of gross revenue and per admission.

	Charity Care	# of Unduplicated Admissions	Charity Care per Unduplicated Admission	Gross Revenue	Charity Care as a % of Gross Revenue
WellCare	**$41,344**	818	**$51**	$2,756,285	**1.5%**
Bayada	$38,585	1,863	$21	$7,717,058	0.5%
PHC	$21,872	996	$22	$2,210,986	1.0%
PruittHealth	$44,290	888	$50	$3,794,706	1.2%
Aldersgate	$36,495	550	$66	$2,150,000	1.7%

Aldersgate projects the highest charity care per unduplicated admission and the highest Charity Care as a percent of Gross Revenue. However, Aldersgate is not conforming to all applicable statutory and regulatory criteria, and therefore Aldersgate is not approvable. After Aldersgate, Well Care projects the highest charity care per unduplicated admission and the second highest Charity Care as a percent of gross

revenue. Therefore, regarding overall access to Charity Care, **Well Care** is the most effective alternative, and the remaining applications are less effective with respect to this comparative factor.

Projected Medicare

The following table compares projected access by Medicare patients in the third full fiscal year following project completion for all the applicants in the review.

	Medicare Revenue (Form F.2b)	Duplicated Medicare Clients (Form C.5)	Revenue per Medicare Client	Gross Revenue (Form F.2b)	Medicare Revenue as a % of Gross Revenue
WellCare	$2,337,042	844	**$2,769**	$2,756,285	**84.8%**
Bayada	$5,621,295	2,066	$2,721	$7,717,058	72.8%
PHC	$1,618,789	930	$1,741	$2,210,986	73.2%
PruittHealth	$2,922,496	2,349	$1,244	$3,794,706	77.0%
Aldersgate	$1,879,620	443	$4,243	$2,150,000	87.4%

PruittHealth proposes the highest number of Medicare clients. Aldersgate proposes the highest Medicare revenue per client and highest Medicare revenue as a percent of gross revenue. Well Care proposes the second-highest Medicare revenue per client and highest Medicare revenue as a percent of gross revenue. Neither PruittHealth nor Aldersgate comply with all applicable statutory and regulatory criteria, and therefore, neither Pruitt Health nor Aldersgate is approvable. Therefore, regarding access by Medicare patients, **Well Care** is the most effective alternative.

Projected Medicaid

The following table compares projected access by Medicaid patients in the third full fiscal year following project completion for all the applicants in the review.

	# of Duplicated Clients	Number of Duplicated Medicaid Clients	Duplicated Medicaid Patients as a % of Total Duplicated Patients	Gross Revenue	Medicaid Revenue (Form F.2b)	Medicaid Revenue as a % of Gross Revenue
WellCare	2,521	**315**	12.5%	$2,756,285	$241,549	**8.8%**
Bayada	7,395	74	1.0%	$7,717,058	$38,927	0.5%
PHC	1,277	292	22.9%	$2,210,986	$376,423	17.0%
PruittHealth	3,040	456	15.0%	$3,794,706	$229,816	6.1%
Aldersgate	675	24	3.5%	$2,150,000	$38,895	1.8%

PruittHealth projects the highest number of duplicated Medicaid clients, and PHC projects the highest Medicaid Revenue as a percent of gross revenue. However, PruittHealth and PHC do not conform with all applicable statutory and regulatory criteria and, therefore, PruittHealth and PHC cannot be approved. Well Care projects the second-highest number of duplicated Medicaid clients and PHC projects the highest Medicaid Revenue as a percent of gross revenue. Therefore, **Well Care** is the most effective alternative with respect to access for Medicaid home health patients.

Projected Charges Per Visit by Staff Discipline

The following table compares charges per visit by staff discipline in the third full fiscal year following project completion for all the applicants in the review. Projected charges were obtained from Form F.5 of the respective applications.

Charges per Visit by Staff Discipline, Project Year 3

	Nursing	Physical Therapy	Speech Therapy	Occupational Therapy	Social Worker	Home Health Aide
WellCare	**$135.00**	**$135.00**	**$135.00**	**$135.00**	$350.00	$70.00
Bayada	$232.00	$232.00	$232.00	$232.00	$315.00	$96.00
PHC	$139.34	$171.49	$171.49	$171.49	$203.65	$64.31
PruittHealth	$165.00	$175.00	$175.00	$175.00	$195.00	$29.00
Aldersgate	$200.00	$200.00	$200.00	$210.00	$230.00	$200.00

Source: Form F.5 from each application

As discussed in detail below, Form F.5 provides the appropriate information for the Agency to evaluate potential costs to patients and third-party payors. Generally speaking, commercial insurance and private pay patients reimburse home health providers on a per visit basis. Thus, lower charges per visit may indicate comparatively lower cost to patients and third-party payors. Medicare and Medicaid have set payments for home health reimbursement that do not vary depending on the provider of the service; therefore, Medicare and Medicaid will not incur higher costs for the services proposed.

Well Care projects the lowest charges per visit for nursing, physical therapy, speech therapy, and occupational therapy and is the most effective alternative for this comparative factor and is the most effective alternative regarding costs to patients and third-party payors.

Projected Average Net Revenue

The following table compares the projected average net revenue per patient day and projected average net revenue per patient for the third year of operation following project completion for all the applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

	# of Unduplicated Admissions	Net Revenue	Net Revenue per Unduplicated Admission
WellCare	818	$2,646,687	**$3,236**
Bayada	1,863	$7,192,298	$3,861
PHC	996	$2,143,964	$2,153
PruittHealth	888	$1,938,473	$2,183
Aldersgate	550	$2,001,790	$3,640

Source: Form C.5 and Form F.2 from each application

As described in the comments regarding PHC's application, PHC's Medicare revenue model erroneously projects reimbursement based on only one 30-day period instead of two 30-day periods, which are included in a 60-day episode. Therefore, PHC's low average net revenue per unduplicated admission is inaccurate. See PHC comments regarding Criterion 5. Consequently, the **Agency cannot determine PHC is the most effective alternative with regard to net revenue per unduplicated admission**.

Regarding this factor, historically the Agency has generally considered the application proposing the lowest average net revenue as the more effective alternative citing the rationale that "a lower average may indicate a lower cost to the patient or third-party payor."[1] However, this is not an accurate conclusion for home health services, especially with consideration of the new CMS PDGM payment system.

[1] Agency Findings for 2019 Wake County MRI Review

The applicants in this Mecklenburg County home health batch review project Medicare and Medicaid reimbursement will account for approximately 73% - 94% of total projected gross revenue. Medicare and Medicaid have set payments for home health reimbursement that do not vary depending on the provider of the service; therefore, the payors for the proposed services will not incur higher costs for the services proposed.

In the context of a comparative analysis, it is critical to note CMS's shift from Prospective Payment System (PPS) to PDGM on January 1, 2020 was a "sea change" that fundamentally overhauled Medicare's home health reimbursement model, thereby significantly impacting how home health revenue is derived. Please see Attachment 1 for an overview of PDGM.

The new PDGM payment construct is a case-mix classification model which factors in the acuity of each patient. PDGM relies more heavily on clinical characteristics and other patient information to place home health periods of care into meaningful payment categories. The case-mix weight for each of the 432 different payment groups under the PDGM is determined by estimating a regression where the dependent variable is the resource use of a 30-day period and the independent variables are categorical indicators representing the five dimensions of the model (timing of a 30-day period, admission source, clinical group, functional impairment level, and comorbidities). In other words, reimbursement under the new CMS PDGM payment system is based on the patient's clinical characteristics. Under PDGM, higher revenues reflect a home health provider caring for a higher complexity of patients. Thus, in this competitive batch review, it would be inappropriate for the Agency to penalize an applicant for comparatively higher net revenues because the revenues are merely a reflection of a patient's admission source, clinical group, functional impairment level, and comorbidities. Doing so would effectively penalize providers for taking care of those home health patients that are the sickest and most in need.

Furthermore, Form F.5 provides the appropriate information for evaluating costs to patients and third-party payors. Specifically, the Agency can compare the projected charges per visit by staff discipline in the third full fiscal year. As discussed in the previous comparative factor, **Well Care projects the lowest charges per visit for nursing, physical therapy, speech therapy, and occupational therapy and is the most effective alternative regarding costs to patients and third-party payors**.

Therefore, because 1) the payors for the proposed home health services will not incur higher costs for the services proposed and 2) the methodology for projecting Medicare PDGM payment is based on clinical characteristics, the Agency cannot make a conclusive determination regarding the most effective alternative for this comparison.

Projected Average Total Operating Cost

The following table compares the projected average operating expense per patient day and per admission for the third year of operation following project completion for all the applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Average Total Operating Cost per Unduplicated Patient

	Total Number of Visits	Total Operating Costs	Average Total Operating Cost per Visit
WellCare	15,002	$1,642,083	**$109**
Bayada	44,703	$6,489,927	$145
PHC	19,052	$1,922,966	$101
PruittHealth	19,218	$2,868,880	$149
Aldersgate	10,076	$1,598,027	$159

Regarding this factor, historically the Agency has considered the application proposing the lowest average operating expense as the more effective alternative citing the rationale that "a lower average cost may indicate a lower cost to the patient or third-party payor or a more cost-effective service."[2]

PHC proposes the lowest average total operating cost per visit. However, PHC fails to conform to all applicable review criteria and cannot be approved. Well Care proposes the second-lowest total operating cost per visit. Therefore, the application submitted **Well Care** is the most effective alternative with regard to average total operating cost per visit.

To be consistent with the Agency's approach in prior home health reviews, the Agency should conclude that comparing PHC to other applicants on operating costs "is meaningless." To the extent operating costs are a function of projected revenues, PHC's projected operating costs are unreliable because PHC's Medicare revenue projections are unsupported and unreliable. See PHC discussion regarding Criterion 5.

Additionally, when an applicant's utilization projections are not reasonable, credible, or supported the respective projections of revenues and costs are not reasonable, credible, or supported, thus, the application is not approvable. In such instances, the Agency has found that comparing such applicants to other applicants on operating costs "is meaningless." See, e.g., Agency Findings, 2012 Mecklenburg County Home Health Review, p. 139. As it did in the 2013 Forsyth County home health review and has done in multiple reviews since then, the Agency should conclude that applicants cannot be compared as to costs and revenues on the basis of unreliable projections of utilization. See, e.g., Agency Findings, 2013 Forsyth County home health review, p. 83.

[2] Agency Findings for 2019 Wake County MRI Review, Agency Findings for 2020 Rowan County Hospice Home Care Review

Salaries for Direct Care Staff

In recruitment and retention of personnel, salaries are a significant factor. The applicants provide the following information in Section Q, Form H.2. The following table compares the proposed salaries for direct-care staff. Generally, the application proposing the highest annual salary is the more effective alternative with regard to this comparative factor.

Direct Care Staff	Well Care	Bayada	PHC	PruittHealth	Aldersgate
Registered Nurse	**$103,487**	$85,059	$84,700	$98,093	$74,533
Licensed Practical Nurse	**$67,611**	$55,683	N/A	$62,433	N/A
Home Health Aide	**$44,126**	$36,835	$36,599	$42,451	$36,971
Social Worker	**$81,949**	$68,107	$61,695	$79,905	$70,090
Physical Therapist	**$118,626**	$89,303	$90,974	$112,722	N/A
Speech Therapist	**$105,098**	$85,626	$86,791	$105,037	N/A
Occupational Therapist	**$115,739**	$85,626	$90,974	$107,552	N/A

As shown in the table above, Well Care projects the highest annual salaries in Project Year 3 for all direct care staff positions. Therefore, with regard to the salaries of key direct care staff, the application submitted by **Well Care** is the most effective alternative.

Competition (Access to a New or Alternate Provider)

Well Care, Bayada, PHC, and PruittHealth currently provide home health services in Mecklenburg County either directly or via a related entity. Aldersgate would be a new entrant in the North Carolina and Mecklenburg County home health markets; however, the Aldersgate application does not conform to all applicable statutory and regulatory criteria. Therefore, Aldersgate is not approvable.

Therefore, Well Care, Bayada, PHC, and PruittHealth are equally effective alternatives with respect to this comparative.

Average Number of Visits per Unduplicated Patient

The following table shows the average number of visits per unduplicated patient projected by each applicant in Project Year 3.

Average Visits per Unduplicated Patient

	Unduplicated Patients	Total Visits	Average Visits per Unduplicated Patient
WellCare	818	15,002	18.34
Bayada	1,863	44,703	24.00
PHC	996	19,052	19.13
PruittHealth	888	19,218	21.64
Aldersgate	550	10,076	18.32

In the 2017 Mecklenburg County home health review comparative analysis, the Agency stated, "[T]he majority of home health care services are covered by Medicare, which does not reimburse on a per visit basis. Rather, Medicare reimburses on a per episode basis. Thus, there is a financial disincentive to providing more visits per Medicare episode…Generally, the application proposing the highest number of visits per unduplicated patient is the more effective alternative with regard to this comparative factor."

In this 2021 Mecklenburg County home health review, Well Care anticipates the Agency will compare average visits per unduplicated patient and form the same conclusion. As discussed separately in this document, Bayada, PruittHealth, PHC, and Aldersgate failed to conform to Criterion 3; thus, the patient utilization projections for each respective applicant are not supported. The Well Care application for a new home health agency is based on reasonable and supported volume projections and adequate projections of cost and revenues. Therefore, **Well Care** is the most effective alternative regarding average number of visits per unduplicated patient.

Summary

The following table lists the comparative factors and indicates the relative rank of each applicant for each metric. A value of "1" reflects the most effective alternative as well as equally effective alternatives. A value of "2" reflects the second most effective alternative, and so forth. A value of "5" reflects the least effective alternative.

The following table makes no assumptions on the factor "Conformity with Review Criteria."

Comparative Factor	Well Care	Bayada	PHC	PruittHealth	Aldersgate
Scope of Services	Equally Effective	Equally Effective	Equally Effective	Equally Effective	Equally Effective
Historical Utilization	Equally Effective	Equally Effective	Equally Effective	Equally Effective	5
Geographic Accessibility	Equally Effective	Equally Effective	Equally Effective	Equally Effective	Equally Effective
Access by Service Area Residents: Number of Residents	3	1	4	2	5
Access by Service Area Residents: Service Area Residents as a % of Total	2	4	5	3	1
Charity Care Deduction	2	3	5	1	4
Charity Care per Unduplicated Admission	2	5	4	3	1
Charity Care as a % of Gross Revenue	2	5	4	3	1
Medicare (Percent of Total Gross Revenue)	2	5	4	3	1
Medicaid (Percent of Total Gross Revenue)	2	5	1	3	4
Projected Avg Net Revenue per Patient	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Avg Op Ex per Patient	2	5	1	4	3
Projected Avg Operating Expense per Visit	2	3	1	4	5
Charges per Visit by Staff Discipline: Nursing	1	5	2	3	4
Charges per Visit by Staff Discipline: Therapy	1	5	2	3	4
Charges per Visit by Staff Discipline: MSW	3	4	2	1	5
Charges per Visit by Staff Discipline: Aide	3	4	2	1	5
RN Salaries	1	4	3	2	5
HHA Salaries	1	4	5	2	3
Social Worker Salaries	1	4	5	2	3
Access to New or Alternative Provider	5	5	5	5	1
Total (Lowest # = Most Effective Overall) (Highest # = Least Effective Overall)	**35**	**71**	**55**	**45**	**60**
# of Most Effective Alternatives	**5**	**1**	**3**	**3**	**5**
# of Least Effective Alternatives	**1**	**8**	**5**	**1**	**6**

Overall, Well Care's proposal is the most effective alternative based on a comparison of the collective suggested comparative factors in this Mecklenburg County home health batch review.

Notably, while Aldersgate appears to be the most effective alternative for five comparative factors (setting aside the issue of non-conformity), it is the least effective alternative for six comparative factors. An applicant that is the **least effective** alternative for more factors compared to the total for which it is most effective (setting aside the issue of non-conformity) cannot be the most effective alternative in a competitive batch review.

Similarly, while PHC appears to be the most effective alternative for three comparative factors (setting aside the issue of non-conformity), it is the least effective alternative for five comparative factors. An applicant that is the **least effective** alternative for more factors compared to the total for which it is most effective (setting aside the issue of non-conformity) cannot be the most effective alternative in a competitive batch review.

Similarly, while Bayada appears to be the most effective alternative for one comparative factor (setting aside the issue of non-conformity), it is the least effective alternative for eight comparative factors. An applicant that is the **least effective** alternative for more factors compared to the total for which it is most effective (setting aside the issue of non-conformity) cannot be the most effective alternative in a competitive batch review.

COMMENTS SPECIFIC TO BAYADA HOME HEALTH CARE INC. (Bayada)
PROJECT ID No. F-012053-21

Certification Page

By regulation, an application is only complete for inclusion in the review if the Agency determines that "each applicant identified in Section A of the application form signed the certification page that asks the applicant to certify that the information in the application is correct and they intend to develop and offer the project as described in the application." *See* 10A N.C.A.C. 14C.0203(e)(4).

Bayada provided a Certification Page that was signed only by Lena Trejbal, identified as "Division Director." Nothing on the Bayada Certification Page indicates that Ms. Trejbal is an officer of Bayada. *See* discussion of the authority of officers to act on behalf of a corporation.

If an application is not complete, the Agency is directed to notify the contact person of what is missing or incorrect. The applicant is permitted to provide a Certification Page (or a copy of its application) to complete its application and can do so, per the regulations, after the application deadline. For instance, in Dialysis Care of N. Carolina, LLC v. N. Carolina Dep't of Health & Hum. Servs., 137 N.C. App. 638, 641–42, 529 S.E.2d 257, 259, aff'd, 353 N.C. 258, 538 S.E.2d 566 (2000), the Court of Appeals noted that "Initially, the CON Section found BMA's application incomplete because the lessor, MNA, had not submitted a certification page with the application. In response, [an officer of the applicant] submitted a notarized certification page to the CON Section … Upon receipt of this certification page, the CON Section deemed BMA's application to be complete."

Regardless of whether the Agency notified Bayada of the lack of a properly signed Certification Page, the Bayada application cannot be properly included in this review in accordance with the CON regulations.

By regulation, a signed Certification Page must be received by the Agency "no later than 5:00 p.m. on the last business day of the month preceding the first day of the review period." *See* 10A N.C.A.C. 14C.0203(i). Here, the review began in May such that the Agency would have to have received a properly signed Certification Page no later than 5:00 p.m. on April 30, the last day of the month preceding the first day of the review period. Nothing indicates that the Agency received a properly signed Certification Page from BAYADA by 5:00 p.m. on April 30, 2021.

The regulations provide that:

> The [Agency] **shall not** include the application in the review period if it is not complete pursuant to Paragraph (e) of this Rule by 5:00 p.m. on the last business day of the month preceding the first day of the review period.

Here, unless Bayada provided the Agency with a Certification Page signed by an officer of the applicant on or before 5:00 p.m. on April 30, 2021, the Agency's own regulations expressly prohibit it from including the Bayada application in this review.

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

POLICY GEN-3: BASIC PRINCIPLES states:

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

Bayada fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 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."*

Assumptions & Methodology for Projected Home Health Patients

Bayada's methodology for projecting home health patients is premised on unreasonable and unrealistic assumptions. The methodology for projecting home health patients consists of two cohorts summarized on page 125 and include 1) projections based on the 2021 SMFP home health patient deficits and 2) projections based on the expected shift of patients from the existing Bayada office to the new Bayada office in Matthews. While these fundamental assumptions may sound like a plausible approach to project patients for a new home health office, the facts presented in the Bayada application contradict logic and render the methodology unreasonable.

As described on pages 126-127, in project year one, Bayada projects the new home health office will serve the following percentages of 2022 deficits identified in the SMFP: 90% for Mecklenburg County, 60% for Cabarrus County, and 10% for Union County. These assumptions are based on 1) "the location of the proposed office" and 2) "Bayada having extensive existing referral relationships through its existing home health and home care offices." The home health patient projections are assumed to increase by each

county's respective population growth rate. Bayada's approach to projecting home health patients is flawed for several reasons.

Errors in Growth Rate Calculations Resulting in Overstated Projections

First, the compound annual growth rates (CAGR) for the populations in Mecklenburg, Union, and Cabarrus counties presented in Step 2 of Bayada's methodology do not compute. Bayada presents a table on page 126 of its application containing 2020 and 2025 population projections for Mecklenburg, Union, and Cabarrus counties and a "2019-22" percentage rate, which is assumed to be a CAGR.[3] The Bayada table from page 126 is presented below (the percentage rates have been highlighted for ease of reference).

Bayada Step 2 Compound Annual Growth Rate Table, Page 126

	2020	*2025*	*2019-22*
Mecklenburg	1,131,342	1,240,325	2.33%
Union	242,657	272,641	2.96%
Cabarrus	216,608	238,400	2.43%

Source: Annual County Populations https://www.osbm.nc.gov
Accessed Feb 16, 2021

As shown above and on page 126 of its application, Bayada did not include 2019-2022 population data. Thus, it is not certain what the 2019-22 percentages reference. Furthermore, if "2019-22" is referring to annual population estimates, these estimates are not reflective of Bayada's first three project years, i.e., 2022-2024. For information purposes, the following table provides population data from NCOSBM.

Projected Population and CAGRs

	2020	***2021***	***2022***	***2023***	***2024***	***2025***	***2-YR CAGR 22-24***	***4-YR CAGR 21-25***	***5-YR CAGR 20-25***
Mecklenburg	1,131,342	1,156,107	1,178,511	1,199,228	1,219,203	1,240,325	1.71%	1.77%	1.86%
Union	242,657	248,429	254,427	260,510	266,593	272,641	2.36%	2.35%	2.36%
Cabarrus	216,608	220,437	224,627	229,130	233,796	238,400	2.02%	1.98%	1.94%

Source: Annual County Populations[4] https://www.osbm.nc.gov

As summarized in the previous table, the percentages from Bayada's page 126 table do not reconcile with any of the population CAGRs for Mecklenburg, Union, or Cabarrus County. Furthermore, the percentages from Bayada's page 126 table exceed each of the respective population CAGRs for Mecklenburg, Union, and Cabarrus County. Therefore, for the reasons previously stated, Bayada's projected growth rates

[3] The population data table is also contained on page 43 of Bayada's application.
[4] NCOSBM population projections were updated February 18, 2021, which is after the date Bayada accessed the information from the NCOSBM website (i.e., 2/16/21). Thus, the population data presented in the table is consistent with the population estimates available on February 16, 2021.

calculated in Step 2 (page 126) and used to project future home health patient utilization in Step 4 (page 127) are unreliable and result in overstated home health patient projections.

Well Care attempted to quantify the impact of Bayada's previously described methodology errors. For example, the following table reflects the most conservative scenario which applies the *correct* projected population CAGRs during 2022-2024 for Mecklenburg, Union, and Cabarrus counties. This scenario results in seven fewer patients during 2024 based on Step 4 of Bayada's methodology (i.e., 651 vs. 658).

	Step 3	**Step 4**			
	2022	**% Increase**	**2023**	**% Increase**	**2024**
Mecklenburg	472	1.71%	480	1.71%	488
Union	147	2.36%	150	2.36%	154
Cabarrus	8	2.02%	8	2.02%	8
Total	**627**		**639**		**651**

Bayada's erroneous CAGRs are also used to project future utilization for the numbers of unduplicated patients for the existing Bayada home health office (HC0355). The following table recalculates Step 6 of Bayada's methodology based on the *correct* projected population CAGRs during 2022-2044 for Mecklenburg, Union, and Cabarrus counties.

Step 6						
	% Increase (2-YR CAGR)	**2020 (Actual)**	**2021**	**2022**	**2023**	**2024**
Mecklenburg	1.71%	1,718	1,747	1,777	1,808	1,839
Union	2.36%	372	381	390	399	408
Cabarrus	2.02%	340	347	354	361	368
Total		**2,430**	**2,475**	**2,521**	**2,568**	**2,615**

The correct population CAGRs result in 61 fewer patients during 2024 based on Step 6 of Bayada's methodology (i.e., 2,615 vs. 2,676). This is problematic because Bayada assumes 45% of patients calculated in Step 6 will shift from the existing Bayada home health office (HC0355) to the proposed new home health office in project year 3. The following table recalculates Step 8 of Bayada's methodology, based on Bayada's assumed annual patient shift percentages and the *corrected* Step 6 patient projections that are based on projected population CAGRs during 2022-2044 for Mecklenburg, Union, and Cabarrus counties. This scenario results in 27 fewer patients during 2024 based on Step 8 of Bayada's methodology (i.e., 1,177 vs. 1,204). Thus, the assumed shift of patients is unreliable and overstated because it is premised on faulty assumptions.

Step 8						
	2022	**25% Shift**	**2023**	**35% Shift**	**2024**	**45% Shift**
Mecklenburg	1,777	444	1,808	633	1,839	827
Union	390	97	399	140	408	184
Cabarrus	354	88	361	126	368	166
Total	2,521	**630**	2,568	**899**	2,615	**1,177**

The following table recalculates Step 9 of Bayada's methodology which adds the results of the corrected number of patients from Steps 4 – 8.

Step 9						
	2022 Deficits	**2022 Shift**	**2023 Deficits**	**2023 Shift**	**2024 Deficits**	**2024 Shift**
Mecklenburg	472	444	480	633	488	827
Union	147	97	150	140	154	184
Cabarrus	8	88	8	126	8	166
Total	**627**	**630**	**639**	**899**	**651**	**1,177**

	2022 Combined	**2023 Combined**	**2024 Combined**
Mecklenburg	916	1,113	1,316
Union	244	290	338
Cabarrus	96	135	174
Total	**1,257**	**1,537**	**1,828**

Using the *correct* population CAGRs for Mecklenburg, Union, and Cabarrus counties during 2022-2024, Bayada's methodology results in **35 fewer unduplicated home health patients** during 2024 for the proposed new Bayada home health agency (i.e., 1,828 vs. 1,863). Said another way, Bayada's methodology and use of erroneous CAGRs result in an **overstatement of 35 unduplicated home health patients** during 2024 for the proposed new Bayada home health agency. Assuming Bayada's ratio of 24 visits per unduplicated client, this results in an **overstatement of 840 home health visits** during 2024 (35 overstated home health patients x 24 visits per unduplicated client). Consequently, Bayada does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions.

Well Care recalculated Bayada's methodology for illustrative purposes to underscore the magnitude of Bayada's erroneous assumptions and the resulting unreliable projected patient utilization. To be consistent with the approach taken in prior home health reviews, the Agency should conclude that Bayada used unreliable utilization projections for revenue purposes, rendering its application non-conforming with multiple review criteria.

In the 2013 Forsyth Home Health Review, Well Care was found to have provided conflicting data on visits per patient, the distribution of patients by payor and the total number of visits. While Well Care correctly presented patients and visits on multiple tables in its application, it used conflicting projections on total visits for purposes of projecting revenue. The Agency did not make new assumptions for the applicant

nor did it recalculate the visits per patient by payor to determine total visits for revenue purposes. Instead, the Agency concluded that the Well Care "utilization projections are unreliable." Agency Findings, 2013 Forsyth Home Health Review, p. 19. Having so concluded, the Agency found the applicant did not adequately demonstrate need and financial feasibility "based upon reasonable projections of costs and charges," rendering it non-conforming with multiple review criteria.

In the 2013 Forsyth Home Health Review, the issue with the Well Care application was, specifically, an error in the visits "per episode" projection. While Well Care's problem was simply caused by a mistaken use of different numbers in its utilization and revenue projections, ultimately, the resulting problem -- the use of incorrect visits for revenue projections -- is an issue strikingly similar to the error by Bayada in this review.

The Bayada flaw in its methodology is a problem that ripples through its application, creating a number of non-conformities. In the 2013 Forsyth County Review, the Agency noted that Well Care's error in its visit projections "could result in a longer initial operating period and the need for additional initial operating expenses." The Agency concluded "erroneous assumptions in the projections of visits renders those projections unreliable; therefore, the projected staffing is unreliable because it is not based on credible assumptions." The error in the visit assumption used for revenue projections was found to result in a non-conformity with Criteria 5 and 7; the same result should occur with the Bayada error in its patient projections. See, Agency Findings, 2013 Forsyth County Review, p. 37.

When applications have based projections on erroneous assumptions or otherwise presented conflicting projections, the Agency has refrained from re-calculating the applicant's projections and has, instead, concluded that the issues created non-conformities. In the 2013 Chatham County Nursing Home Review, PruittHealth provided "conflicting data regarding contractual adjustments in Form B and the assumptions … of the application, which directly impacts net profit, making the net profit projection unreliable." Instead of attempting to create a new set of projections, the Agency simply concluded PruittHealth's "inconsistencies render the net profit projection unreliable" and found the application as submitted unapprovable. The Agency should similarly find Bayada's application as submitted unapprovable.

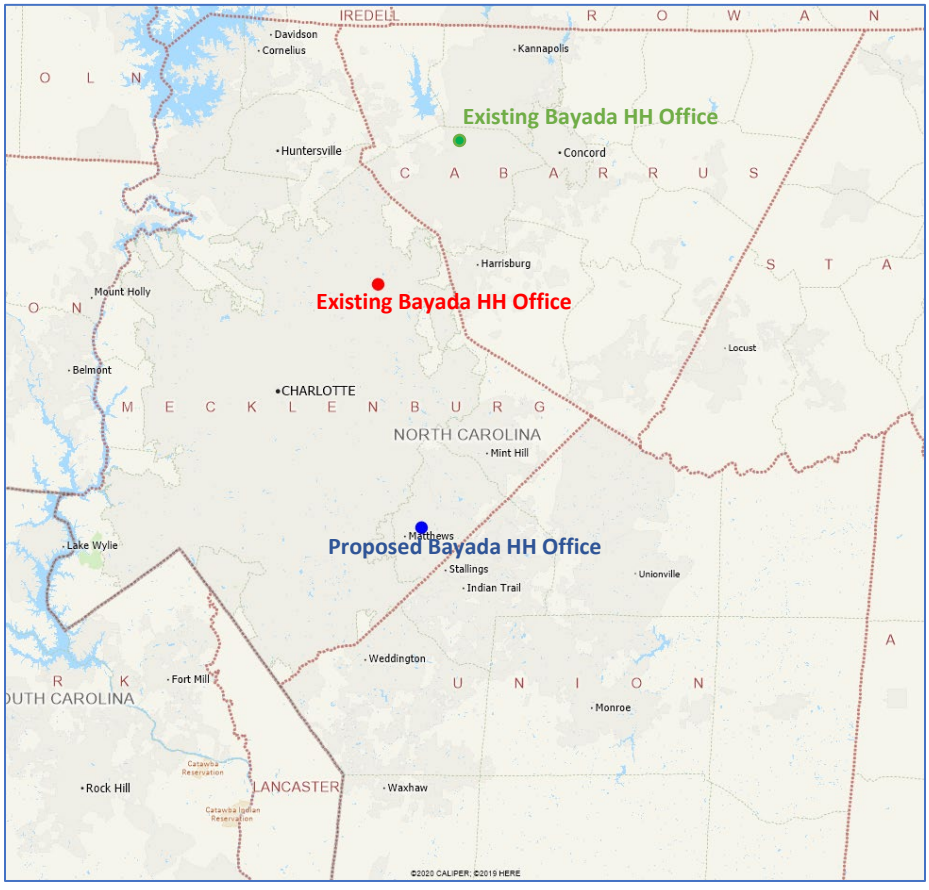
Unreasonable Home Health Patient Projection Assumptions

In addition to the errors present in Bayada's growth rate calculations, there are detrimental deficiencies among Bayada's assumptions for projecting the percentages of projected patient deficits the new office will serve.

The location of Bayada's proposed home health office is in Matthews, which is located in the southeast corner of Mecklenburg County (see map on the following page). Bayada's projects its new home health office will serve 90% of the Mecklenburg County patient deficit (472), which implicitly includes patients throughout Mecklenburg County, specifically including the northern portions of Mecklenburg County where its existing home health office is located on 8801 JM Keynes Drive in North Charlotte. Bayada failed to demonstrate in its application that the Mecklenburg County residents it proposes to serve in the northern part of the county (for example, Davidson, Cornelius, Huntersville, and north Charlotte) need Bayada to locate an office in southern Mecklenburg County as opposed to Bayada continuing to provide

services to these Mecklenburg County residents from its existing Mecklenburg County agency in north Charlotte.

The narrative methodology on page 126 states Bayada's new home health office also projects to serve 60% of the Cabarrus County patient deficit during project year one (83). However, there is a discrepancy between the narrative description for Step 3 of Bayada's methodology and the table presented under Step 3 on page 126. Specifically, the narrative description states Bayada's new home health office will serve 60% of the Cabarrus County patient deficit during project year one; however, the table applies 10% of the Cabarrus County patient deficit during project year one. It is not clear which is correct, the narrative description or the table. Bayada assumes the new home health office located in southeastern Mecklenburg County (Matthews) will have "*good proximity to all three counties*." However, as shown on the following map, Cabarrus County is primarily adjacent to the northern quadrant of Mecklenburg County.



In contrast, the majority of Cabarrus County is more geographically proximate to Bayada's existing home health office in North Charlotte (HC0355), which served 378 Cabarrus County home health patients in FY2019, than the proposed new office in Matthews. This is illustrated via the following table which summarizes the distance in road miles and drive time from the existing and proposed Bayada home health offices and several Cabarrus County municipalities.

Summary Comparison of Distance & Drive Times to Cabarrus County

	Kannapolis	Concord	Harrisburg
Existing Mecklenburg Co. Bayada Office	17.5 miles / 22 min	12 miles / 24 min	6.5 miles / 14 min
Proposed New Mecklenburg Co. Office	37 miles / 40 min	32 miles / 42 min	20 miles / 32 min

In addition to Bayada's existing Mecklenburg County home health office, Bayada operates a home health office in Cabarrus County (HC0486) which served 1,024 Cabarrus County home health patients during FY2019. Bayada also operates **two** home health offices in Rowan County (HC0357 & HC0486) (which is also adjacent to Cabarrus County) that served 19 Cabarrus County home health patients during FY2019. Bayada failed to demonstrate in its application that the Cabarrus County residents it proposes to serve need Bayada to locate an office in southern Mecklenburg County as opposed to Bayada continuing to provide services to Cabarrus County residents from its existing Cabarrus County agency, its existing Mecklenburg County agency in North Charlotte, and its existing Rowan County agencies.

In summary, Bayada's application contains erroneous growth rates that cascade through multiple steps of its methodology and result in overstated unduplicated patient projections and visits. Additionally, Bayada's assumptions regarding the patients to be served by the new home health agency are unsupported based on the number and location of existing Bayada home health agencies in the counties it projects to serve via the proposed project. Therefore, Bayada does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. Consequently, the application does not conform to Criterion 3.

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

Bayada is nonconforming with the following statutory review criteria: Criteria 1, 3, 5, 6, and 18a. See these criteria for discussion. Therefore, Bayada failed to adequately demonstrate that its proposal is an effective alternative for development of a home health agency in Mecklenburg County. Consequently, the application is nonconforming to Criterion 4.

Criterion 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."*

Based on the Application as submitted, Bayada has failed to provide a certification from an Officer of the Applicant attesting to the correctness of the information in the Application as well as the intent of the

Applicant to develop the project within the timeframe identified in Section P and as described in the Application.

An applicant is only required to furnish that information ***necessary*** to determine whether the proposed new institutional health service is consistent with the review criteria and duly adopted standards, plans and criteria. N.C. Gen. Stat. § 131E-182(b). The Application Form requests a Certification Page which indicates the information on that page is deemed necessary for the Agency to determine consistency with applicable criteria.

As discussed above, the Agency, by regulation, cannot include the Bayada application in this review because it did contain a properly signed Certification Page. If the Agency includes Bayada in this review (which it cannot do per its own regulations), the Agency cannot determine the Bayada application is consistent with the various review criteria if it lacks a certification from an Officer of the Applicant that the information included in the Application is correct and that the Applicant intends to develop and offer the proposed service within the timeframe identified in Section P and as described in the Application. This is not an instance where the Agency can reference publicly available data for the information at issue.

The Officers of a corporation have the power to act on behalf of a corporation. 6 N.C. Index 4th Corporations § 111. When evidence exists that an individual has no corporate authority, that individual lacks the requisite authority to bind the corporation.[5]

An Applicant that has not validly certified – through a corporate Officer - its intent to develop the proposed project within the Section P timeframes cannot demonstrate financial feasibility under Criterion (5). (Nor does such a non-certified Application present the most effective alternative under Criterion (4), etc.)

As noted above, the only corporate documentation for Bayada included in the CON Application is a 2018 Application for a Certificate of Authority to conduct affairs in the State of North Carolina. There is a publicly available 2019 Certificate of Authority filing for Bayada (see Attachment 2) which identifies several Officers/officials current as of the date of that filing, 1/3/2019. Lena Trejbal is not identified as a corporate Officer —the listed Officers/officials are: (a) David L. Baiada, President and Secretary; (b) Thomas Sibson, Treasurer; and (c) J. Mark Sibson, Chairman of the Board.

The only signature on the Bayada Certification Page is that of Lena Trejbal and nothing shows her to be an officer of Bayada. And, nothing in the Bayada Application nor in the publicly available data exists to confirm that Brian Pressler is a corporate Officer of Bayada. In his letter in Exhibit F.2, Brian Pressler signs as "Chief Financial Officer." Yet, his letter does not indicate he is authorized to commit the funds of Bayada.

While it is possible that the Officers could have changed since the 2019 filing, nothing publicly available nor within the Bayada Application provides the relevant documentation to demonstrate conformity. Because there is no annual report requirement imposed by North Carolina on Bayada, there are no publicly available filings available on the NC Secretary of State web-site to reference the identity of Bayada's corporate Officers. There also does not appear to be any publicly available new filings with the Pennsylvania Secretary of State, per its website, to confirm whether Ms. Trejbal or Mr. Pressler are

[5] § 17:10. Execution of documents—Authority and proof, N.C. Corp. Law and Prac. § 17:10 (4th ed.)

Officers of Bayada. *See* March 26, 2021 Comments of EmergeOrtho, P.A., page 15 (arguing that Exhibit F-2.1 of the Mission Application, Project ID No. B-12035-21, is not written by an Officer of the entity purporting to provide the project funding).

Lacking a certification from an individual shown to have corporate authority as an Officer to act on behalf of BAYADA, the BAYADA Application is not approvable. Moreover, the lack of evidence (either publicly available or within the BAYADA Application) to confirm that either Ms. Trejbal or Mr. Pressler are corporate Officers with power to act on behalf of BAYADA, the BAYADA Application is defective and fails to document availability of funds as required by Criterion 5. The Agency in past reviews has looked for letters "from an officer" as appropriate documentation in an application. See, e.g., 2016 New Hanover County OR Review ("the application does not contain a letter from an officer … confirming how the money would be used or that it would go to the applicant and there is no letter from an officer of the applicant confirming how the money would be used. Therefore, the applicant does not adequately demonstrate the availability of sufficient funds for the capital and working capital needs of the project.")

The Bayada application also fails to conform to Criterion 5 because its projections are not reasonable and adequately supported. See discussion regarding Criterion 3.

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."*

Bayada failed to adequately demonstrate the need for the proposed services (See Criterion 3). Therefore, Bayada failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved home health services and is nonconforming to this criterion.

Further, the applicant did not demonstrate that the proposed services would not duplicate the services provided by its existing Mecklenburg County and Cabarrus County home health agencies (See Criterion 3).

Criterion 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."*

Based on the facts which result in Bayada being non-conforming with Criteria 1, 3, 5, and 6 it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

While Bayada appears to be the most effective alternative for one comparative factor (setting aside the issue of non-conformity), it is the least effective alternative for eight comparative factors. An applicant that is the **least effective** alternative for more factors compared to the total for which it is most effective (setting aside the issue of non-conformity) cannot be the most effective alternative in a competitive batch review.

Service to Mecklenburg County Residents

Applications in this batch were filed in response to the 2021 State Medical Facilities Plan Need Determination for one additional home health home care agency/office in Mecklenburg County.

	Total # of New (Unserved) Mecklenburg County Residents Served	Total # of New (Unduplicated) Patients Served	Mecklenburg County Residents Served as a % of Total New Patients Served
Well Care	752	818	91.9%
Bayada	1,342	1,863	72.0%

As shown in the table above, Bayada projects to serve a comparatively higher number of Mecklenburg County residents than Well Care. However, Bayada does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Well Care proposes that 91.9% of its new (unduplicated) home health patient admissions in its Third Full Fiscal Year will be admissions of patients residing in Mecklenburg County. By contrast, Bayada proposes that 72.0% of its new (unduplicated) admissions in the Third Full Fiscal Year will be admissions of patients residing in Mecklenburg County. Therefore, Well Care is more effective than Bayada with respect to access by service area residents.

In the 2018 Buncombe County Operating Room Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents is the more effective alternative with regard to this comparative factor since the need determination is for two additional ORs to be located in this multi-county service area. The Agency determined that the applicant projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents during the third operating year was the most effective alternative. Similarly, in the 2019 Wake County MRI Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Wake County MRI service area residents is the more effective alternative with regard to this comparative factor since the need determination is for one additional MRI to be located in the MRI service area. The Agency determined that the applicant projecting to serve the highest percentage of Wake County MRI service area residents during the third operating year was the most effective alternative. As it did in the recent

Buncombe OR Review and Wake County MRI Review, the Agency should conclude that the Well Care application is a more effective alternative than the Bayada application because Well Care projects to serve a higher percentage of Mecklenburg County residents in the third operating year.

Costs & Revenues

As previously described, Bayada's operating costs and resulting revenues are not based on adequate home health staff projections. See discussion regarding Criterion 3. Therefore, the conclusion of any comparative analysis of Bayada's costs and revenues would be inconclusive.

For information purposes, Bayada projects comparatively higher net revenue per patient than Well Care. Bayada also projects comparatively higher average total operating cost per visit than Well Care.

Medically Underserved Access

As compared to Well Care's application, Bayada's proposal is inferior with respect to medically underserved access. Bayada projects comparatively lower charity care, Medicaid, and Medicare access than Well Care.

Bayada states on page 22 of its application, "BAYADA is one of the largest providers of home care services to Medicaid patients in the state." However, Bayada's payor mix tells a different story. According to its 2021 License Renewal Application, Bayada's existing Mecklenburg County agency had only 0.4% indigent non-pay payor mix during FY2020. The proposed new home health office projects to serve only 0.5% charity care during project year three, which is the lowest of the competing applicants.

Salaries

As compared to Well Care's application, Bayada's proposal is inferior with respect to salaries for direct care staff. Bayada projects comparatively lower salaries for RNs, LPNs, home health aides, social workers, physical therapists, speech therapists, and occupational therapists than Well Care.

Less Effective Alternative

Setting aside the issue of non-conformity, while Bayada appears to be the most effective alternative for one comparative factor (i.e., access by number of Mecklenburg County residents) it is the least effective alternative for six comparative factors. An applicant that is the **least effective** alternative for more factors compared to the total for which it is most effective (setting aside the issue of non-conformity) cannot be the most effective alternative in a competitive batch review.

COMMENTS SPECIFIC TO ALDERSGATE HOME HEALTH (Aldersgate)
PROJECT ID No. F-012058-21

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

POLICY GEN-3: BASIC PRINCIPLES states:

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

Aldersgate fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 13, and 18a. Therefore, the application is non-conforming with this criterion and cannot be approved.

Criterion 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."*

Form C.5 Home Health Utilization Errors

There are errors in the reported number of "Unduplicated Clients by Admitting Discipline" in Form C.5 Home Health Utilization. For example:

- # of Clients during Partial FY 4/1/22-12/31/22 do not match the table total of 169
  - 78 + 97 + 52 + 15 + 19 + 9 = 270
- # of Clients during 1st Full FY 1/1/23-12/31/23 do not match the table total of 352
  - 116 + 209 + 113 + 30 + 31 + 18 = 518
- # of Clients during 2nd Full FY 1/1/24-12/31/24 do not match the table total of 468
  - 235 + 298 + 164 + 50 + 63 + 27 = 837
- # of Clients during 3rd Full FY 1/1/25-12/31/25 do not match the table total of 550
  - 288 + 375 + 205 + 62 + 81 + 37 = 1,048

There are errors in the reported number of "Duplicated Medicare Clients and Visits" in Form C.5 Home Health Utilization. For example:

- # of Clients during Partial FY 4/1/22-12/31/22 do not match the table total of 99
  - 98 + 1 + 3 + 16 = 118
- # of Clients during 1st Full FY 1/1/23-12/31/23 do not match the table total of 223
  - 219 + 3 + 6 + 36 = 264
- # of Clients during 2nd Full FY 1/1/24-12/31/24 do not match the table total of 323
  - 323 + 5 + 10 + 55 = 393
- # of Clients during 3rd Full FY 1/1/25-12/31/25 do not match the table total of 443
  - 443 + 7 + 13 + 75 = 538

When applications have based projections on erroneous assumptions or otherwise presented conflicting projections, the Agency has refrained from re-calculating the applicant's projections and has, instead, concluded that the issues created non-conformities. In the 2013 Chatham County Nursing Home Review, PruittHealth provided "conflicting data regarding contractual adjustments in Form B and the assumptions … of the application, which directly impacts net profit, making the net profit projection unreliable." Instead of attempting to create a new set of projections, the Agency simply concluded PruittHealth's "inconsistencies render the net profit projection unreliable" and found the application as submitted unapprovable. The Agency should similarly find the Aldersgate application as submitted unapprovable.

In the 2013 Forsyth Home Health Review, Well Care was found to have provided conflicting data on visits per patient, the distribution of patients by payor and the total number of visits. While Well Care correctly presented patients and visits on multiple tables in its application, it used conflicting projections on total visits for purposes of projecting revenue. The Agency did not make new assumptions for the applicant nor did it recalculate the visits per patient by payor to determine total visits for revenue purposes. Instead, the Agency concluded that the Well Care "utilization projections are unreliable." Agency Findings, 2013 Forsyth Home Health Review, p. 19. Having so concluded, the Agency found the applicant did not adequately demonstrate need and financial feasibility "based upon reasonable projections of costs and charges," rendering it non-conforming with multiple review criteria. The Agency should similarly find the Aldersgate application as submitted unapprovable.

Methodology Assumptions

In Step 2 of its methodology (page 130), Aldersgate assumes the percent of unduplicated Medicare home health patients will increase from 50.77% in 2022 to 70.0% in 2025, a CAGR of 11.3%. Aldersgate states this increase is based on population growth for the senior population. However, the senior population in Mecklenburg County is not projected to increase by a CAGR of 11.3% during 2022 to 2025. Page 56 of Aldergate's application indicates the Mecklenburg County population age 65+ is projected to increase by a CAGR of 3.4% for population age 64-74 and 6.3% for population age 75 and over. These respective population growth rates do not substantiate Aldersgate's increase in the percentage of Medicare home

health patients served from 50.77% to 70.0%.[6] Absent any further rationale for its assumption of Medicare payor mix, the projection for unduplicated Medicare patients to be served by Aldersgate's proposed home health agency is unsupported in the application as submitted.

In Step 3 of its methodology (page 132), Aldersgate states "[t]he duplicated patient counts for the Non-Medicare payors is calculated based on the visit utilization per duplicated patient as report[ed] on the Medicare cost report data from fiscal year 2019 counts by payer is as follows:"

Name	Provider #	FY END	Non-Medicare Visits	Dup Patient Count	Visits Per Dup Census
ADVANCED HOME CARE	347114	9/30/2019	21,518	3,733	5.76
LIBERTY HOME CARE II (CHARLOTTE)	347242	9/30/2019	1,516	226	6.71
BAYADA HOME HEALTH CARE- CHARLOTTE	347087	12/31/2019	28,933	3,674	7.88
INTERIM HEALTHCARE OF THE TRIAD	347234	12/31/2019	39,547	6,612	5.98
KINDRED AT HOME	347091	12/31/2019	46,685	5,606	8.33
HEALTHY @ HOME – CAROLINAS MEDICAL	347112	12/31/2019	14,300	2,364	6.05
KINDRED AT HOME	347196	12/31/2019	429	113	3.80
HEALTHY @ HOME - UNIVERSITY	347254	12/31/2019	9,563	1,614	5.93
PHC HOME HEALTH	347244	12/31/2019	9,291	1,080	8.60
Total			171,782	25,022	**6.87**

Source: Aldersgate Application, Section Q page 132

However, the data in the previous table contained in the Aldersgate Application does not provide information regarding FY2019 unduplicated patient counts for the Non-Medicare payors to determine the rationale or ratio for converting unduplicated Non-Medicare patients to duplicated Non-Medicare patients. Upon examination of other data provided in the Aldersgate application, the ratio of unduplicated to duplicated non-Medicare patients appears extremely high. Using Project Year 3 as an example, Aldersgate projects a duplicated count of 223 non-Medicare patients in 2025 (see page 132) and an unduplicated count of 165 Non-Medicare patients on page 130. This equates to a ratio of 1.35 or a 35% readmission rate for Non-Medicare patients. However, Aldersgate states on page 131, "A review of the FY 2019 cost reports shows a 30% re-admission rate. We deemed this very high compared to industry norms therefore applied half the rate." Thus, Aldersgate's application documents its opinion that a readmission rate at or above 30% is unreasonable. Absent any further rationale for its assumption for

[6] Well Care does not insinuate a Medicare payor mix of 70.0% is unreasonable per se. Rather, the assumptions included in the Aldersgate Application, as submitted, do not support its projected shift of Medicare patients served from 50.77% in 2022 to 70.0% in 2025, a CAGR of 11.3%.

determining duplicated Non-Medicare patients, the projections for duplicated non-Medicare patients to be served by Aldersgate's proposed home health agency is unsupported.

In Step 4 (page 133), Aldersgate applied a "PDGM conversion factor to 30 day Episodes" of 1.67 to duplicated Medicare patients to determine "Projected PDGM Episodes." However, it appears this step erroneously inflates the number of projected Medicare episodes in the Aldersgate Application. In conjunction with the implementation of the Patient-Driven Groupings Model (PDGM), CMS has changed the unit of home health payment from a 60-day episode to a 30-day period. A Medicare episode consists of **two 30-day periods of care**. In other words, under PDGM, a provider now receives two payments for a 60-day episode instead of one payment per 60-day episode pre-PDGM (i.e., before January 2, 2020). Based on the information provided in its application as submitted, it appears that Aldersgate assumes a "30-day period" and an "episode" are one and the same. However, this is not accurate. A period includes 30 days and an episode includes 60 days. Consequently, the "Projected PDGM Episodes" reflected in the table on page 133 are actually 30-day periods and not episodes. This results in artificially overstated Medicare episode projections in Table C.5.

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

The Aldersgate Application does not conform to Criterion 4. Aldersgate does not adequately demonstrate that the alternative proposed in its Application is the most effective alternative to meet the need because Aldersgate does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. The Aldersgate Application is not conforming to all statutory and regulatory review criteria. See discussion regarding criteria 1, 3, 5, 6, 8, 13c, and 18a. An application that cannot be approved cannot be the most effective alternative.

Criterion 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."*

The Aldersgate Application is not conforming to Criterion 5. The assumptions used by Aldersgate in preparation of the pro forma financial statements are not reasonable and adequately supported because projected utilization is unfounded. See comments regarding Criterion 3. Since projected revenues and expenses are based on projected utilization, projected revenues and expenses are also poisoned.

Aldersgate Home Health, Inc. ("Aldersgate") is a corporation formed in March of 2021. Nothing in the Aldersgate Application shows the Applicant to itself have any financial resources nor does the Applicant indicate an intent to rely on its own resources to fund its proposed project.

It is permissible for an entity other than the Applicant to provide a commitment of funds to an Applicant but only under defined circumstances. Ret. Villages, Inc. v. N. Carolina Dep't of Hum. Res., 124 N.C. App. 495, 499, 477 S.E.2d 697, 699 (1996) ("[I]n cases where the project is to be funded other than by the applicants, the application must contain evidence of a commitment to provide the funds by the funding

entity. We hold that without such a commitment, an applicant cannot adequately demonstrate availability of funds or the requisite financial feasibility").

Aldersgate indicates funding will come from two entities, Aldersgate United Methodist Retirement Company, Inc. and Aldersgate Life Plan Services, Inc.

For the reasons outlined below, the Aldersgate Application does not properly document availability of funds and thus, does not demonstrate conformity with Criterion 5.

The first letter from Michael Hill included in Exhibit F-2.1 is inadequate in several respects. Aldersgate United Methodist Retirement Company, Inc. must commit to provide funds to the Applicant and the Applicant must, in turn, indicate its intent to use those funds for development of the project proposed in its CON Application. This two-step process is not clearly described in Mr. Hill's letter.

Mr. Hill is not identified as an Officer with authority to commit the funds of Aldersgate United Methodist Retirement Community, Inc. Instead, Mr. Hill indicates he is CFO of another entity, Aldersgate Life Plan Services, Inc. The Application includes a Financial Statement and Auditors' Report for Aldersgate United Methodist Retirement Community, Inc. but no mention is made of the identity of the corporate Officers and no mention is made of Mr. Hill.

Mr. Hill's letter does not recite that he is an Officer nor does he claim to have authority to commit the funds of Aldersgate United Methodist Retirement Community, Inc. Instead, Mr. Hill is plainly identified as holding a position with a different Aldersgate entity.

The rather unusual structure of the Aldersgate financing demonstration creates other issues. The first Hill letter is followed by a Promissory Note which obligates Aldersgate to repay Aldersgate United Methodist Retirement Community, Inc. Under the terms of the Note (Payment Terms (1)), Aldersgate is obligated to make monthly interest payments beginning on the last day of May 2021. The "upshot" of this provision is that interest will be due as soon as any funds are accessed for purposes of the CON project. Moreover, the Note states principal payments are expected to be made after any funds are accessed during the "Draw Period."

The problem with this structure is that Form F.3b includes no dollar amounts for "Interest Expense" and nothing to account for the clearly documented obligation for Aldersgate to re-pay the principal it receives from Aldersgate United Methodist Retirement Community, Inc. (notwithstanding the issues described above). As noted, the Applicant Aldersgate does not document any funds to which it has access per its own accounts. As such, Aldersgate would have to use Project revenues to pay the interest and re-pay the principal and it has not accounted for those costs in its Operating Cost projections.

Because the Section F responses indicate that Aldersgate will need to access nearly $50,000 before the project begins, there is no source identified for the payment of principal and interest which will clearly be owed to Aldersgate United Methodist Retirement Community, Inc. as soon as Aldersgate accesses funds. Thereafter, Aldersgate will need access to over $130,000 in funds to support operations until the proposed Agency is projected to have revenues in excess of expenses. Again, Aldersgate will have to support interest and principal payments out of its projected revenue but it has not accounted for those revenue needs in its Operating Cost projections.

In a prior Buncombe County Operating Room Review, the inability of one co-applicant to point to an adequate source of funds for loan re-payment costs resulted in a non-conformity. Similarly, Aldersgate has not identified how it expects to pay interest and re-pay principal borrowed per the Promissory Note it has entered with Aldersgate United Methodist Retirement Community, Inc.

Although the attached Financial Statement and Auditors' Report references substantial sums, nothing in Mr. Hill's letter or the Statement/Report directly states that funds needed for the project will be available when needed. This is a simple declarative that is specifically requested by the CON Section's Application Form which defines the information necessary for demonstrations of conformity. Here, the requested information is absent.

The second Hill letter is similarly problematic in that it does not commit funds to an Applicant nor contain the Applicant's commitment to use the funds received from the funding source for the project. Although Mr. Hill is properly identified as an Officer of the funding entity, the same issues arises with the attached Promissory Note which clearly states the money from the funding source is to be re-paid with interest. Again, nothing in Form F.3b accounts for interest and repayment of principal. The money at issue is described as intended for use for working capital and start-up expenses which, by definition, are expenses that arise before the Applicant's operations put it in a position to have the revenue needed.

There is no Financial Statement or Auditors' Report specific to Aldersgate Life Plan Services, Inc. and no declaration that funds will be available when needed.

The Aldersgate Application does not specify when (in what months/years) the Applicant intends to access money through the lines of credit described in the Hill letters and there is no Amortization Schedule provided to show when the Applicant will re-pay the sums it is obligated to re-pay with interest. The lack of a borrowing schedule makes it impossible to estimate what an Amortization Schedule would include and thus, it is impossible to conclude that re-payment would even be possible. As the Applicant shows no other available funds, there is no way to conclude that the Applicant has properly documented project funding to demonstrate conformity with Criterion (5). The Applicant has failed to show its projections of financial feasibility are based on reasonable and adequately supported assumptions because it has plainly failed to incorporate projections for the expense of re-paying the funding entities with interest subsequent to accessing funds pursuant to the lines of credit which must be re-paid per the provisions of the Promissory Notes included in the Aldersgate Application. For this additional reason, the Aldersgate Application does not demonstrate conformity with Criterion (5).

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."*

Aldersgate failed to adequately demonstrate the need for the proposed services (See Criterion 3). Therefore, Aldersgate failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved home health services and is nonconforming to this criterion.

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:*

> *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"*

As described previously in the discussion of Criterion 3, Aldersgate failed to demonstrate its Medicare patient projections are reasonable and adequately supported. In Step 2 of its methodology (page 130), Aldersgate assumes the percent of unduplicated Medicare home health patients will increase from 50.77% in 2022 to 70.0% in 2025, a CAGR of 11.3%. Aldersgate states this increase is based on population growth for the senior population. However, the senior population in Mecklenburg County is not projected to increase by a CAGR of 11.3% during 2022 to 2025. Page 56 of the Aldersgate application indicates the Mecklenburg County population age 65+ is projected to increase by a CAGR of 3.4% for population age 64-74 and 6.3% for population age 75 and over. These respective population growth rates do not substantiate Aldersgate's increase in the percentage of Medicare home health patients served from 50.77% to 70.0%.[7] Absent any further rationale for its assumption of Medicare payor mix, the projection for unduplicated Medicare patients to be served by Aldersgate's proposed home health agency is unsupported in the application as submitted. Therefore, based on these facts for which Aldersgate is non-conforming to Criterion 3, it is also non-conforming to Criterion 13c.

Criterion 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."*

Based on the facts which result in Aldersgate being non-conforming with Criteria 1, 3, 5, 6, 8, and 13, it should also be found non-conforming with Criterion 18a.

[7] Well Care does not insinuate a Medicare payor mix of 70.0% is unreasonable per se. Rather, the assumptions included in the Aldersgate Application, as submitted, do not support its projected shift of Medicare patients served from 50.77% in 2022 to 70.0% in 2025, a CAGR of 11.3%.

Comments Regarding Comparative Analysis

Notably, while Aldersgate appears to be the most effective alternative for five comparative factors (setting aside the issue of non-conformity), it is the least effective alternative for six comparative factors. An applicant that is the **least effective** alternative for more factors compared to the total for which it is most effective (setting aside the issue of non-conformity) cannot be the most effective alternative in a competitive batch review.

Service to Mecklenburg County Residents

Applications in this batch were filed in response to the 2021 State Medical Facilities Plan Need Determination for one additional home health home care agency/office in Mecklenburg County.

	Total # of New (Unserved) Mecklenburg County Residents Served	Total # of New (Unduplicated) Patients Served	Mecklenburg County Residents Served as a % of Total New Patients Served
Well Care	752	818	91.9%
Aldersgate	550	550	72.0%

As shown in the table above, Aldersgate projects to serve a comparatively higher percentage of Mecklenburg County residents than Well Care. However, Aldersgate does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Well Care proposes that 752 of its new (unduplicated) home health patient admissions in its Third Full Fiscal Year will be admissions of patients residing in Mecklenburg County. By contrast, Aldersgate proposes that 550 of its new (unduplicated) admissions in the Third Full Fiscal Year will be admissions of patients residing in Mecklenburg County. Therefore, Well Care is more effective than Aldersgate with respect to access by service area residents.

Costs & Revenues

As previously described, Aldersgate's operating costs and resulting revenues are not based on adequate home health staff projections. See discussion regarding Criterion 3. Therefore, the conclusion of any comparative analysis of Aldersgate's costs and revenues would be inconclusive.

For information purposes, Aldersgate projects comparatively higher net revenue per patient than Well Care. Aldersgate also projects comparatively higher average total operating cost per visit than Well Care.

Medically Underserved Access

As compared to Well Care's application, Aldersgate's proposal is inferior with respect to medically underserved access. Aldersgate projects comparatively lower Medicaid and Medicare access than Well Care.

Salaries

As compared to Well Care's application, Aldersgate's proposal is inferior with respect to salaries for direct care staff. Aldersgate projects comparatively lower salaries for RNs, home health aides, and social workers than Well Care.

COMMENTS SPECIFIC TO PHC HOME HEALTH (PHC)
Project ID No. F-012061-21

General Comments

Viability of Applicant

Personal Home Care of North Carolina, LLC (NC SOS ID # 0668845) ("**PHC**") is a North Carolina limited liability company formed on March 25, 2003. As of May 11, 2021, PHC had not satisfied its reporting obligations under applicable North Carolina law, as explained in detail below.

Under North Carolina law, apart from professional limited liability companies governed by N.C. Gen. Stat. § 57D-2-02, all domestic and foreign limited liability companies ("**LLCs**") are required to "deliver to the Secretary of State, for filing, annual reports on a form prescribed by, and in the manner required by, the Secretary of State and as otherwise provided [by law]." N.C. Gen. Stat § 57D-2-24(a). A domestic LLC's initial annual report must be filed on or before "April 15 of the year following . . . the calendar year in which the LLC's Articles of Organization. . . become[s] effective." *Id.* § 57D-2-24(b) Thereafter, annual report filings are due "by April 15 of each subsequent year" until the LLC is dissolved in accordance with N.C. Gen. Stat. § 57D-6-05 or 6(c). *Id.*

An LLC may be "administratively dissolved" by the North Carolina Secretary of State if the LLC "does not deliver its annual report to the Secretary of State on or before the 60th day after it is due." *Id.* § 57D-6-06(a)(3). If one or more grounds is determined to exist for administrative dissolution, "the Secretary of State shall mail the LLC" notice of such determination and "if, within 60 days after the notice is mailed, the LLC does not correct each ground for dissolution or demonstrate to the satisfaction of the Secretary of State that each ground does not exist, the Secretary of State shall administratively dissolve the LLC." *Id.* § 57D-6-06(b). In addition, an LLC that "fails to file any report or return or to pay any tax or fee" required under North Carolina law within 90 days after the filing deadline is also subject to suspension at the direction of the North Carolina Department of Revenue. *Id.* § 105-230(a). North Carolina law provides that all the "powers, privileges, and franchises" conferred upon an LLC and its members and officers pursuant to its Articles of Organization "terminate upon suspension." *Id.* Moreover, "[a]ny act performed or attempted to be performed during the period of suspension is invalid and of no effect," unless and until the LLC's past-due annual report is filed, all accompanying fees are paid, and the Secretary of State reinstates the LLC in accordance with N.C. Gen. Stat. § 105-232. *Id.* § 105-230(b). In addition, "if there remains property held in the name of [an LLC that is] undisposed of at the time of the suspension," such property could be subject to receivership proceedings. *Id.* § 105-232(b).

As a domestic LLC, PHC is required to file an annual report each year by April 15; accordingly, PHC's annual report for 2021 was due by April 15, 2021. As of May 11, 2021, PHC has not filed its 2021 annual report with the NC Secretary of State, according to the NC SOS's website. If PHC does not file its past-due annual report on or before June 15, 2021, PHC will be notified by the NC Secretary of State that grounds for its administrative dissolution exist. N.C. Gen. Stat. § 57D-6-06(a)(3), (b). If PHC's 2021 annual report remains outstanding within 60 days thereafter (i.e., or about August 13, 2021), it will be administratively dissolved pursuant to N.C. Gen. Stat. 57D-6-06(b). In addition, PHC could face suspension at the direction of the NC

Department of Revenue should its 2021 annual report filing remain delinquent as of July 15, 2021, in accordance with N.C. Gen. Stat. § 105-230(a).

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

POLICY GEN-3: BASIC PRINCIPLES states:

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

The PHC Application fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The application does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 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."*

Unrealistic Home Health Patient Projections

In Step 2 of PHC's methodology (Section Q, page 3), PHC describes its decision to use county-based rates of change to project future home health patients to be served by age group in Mecklenburg, Cabarrus, and Iredell County, respectively. This approach deviates from the home health standard methodology which applies COG use rates to projected population to project future home health patients. Instead, PHC applies county-based growth rates to 2022 home health patients to project future home health patients. PHC states "applying a regional rate runs the risk of over or understating need in particular counties or age groups in the selected area." Generally speaking, utilizing assumptions that result in understated need would simply render a methodology more conservative. Conversely, a decision to utilize growth rates that result in overstating need would render a methodology unreasonable and non-conforming.

PHC's decision to use county-based rates of change results in artificially inflated projected home health patients in Mecklenburg, Cabarrus, and Iredell counties compared to historical utilization. Thus, PHC's arbitrary assumption has a material impact on PHC's home health patient projections beginning with the underlying assumptions.

The following table summarizes the historical number of unduplicated home health patients served in Mecklenburg, Cabarrus, and Iredell counties during 2017-2019 as reported in Chapter 12, Table 12B of the 2021 SMFP.

Unduplicated Home Health Patients, 2017-2019

County	2017	2018	2019	*CAGR*
Mecklenburg	17,375.00	18,002.00	17,668.00	*0.8%*
Cabarrus	4,039.00	5,165.00	5,350.00	*15.1%*
Iredell	4,000.00	4,255.00	4,813.00	*9.7%*
Total	***25,414.00***	***27,422.00***	***27,831.00***	***4.6%***

Source: 2021 SMFP Chapter 12, Table 12B

The following table summarizes the projected number of unduplicated home health patients in Mecklenburg, Cabarrus, and Iredell counties during 2022-2025 according to Table 5 of PHC's methodology.

Projected Unduplicated Home Health Patients, 2022-2025 (PHC Methodology, Table 5)

County	2022	2023	2024	2025	*CAGR*
Mecklenburg	21,055.79	21,546.20	22,036.62	22,527.03	*2.3%*
Cabarrus	6,114.53	7,137.58	8,160.64	9,183.69	*14.5%*
Iredell	5,602.37	6,210.22	6,818.07	7,425.92	*9.8%*
Total	***32,772.69***	***34,894.00***	***37,015.33***	***39,136.64***	***6.1%***

Source: PHC Application, Section Q, page 6 (PDF page 122)

There is a material difference between the growth rates of historical unduplicated home health patients as reported in the 2021 SMFP and the projected unduplicated home health patients resulting from PHC's artificially inflated methodology. Specifically, PHC projects Mecklenburg County home health patients will increase by a CAGR of 2.3% vs. a historical growth rate of 0.8%. PHC's growth rate for Mecklenburg home health patients is nearly three times higher than the actual growth rate. PHC's projects the total number of home health patients in its service area will increase by a CAGR of 6.1% vs. a historical growth rate of 4.6%. It is clear from this data that use of PHC's inflated assumptions to project future home health patients unreasonably **amplifies the denominator of home health patient projections**.

In Step 6, PHC assumes the 2022 adjusted potential total patients served from Table 12C of the SMFP will remain constant for each county each year from 2022 through 2025, a decision that contradicts its previous election of county-based annual rates of change for home health patients. PHC projects the total denominator of Mecklenburg County residents needing home health services will increase by a CAGR of 2.3%, but the numerator of home health patients served will not increase at all from 2022 through 2025. Based on these assumptions, PHC unreasonably assumes the existing Mecklenburg County home

health agencies (including PHC) will experience zero increase in the number of home health patients served during 2022 through 2025. The following tables summarize Step 5 through Step 7 of PHC's methodology and illustrate the drastic increase in projected unmet need for the counties in PHC's service area.

Projected HH Patients (Step 5)					
County	**2022**	**2023**	**2024**	**2025**	***CAGR***
Mecklenburg	21,055.79	21,546.20	22,036.62	22,527.03	*2.3%*
Cabarrus	6,114.53	7,137.58	8,160.64	9,183.69	*14.5%*
Iredell	5,602.37	6,210.22	6,818.07	7,425.92	*9.8%*
Total	***32,772.69***	***34,894.00***	***37,015.33***	***39,136.64***	***6.1%***

Projected HH Patients Served (Step 6)					
County	**2022**	**2023**	**2024**	**2025**	***CAGR***
Mecklenburg	20,531.87	20,531.87	20,531.87	20,531.87	*0.0%*
Cabarrus	6,031.62	6,031.62	6,031.62	6,031.62	*0.0%*
Iredell	5,570.98	5,570.98	5,570.98	5,570.98	*0.0%*
Total	***32,134.47***	***32,134.47***	***32,134.47***	***32,134.47***	***0.0%***

PHC Calculated Unmet Need HH Patients (Step 7)					
County	**2022**	**2023**	**2024**	**2025**	***CAGR***
Mecklenburg	524	1,014	1,505	1,995	*56.2%*
Cabarrus	83	1,106	2,129	3,152	*236.3%*
Iredell	31	639	1,247	1,855	*289.5%*
Total	***638***	***2,760***	***4,881***	***7,002***	***122.2%***

Source: PHC application, Section Q, pages 6-8 (PDF pages 122-124)

As shown in the previous table, the unmet need of home health patients in each of the counties in PHC's service area skyrockets from 2022 to 2023. The resulting CAGRs for each county (Step 7) are in no way realistic or plausible compared to actual home health utilization. The CAGRs are likewise out of touch with PHC's own projected CAGRs in Step 5 and Step 6 in the previous table. Subsequently, the series of assumptions previously described in Step 2 through Step 7 of PHC's methodology render the home health patient projections unreasonable and unsupported.

Step 8 projects PHC market share and Step 9 calculates projected PHC unduplicated home health patients based on the market shares from Step 8 applied to the unmet patient need in Step 7. Therefore, PHC's unduplicated patient projections are premised on a fragile house of cards that quickly fall upon closer examination as previously described. Thus, PHC does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions and the application does not conform to Criterion 3.

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

The PHC Application is not conforming to Criterion 4. PHC does not adequately demonstrate that the alternative proposed in its Application is the most effective alternative to meet the need because the Application is not conforming to all statutory and regulatory review criteria. See discussion regarding Criterion 3. An application that cannot be approved cannot be the most effective alternative.

Criterion 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."*

The PHC application also fails to conform to Criterion 5 because its projections are not reasonable and adequately supported. See discussion regarding Criterion 3.

In addition, PHC did not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable and supported projections of operating costs and revenues.

Form F.2b Errors

PHC failed to project Medicare revenues based on reasonable and adequately supported assumptions. Specifically, "Form F.2b Projected Revenues and Net Income upon Project Completion Assumptions" (see PDF page 148) reflects the revenue assumptions for each payor mix. The following table summarizes PHC's assumptions for projecting annual Medicare revenue.

Revenue by payor source

	2022			2023			2024			2025		
Medicare	Episodes	Reimb	Revenue	Episodes	Reimb	Revenue	Episodes	Reimb	Revenue	Episodes	Reimb	Revenue
Full Episodes	67	$ 1,837	$ 123,298	235	$ 1,869	$ 438,396	485	$ 1,902	$ 922,433	819	$ 1,935	$ 1,583,990
Full Episodes w/Outliers	0	$ 1,986	$ 757	1	$ 2,020	$ 2,693	3	$ 2,056	$ 5,666	5	$ 2,092	$ 9,729
LUPA Visits	8	$ 149	$ 1,181	28	$ 151	$ 4,198	57	$ 154	$ 8,834	97	$ 157	$ 15,170
Partial Episodes	1	$ 918	$ 771	3	$ 934	$ 2,740	6	$ 951	$ 5,765	10	$ 967	$ 9,900
Total	76		$ 126,007	267		$ 448,027	551		$ 942,698	930		$ 1,618,789

As summarized in the previous table and on PDF page 156 of its application, PHC projects Medicare revenue based on "based upon [the] CMS Final CY 2021 national **30-day standardized episode payment rate**, national per-visit payment amounts, and cost-per-unit payment rates for the calculation of outlier payments, adjusted for case mix and Mecklenburg County, NC, using Charlotte-Concord-Gastonia, NC-SC wage index, as posted in the Federal Register. Annual inflation is estimated at 1.75%." E*mphasis added.* The CMS CY2021 National, Standardized 30-Day Period Payment Amount is $1,901.12. However, there are serious and fatal errors in PHC's revenue assumptions that fail to incorporate recent changes in Medicare reimbursement for home health.

In conjunction with the implementation of the Patient-Driven Groupings Model (PDGM), CMS has changed the unit of home health payment from a 60-day episode to a 30-day period. A Medicare episode consists of **two 30-day periods of care**. In other words, under PDGM a provider now receives two period payments during a 60-day episode instead of one payment per 60-day episode pre-PDGM (i.e., before January 1,

2020). Based on the information provided in its application as submitted, it appears that PHC assumes a "30-day period" and an "episode" are one and the same. However, this is not accurate. A period includes 30 days and an episode includes 60 days. Consequently, PHC failed to incorporate revenue for two 30-day periods in each Medicare full episode and Medicare full episode with outliers. Instead, PHC projects Medicare revenue for only one 30-day period for Medicare full episode patients and full episode with outlier patients. As a result of this omission, PHC projects Medicare revenues that are materially understated compared to Medicare revenues for two 30-day periods of care.

PHC could attempt to downplay this error by claiming the proposed home health agency remains profitable even with understated revenue assumptions; however, PHC's failure to appropriately project Medicare revenues has a clear and direct impact on several comparative factors, effectively poisoning PHC's application and eliminating all opportunity for viability. As shown previously in the discussion of comparative factors and summarized in the table below, PHC projects the lowest net revenue per unduplicated admission during the third project year. As stated in numerous Agency Findings including the 2017 Mecklenburg County home health review, generally the application proposing the lowest average net revenue per unduplicated patient is the more effective alternative with regard to this comparative factor.

	# of Unduplicated Admissions	Net Revenue	Net Revenue per Unduplicated Admission
WellCare	818	$2,646,687	$3,236
Bayada	1,863	$7,192,298	$3,861
PHC	996	$2,143,964	$2,153
PruittHealth	888	$1,938,473	$2,183
Aldersgate	550	$2,001,790	$3,640

PHC projects 65.6% of unduplicated patients will consist of Medicare patients and 73.2% of gross revenue will be attributed to Medicare reimbursement. Therefore, Medicare reimbursement is a fundamental driver of PHC's overall net revenue. PHC's flawed Medicare reimbursement model and its omission of two 30-day revenue periods are why PHC shows the lowest average net revenue per unduplicated admission in the comparative analysis. Therefore, at a minimum, the **Agency cannot determine PHC is the most effective alternative with regard to net revenue per unduplicated admission**. PHC should also be found non-conforming to Criterion 5 because a showing of conformity with Criterion 5 requires a demonstration of financial feasibility based on reasonable projections of costs and charges; here, PHC has not relied on reasonable projections and thus, has failed to make the demonstration required by Criterion 5.

Consistency in approach demonstrates the reasonableness of Agency action and avoids arbitrary and capricious decision-making. To be consistent with the approach taken in prior home health reviews, the Agency should conclude that PHC used unreliable utilization projections for revenue purposes, rendering its application non-conforming with multiple review criteria.

In the 2013 Forsyth Home Health Review, Well Care was found to have provided conflicting data on visits per patient, the distribution of patients by payor and the total number of visits. While Well Care correctly presented patients and visits on multiple tables in its application, it used conflicting projections on total visits for purposes of projecting revenue. The Agency did not make new assumptions for the applicant nor did it recalculate the visits per patient by payor to determine total visits for revenue purposes. Instead, the Agency concluded that the Well Care "utilization projections are unreliable." Agency Findings, 2013 Forsyth Home Health Review, p. 19. Having so concluded, the Agency found the applicant did not adequately demonstrate need and financial feasibility "based upon reasonable projections of costs and charges," rendering it non-conforming with multiple review criteria.

In the 2013 Forsyth Home Health Review, the issue with the Well Care application was, specifically, an error in the visits "per episode" projection. While Well Care's problem was simply caused by a mistaken use of different numbers in its utilization and revenue projections, ultimately, the resulting problem -- the use of incorrect visits for revenue projections -- is an issue strikingly similar to the error by PHC in this review.

PHC based its revenues on the "old" PPS structure and failed to account for the "sea change" in reimbursement resulting from the move to the current PDGM payment construct. The change from PPS to PDGM is fairly termed a "sea change" as it represents a profound or notable transformation. Specifically, PHC failed to take into consideration the two 30-day periods that undergird the current PDGM reimbursement model and therefore misrepresented its projected revenue to the Agency in its application. Just as in the 2013 Forsyth County Review, the Agency cannot rectify the PHC error – rather, as it did in the Forsyth County Review, it can and should simply conclude the PHC revenue projections are based on unreliable utilization projections, rendering the application non-conforming with multiple review criteria.[8]

Ultimately, the assumptions used by an applicant in preparation of the pro forma financial statements are not reasonable and adequately supported when projected utilization is not based on reasonable and adequately supported assumptions. See, e.g., Agency Findings, 2017 New Hanover County OR Review, Agency Findings, p. 23 (citing an incorrect CAGR calculation, among other issues); 2018 Forsyth County OR Review, p. 101. The PHC error in basing its revenue projections on assumptions for the payment structure (PPS) that is no longer in use and has been replaced by a different payment structure (PDGM) is an error that goes to the heart of the PHC application and renders the application as submitted unapprovable.

[8]An application based on unreliable utilization projections is not conforming to all applicable statutory and regulatory review criteria, and thus, the application is not approvable. An application that cannot be approved is not an effective alternative under Criterion 4. Such an applicant cannot demonstrate that it will maximize healthcare value for resources expended under Criterion 1, cannot demonstrate need based on reliable projections of utilization under Criterion 3, cannot show financial feasibility under Criterion 5, nor demonstrate conformity with Criteria 6 and 18(a).

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*."

PHC did not demonstrate that the proposed home health services would not duplicate the services provided by its existing Mecklenburg County home health office. See discussion regarding Criterion 3.

Criterion 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."*

Based on the facts which result in PHC being non-conforming with Criterion 3, it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

While PHC appears to be the most effective alternative for three comparative factors (setting aside the issue of non-conformity), it is the least effective alternative for five comparative factors. An applicant that is the **least effective** alternative for more factors compared to the total for which it is most effective (setting aside the issue of non-conformity) cannot be the most effective alternative in a competitive batch review.

Service to Mecklenburg County Residents

Applications in this batch were filed in response to the 2021 State Medical Facilities Plan Need Determination for one additional home health home care agency/office in Mecklenburg County.

	Total # of New (Unserved) Mecklenburg County Residents Served	Total # of New (Unduplicated) Patients Served	Mecklenburg County Residents Served as a % of Total New Patients Served
Well Care	752	818	91.9%
PHC	599	1,007	59.5%

As shown in the table above, PHC projects to serve a comparatively higher number of Mecklenburg County residents than Well Care. However, PHC does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Well Care proposes that 91.9% of its new (unduplicated) home health patient admissions in its Third Full Fiscal Year will be admissions of patients residing in Mecklenburg County. By contrast, PHC proposes that 59.5% of its new (unduplicated) admissions in the Third Full Fiscal Year will be admissions of patients residing in

Mecklenburg County. Therefore, Well Care is more effective than PHC with respect to access by service area residents.

In the 2018 Buncombe County Operating Room Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents is the more effective alternative with regard to this comparative factor since the need determination is for two additional ORs to be located in this multi-county service area. The Agency determined that the applicant projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents during the third operating year was the most effective alternative. Similarly, in the 2019 Wake County MRI Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Wake County MRI service area residents is the more effective alternative with regard to this comparative factor since the need determination is for one additional MRI to be located in the MRI service area. The Agency determined that the applicant projecting to serve the highest percentage of Wake County MRI service area residents during the third operating year was the most effective alternative. As it did in the recent Buncombe OR Review and Wake County MRI Review, the Agency should conclude that the Well Care application is a more effective alternative than the PHC application because Well Care projects to serve a higher percentage of Mecklenburg County residents in the third operating year.

Costs & Revenues

As previously described, PHC does not adequately demonstrate the financial feasibility of the project is based upon reasonable and adequately supported assumptions regarding projected utilization and revenues. See discussion regarding Criteria 3 and 5. Therefore, the Agency cannot determine PHC to be an effective alternative in any comparative analysis regarding revenues and costs.

For information purposes, PHC projects comparatively higher average total operating costs per visit than Well Care.

Medically Underserved Access

As compared to Well Care's application, PHC's proposal is inferior with respect to medically underserved access. PHC projects comparatively lower charity care, Medicare, and Medicaid access than Well Care.

Salaries

As compared to Well Care's application, PHC's proposal is inferior with respect to salaries for direct care staff. PHC projects comparatively lower salaries for RNs, LPNs, home health aides, social workers, physical therapists, speech therapists, and occupational therapists than Well Care.

COMMENTS SPECIFIC TO PRUITTHEALTH @ HOME – HOME HEALTH (PruittHealth)
PROJECT ID No. F-012072-21

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

POLICY GEN-3: BASIC PRINCIPLES states:

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

PruittHealth fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The application does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding Criteria 3, 4, 5, 6, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 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."*

Step 9 of PruittHealth's methodology for projecting home health utilization (application page 163) indicates the applicant relied on PruittHealth's North Carolina home health agency data from 2019 to project Medicare episodes by reimbursement type. It is important to note the respective data reflects home health utilization patterns before the implementation of the new PDGM payment system (effective January 1, 2020). In fact, PruittHealth states on page 163, "*Notably, PEPs and LUPAs are different in the new PDGM payment model in that they have a different number of visits per period than the previously utilized episode*." Therefore, PruittHealth acknowledges the 2019 data is not representative of utilization patterns subsequent to the new PDGM payment system.

The most notable change to Medicare episodes by reimbursement type based on the new PDGM payment system is for low utilization payment adjustments, or LUPA. A LUPA is a standard per-visit payment for

episodes of care with a low number of visits. Pre-PDGM (i.e., before January 1, 2020), LUPA occurred when there were four or fewer visits during a 60-day episode of care. Under PDGM, LUPA thresholds are based on clinical grouping and episode timing. Additionally, each of the 432 case-mix groups (vs. 153 case-mix groups under the previous CMS PPS payment system) has a threshold to determine if the period of care would receive a LUPA. New LUPA episodes now range from two to six visit thresholds and vary across the clinical groupings. In addition, LUPA potential is now within each 30-day payment period within the 60-day episode of care. As a result of these fundamental changes to LUPA determinations under PDGM, PruittHealth's 2019 LUPA episodes as a percent of total Medicare episodes under the previous CMS PPS payment system is very likely to be much different compared to PruittHealth's current LUPA episodes under PDGM. Therefore, PruittHealth's projected number of Medicare episodes by reimbursement type are questionable. Errors within the assumptions used to project Medicare episodes by reimbursement type creates a domino effect in the following steps of the methodology resulting in unreliable patient projections and visit projections.

Unreliable Medicare episode projections also call into question the reliability of PruittHealth's financial projections. For example, LUPA can result in an adjusted payment of $300 for what could have been a $2,600 payment for an episode of care. Therefore, PruittHealth's revenue projections are similarly questionable.

In the 2010 Wake County Home Health Review, 3HC was found to have unreliable Medicare revenue projections based on errors projecting "episodes of care and the projected number of low or partial utilization patients." Agency Findings, 2010 Wake Home Health Review, p. 97. The Agency concluded "Reimbursement is lower for LUPAs and PEPs because they are based on individual visits rather than a full episode. Thus, 3HC overstates its projected Medicare reimbursement and did not adequately demonstrate that its projected Medicare revenue is based on reasonable and supported assumptions."

In the 2010 Wake County Home Health Review, the issue with the 3HC application was an error projecting Medicare patients by reimbursement type. Erroneous Medicare projections by reimbursement is an issue strikingly similar to the error by PruittHealth in this review. Just as it did in the 2010 Wake County Home Health Review, the Agency can and should conclude the PruittHealth revenue projections are based on unreliable utilization projections, rendering the application non-conforming with multiple review criteria.

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

The PruittHealth application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative. See discussion regarding criteria 1, 3, 4, 5, 6, 18a.

Criterion 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."*

Availability of Funds

To indicate availability of funds, PruittHealth includes a letter at Exhibit F.2. The letter indicates that United Health Services, Inc., the ultimate parent of PruittHealth Home Health, makes a funding commitment. However, the letter is not authored by an individual writing on behalf of United Health Services, Inc. Instead, the letter is signed by Jeff Charron who lists his title as the Senior Vice President of Treasury Management and Treasurer for PruittHealth.

PruittHealth is, in effect, the borrower of the funds. As such, the letter is written not by an Officer with United Health Services, Inc. who will ostensibly provide the funds but by a Senior VP with the company, PruittHealth, who will receive the funds.

Ordinarily, a corporation and its subsidiaries maintain their separate legal identities, even if "the parent corporation owns all of the capital stock of the subsidiaries and the corporations have identical membership on their boards of directors." Cf. 6 N.C. Index 4th Corporations § 7. A funding commitment TO an applicant must come FROM the funder, not the borrower. A child cannot state that his parent will provide an allowance; to document a commitment of funds, the parent must be the one to write to commit the allowance of funds.

Here, Mr. Charron indicates he is a "financial representative" of United Health Services, Inc. He states he is authorized to commit the funds but there is no indication in the letter that Jeff Charron is an Officer of United Health Services, Inc.

As a matter of corporate law, it is an Officer of a corporation that holds the authority to act on behalf of the corporation. See, e.g., Sentry Enters., Inc. v. Canal Wood Corp., 94 N.C. App. 293, 297 (1989) ("The president of a corporation has the apparent authority to bind the corporation to contracts which are within the corporation's ordinary course of business.") There is no legal significance to the title "financial representative" and holding such a title is not an indication that an individual is an Officer empowered to act on the corporation's behalf. Absent additional facts or indicia to conclusively demonstrate that United Health Services, Inc. has conferred upon Mr. Charron the authority to transact for and contractually bind the PruittHealth parent company, Mr. Charron lacks actual or apparent authority to act on the parent's behalf.

While it is permissible for a project to be funded by a non-applicant, our courts have held that "where the project is to be funded other than by the applicants, the application must contain evidence of **a commitment** to provide the funds **by the funding entity**." Ret. Villages, Inc. v. N. Carolina Dep't of Hum. Res., 124 N.C. App. 495, 499, 477 S.E.2d 697, 699 (1996) (emphasis supplied). In North Carolina, "without such a commitment, an applicant cannot adequately demonstrate availability of funds or the requisite financial feasibility." *Id*.

Ultimately, the problems explained here are not resolved because the applicant has some form of corporate relationship with the entity that, at least arguably, is the intended source of project funds. This

is an issue that was put to rest years ago in the Retirement Villages case cited above. Ret. Villages, Inc. v. N. Carolina Dep't of Hum. Res., 124 N.C. App. 495, 499, 477 S.E.2d 697, 699 (1996). The mere fact of a corporate relationship does not absolve an applicant from its legal obligations under Criterion (5).

Another significant issue with the letter at Exhibit F.2 is that it does not recite that the parent, United Health Services, Inc., has no expectation of re-payment. In the case of an inter-company commitment of funds, unless stated otherwise, it is reasonable to assume that the funding corporate entity will be repaid by the entity to whom the funds are made available. Here, the letter does not say that there is no obligation to re-pay the funds nor does the letter indicate the applicable terms for re-payment such as time for re-payment or interest rate.

While Mr. Charron references and attaches documentation of a considerable sum of money, nothing in Mr. Charron's letter recites that the funds necessary for the project are likely to be available when needed for the project. This is information directly requested by the CON Application Form, and thus, information the CON Section has deemed necessary to evaluate conformity with Criterion 5.

It is notable that the letter does not state how much money the project will require or make any other statements to indicate that funding, for example, in an amount up to a certain dollar amount will be furnished. While the parent company obviously has considerable resources, the letter is in the nature of a blank check which is not reliable evidence of a specific commitment of a stated amount of funds.

In order to fairly and consistently apply Criterion 5, the CON Section should be consistent in its application of Criterion 5 and unwilling to turn a blind eye to inadequacies in documentation simply because the putative funder has considerable resources.

Regardless of the size of the parent company, the CON Section should expect to see an Officer with authority to act on behalf of the funding Corporation provide a letter committing the funding entity to provide the funds, and reciting the extent of any expectation of re-payment and the associated terms.

To be sufficient, a funding letter needs to state that the funds will be or are reasonably expected to be available when needed. And, the letter should state the dollar amount or an "up to" amount to describe the extent of the financial commitment.

The PruittHealth letter fails all these tests: it is not written by a corporate Officer with authority under the law to act on behalf of the funding Corporation; it does not indicate whether the funds must be repaid nor the applicable terms of re-payment; it does not state the funds will be available when needed; and it does not describe a dollar amount or a limit on the amount of funds committed.

Financial Feasibility

The assumptions used by PruittHealth in preparation of the pro forma financial statements are not reasonable, including projected utilization, costs, and charges. See the financial section of the application for the assumptions used regarding costs and charges. The discussion regarding projected utilization found in Criterion 3 is incorporated herein by reference. Therefore, the applicant does not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and charges. Consequently, the application is not conforming to this criterion.

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."*

PruittHealth failed to adequately demonstrate the need for the proposed services (See Criterion 3). Therefore, PruittHealth failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved home health services and is nonconforming to this criterion.

Criterion 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."*

Based on the facts which result in PruittHealth being non-conforming with Criteria 1, 3, 4, 5, and 6, it should also be found non-conforming with Criterion 18a.

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

PruittHealth is an applicant already involved in the provision of health services. As previously described, PruittHealth-Wilkes provides home health services to Mecklenburg County residents. PruittHealth also operates home health offices in Craven, Cumberland, Edgecombe, and Pitt counties. PruittHealth also operates numerous nursing facilities in North Carolina and throughout the southeast.

PruittHealth-Carolina Point (Durham County) has been cited for multiple deficiencies during the last 18 months, including two fines totaling $14,927. On March 27, 2019, PruittHealth-Carolina Point was issued a $6,633 fine for failing to prevent a resident with dementia from exiting the facility while unsupervised for an unknown amount of time. The Resident was found outside lying in a drainage ditch approximately 178 feet away from the facility. The resident was returned inside the facility and his body temperature was below normal at 90.5 degrees Fahrenheit and he was transported to the hospital for evaluation. Also, on June 27, 2019, PruittHealth-Carolina Point was issued a $8,294 fine for failing to prevent staff to resident abuse.

On February 8, 2019, PruittHealth-Rockingham (Rockingham County) was fined $244,199 for failing to provide showers for residents.

On October 16, 2019, PruittHealth-Union Pointe was fined $9,360 for failure to provide incontinent care in a safe manner to prevent a fall from the bed [resulting]… in fractured leg.

The Georgia Department of Community Health (DCH) Healthcare Facility Regulation (HFR) division recently determined that a situation in which one of PruittHealth's facility's was noncompliant with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm,

impairment or death to residents. PruittHealth-Palmyra's Administrator and Director of Health Services were informed of the Immediate Jeopardy on October 8, 2019 at 4:55 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on September 10, 2019. The U.S. Center for Medicare and Medicaid Services reports that it fined PruittHealth Palmyra $186,564.

The Agency should consider these quality deficiencies in its evaluation of PruittHealth's conformity to Criterion 20.

Comments Regarding Comparative Analysis

Service to Mecklenburg County Residents

Applications in this batch were filed in response to the 2021 State Medical Facilities Plan Need Determination for one additional home health home care agency/office in Mecklenburg County.

	Total # of New (Unserved) Mecklenburg County Residents Served	Total # of New (Unduplicated) Patients Served	Mecklenburg County Residents Served as a % of Total New Patients Served
Well Care	752	818	91.9%
PruittHealth	786	889	88.4%

As shown in the table above, PruittHealth projects to serve a comparatively higher number of Mecklenburg County residents than Well Care. However, PruittHealth does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Well Care proposes that 91.9% of its new (unduplicated) home health patient admissions in its Third Full Fiscal Year will be admissions of patients residing in Mecklenburg County. By contrast, PruittHealth proposes that 88.4% of its new (unduplicated) admissions in the Third Full Fiscal Year will be admissions of patients residing in Mecklenburg County. Therefore, Well Care is more effective than PruittHealth with respect to access by service area residents.

In the 2018 Buncombe County Operating Room Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents is the more effective alternative with regard to this comparative factor since the need determination is for two additional ORs to be located in this multi-county service area. The Agency determined that the applicant projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents during the third operating year was the most effective alternative. Similarly, in the 2019 Wake County MRI Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Wake County MRI service area residents is the more effective alternative with regard to this comparative factor since the need determination is for one additional MRI to be located in the MRI service area. The Agency determined that the applicant projecting to serve the highest percentage of Wake County MRI service

area residents during the third operating year was the most effective alternative. As it did in the recent Buncombe OR Review and Wake County MRI Review, the Agency should conclude that the Well Care application is a more effective alternative than the PruittHealth application because Well Care projects to serve a higher percentage of Mecklenburg County residents in the third operating year.

Costs & Revenues

As previously described, PruittHealth's operating costs and resulting revenues are not based on adequate home health staff projections. See discussion regarding Criterion 5. Therefore, the conclusion of any comparative analysis of PruittHealth's costs and revenues would be inconclusive.

For information purposes, PruittHealth projects comparatively higher average total operating costs per visit than Well Care.

Medically Underserved Access

As compared to Well Care's application, PruittHealth's proposal is inferior with respect to medically underserved access. PruittHealth projects comparatively lower charity care and Medicaid access than Well Care.

Salaries

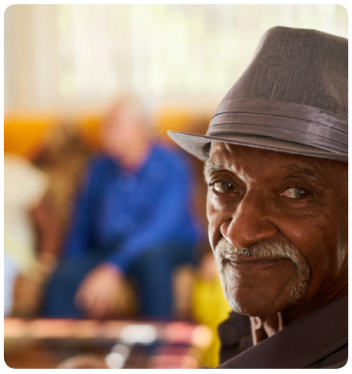
As compared to Well Care's application, PruittHealth's proposal is inferior with respect to salaries for direct care staff. PruittHealth projects comparatively lower salaries for RNs, LPNs, home health aides, social workers, physical therapists, speech therapists, and occupational therapists than Well Care.

Attachment 1

PDGM Overview

Centers for Medicare & Medicaid Services Patient-Driven Groupings Model





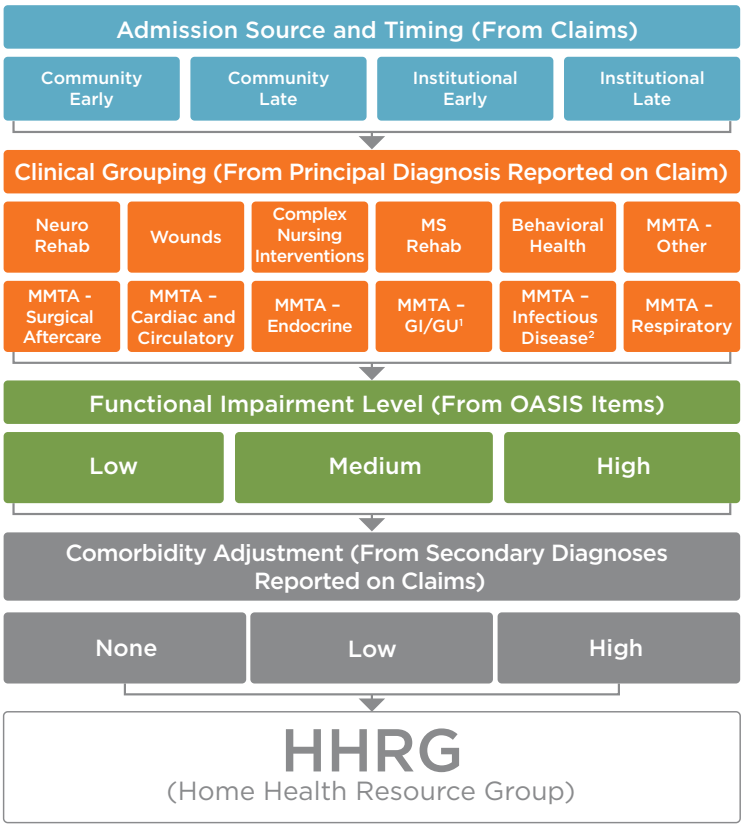

Overview of the Patient-Driven Groupings Model

The Patient-Driven Groupings Model (PDGM) uses 30-day periods as a basis for payment. Figure 1 below provides an overview of how 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment in the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- **Admission source (two subgroups):** community or institutional admission source
- **Timing of the 30-day period (two subgroups):** early or late
- **Clinical grouping (twelve subgroups):** musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; medication management, teaching, and assessment (MMTA) - surgical aftercare; MMTA - cardiac and circulatory; MMTA - endocrine; MMTA - gastrointestinal tract and genitourinary system; MMTA - infectious disease, neoplasms, and blood-forming diseases; MMTA - respiratory; MMTA- other; behavioral health; or complex nursing interventions
- **Functional impairment level (three subgroups):** low, medium, or high
- **Comorbidity adjustment (three subgroups):** none, low, or high based on secondary diagnoses.

In total, there are 2*2*12*3*3 = 432 possible case-mix adjusted payment groups. The remainder of this overview provides more detail on each PDGM grouping category and additional adjustments to payment that are made within the PDGM.

FIGURE 1: STRUCTURE OF THE PATIENT-DRIVEN GROUPINGS MODEL



Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

1 Gastrointestinal tract/Genitourinary system
2 The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

Timing

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods in the sequence (second or later) are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early). The comprehensive assessment must be completed within five days of the start of care date and updated no less frequently than during the last five days of every 60 days beginning with the start of care date (as currently required by the Medicare Conditions of Participation at 42 CFR 484.55). As a result, information obtained from the Outcome and Assessment Information Set (OASIS) used in the PDGM may not change over the two 30-day periods the OASIS covers. However, if a patient experiences a significant change in condition before the start of a subsequent, contiguous 30-day period, for example due to a fall; a follow-up assessment would be submitted at the start of a second 30-day period to reflect any changes in the patient's condition, including functional abilities, and the second 30-day claim would be grouped into its appropriate case-mix group accordingly.

Admission Source

Under the PDGM, each 30-day period is classified into one of two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute hospitalization in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay.

Clinical Grouping

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit.

Table 1 below describes the twelve clinical groups. These groups are designed to capture the most common types of care that home health agencies (HHAs) provide.

TABLE 1: PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions
Medication Management, Teaching and Assessment (MMTA) • **MMTA –Surgical Aftercare** • **MMTA – Cardiac/Circulatory** • **MMTA – Endocrine** • **MMTA – GI/GU** • **MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases** • **MMTA –Respiratory** • **MMTA – Other**	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

Functional Impairment Level

The PDGM designates a functional impairment level for each 30-day period based on the following OASIS items:

VARIABLE #	DESCRIPTION
M1800	Grooming
M1810	Current ability to dress upper body safely
M1820	Current ability to dress lower body safely
M1830	Bathing
M1840	Toilet transferring
M1850	Transferring
M1860	Ambulation and locomotion
M1033	Risk for hospitalization

CMS estimates a regression model that determines the relationship between the responses for the listed OASIS items and average 30-day period resource use. The coefficients from the regression are used to assign points to a 30-day period. Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with having larger coefficients and are therefore assigned higher points. The points are then summed, and thresholds are applied to determine whether a 30-day period is assigned a low, medium, or high functional impairment level. Each clinical group is assigned a separate set of thresholds. On average, 30-day periods in the low level have responses for the listed OASIS items that are associated with the lowest resource use. On average, 30-day periods in the high level have responses on the above OASIS items that are associated with the highest resource use.

Comorbidity Adjustment

The PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses. Depending on a patient's secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment. Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:

- **Low comorbidity adjustment:** There is a reported secondary diagnosis that is associated with higher resource use, or;
- **High comorbidity adjustment:** There are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.

A 30-day period can have a low comorbidity adjustment or a high comorbidity adjustment, but not both. If a 30-day home health period of care does not have reported comorbidities that fall into one of the adjustments described above, there would be no comorbidity adjustment applied.

Determining Case-Mix Weights for the Patient-Driven Groupings Model

The case-mix weight for each of the 432 different payment groups under the PDGM are determined by estimating a regression where the dependent variable is the resource use of a 30-day period and the independent variables are categorical indicators representing the five dimensions of the model described above (timing of a 30-day period, admission source, clinical group, functional impairment level, and comorbidities). Case-mix weights are produced by dividing the predicted resource use for each PDGM payment group by the overall average resource use of all 30-day periods. The case-mix weights are then used to adjust the 30-day payment rate. Figure 2 (Page 5) describes how 30-day periods are paid and when payment adjustments are made.

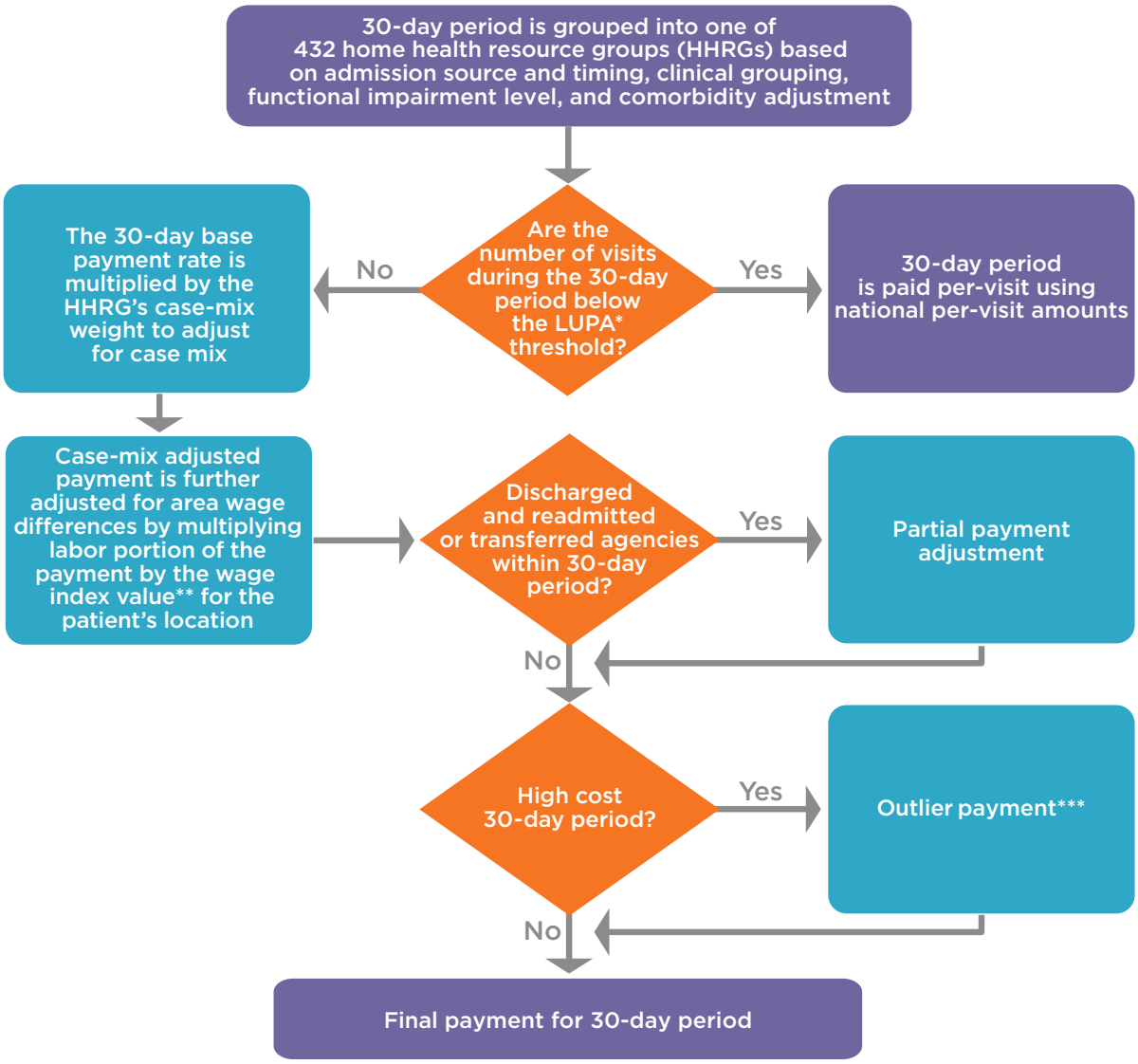
Additional Payment Adjustments for the Patient-Driven Groupings Model

Payments for 30-day periods with a low number of visits are not case-mix adjusted, but instead paid on a per-visit basis using the national per-visit rates. Each of the 432 different PDGM payment groups has a threshold that determines if the 30-day period receives this Low-Utilization Payment Adjustment (LUPA). For each payment group, the 10th percentile value of visits is used to create a payment group specific LUPA threshold with a minimum threshold of at least two for each group. A 30-day period with a total number of visits below the LUPA threshold are paid per-visit rather than being paid the case-mix adjusted 30-day payment rate. A 30-day period with a total number of visits at or above the LUPA threshold is paid the case-mix adjusted 30-day payment rate rather than being paid per-visit.

When a 30-day period of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an additional outlier payment (See Figure 3). Once the imputed cost of a 30-day period of care exceeds a threshold amount, the HHA receives a payment equal to 80 percent of the difference between the imputed costs and the threshold amount.

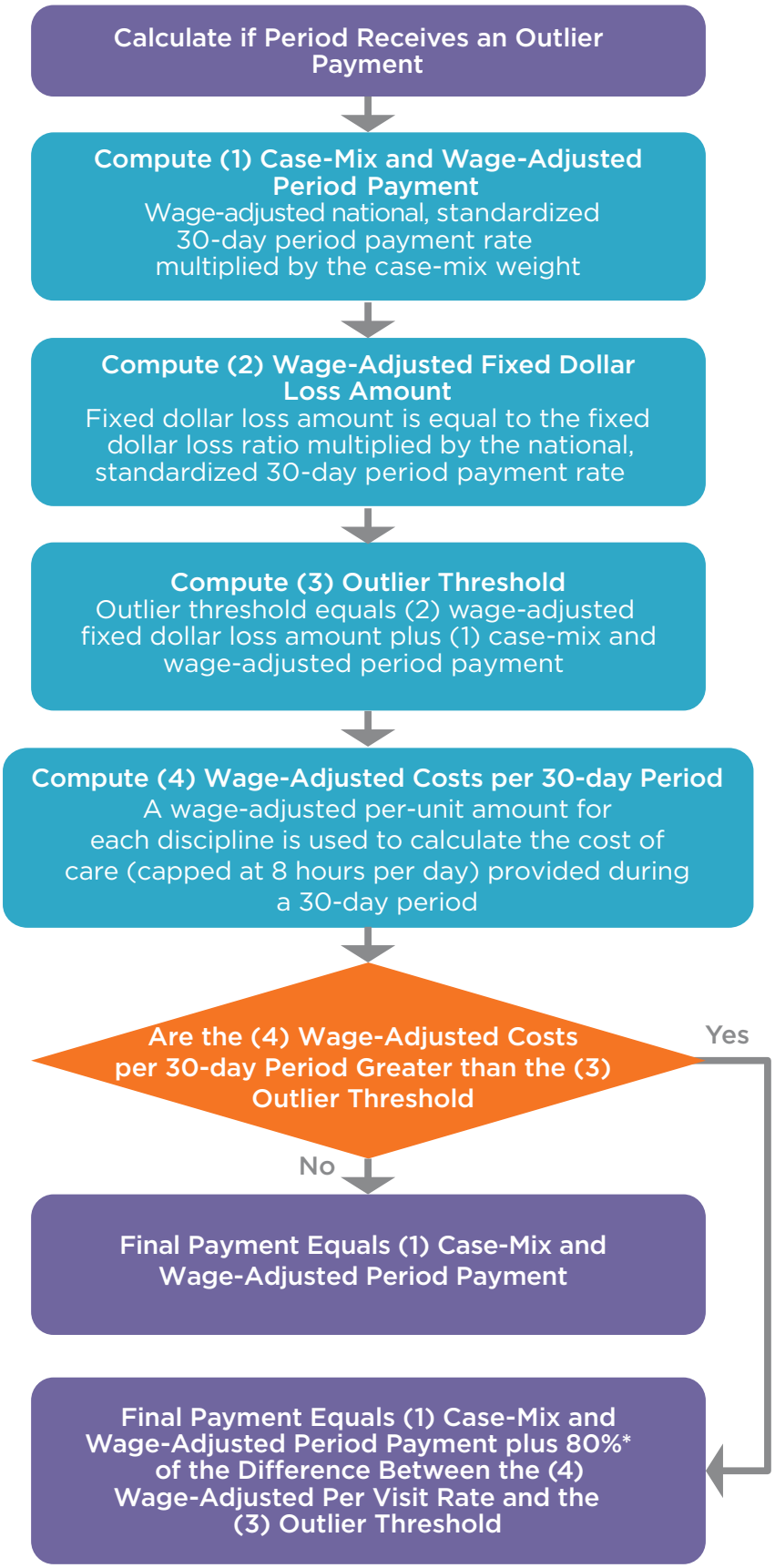
Payments would be adjusted if a beneficiary transfers from one home health agency to another or is discharged and readmitted to the same agency within 30 days of the original 30-day period start date. The case-mix adjusted payment for 30-day periods of that type is pro-rated based on the length of the 30-day period ending in transfer or discharge and readmission, resulting in a partial period payment.

FIGURE 2: HOW PAYMENTS AND ADJUSTMENTS ARE CALCULATED FOR THE PATIENT-DRIVEN GROUPINGS MODEL



* LUPA = Low Utilization Payment Adjustment
** The wage-adjusted payment for a 30-day period is calculated by taking the case-mix adjusted 30-day payment amount and multiplying 76.1% of that payment by a wage-index value that controls for area wage differences. That value is then added to 23.9% of the case-mix adjusted base-payment to determine the wage-adjusted payment amount.
*** Outlier payment is in addition to the wage-adjusted and case-mix adjusted 30-day period payment

FIGURE 3: CALCULATION OF OUTLIER PAYMENT



*80% is referred to as the loss sharing ratio

BOLD
THINKERS
DRIVING
REAL-WORLD
IMPACT

Attachment 2

Bayada Home Health Care, Inc.

Application for Certificate of Authority

SOSID: 1787563
Date Filed: 1/3/2019 1:03:00 PM
Elaine F. Marshall
North Carolina Secretary of State
C2019 003 00219

State of North Carolina
Department of the Secretary of State

APPLICATION FOR CERTIFICATE OF AUTHORITY FOR NONPROFIT CORPORATION

Pursuant to §55A-15-03 of the General Statutes of North Carolina, the undersigned corporation hereby applies for a Certificate of Authority to conduct affairs in the State of North Carolina, and for that purpose submits the following:

1. The name of the corporation is BAYADA Home Health Care, Inc.

   and if that name is unavailable for use in the State of North Carolina, the name the corporation wishes to use is: _____

2. The state or country under whose laws the corporation was organized is: Pennsylvania
3. The date of incorporation was 01/17/1975 ; its period of duration is: Perpetual
4. The street address of the principal office of the corporation is:

   Number and Street 4300 Haddonfield Road

   City, State, Zip Code Pennsauken, NJ 08109

5. The mailing address *if different from the street address* of the principal office of the corporation is:

   _____

6. The street address and county of the registered office in the State of North Carolina is:

   Number and Street 2626 Glenwood Avenue Suite 550

   City, State, Zip Code Raleigh, North Carolina 27608 County: Wake

7. The mailing address *if different from the street address* of the registered office in the State of North Carolina is:

   _____

8. The name of the registered agent in the State of North Carolina is: Corporation Service Company
9. The names and usual business addresses of the current officers of the corporation are:

Name	Title	Business Address
David L. Baiada	President	4300 Haddonfield Road, Pennsauken, NJ 08109
David L. Baiada	Secretary	4300 Haddonfield Road, Pennsauken, NJ 08109
Thomas Sibson	Treasurer	4300 Haddonfield Road, Pennsauken, NJ 08109
J. Mark Baiada	Chairman	4300 Haddonfield Road, Pennsauken, NJ 08109

APPLICATION FOR CERTIFICATE OF AUTHORITY
FOR NONPROFIT CORPORATION
Page 2

10. (*Check one of the following.*)

    a. [✓] The corporation has members.

    b. [ ] The corporation does not have members.

11. Attached is a certificate of existence (or document of similar import), duly authenticated by the Secretary of State or other official having custody of corporate records in the state or country of incorporation.

12. If the corporation is required to use a fictitious name in order to conduct affairs in this State, a copy of the resolution of its board of directors, certified by its secretary, adopting the fictitious name is attached.

13. This application will be effective upon filing, unless a date and/or time is specified: _____

This the 31st day of December, 20 18.

BAYADA Home Health Care, Inc.
Name of Corporation

J Mark Baiada
Signature

J. Mark Baiada, Chairman
Type or Print Name and Title

Notes:
1. Filing fee is $125.
2. This document must be filed with the Secretary of State.

BUSINESS REGISTRATION DIVISION
(Revised August 2017)

P. O. BOX 29622

RALEIGH, NC 27626-0622
Form N-09

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF STATE

12/31/2018

TO ALL WHOM THESE PRESENTS SHALL COME, GREETING:

I DO HEREBY CERTIFY THAT,

BAYADA Home Health Care, Inc.

is duly registered as a Pennsylvania Non-Profit (Non Stock) under the laws of the Commonwealth of Pennsylvania and remains subsisting so far as the records of this office show, as of the date herein.

I DO FURTHER CERTIFY THAT this Subsistence Certificate shall not imply that all fees, taxes and penalties owed to the Commonwealth of Pennsylvania are paid.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Seal of the Secretary's Office to be affixed, the day and year above written

Robert Torres

Acting Secretary of the Commonwealth

Certification Number: TSC181231090248-1

Verify this certificate online at http://www.corporations.pa.gov/orders/verify