STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE
RALEIGH, NC 27603
CONFERENCE ROOM #026 - EDGERTON BUILDING
CONFERENCE CALL
FRIDAY, MAY 15, 2020
9:00 A.M.

Agenda

I. Meeting Opens

II. Chairman's Comments……………………………………….……………………………..Dr. John Meier

III. Public Meeting Statement…………..…………………………………………………Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement……………………………………………….…………………………Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest. Any conflicts of interest and recusals in connection with each proposed financing arrangement on the agenda were raised prior to any vote on the arrangement. Under the Health Care Financing Act, any ownership interest in the bank or financial institution that services the bond is a conflict of interest requiring a recusal.

V. Approval of Minutes (Action Items)…………..……………………………………..Dr. John Meier

- **February 14, 2020 (Medical Care Commission Quarterly Meeting)** (See Exhibit A)

- **March 26, 2020 (Executive Committee) –** To authorize the execution and delivery of First Supplemental Trust Agreements for the Series 2014A & Series 2017D Bonds issued for the benefit of FirstHealth of the Carolinas, Inc. (See Exhibit B/1)

- **April 9, 2020 (Full Commission Emergency Rule Conference Call)** – To authorize an emergency & temporary rule for the Nurse Aide I Registry. (See Exhibit B/2)

VI. Bond Program Activities ………………………………………..……………..…Geary W. Knapp

A. Quarterly Report on Bond Program (See Exhibit B)
B. The following notices and non-action items were received by the Executive Committee:

March 9, 2020 – Duke Health 2017 Master Lease Schedules 16 – 19 (Master Lease Additions)
- Schedule 18 – Somatom Force YMAT ($1,805,000) – Duke Regional
- Schedule 19 – System Vascular IGS 740 ($1,054,612.85) – Duke University
- Schedule 20 – Braun Super Chief Custom Ambulance ($449,304) – Duke University
- Schedule 21 – ProxiDiagnostic N90 ($496,16.83) – Duke Raleigh
- Funds provided by TD Equipment Finance, Inc.

March 10, 2020 – FirstHealth of the Carolinas Series 2008A (Redemption)
- Redemption Amount – $29,420,000
- Funds provided by a taxable public offering

April 6, 2020 – Iredell Memorial Hospital Series 2007 (Redemption)
- Redemption Amount – $24,820,000
- Funds provided by a public offering thru PFA (Wisconsin)

July 1, 2020 – CaroMont Health Series 2003 (Conversion)
- New Bank Bought Interest Rate
- New Holding Period
- New Bank Holder

VII. Bond Project (Action Items)

A. Maryfield, Inc. – Pennybyrn (High Point)………..…………………………..Geary W. Knapp

Compliance Summary:

No Violation of NCMCC Compliance Policy

History:
FYE19 – No findings (Review of Annual & Quarterly Filings)
FYE18 – No findings (Review of Annual & Quarterly Filings)
FYE17 – No findings (Review of Annual & Quarterly Filings)
FYE16 – 2 Findings
- Late filing of Operating and Capital Budget
- Late filing of Rebate Reports

Selected Application Information:

1) Information from FYE 2019 (9/30 Year End) Audit of Maryfield, Inc.:

Operating income	$ 318,034
Change in unrestricted net assets	$ 453,044
Change in net assets	$ 6,484,079
Net cash provided by operating activities	$ 13,496,391
Unrestricted cash	$ 3,790,105
Change in cash	$ 4,483,474

2) Forecasted Long-Term Debt Service Coverage Ratio:

Actual	FYE	2019	1.44
Forecasted	FYE	2020	1.47
Forecasted	FYE	2021	1.54
Forecasted	FYE	2022	1.56
Forecasted	FYE	2023	1.46
Forecasted	FYE	2024	1.51

3) Ratings:

No Ratings

4) Transaction Participants:

Underwriter	B.C. Ziegler and Company
Feasibility Consultant	Dixon Hughes Goodman LLP
Bond Counsel	Womble Bond Dickinson (US) LLP
Underwriter Counsel	Parker Poe Adams & Bernstein LLP
Trustee	The Bank of New York Mellon Trust Company, N.A.
Trustee Counsel	*To be determined*
Bank Purchaser	*To be determined*
Bank Counsel	*To be determined*

5) Community Benefits:

Per N.C.G.S § 105 – 9.03% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $2,301,966

6) Diversity Information:

Board Diversity (23 Members)
Gender: 13 Male / 10 Female
Race: 21 Caucasian / 2 African American

Resident Diversity (372 Residents)
Gender: 116 Male / 256 Female
Race: 363 Caucasian / 1 Hispanic / 9 African American

<u>Resolution</u>: The Commission grants preliminary approval for a Maryfield Inc. (d/b/a Pennybryn) project to provide funds to be used, together with other available funds, to *construct* the following:

(A) 42 Unit Independent Living Wing
- 4 stories, 88,395 sq. ft.
- Surface Parking

(B) Renovations to Existing Independent Living Facility
- Modifications to Dining, Community Room, Terraces
- New Wellness Area and Clinic
- Connector to New 42 Unit Independent Living

(C) Renovations to Healthcare Neighborhoods
- Interior Expansion and Re-configuration
- Adult Day Center Neighborhood Addition

(D) 24 Bed Short-Term Stay Rehabilitation Facility
- 23,780 sq. ft. Transitional Rehab Therapy Household
- 3920 sq. ft. Therapy Space

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Cash and Negotiable Securities from Reserves	$ 5,000,000
Principal amount of bonds to be issued	55,150,000
Total Sources	**$ 60,150,000**

ESTIMATED USES OF FUNDS

Land Acquistion	$ 270,000
Site Utility Development	3,115,418
Construction Contracts	34,951,086
Construction Contingency (5% of Construction Contracts)	3,493,913
Architect Fees	1,453,641
Architect's Reimbursables	125,000
Moveable Equipment	195,000
Survey, Tests, Insurance	490,000
Consultant Fees (Development/Construction Monitoring)	1,787,102
DHSR Reimbursables (G.S. § 131-E-267)	40,301
Engineering Fees	1,048,977
Furniture/Fixtures/Art	1,853,199
Marketing Costs	1,125,000
Technology	595,000
Bond Interest during Construction	4,135,925
Debt Service Reserve Fund	4,402,000
Underwriter Discount/Placement Fee	550,188

Feasibility Study Fee	125,000
Accountant Fee	20,000
Corporation Counsel	50,000
Bond Counsel	100,000
Trustee Fee & Counsel	15,000
Bank Counsel	40,000
Printing Cost	20,000
Local Government Commission	8,750
Underwriter Counsel & Blue Sky Fee	65,000
Bank Fee	11,000
Appraisals	25,000
Placement Agent Fee	38,500
Total Uses	**$ 60,150,000**

Tentative approval is given with the understanding that the governing board of Maryfield, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on preliminary information furnished by applicant, the project is:

1. Financially feasible	✓	Yes		No		N/A
2. Construction and related costs are reasonable	✓	Yes		No		N/A

See **Exhibit F** for facility fees and bond sale approval form.

B. Presbyterian Homes – Glenaire (Cary)……………..……………………….Geary W. Knapp

Compliance Summary:

No Violation of NCMCC Compliance Policy

History: FYE19 – No findings (Review of Annual & Quarterly Filings)
FYE18 – No findings (Review of Annual & Quarterly Filings)
FYE17 – No findings (Review of Annual & Quarterly Filings)
FYE16 – 1 Finding

- Late filing of Opinion of Counsel Letter

Selected Application Information:

1) Information from FYE 2019 (9/30 Year End) Audit of Presbyterian Homes, Inc.:

Operating income	$ 8,916,303
Change in unrestricted net assets	$ 10,713,117
Change in net assets	$ 11,579,319
Net cash provided by operating activities	$ 34,610,213
Unrestricted cash	$ 32,217,151
Change in cash	$ 10,495,753

2) Forecasted Long-Term Debt Service Coverage Ratio:

Actual	FYE	2019	2.31
Forecasted	FYE	2020	2.36
Forecasted	FYE	2021	1.94
Forecasted	FYE	2022	2.17
Forecasted	FYE	2023	2.28
Forecasted	FYE	2024	1.94

3) Ratings:

Fitch – 'A-' Outlook Stable

4) Transaction Participants:

Underwriter	B.C. Ziegler and Company
Feasibility Consultant	Dixon Hughes Goodman LLP
Bond Counsel	Parker Poe Adams & Bernstein LLP
Corporation Counsel	Wyatt, Early, Harris, Wheeler LLP

Underwriter Counsel	Robinson, Bradshaw, & Hinson
Trustee	U.S. Bank National Association
Trustee Counsel	McGuireWoods
Bank Purchaser	Truist Bank
Bank Counsel	Moore & Van Allen PLLC

5) Community Benefits:

Per N.C.G.S § 105 – 6% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $4,287,947

6) Diversity Information:

Board Diversity (4 Boards / 58 Members)
Gender: 38 Male / 20 Female
Race: 50 Caucasian / 8 African American

Resident Diversity (1,427 Residents)
Gender: 499 Male / 928 Female
Race: 1,412 Caucasian / 7 Hispanic / 5 African American / 3 Asian

Resolution: **The Commission grants preliminary approval for a Presbyterian Homes, Inc. project on their Glenaire campus to provide funds to be used, together with other available funds, to *construct* a new building that includes the following:**

(A) 192 Independent Living Apartments
- Sizes range from 1,450 to 2,700 square feet
- Underground parking
- 3 Dining Venues
- Potter/Fine Arts/Music Studio
- Auditorium/Theater
- Chapel
- Wellness Center

(B) 38 Multi-Unit Housing with Service Units

(C) Adult Day Center

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$ 216,270,000
Total Sources	**$ 216,270,000**

ESTIMATED USES OF FUNDS

Site Costs	$ 811,775
Construction Contracts	168,235,000
Construction Contingency (5% of Construction Contracts)	1,682,350
Architect Fees	6,086,125
Architect's Reimbursables	26,170
Moveable Equipment	5,091,626
Survey, Tests, Insurance	538,427
Consultant Fees (Landscape/Kitchen/Acoustic/3rd Party Commissioning)	436,000
DHSR Reimbursables (G.S. § 131-E-267)	103,079
Interior/Exterior Signage	418,000
Town of Cary - Permits	1,571,448
Bond Interest during Construction	17,531,570
Debt Service Reserve Fund	11,644,750
Underwriter Discount/Placement Fee	1,247,065
Feasibility Study Fee	175,000
Accountant Fee	20,000
Corporation Counsel	75,000
Bond Counsel	95,000
Rating Agency	105,000
Trustee Fee & Counsel	20,365
Bank Counsel	45,000
Printing Cost	15,000
Local Government Commission	8,750
Underwriter Counsel & Blue Sky Fee	85,000
Bank Fee	127,500
Placement Agent Fee	75,000
Total Uses	**$216,270,000**

Tentative approval is given with the understanding that the governing board of Presbyterian Homes, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is:

1. Financially feasible	✓ Yes	______ No	______ N/A
2. Construction and related costs are reasonable	✓ Yes	______ No	______ N/A

See **Exhibit E** for facility fees and bond sale approval form.

VIII. Old Business (Action Item)

A. Rules for Adoption (Discuss rules, fiscal note, and comments submitted)

1. Licensing of Hospital Bylaws Rules (11 Rules)..……….……………N. Pfeiffer & Dr. Fagg

Readoption of eight rules following Periodic Review & Amendment of three rules

- Rules: 10A NCAC 13B .3501 - .3503 and .3701 - .3708 (See Exhibits C - C/3)

IX. New Business (Action Items)

A. Rules for Adoption (Discuss rules, fiscal note, and comments submitted)

1. Ambulatory Surgical Center Rules……………….…………..……..N. Pfeiffer & A. Conley

Readoption of four rules following Periodic Review & Amendment of two rules

- Rules: 10A NCAC 13C .0202, .0203, .0301, .0501, .0702, and .0902 (See Exhibits D - D/1)

2. Hospice Licensing Rules………………………………..……N. Pfeiffer & C. Deporter

Readoption of five rules following Periodic Review

- Rules: 10A NCAC 13K .0102, .0401, .0604, .0701, and .1104 (See Exhibits D/2 - D/3)

3. Licensing of Nursing Home Rules……………..……..…………N. Pfeiffer & B. Speroff

Amendment of two rules and Repeal of one rule for ventilator assisted care

- Rules: 10A NCAC 13D .2001, .2506, and .3003 (See Exhibits D/4 - D/5)

X. Refunding of Commission Bond Issues (Action Item)..……………………...……..Geary W. Knapp

Recommended:

WHEREAS, the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until August 14, 2020 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt between this date and August 14, 2020.

XI. Rule Meeting Reminder…………………………..………………...…………………Dr. John Meier

The Commission will meet **June 9th, 2020 at 9:00 am**, via teleconference, to review and adopt the temporary rules for nurse aide certification or registration reciprocity.

XII. Adjournment – A motion to adjourn is requested.

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
801 BIGGS DRIVE
RALEIGH, NC 27603
CONFERENCE ROOM #104 - BROWN BUILDING

FRIDAY, FEBRUARY 14, 2020
9:00 A.M.

MINUTES

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Sally B. Cone John A. Fagg, M.D. Bryant C. Foriest Linwood B. Hollowell, III Ashley H. Lloyd, D.D.S. Albert F. Lockamy, Jr., RPh Karen E. Moriarty Stephen T. Morton J. William Paugh Robert E. Schaaf, M.D. Patrick D. Sebastian (Via Conference Call) Jeffrey S. Wilson **DIVISION OF HEALTH SERVICE REGULATION STAFF** S. Mark Payne, DHSR Director, MCC Secretary Emery E. Milliken, Deputy Director, DHSR Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Kimberly Randolph, Attorney General’s Office Steven Lewis, Chief, Construction Section, DHSR Jeff Harms, Engineering Supervisor, DHSR Construction Nadine Pfeiffer, Rules Review Manager, DHSR Azzie Conley, Chief, Acute & Home Care Licensure Branch Megan Lamphere, Chief, Adult Care Licensure Section Tichina Hamer, Assistant Chief, Adult Care Licensure Section Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC	Paul R.G. Cunningham, M.D. Charles H. Hauser Eileen C. Kugler, RN, MSN, MPH, FNP

Other Attendance (See Exhibit E)

II. Chairman's Comments……………………………………………………………..Dr. John Meier

Dr. John Meier thanked everyone for their attendance and serving the patients/citizens of North Carolina. Dr. Meier emphasized the meeting of the Medical Care Commission is a public **meeting**, open to the public, but is not a public **hearing**. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

III. Ethics Statement………………………………………………………………….Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest. Any conflicts of interest and recusals in connection with each proposed financing arrangement on the agenda were raised prior to any vote on the arrangement. Under the Health Care Financing Act, any ownership interest in the bank or financial institution that services the bond is a conflict of interest requiring a recusal.

IV. Approval of Minutes (Action Items)…………………………………………………..Dr. John Meier

- **November 8, 2019 (Medical Care Commission Quarterly Meeting)** (See Exhibit A)
- **November 22, 2019 (Executive Committee) –** To authorize the sale of bonds, the proceeds of which are to be loaned to The Presbyterian Home at Charlotte, Inc. (See Exhibit B/1).
- **December 13, 2019 (Executive Committee)** – To authorize a Supplemental Trust Agreement for Wayne Memorial Hospital, Series 2017A Bonds. (See Exhibit B/2).
- **January 31, 2020 (Executive Committee)** – To authorize the sale of bonds, the proceeds of which are to be loaned to UNC Rex Healthcare (See Exhibit B/3).

COMMISSION ACTION: Motion to approve the minutes was made by Mr. Joe Crocker, seconded by Mr. Al Lockamy, and unanimously approved.

V. Bond Program Activities ………………………………………..……………..….Geary W. Knapp

A. Quarterly Report on Bond Program (See Exhibit B)
B. The following notices and non-action items were received by the Executive Committee:

November 21, 2019 – Carolina Meadows, Series 2004 (Redemption)
- Outstanding Balance: $12,810,000
- Funds provided by Public Finance Authority (Wisconsin) bonds

January 13, 2020 – Duke Health, Series 2012A (Redemption)
- Redemption Amount - $273,000,000
- Funds provided by taxable public offering

VI. Bond Project (Action Item)..Geary W. Knapp

A. Friends Homes, Inc. (Greensboro)……………………………….....G. Knapp, J. Harms, & S. Lewis

Resolution: The Commission grants preliminary approval for a Friends Homes, Incorporated project to provide funds to be used, together with other available funds, to ***construct*** the following:

- 73 Independent Living Units (West Campus)
  - 54 Villa Apartments w/parking beneath
  - 11 Single Tenant Cottages
  - 8 Duplexes
- Bistro Addition (West Campus)
  - Kitchen / Bistro Seating / Servery / Market Area
- Wellness Center Addition (West Campus)
  - Dental Clinic
  - Multi-purpose / Exercise / Strength Training / Cardio Rooms
  - Indoor Sports Court
  - New Roof over Indoor Pool
- Dining Hall Renovations (West Campus)
  - General and Private Dining & Expo Cooking Area

Capital expenditures for new construction and the refunding shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$68,185,000
Total Sources	**$68,185,000**

ESTIMATED USES OF FUNDS

Construction Contracts	55,000,000
Construction Contingency (5% of Construction Contracts)	2,750,000
Bond Interest during Construction	5,072,541
Debt Service Reserve Fund	4,304,100
Underwriter Discount/Placement Fee	537,625
Feasibility Study Fee	150,000
Accountant Fee	5,000
Corporation Counsel	30,000
Bond Counsel	85,000
Trustee Fee	5,000
Trustee Counsel	10,000
Bank Counsel	50,000
Survey	20,000
Printing Cost	15,000
DHSR Reimbursables (G.S. § 131-E-267)	70,000
Local Government Commission	8,750
Underwriter Counsel & Blue Sky Fee	55,000
Phase 1 Environmental	7,611
Appraisal	9,373
Total Uses	**$68,185,000**

Tentative approval is given with the understanding that the governing board of Friends Homes accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Final Financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant at preliminary approval, the project is:

1. Financially feasible ✓ Yes ______ No ______ N/A

2. Construction and related costs are reasonable ✓ Yes ______ No ______ N/A

See **Exhibit D** for compliance and selected application information.

See **Exhibit G** for presentation.

Dr. John Meier conducted the discussion and voting on the Bond Project for Friends Homes. A presentation was given by Mr. Arnie Thompson, CEO, Julia Hanover, CFO of Friends Homes, and Mr. Seth Wagner of BB&T Capital Markets.

COMMISSION ACTION: A motion for preliminary approval of the project was made by Dr. Robert Schaaf, seconded by Mr. Joe Crocker, and unanimously approved with the recusal for Dr. John Fagg.

VII. MCC Breakout Session…………………………………………………………………Dr. John Meier

Geary Knapp gave a presentation on the Medical Care Commission's Compliance Policy.
(See Exhibit F)

Remarks were made on the presentation by Mr. Bill Paugh, Dr. John Meier, Mr. Joe Crocker, Mr. Bryant Foriest, Mr. Mark Payne, Dr. John Fagg, Mrs. Sally Cone, and Mr. Steve Morton.

VIII. Old Business (Action Items)…………………………………………………………..Nadine Pfeiffer

A. Rules for Adoption (Discuss rules, fiscal note, and comments submitted)

1. Adult Care Home/Family Care Home Rules…………..………N. Pfeiffer & M. Lamphere

Readoption of six rules following Periodic Review (Phase 1.5), Amendment of four rules, and Repel of 1 rule (Total 11 rules)

- Rules: 10A NCAC 13F .0202, .0204, .0208, .0209, and .0212;
- 10A NCAC 13G .0202, .0204, .0208, .0209, .0212, and .0213 (See Exhibits C/1 – C/3)

COMMISSION ACTION: Motion was made to approve the Adult Care/Family Care Home Rules by Dr. Robert Schaaf, seconded by Mr. Al Lockamy, and unanimously approved.

2. Licensing of Hospital Rules – Phase III Readoption Rules…..…..N. Pfeiffer & A. Conley

Readoption of thirteen rules following Periodic Review

- Rules: 10A NCAC 13B .1902, .1915, .1918, .1925, .3001, .3101, .3110, .3204, .3205, .3302, .3303, .5412, and .5413. (See Exhibits C/4 – C/6)

COMMISSION ACTION: Motion was made to approve the Hospital Rules/Phase III by Mr. Joe Crocker, seconded by Dr. John Fagg, and unanimously approved.

IX. Refunding of Commission Bond Issues (Action Item)..……………………..……..Geary W. Knapp

Recommended:

WHEREAS, the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

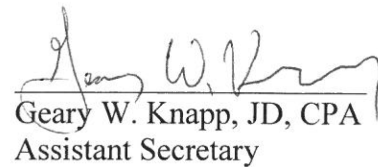
WHEREAS, the Commission will not meet again until May 15, 2020 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt between this date and May 15, 2020.

COMMISSION ACTION: Motion was made to authorize the Executive Committee to approve projects involving the refunding of existing Commission debt between this date and May 15, 2020 by Mr. Joe Crocker, seconded by Mr. Bryant Foriest, and unanimously approved.

X. **Adjournment** – There being no further business the meeting was adjourned at 11:25 a.m.

Respectfully Submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
801 BIGGS DRIVE
RALEIGH, NC 27603
CONFERENCE ROOM #104 - BROWN BUILDING
FRIDAY, NOVEMBER 8, 2019
9:00 A.M.

MINUTES

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Sally B. Cone John A. Fagg, M.D. Bryant C. Foriest Charles H. Hauser Linwood B. Hollowell, III Eileen C. Kugler, RN, MSN, MPH, FNP Ashley H. Lloyd, D.D.S. Albert F. Lockamy, Jr., RPh Stephen T. Morton - (Via Conference Call) J. William Paugh Robert E. Schaaf, M.D. Patrick D. Sebastian Jeffrey S. Wilson **DIVISION OF HEALTH SERVICE REGULATION STAFF** S. Mark Payne, DHSR Director, MCC Secretary Emery E. Milliken, Deputy Director, DHSR Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Steven Lewis, Chief, Construction Section, DHSR Jeff Harms, Engineering Supervisor, DHSR Construction Nadine Pfeiffer, Rules Review Manager, DHSR Azzie Conley, Chief, Acute & Home Care Licensure Branch Megan Lamphere, Chief, Adult Care Licensure Section Doug Barrick, Policy Coordinator, Adult Care Licensure Section Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC	Paul R.G. Cunningham, M.D. Karen E. Moriarty

Other Attendance (See Exhibit F)

II. Chairman's Comments…………………………………………………………………..Dr. John Meier

Dr. John Meier thanked everyone for taking time out of their busy schedules to attend the meeting and their service to the State, citizens, and patients of North Carolina. Dr. Meier formally introduced himself as the new Chairman and asked each Commission Member and staff to introduce themselves. Dr. Meier yielded time to outgoing Chairman, Dr. Fagg, for further comments. Dr. Fagg thanked Commission Members and staff for all their hard work and efforts during his tenure.

III. Resolutions of Appreciation for Former Members & Former Chairman.………..….Dr. John Meier

- Dr. Robert S. Alphin (See Exhibit A/3)
- Dr. Devdutta G. Sangvai (See Exhibit A/4)
- Dr. John Fagg (See Exhibit A/5 & A/6)

IV. Ethics Statement……………………………………………….………………………Dr. John Meier

Dr. Meier reminded Commission Members of the State Government Ethics Act. The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest. Any conflicts of interest and recusals in connection with each proposed financing arrangement on the agenda were raised prior to any vote on the arrangement. Under the Health Care Financing Act, any ownership interest in the bank or financial institution that services the bond is a conflict of interest requiring a recusal.

V. North Carolina Board of Ethics Letters…………………………………………………Dr. John Meier

North Carolina Board of Ethics letters were received for the following newly-appointed members and were noted for a potential conflict of interest:

- Sally B. Cone (See Exhibit A/1)
- Bryant C. Foriest (See Exhibit A/2)

VI. New Business (Action Item)

A. Rules for Initiating Rulemaking Approval (Discuss rules & fiscal note)……………......N. Pfeiffer

1. Licensing of Hospital Bylaws Rules (11 rules)…………………..……Dr. Fagg & N. Pfeiffer

   Readoption of eight rules following Periodic Review and amendment of three rules
   - Rules: 10A NCAC 13B .3501-.3503 and .3701-.3708 (Exhibit D thru D/2)

Remarks of approval and recommendation for the Hospital Bylaws Rules were made by Dr. Fagg, Robert Wilson, and Bill Paugh. Dr. Meier provided the Commission a joint letter from the Medical Society and NC Healthcare Association expressing support for the Bylaws rules (See Exhibit D/3).

<u>**COMMISSION ACTION**</u>: Motion was made to approve the Hospital Bylaws Rules by Mr. Charles Hauser, seconded by Dr. Robert Schaaf, and unanimously approved.

VII. Old Business (Action Items)……………….…………………………………………..Nadine Pfeiffer

A. Rules for Adoption/Readoption (Discuss rules and fiscal note)

1. Adult Care Home/Family Care Home Rules………...………N. Pfeiffer & M. Lamphere

Readoption of seven rules following Periodic Review (Phase 1)

- Rules: 10A NCAC 13F .0203, .0207, .0214, and .1206; 10A NCAC 13G .0207, .0214 and .1207 (See Exhibits C thru C/3)

COMMISSION ACTION: Motion was made to approve the Adult Care Home/Family Care Home Rules by Mr. Bill Paugh, seconded by Mr. Jeff Wilson and unanimously approved.

2. Ambulatory Surgical Center Construction Rules…………………..N. Pfeiffer & S. Lewis

Readoption of five rules following Periodic Review - Amendment of three rules and repeal of two rules

- Rules: 10A NCAC 13B .1401 - .1410 (See Exhibits C/4 thru C/5)

COMMISSION ACTION: Motion was made to approve the Ambulatory Surgical Center Construction Rules by Mr. Charles Hauser, seconded by Mr. Joe Crocker, and unanimously approved.

VIII. Approval of Minutes (Action Items)…………………………………………………..Dr. John Meier

- **August 21, 2019 – Medical Care Commission Quarterly Meeting** (See Exhibit A)

- **September 26, 2019 (Executive Committee)** – To authorize the sale of bonds, the proceeds of which are to be loaned to Lutheran Retirement Ministries of Alamance County (Twin Lakes Community), North Carolina (See Exhibit B/1).

- **October 2, 2019 (Executive Committee)** – To consider a resolution (A) authorizing the sale and issuance of bonds, the proceeds of which will be loaned to University Health Systems of Eastern Carolina, Inc. d/b/a Vidant Health and Pitt County Memorial Hospital, Incorporated d/b/a Vidant Medical Center and to consider a resolution (B) granting Rex Hospital Inc. an exception to the Commission's compliance policy (See Exhibit B/2).

- **October 11, 2019 (Executive Committee) –** To authorize the sale of bonds, the proceeds of which are to be loaned to Galloway Ridge (See Exhibit B/3).

COMMISSION ACTION: Motion to approve the minutes was made by Mrs. Eileen Kugler, seconded by Mr. Joe Crocker, and unanimously approved.

IX. Bond Program Activities ……………………………………….……………..….Geary W. Knapp

A. Quarterly Report on Bond Program (See Exhibit B)
B. The following notices and non-action items were received by the Executive Committee:

October 16, 2019 – Friends Homes, Inc. Series 2011 (Redemption)

- Outstanding Balance: $14,533,690.69
- Funds provided by Public Finance Authority (Wisconsin) bonds

November 6, 2019 – Penick Village Series 2010B (Redemption)

- Outstanding Balance: $27,875,000
- Funds provided by Public Finance Authority (Wisconsin) bonds

November 7, 2019 – Duke Health 2017 Master Lease Agreement (Additions to Master Lease)

- Schedule 16 – MRI ($1,608,437) – Duke University Hosptial
- Schedule 17 – CT Scanner ($1,869,000) – Duke Regional Hospital
- Funds provided by TD Equipment Finance, Inc.

November 19, 2019 – CaroMont Health Series 2019 (Conversion of Series 2018 (Taxable) to Series 2019 (Tax-Exempt))

- Outstanding Balance: $41,460,000
- Bank Holder: TD Bank, N.A.

C. Technical Change Rules Amended by Codifier per Staff approval (in accordance with 8/21/19 MCC Resolution):

- Licensing of Ambulatory Surgical Facility rules: 1 rule updated repealed statute
- Licensing of Overnight Respite Services rules: 2 rules updated website addresses
- Emergency Medical Services and Trauma rules: 5 rules updated website addresses
- Licensing of Hospital rules: 7 rules updated agency names, addresses and phone numbers, a typographical error, and a rule citation reference.

X. MCC Breakout Session…………………………………………………………………Dr. John Meier

Geary Knapp gave a presentation on the Medical Care Commission process for administering the Healthcare Facilities Finance Act (See Exhibit E).

Remarks were made on the presentation by Dr. John Meier, Mr. Mark Payne, Mr. Charles Hauser, Mr. Joe Crocker, Mr. Bryant Foriest, Mrs. Eileen Kugler, Mrs. Sally Cone, Mr. Steven Lewis, and Mr. Bill Paugh.

XI. Appointment of Two Executive Committee Members (Action Item)…………………..Dr. John Meier

In accordance with 10A NCAC 13A.0101, the NCMCC's Chairman shall appoint two members to the Executive Committee to serve for a term of two years or until expiration of his/her regularly appointed term. No member of the Executive Committee, except the Chairman and Vice-Chairman, shall serve more than two two-year terms in succession. The Chairman's appointees are for vacated seats and the terms will expire 12/31/2020.

COMMISSION ACTION: Dr. Meier appointed Mrs. Sally Cone and Mr. Bill Paugh to serve out the two vacant seats on the Executive Committee that will expire 12/31/2020.

XII. Election of Three Executive Committee Members (Action Item)..........................Dr. John Meier

In accordance with 10A NCAC 13A.0101, three members of the Executive Committee shall be appointed by a vote of the Commission at the November meeting of each odd year. No member of the Executive Committee, except the Chairman and Vice-Chairman, shall serve more than two-year terms in succession.

COMMISSION ACTION: Mr. Linwood Hollowell, Mr. Al Lockamy, and Mr. Jeff Wilson agreed to serve two-year terms on the Executive Committee that expire December 31, 2021. No vote was necessary due to only three interested Members. Unanimously approved by the Commission.

XIII. Adoption of 2020 Medical Care Commission Meeting Dates (Action Item).............Dr. John Meier

February 13-14, 2020
May 14-15, 2020
August 13-14, 2020
November 12-13, 2020

COMMISSION ACTION: A motion to approve the Commission Meeting dates for 2020 was made by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.

XIV. Refunding of Commission Bond Issues (Action Item)...................................Geary W. Knapp

Recommended:

WHEREAS, the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

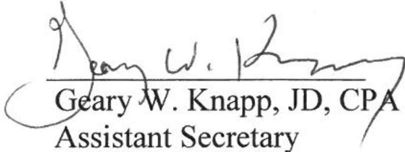
WHEREAS, the Commission will not meet again until February 14, 2020 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt between this date and February 14, 2020.

COMMISSION ACTION: Motion was made to authorize the Executive Committee to approve projects involving the refunding of existing Commission debt between this date and February 14, 2020 by Mrs. Eileen Kugler, seconded by Mr. Al Lockamy, and unanimously approved.

XV. Adjournment – There being no further business the meeting was adjourned at 11:49 a.m.

Respectfully Submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 2nd Quarter FYE 2020)

Program Measures	FYE 2019 Ending: 6/30/2019	FYE 2020 Ending: 12/31/2019
Outstanding Debt	**$5,878,126,412**	**$6,146,536,291**
Outstanding Series	**131**	**130**[1]

Detail of Program Measures	Ending: 6/30/2019	Ending: 12/31/2019
Outstanding Debt per Hospitals and Healthcare Systems	$4,672,572,057	$4,918,980,587
Outstanding Debt per CCRCs	$1,147,209,355	$1,170,115,704
Outstanding Debt per Other Healthcare Service Providers	$58,345,000	$57,440,000
Outstanding Debt Total	**$5,878,126,412**	**$6,146,536,291**
Outstanding Series per Hospitals and Healthcare Systems	76	76
Outstanding Series per CCRCs	53	52
Outstanding Series per Other Healthcare Service Providers	2	2
Series Total	**131**	**130**
Number of Hospitals and Healthcare Systems with Outstanding Debt	19	19
Number of CCRCs with Outstanding Debt	20	17
Number of Other Healthcare Service Providers with Outstanding Debt	2	2
Facility Total	41	38

Note 1: For FYE 2020, NCMCC closed 13 **Bond Series** thru the 2nd Quarter. Out of the 13 closed Bond Series: 5 were conversions, 3 were new money projects, 3 were a combination of refundings and new money projets, and 2 were refundings. The loss of 1 Bond Series outstanding from FYE 2019 to current represents all new money projects, refundings, conversions, and redemptions.

GENERAL NOTES: Facility Totals represent a parent entity total and do not represent each individual facility owned by the parent entity. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities. The following parent entities represent the current "other healthcare service providers" with outstanding NC MCC debt: DePaul (Assisted Living); Lutheran Services (Assisted Living)

Exhibit B (Outstanding Balance)

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 2nd Quarter FYE 2020)

Program Measures	FYE 2019 Ending: 6/30/2019	FYE 2020 Ending: 12/31/2019
Total PAR Amount of Debt Issued	**$25,538,623,155**	**$26,338,296,111**
Total Project Debt Issued (excludes refunding/conversion proceeds) [1]	**$12,288,054,987**	**$12,727,831,205**
Total Series Issued	**629**	**642**

Detail of Program Measures	Ending: 6/30/2019	Ending: 12/31/2019
PAR Amount of Debt per Hospitals and Healthcare Systems	$20,794,927,185	$21,371,719,622
PAR Amount of Debt per CCRCs	$4,369,400,740	$4,592,281,259
PAR Amount of Debt per Other Healthcare Service Providers	$374,295,230	$374,295,230
Par Amount Total	**$25,538,623,155**	**$26,338,296,111**
Project Debt per Hospitals and Healthcare Systems	$9,643,788,740	$9,964,229,440
Project Debt per CCRCs	$2,397,252,332	$2,516,587,851
Project Debt per Other Healthcare Service Providers	$247,013,915	$247,013,915
Project Debt Total	**$12,288,054,987**	**$12,727,831,205**
Series per Hospitals and Healthcare Systems	397	403
Series per CCRCs	193	200
Series per Other Healthcare Service Providers	39	39
Series Total	**629**	**642**
Number of Hospitals and Healthcare Systems issuing debt	99	99
Number of CCRCs issuing debt	40	40
Number of Other Healthcare Service Providers issuing debt	46	46
Facility Total	185	185

Note 1: Project Debt excludes bond proceeds that directly refunded prior NCMCC outstanding issues and conversion par amounts. Project Debt is an accumulation of all new project money, issuance costs (including issuance costs for refundings/conversions (if any)), and refundings of non-NCMCC debt.

GENERAL NOTES: Facility Totals represent each individual facility and do not represent parent entity totals. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities.

Exhibit B (History)

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE NOVEMBER 22, 2019 11:00 A.M.

Members of the Executive Committee Present:

Dr. John Meier, IV, M.D., Chairman
Sally B. Cone
Charles H. Hauser
Albert F. Lockamy, RPh
J. William Paugh

Members of the Executive Committee Absent:

Joseph D. Crocker, Vice-Chairman
Eileen C. Kugler, RN, MSN, MPH, FNP

Members of Staff Present:

S. Mark Payne, DHSR Director/MCC Secretary
Geary W. Knapp, Assistant Secretary
Crystal Watson-Abbott, Auditor
Alice S. Creech, Executive Assistant

Others Present:

Chuck Gaskins, Sharon Towers
Tad Melton, Ziegler
Anne Moffat, Sharon Towers
Jeff Poley, Parker Poe Adams & Bernstein, LLP

1. **Purpose of Meeting**

To authorize the sale of bonds, the proceeds of which are to be loaned to The Presbyterian Home at Charlotte, Inc.

A. **Resolution of the North Carolina Medical Care Commission Authorizing the Issuance of $75,940,000 North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Bonds (Sharon Towers) Series 2019A.**

Remarks were made on the financing by Mr. Geary Knapp, Mr. Jeff Poley, and Mr. Tad Melton.

Executive Committee Action: Motion was made to approve the Series 2019A Revenue Bonds by Mr. Al Lockamy, seconded by Mr. Charles Hauser, and unanimously approved.

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities (including retirement facilities) and to refund bonds previously issued by the Commission; and

WHEREAS, The Presbyterian Home at Charlotte Inc. (the "Corporation") is a North Carolina nonprofit corporation and a "non-profit agency" within the meaning and intent of the Act, which owns and operates a continuing care facility for the elderly in the City of Charlotte, North Carolina; and

WHEREAS, the Corporation has made application to the Commission for a loan for the purpose of providing funds, together with other available funds, to (i) pay or reimburse the Corporation for paying all or a portion of the Costs of the Project (as defined in the hereinafter defined Loan Agreement), (ii) refund all of the Commission's outstanding Variable Rate Demand Health Care Facilities Revenue Bonds (The Presbyterian Home at Charlotte, Inc. Project), Series 2001 (the "Prior Bonds") and pay a swap termination payment with respect to a hedging instrument for such Prior Bonds; (iii) fund the Debt Service Reserve Fund (as defined in the hereinafter defined the Trust Agreement) so that the amount on deposit in such fund is equal to the Debt Service Reserve Fund Requirement (as defined in the Master Indenture described below), (iv) pay a portion of the interest accruing on the Bonds (hereinafter defined) and (v) pay certain expenses incurred in connection with the issuance of the Bonds by the Commission; and

WHEREAS, the Commission has determined that the public will best be served by the proposed financing and refinancing and, by a resolution adopted on August 21, 2019, has approved the issuance of the Bonds, subject to compliance by the Corporation with the conditions set forth in such resolution, and the Corporation has complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented to officers and staff of the Commission draft copies of the following documents relating to the issuance of the Bonds:

(a) a Contract of Purchase, to be dated the date thereof (the "Purchase Agreement"), between the Local Government Commission of North Carolina (the "LGC") and B.C. Ziegler and Company, as representative of the underwriters of Bonds, and approved by the Corporation and the Commission, pursuant to which the underwriters will offer to purchase the Bonds on the terms and conditions set forth therein;

(b) a Trust Agreement, to be dated as of December 1, 2019 (the "Trust Agreement"), by and between the Commission and U.S. Bank National Association, as bond trustee (the "Bond Trustee");

(c) a Loan Agreement, to be dated as of December 1, 2019 (the "Loan Agreement"), between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the Bonds to the Corporation;

(d) a Master Trust Indenture, to be dated as of December 1, 2019 (the "Master Indenture"), by and between the Corporation and U.S. Bank National Association, as master trustee (the "Master Trustee");

(e) a Deed of Trust, Assignment of Rents, Security Agreement and Fixture Filing, to be dated as of December 1, 2019 (the "Corporation Deed of Trust"), from the Corporation for the benefit of the Master Trustee and securing the Corporation's facilities;

(f) a Supplemental Indenture for Obligation No. 1, to be dated as of December 1, 2019 ("Supplement No. 1"), between the Corporation and the Master Trustee;

(g) Obligation No. 1, to be dated the date of delivery thereof ("Obligation No. 1"), from the Corporation to the Commission in connection with the Bonds; and

(h) a Preliminary Official Statement dated November 6, 2019 relating to the Bonds (the "Preliminary Official Statement"); and

WHEREAS, the Commission has determined that the Corporation is financially responsible and capable of fulfilling its obligations under the Loan Agreement, the Master Indenture, Supplement No. 1, Obligation No. 1 and the Corporation Deed of Trust; and

WHEREAS, the Commission has determined that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. Capitalized words and terms used in this Series Resolution and not defined herein shall have the same meanings in this Series Resolution as such words and terms are given in the Master Indenture, the Trust Agreement and the Loan Agreement.

Section 2. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes the issuance of North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Bonds (Sharon Towers) Series 2019A (the "Bonds"), in the aggregate principal amount of

$75,940,000. The Bonds shall mature in such amounts and at such times and shall bear interest at such rates as are set forth in Schedule 1 attached hereto. The Bonds designated as Term Bonds shall be subject to the Sinking Fund Requirements set forth in Schedule 1 hereto.

The Bonds shall be issued as fully registered bonds in the denominations of $5,000 or any whole multiple thereof. The Bonds shall be issued in book-entry form as provided in the Trust Agreement. Interest on the Bonds shall be paid on each January 1 and July 1, beginning July 1, 2020. Payments of principal of and interest on the Bonds shall be made to the registered owners of the Bonds in such manner as is set forth in the Trust Agreement.

Section 3. The Bonds shall be subject to optional, extraordinary and mandatory sinking fund redemption, all at the times, upon the terms and conditions, and at the prices set forth in the Trust Agreement.

Section 4. The proceeds of the Bonds shall be applied as provided in Section 2.08 of the Trust Agreement. The Commission hereby finds that the use of the proceeds of the Bonds for a loan for the purposes set forth above will accomplish the public purposes set forth in the Act.

Section 5. The forms, terms and provisions of the Trust Agreement and the Loan Agreement are hereby approved in all respects, and the Chairman or Vice Chairman (or any member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Trust Agreement and the Loan Agreement in substantially the forms presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 6. The form, terms and provisions of the Purchase Agreement are hereby approved in all respects, and the Chairman, Vice Chairman, Secretary or any Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) is hereby authorized and directed to execute and deliver the Purchase Agreement in substantially the form presented at this meeting, together with such changes, modifications, insertions and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The forms of the Bonds set forth in the Trust Agreement are hereby approved in all respects, and the Chairman or Vice Chairman (or any member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature as provided in such forms of the Bonds, and to deliver to the Bond Trustee for authentication on behalf of the Commission, the Bonds in definitive form, which shall be in substantially the forms presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary, appropriate and consistent with the Trust Agreement, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. The forms, terms and provisions of Supplement No. 1, Obligation No. 1, the Master Indenture and the Corporation Deed of Trust are hereby approved in substantially the forms presented to this meeting, together with such changes, modifications and deletions as the Chairman or Vice Chairman (or any member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission, with the advice of counsel may deem necessary and appropriate;

and the execution and delivery of the Trust Agreement as provided in Section 5 of this Series Resolution shall be conclusive evidence of the approval of the documents listed in this Section by the Commission.

Section 9. The Commission hereby approves the action of the Local Government Commission in awarding the Bonds to the Underwriters at the purchase price of $83,046,681.30 (representing the principal amount of the Bonds plus original issue premium of $8,055,931.30 and less underwriters' discount of $949,250.00).

Section 10. Upon their execution in the form and manner set forth in the Trust Agreement, the Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Bonds and, upon the satisfaction of the conditions set forth in Section 2.08 of the Trust Agreement, the Bond Trustee shall deliver the Bonds to the Underwriters against payment therefor.

Section 11. The Commission hereby approves and ratifies the use and distribution of the Preliminary Official Statement and approves the use and distribution of a final Official Statement (the "Official Statement"), both in connection with the sale of the Bonds. The Chairman, Vice Chairman, Secretary or any Assistant Secretary (or any member of the Commission designated by the Chairman) is hereby authorized to execute, on behalf of the Commission, the Official Statement in substantially the form of the Preliminary Official Statement, together with such changes, modifications and deletions as they, with the advice of counsel, may deem appropriate. Such execution shall be conclusive evidence of the approval thereof by the Commission. The Commission hereby approves and authorizes the distribution and use of copies of the Official Statement, the Trust Agreement, the Loan Agreement, the Master Indenture, Supplement No. 1, Obligation No. 1 and the Corporation Deed of Trust by the Underwriters in connection with such sale.

Section 12. U.S. Bank National Association is hereby appointed as the initial Bond Trustee for the Bonds.

Section 13. The Depository Trust Company, New York, New York is hereby appointed as the initial Securities Depository for the Bonds, with Cede & Co., a nominee thereof, being the initial Securities Depository Nominee and initial registered owner of the Bonds.

Section 14. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary of the Commission, and Kathy C. Larrison and Crystal Watson-Abbott, Auditors for the Commission, are each hereby appointed a Commission Representative as that term is defined in the Loan Agreement, with full power to carry out the duties set forth therein.

Section 15. The Chairman, Vice Chairman, Secretary, and any Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are each hereby authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments (including tax certificates and IRS Form 8038) as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the Trust Agreement, the Loan Agreement, the Purchase Agreement and the Official Statement. Such officers may take any action necessary to redeem the Prior Bonds and any action heretofore taken is hereby ratified and confirmed.

Section 16. This Series Resolution shall take effect immediately upon its passage.

B. **<u>Resolution of the North Carolina Medical Care Commission Authorizing the Issuance of $18,000,000 North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Bonds (Sharon Towers) Series 2019B.</u>**

<u>Executive Committee Action</u>:

Remarks were made on the financing by Mr. Geary Knapp, Mr. Jeff Poley, and Dr. John Meier.

<u>Executive Committee Action</u>: Motion was made to approve the Series 2019B Revenue Bonds by Mr. Charles Hauser, seconded by Mr. Al Lockamy, and unanimously approved.

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities (including retirement facilities) and to refund bonds previously issued by the Commission; and

WHEREAS, The Presbyterian Home at Charlotte, Inc. (the "Corporation"), is a North Carolina nonprofit corporation and a "non-profit agency" within the meaning and intent of the Act, which owns and operates a continuing care facility for the elderly in the City of Charlotte, North Carolina; and

WHEREAS, the Corporation has made application to the Commission for a loan for the purpose of providing funds, together with other available funds, to (a) pay Costs of the Project (as defined in the hereinafter defined Loan Agreement), (b) pay a portion of the interest accruing on the Bonds (hereinafter defined) and (c) pay certain fees and expenses incurred in connection with the issuance and sale of the Bonds by the Commission; and

WHEREAS, the Commission has determined that the public will best be served by the proposed financing and, by a resolution adopted on August 21, 2019, has approved the issuance of the Bonds, subject to compliance by the Corporation with the conditions set forth in such resolution, and the Corporation has complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented to officers and staff of the Commission draft copies of the following documents relating to the issuance of the Bonds:

(i) a Contract of Purchase, to be dated the date of delivery thereof (the "Purchase Agreement"), between the Local Government Commission of North Carolina (the "LGC") and BB&T Community Holdings Co. (the "Purchaser") and approved by the Corporation and the Commission, pursuant to which the Purchaser will offer to purchase the Bonds on the terms and conditions set forth therein;

(j) a Trust Agreement, to be dated as of December 1, 2019 (the "Trust Agreement"), by and between the Commission and U.S. Bank National Association, as bond trustee (the "Bond Trustee");

(k) a Loan Agreement, to be dated as of December 1, 2019 (the "Loan Agreement"), between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the Bonds to the Corporation;

(l) a Master Trust Indenture, to be dated as of December 1, 2019 (the "Master Indenture"), by and between the Corporation and U.S. Bank National Association, as master trustee (the "Master Trustee");

(m) a Deed of Trust, Assignment of Rents, Security Agreement and Fixture Filing, to be dated as of December 1, 2019 (the "Corporation Deed of Trust"), from the Corporation for the benefit of the Master Trustee and securing the Corporation's facilities;

(n) a Supplemental Indenture for Obligation No. 2, to be dated as of December 1, 2019 ("Supplement No. 2"), between the Corporation and the Master Trustee;

(o) Obligation No. 2, to be dated the date of delivery thereof ("Obligation No. 2"), from the Corporation to the Commission in connection with the Bonds;

(p) a Supplemental Indenture for Obligation No. 3, to be dated as of December 1, 2019 ("Supplement No. 3"), between the Corporation and the Master Trustee;

(q) Obligation No. 3, to be dated the date of delivery thereof ("Obligation No. 3"), to be issued by the Corporation to the Purchaser; and

(r) a Continuing Covenants Agreement, dated as of December 1, 2019, between the Corporation and the Purchaser; and

WHEREAS, the Commission has determined that the Corporation is financially responsible and capable of fulfilling its obligations under the Loan Agreement, the Master Indenture, Supplement No. 2, Supplement No. 3, Obligation No. 2, Obligation No. 3 and the Corporation Deed of Trust; and

WHEREAS, the Purchaser has offered to purchase the Bonds at a variable interest rate equal to (79% of One-Month LIBOR) plus 0.5925% (which was 1.99% as of November 15, 2019) and hold the Bonds until maturity; and

WHEREAS, the Commission has determined that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. Capitalized words and terms used in this Series Resolution and not defined herein shall have the same meanings in this Series Resolution as such words and terms are given in the Master Indenture, the Trust Agreement and the Loan Agreement.

Section 2. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes the issuance of North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Bonds (Sharon Towers) Series 2019B (the "Bonds"), in an aggregate principal amount not to exceed $18,000,000. The Bonds shall mature in such amounts and at such times and shall bear interest at such rates as are set forth in the Trust Agreement.

The Bonds shall be issued as fully registered bonds in denominations of $1. Interest on the Bonds shall be paid at the times and at the rates determined as specified in the Trust Agreement. Payments of principal of and interest on the Bonds shall be made to the registered owners of the Bonds in such manner as is set forth in the Trust Agreement.

Section 3. The Bonds shall be subject to optional, extraordinary optional, and mandatory redemption, all at the times, upon the terms and conditions, and at the prices set forth in the Trust Agreement. The Purchaser will require certain optional redemptions from initial entrance fees from the independent living units which are part of the Project.

Section 4. The proceeds of the Bonds shall be drawn-down and applied as provided in Section 2.12 of the Trust Agreement. The Commission hereby finds that the use of the proceeds of the Bonds for a loan for the purposes set forth above will accomplish the public purposes set forth in the Act.

Section 5. The forms, terms and provisions of the Trust Agreement and the Loan Agreement are hereby approved in all respects, and the Chairman or Vice Chairman (or any member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Trust Agreement and the Loan Agreement in substantially the forms presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 6. The form, terms and provisions of the Purchase Agreement are hereby approved in all respects, and the Chairman, Vice Chairman, Secretary or any Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) is hereby authorized and directed to execute and deliver the Purchase Agreement in substantially the form presented at this meeting, together with such changes, modifications, insertions and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The forms of the Bonds set forth in the Trust Agreement are hereby approved in all respects, and the Chairman or Vice Chairman (or any member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature as provided in such forms of the Bonds, and to deliver to the Bond Trustee for authentication on behalf of the Commission, the Bonds in definitive form, which shall be in substantially the forms presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary, appropriate and consistent with the Trust Agreement, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. The forms, terms and provisions of Supplement No. 2, Supplement No. 3, Obligation No. 2, Obligation No. 3, the Master Indenture and the Corporation Deed of Trust are hereby approved in substantially the forms presented to this meeting, together with such changes, modifications and deletions as the Chairman or Vice Chairman (or any member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission, with the advice of counsel may deem necessary and appropriate; and the execution and delivery of the Trust Agreement as provided in Section 5 of this Series Resolution shall be conclusive evidence of the approval of the documents listed in this Section by the Commission.

Section 9. The Commission hereby approves the action of the LGC authorizing the private sale of the Bonds to the Purchaser in accordance with the Purchase Agreement at the purchase price of 100% of the principal amount thereof.

Section 10. Upon their execution in the form and manner set forth in the Trust Agreement, the Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby

authorized and directed to authenticate the Bonds and, upon the satisfaction of the conditions set forth in Section 2.11 of the Trust Agreement, the Bond Trustee shall deliver the Bonds to the Purchaser against payment therefor.

Section 11. U.S. Bank National Association is hereby appointed as the initial Bond Trustee for the Bonds.

Section 12. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary of the Commission, and Kathy C. Larrison and Crystal Watson-Abbott, Auditors for the Commission, are each hereby appointed a Commission Representative as that term is defined in the Loan Agreement, with full power to carry out the duties set forth therein.

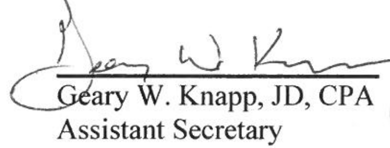
Section 13. The Chairman, Vice Chairman, Secretary, and any Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are each hereby authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments (including tax certificates and IRS Form 8038) as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the Trust Agreement, the Loan Agreement, the Purchase Agreement and the Official Statement.

Section 14. This Series Resolution shall take effect immediately upon its passage.

2. Adjournment

There being no further business, the meeting was adjourned at 11:10 a.m.

Respectfully submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

SCHEDULE 1

SERIES 2019A BONDS

$20,695,000 Serial Bonds

YEAR (JULY 1)	AMOUNT	RATE	YEAR (JULY 1)	AMOUNT	RATE
2025	$1,755,000	3.00%	2030	$2,075,000	4.00%
2026	1,805,000	3.00	2031	2,155,000	5.00
2027	1,860,000	3.00	2032	2,265,000	5.00
2028	1,915,000	4.00	2033	2,375,000	5.00
2029	1,995,000	4.00	2034	2,495,000	5.00

$4,500,000 4.00% Term Bonds due July 1, 2039

Due July 1	Sinking Fund Requirement
2035	$830,000
2036	865,000
2037	900,000
2038	935,000
2039*	970,000

* Maturity

$9,885,000 5.00% Term Bonds due July 1, 2039

Due July 1	Sinking Fund Requirement
2035	$1,790,000
2036	1,880,000
2037	1,970,000
2038	2,070,000
2039*	2,175,000

* Maturity

$7,000,000 4.00% Term Bonds due July 1, 2044

Due July 1	Sinking Fund Requirement
2040	$1,290,000
2041	1,340,000
2042	1,400,000
2043	1,455,000
2044*	1,515,000

* Maturity

$11,060,000 5.00% Term Bonds due July 1, 2044

Due July 1	Sinking Fund Requirement
2040	$2,005,000
2041	2,105,000
2042	2,205,000
2043	2,315,000
2044*	2,430,000

* Maturity

$22,800,000 5.00% Term Bonds due July 1, 2049

Due July 1	Sinking Fund Requirement
2045	$4,125,000
2046	4,335,000
2047	4,550,000
2048	4,775,000
2049*	5,015,000

* Maturity

PROFESSIONAL FEES COMPARISON FOR
THE PRESBYTERIAN HOME AT CHARLOTTE, INC.
(Both Series of Bonds Combined)

Professional	Fees Estimated In Preliminary Approval Resolution	Actual Fees
Underwriters' discount/Placement Fee	$1,145,000	$1,024,250
Feasibility Study Fee	125,000	130,000
Accountant's fees	20,000	20,000
Corporation counsel	80,000	80,000
Bond counsel	85,000	85,000
Underwriters' counsel & Blue Sky Fee	65,000	68,500
Trustee fees and counsel	10,000	11,700
Bank Counsel	50,000	40,000
Bank Fee	N/A	18,000
Financial Advisor	105,000	105,000

NC MCC Bond Sale Approval Form
Facility Name: Sharon Towers (Charlotte, North Carolina)

SERIES: 2019A (Public Bonds)	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Explanation of Variance
PAR Amount	$85,685,000.00	$82,460,000.00	$75,940,000.00	Amount lowered due to more original issue premium
Estimated Interest Rate	5.00%	4.23%	3.03%	Arbitrage Yield
All-in True Interest Cost	5.25%	4.53%	3.81%	
Maturity Schedule (Interest) - Date	1/01/2020 - 7/01/2049	7/01/2020 - 7/01/2049	7/01/2020 - 7/01/2049	
Maturity Schedule (Principal) - Date	7/01/2024 - 7/01/2049	7/01/2025 - 7/01/2049	7/01/2025 - 7/01/2049	
Bank Holding Period (if applicable) - Date	N/A	N/A	N/A	
Estimated NPV Savings ($) (if refunded bonds)	N/A	N/A	N/A	
Estimated NPV Savings (%) (if refunded bonds)	N/A	N/A	N/A	
NOTES:				

SERIES: Series 2019B (Bank Bonds)	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Explanation of Variance
PAR Amount	$18,000,000.00	$18,000,000.00	$18,000,000.00	
Estimated Interest Rate	3.25%	2.50%	2.50%	Variable rate (rate is an assumption)
All-in True Interest Cost	3.50%	2.67%	2.67%	Variable rate (rate is an assumption)
Maturity Schedule (Interest) - Date	11/01/2019 - 7/01/2024	1/01/2020 - 12/05/2024	1/01/2020 - 12/05/2024	
Maturity Schedule (Principal) - Date	7/1/2024	12/5/2024	12/5/2024	Could be pre-paid from entrance fees sooner than maturity
Bank Holding Period (if applicable) - Date	5 Years	5 Years	5 Years	
Estimated NPV Savings ($) (if refunded bonds)	N/A	N/A	N/A	
Estimated NPV Savings (%) (if refunded bonds)	N/A	N/A	N/A	
NOTES:				

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE DECEMBER 13, 2019 11:00 A.M.

Members of the Executive Committee Present:

John J. Meier, IV, M.D., Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Charles H. Hauser
Albert F. Lockamy, RPh

Members of the Executive Committee Absent:

Eileen C. Kugler, RN, MSN, MPH, FNP
J. William Paugh

Members of Staff Present:

Geary W. Knapp, Assistant Secretary
Kathy Larrison, Auditor
Crystal Abbott, Auditor
Alice Creech, Executive Assistant

Others Present:

Rebecca Craig, UNC Wayne Memorial Hospital
Kevin Dougherty, McGuire Woods, LLP

1. **Purpose of Meeting**

To authorize a supplemental trust agreement for Wayne Memorial Hospital's Series 2017A bonds.

A. RESOLUTION AUTHORIZING A SUPPLEMENTAL TRUST AGREEMENT AND CERTAIN OTHER ACTION FOR THE PURPOSE OF MODIFYING CERTAIN TERMS OF THE NORTH CAROLINA MEDICAL CARE COMMISSION HOSPITAL REVENUE BONDS (WAYNE MEMORIAL HOSPITAL), SERIES 2017A

Statements were given by Geary Knapp, Kevin Dougherty, and Joe Crocker.

Executive Committee Action: Motion was made to approve the Supplemental Trust Agreement by Mr. Joe Crocker, seconded by Mr. Al Lockamy, and unanimously approved.

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina, and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to lend the same to any public or nonprofit agency for the purpose of providing funds to pay all or any part of the cost of health care facilities; and

WHEREAS, Wayne Memorial Hospital, Inc. (the "Hospital") is a private, nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina and a "nonprofit agency" within the meaning and intent of the Act, which owns and operates health care facilities located in the City of Goldsboro, North Carolina; and

WHEREAS, Wayne Health Corporation (the "Corporation") is a private, nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina and a "nonprofit agency" within the meaning and intent of the Act, which owns and operates health care facilities located in the City of Goldsboro, North Carolina; and

WHEREAS, the Commission has heretofore issued its Hospital Revenue Bonds (Wayne Memorial Hospital), Series 2017A (the "Series 2017A Bonds") pursuant to a Trust Agreement, dated as of May 1, 2017, as amended and supplemented by a Supplemental Trust Agreement, dated as of November 1, 2018 (together, the "Series 2017A Trust Agreement"), each between the Commission and Branch Banking and Trust Company, as bond trustee (the "Bond Trustee"); and

WHEREAS, the Commission has heretofore loaned the proceeds of the Series 2017A Bonds to the Corporation and the Hospital pursuant to a Loan Agreement, dated as of May 1, 2017, among the Commission, the Corporation and the Hospital; and

WHEREAS, the Series 2017A Bonds are currently held by BB&T Community Holdings Co. (the "Holder") and bear interest at a Bank-Bought Rate (as defined in the Series 2017A Trust Agreement); and

WHEREAS, the Holder has offered to extend the Bank-Bought Minimum Holding Period (as defined in the Series 2017A Trust Agreement) to December 19, 2031 and to modify the Bank-Bought Rate borne by the Series 2017A Bonds during the Bank-Bought Minimum Holding Period as so extended from an Adjusted LIBOR Rate (as defined in the Series 2017A Trust Agreement) to a fixed rate of 2.49% per annum; and

WHEREAS, the Corporation and the Hospital have accepted such offer and have requested that the Commission and the Bond Trustee amend the Series 2017A Trust Agreement for the purpose of modifying certain terms of the Series 2017A Bonds, as summarized in Attachment A hereto; and

WHEREAS, Section 11.02 of the Series 2017A Trust Agreement provides for the execution of such trust agreements supplemental thereto with the consent of the Holders (as defined in the Series 2017A Trust Agreement) of not less than a majority of the aggregate principal amount of the Series 2017A Bonds then Outstanding (as defined in the Series 2017A Trust Agreement); and

WHEREAS, there has been presented to the officers and staff of the Commission (i) a draft of a Second Supplemental Trust Agreement amending the Series 2017A Trust Agreement, dated as of December 1, 2019 (the "Second Supplemental Trust Agreement"), between the Commission and the Bond Trustee, and (ii) a draft of an Allonge to the Series 2007A Bonds (the "Series 2017A Allonge"), modifying certain terms of the Series 2017A Bonds; and

WHEREAS, the Holder, as the sole Holder of the Series 2017A Bonds, has indicated its willingness to give its consent to the terms and provisions of the Second Supplemental Trust Agreement and the Series 2017A Allonge; and

WHEREAS, the Commission has determined that the public will best be served by the amendment of the Series 2017A Trust Agreement and the modification of certain terms of the Series 2017A Bonds;

NOW, THEREFORE, THE EXECUTIVE COMMITTEE OF THE NORTH CAROLINA MEDICAL CARE COMISISON DOES HEREBY RESOLVE, as follows:

Section 1. The form, terms and provisions of the Second Supplemental Trust Agreement are hereby approved in all respects, and the Chairman, Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose and the Secretary or the Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Second Supplemental Trust Agreement in substantially the form presented to the officers and staff of the Commission, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 2. The form, terms and provisions of the Series 2017A Allonge set forth in the Second Supplemental Trust Agreement are hereby approved in all respects and the Chairman, Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose and the Secretary or the Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature, and to deliver to the Bond Trustee for authentication on behalf of the Commission, the Series 2017A Allonge in definitive form, which shall be in substantially the form presented to the officers and staff of the Commission, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 3. Upon its execution, the Series 2017A Allonge shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Series 2017A Allonge and deliver the Series 2017A Allonge to the Holder of the Series 2017A Bonds in accordance with the Series 2017A Trust Agreement and the Second Supplemental Trust Agreement.

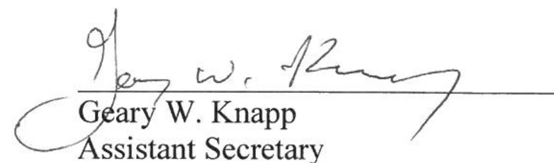
Section 4. The Chairman, the Vice Chairman, any member of the Commission designated in writing by the Chairman of the Commission for such purpose, the Secretary and the Assistant Secretary of the Commission are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments, including delivery of the Series 2017A Allonge to the Holder, as they, with the advice of counsel, may deem necessary or appropriate to effect the amendment of the Series 2017A Trust Agreement and the modification of certain terms of the Series 2017A Bonds.

Section 5. This Resolution shall take effect immediately upon its passage.

2. Adjournment

There being no further business, the meeting was adjourned at 11:06 a.m.

Respectfully submitted,



Geary W. Knapp
Assistant Secretary

ATTACHMENT A

Amendments to the Trust Agreement; Allonge.

(a) The Trust Agreement shall be amended as follows:

(i) The reference to "May 25, 2027" in the definition of "Bank-Bought Minimum Holding Period" set forth in Section 1.01 of the Trust Agreement is hereby deleted and "December 19, 2031" is hereby substituted therefor.

(ii) Section 3.01(a)(i) of the Trust Agreement is hereby amended and restated in its entirety to read as follows:

> "(a) Optional Redemption.
>
> (i) While the Bonds bear interest at the Bank-Bought Rate, the Bonds shall be subject to optional redemption by the Commission, at the direction of the Group Representative, in whole on any Business Day or in part (in Authorized Denominations) on any Interest Payment Date, at a Redemption Price equal to 100% of the principal amount of the Bonds to be redeemed, plus (A) interest accrued to the redemption date and (B) prepayment compensation (if any) in the amount described in the Bonds. During any Bank-Bought Rate Period, the Bonds are required to be optionally redeemed on the dates and in the amounts described in the Conversion Notice for such Bank-Bought Rate Period."

(iii) Exhibit C to the Trust Agreement is hereby deleted in its entirety and a new Exhibit C attached to this Second Supplemental Trust Agreement shall be substituted therefor.

(b) Exhibit 1 to the Bonds is hereby deleted in its entirety and a new Exhibit 1 as set forth in the form of the Allonge attached to this Second Supplemental Trust Agreement shall be substituted therefor.

EXHIBIT C

BANK-BOUGHT RATE PROVISIONS

Notwithstanding any provision of this Trust Agreement to the contrary, beginning on the Modification Date, the following provisions shall apply to the Bonds:

Definitions.

"Business Day" means any day of the year, other than a Saturday or a Sunday, on which the office of the Holder at which payments on the Bonds are to be made and banks located in the city in which the designated corporate trust office of the Bond Trustee is located are not authorized or required to remain closed.

"Date of Taxability" means the earliest date as of which interest on the Bonds shall have been determined to be includable in the gross income of the Bank Holder pursuant to a Determination of Taxability.

"Default Rate" means the greater of (i) a fluctuating interest rate equal to 2.00% per annum above the Prime Rate in effect from time to time and (ii) 6.00% per annum.

"Determination of Taxability" means and shall be deemed to have occurred on the first to occur of the following:

(i) on that date when the Hospital and the Corporation file any statement, supplemental statement or other tax schedule, return or document which discloses that an Event of Taxability shall have in fact occurred;

(ii) on the date when any Holder or prior Holder notifies the Commission, the Hospital and the Corporation that it has received a written opinion by an attorney or firm of attorneys of recognized standing on the subject of tax-exempt municipal finance to the effect that an Event of Taxability has occurred unless, within 180 days after receipt by the Commission, the Hospital and the Corporation of such notification from such Holder or prior Holder, the Commission, the Hospital or the Corporation shall deliver to each Holder and prior Holder (A) a ruling or determination letter issued to or on behalf of the Commission, the Hospital or the Corporation by the Commissioner or any District Director of Internal Revenue (or any other governmental official exercising the same or a substantially similar function from time to time) or (B) a written opinion by an attorney or firm of attorneys of recognized standing on the subject of tax-exempt municipal finance to the effect that, after taking into consideration such facts as form the basis for the opinion that an Event of Taxability has occurred, an Event of Taxability shall not have occurred;

(iii) on the date when the Commission, the Hospital or the Corporation shall be advised in writing by the Commissioner or any District Director of Internal Revenue (or any other government official or agent exercising the same or a substantially similar function from time to time) that, based upon filings by the Commission, the Hospital or the Corporation, or upon any review or audit of the

Commission, the Hospital or the Corporation or upon any other ground whatsoever, an Event of Taxability shall have occurred; or

(iv) on that date when the Commission, the Hospital or the Corporation shall receive notice from any Holder or prior Holder that the Internal Revenue Service (or any other government official or agency exercising the same or a substantially similar function from time to time) has assessed as includable in the gross income of such Holder or prior Holder the interest on the Bonds due to the occurrence of an Event of Taxability;

provided, however, no Determination of Taxability shall occur under subparagraph (iii) or (iv) above unless the Commission, the Hospital and the Corporation have been afforded the opportunity, at the sole expense of the Hospital and the Corporation, to contest any such assessment, and, further, no Determination of Taxability shall occur until such contest, if made, has been finally determined; provided further, however, that upon demand from any Holder or prior Holder, the Hospital and the Corporation shall immediately reimburse such Holder or prior Holder for any payments such Holder or prior Holder shall be obligated to make as a result of the Determination of Taxability during any such contest.

"Event of Taxability" means a change in law or fact or the interpretation thereof; or the occurrence or existence of any fact, event or circumstance (including, without limitation, the taking of any action by the Commission, the Hospital or the Corporation, or the failure to take any action by the Commission, the Hospital or the Corporation, or the making by the Commission, the Hospital or the Corporation of any misrepresentation herein or in any certificate required to be given in connection with the issuance, sale or delivery of the Bonds) which has the effect of causing interest paid or payable on any Bonds to become includable, in whole or in part, in the gross income of a Holder or any prior Holder for federal income tax purposes.

"Modification Date" means December 19, 2019.

"Prime Rate" means the interest rate announced by Branch Banking and Trust Company from time to time as its prime rate. Any change in the Prime Rate shall be effective as of the date such change is announced by Branch Banking and Trust Company.

Bank-Bought Rate.

The Bonds shall bear interest at the rate of 2.49% per annum unless:

(i) a Determination of Taxability shall have occurred, in which case the Bonds shall be deemed to have been redeemed with the proceeds of a taxable loan made by the Bank Holder to the Hospital and the Corporation, and the Bank Holder shall surrender the Bonds to the Bond Trustee for immediate cancellation. Such taxable loan shall be deemed to have been made as of the Date of Taxability and shall be evidenced by Obligation No. 11 and shall bear interest from the Date of Taxability at the Default Rate;

(ii) at any time after the Modification Date there should be any change in the maximum marginal rate of federal income tax applicable to the taxable income of the Bank Holder (the "Bank Holder Tax Rate"), then the interest rate per

annum in effect hereunder from time to time as herein provided, for so long as there shall not have occurred a Determination of Taxability, shall be adjusted upward or downward, as the case may be, effective as of the effective date of any such change in the Bank Holder Tax Rate, by multiplying the interest rate per annum by a fraction, the denominator of which is one hundred percent (100%) minus the Bank Holder Tax Rate in effect upon the Modification Date, and the numerator of which is one hundred percent (100%) minus the Bank Holder Tax Rate after giving effect to such change; or

(iii) an Event of Default shall have occurred and be continuing, in which case the Bonds shall bear interest at the Default Rate.

Interest shall be paid on the first calendar day of each month, commencing January 1, 2020, and shall be computed on the basis of a year of 360 days for the actual number of days elapsed.

Additional Required Payments under the Agreement.

The following shall be additional Required Payments under the Agreement:

(i) Upon an Event of Taxability, the Hospital and the Corporation shall pay to the Bank Holder any amounts that may be necessary to reimburse the Bank Holder for any interest, penalties or other charges assessed against the Bank Holder by reason of the Bank Holder not including interest on the Bonds in its federal gross income during the period following the Event of Taxability. The Hospital and the Corporation shall make reasonable arrangements satisfactory to the Commission and the Bank Holder for the payment of their reasonable expenses, including, but not limited to, reasonable legal expenses incurred in connection with any Event of Taxability. Notwithstanding any other provision of this Trust Agreement or the Agreement, the obligations of the Hospital and the Corporation pursuant to this paragraph shall continue following the expiration of the term of the Agreement; and

(ii) So long as any portion of the principal amount of the Bonds or interest thereon remains unpaid, if (i) any law, rule, regulation or executive order is or has been enacted or promulgated by any public body or governmental agency which changes the basis of taxation of payments to the Bank Holder of principal or interest payable pursuant to the Bonds, including without limitation the imposition of any excise tax or surcharge thereon, but excluding changes in the rates of tax applicable to the overall net income of the Bank Holder, or (ii) as a result of action by any public body or governmental agency, any payment is required to be made by, or any federal, state or local income tax deduction is denied to, the Bank Holder by reason of the ownership of, borrowing money to invest in, or receiving principal or interest from the Bonds, the Hospital and the Corporation agree to reimburse on demand for, and do hereby indemnify the Bank Holder against, any loss, cost, charge or expense with respect to any such change, payment or loss of deduction.

Exhibit 1

BANK-BOUGHT RATE PROVISIONS

Notwithstanding any provision of this Trust Agreement to the contrary, beginning on the Modification Date, the following provisions shall apply to the Bonds:

Definitions.

"Business Day" means any day of the year, other than a Saturday or a Sunday, on which the office of the Holder at which payments on the Bonds are to be made and banks located in the city in which the designated corporate trust office of the Bond Trustee is located are not authorized or required to remain closed.

"Date of Taxability" means the earliest date as of which interest on the Bonds shall have been determined to be includable in the gross income of the Bank Holder pursuant to a Determination of Taxability.

"Default Rate" means the greater of (i) a fluctuating interest rate equal to 2.00% per annum above the Prime Rate in effect from time to time and (ii) 6.00% per annum.

"Determination of Taxability" means and shall be deemed to have occurred on the first to occur of the following:

(i) on that date when the Hospital and the Corporation file any statement, supplemental statement or other tax schedule, return or document which discloses that an Event of Taxability shall have in fact occurred;

(ii) on the date when any Holder or prior Holder notifies the Commission, the Hospital and the Corporation that it has received a written opinion by an attorney or firm of attorneys of recognized standing on the subject of tax-exempt municipal finance to the effect that an Event of Taxability has occurred unless, within 180 days after receipt by the Commission, the Hospital and the Corporation of such notification from such Holder or prior Holder, the Commission, the Hospital or the Corporation shall deliver to each Holder and prior Holder (A) a ruling or determination letter issued to or on behalf of the Commission, the Hospital or the Corporation by the Commissioner or any District Director of Internal Revenue (or any other governmental official exercising the same or a substantially similar function from time to time) or (B) a written opinion by an attorney or firm of attorneys of recognized standing on the subject of tax-exempt municipal finance to the effect that, after taking into consideration such facts as form the basis for the opinion that an Event of Taxability has occurred, an Event of Taxability shall not have occurred;

(iii) on the date when the Commission, the Hospital or the Corporation shall be advised in writing by the Commissioner or any District Director of Internal Revenue (or any other government official or agent exercising the same or a substantially similar function from time to time) that, based upon filings by the

Commission, the Hospital or the Corporation, or upon any review or audit of the Commission, the Hospital or the Corporation or upon any other ground whatsoever, an Event of Taxability shall have occurred; or

(iv) on that date when the Commission, the Hospital or the Corporation shall receive notice from any Holder or prior Holder that the Internal Revenue Service (or any other government official or agency exercising the same or a substantially similar function from time to time) has assessed as includable in the gross income of such Holder or prior Holder the interest on the Bonds due to the occurrence of an Event of Taxability;

provided, however, no Determination of Taxability shall occur under subparagraph (iii) or (iv) above unless the Commission, the Hospital and the Corporation have been afforded the opportunity, at the sole expense of the Hospital and the Corporation, to contest any such assessment, and, further, no Determination of Taxability shall occur until such contest, if made, has been finally determined; provided further, however, that upon demand from any Holder or prior Holder, the Hospital and the Corporation shall immediately reimburse such Holder or prior Holder for any payments such Holder or prior Holder shall be obligated to make as a result of the Determination of Taxability during any such contest.

"Event of Taxability" means a change in law or fact or the interpretation thereof; or the occurrence or existence of any fact, event or circumstance (including, without limitation, the taking of any action by the Commission, the Hospital or the Corporation, or the failure to take any action by the Commission, the Hospital or the Corporation, or the making by the Commission, the Hospital or the Corporation of any misrepresentation herein or in any certificate required to be given in connection with the issuance, sale or delivery of the Bonds) which has the effect of causing interest paid or payable on any Bonds to become includable, in whole or in part, in the gross income of a Holder or any prior Holder for federal income tax purposes.

"Modification Date" means December 19, 2019.

"Prime Rate" means the interest rate announced by Branch Banking and Trust Company from time to time as its prime rate. Any change in the Prime Rate shall be effective as of the date such change is announced by Branch Banking and Trust Company.

Bank-Bought Rate.

The Bonds shall bear interest at the rate of 2.49% per annum unless:

(i) a Determination of Taxability shall have occurred, in which case the Bonds shall be deemed to have been redeemed with the proceeds of a taxable loan made by the Bank Holder to the Hospital and the Corporation, and the Bank Holder shall surrender the Bonds to the Bond Trustee for immediate cancellation. Such taxable loan shall be deemed to have been made as of the Date of Taxability and shall be evidenced by Obligation No. 11 and shall bear interest from the Date of Taxability at the Default Rate;

(ii) at any time after the Modification Date there should be any change in the maximum marginal rate of federal income tax applicable to the taxable income of the Bank Holder (the "Bank Holder Tax Rate"), then the interest rate per annum in effect hereunder from time to time as herein provided, for so long as there shall not have occurred a Determination of Taxability, shall be adjusted upward or downward, as the case may be, effective as of the effective date of any such change in the Bank Holder Tax Rate, by multiplying the interest rate per annum by a fraction, the denominator of which is one hundred percent (100%) minus the Bank Holder Tax Rate in effect upon the Modification Date, and the numerator of which is one hundred percent (100%) minus the Bank Holder Tax Rate after giving effect to such change; or

(iii) an Event of Default shall have occurred and be continuing, in which case the Bonds shall bear interest at the Default Rate.

Interest shall be paid on the first calendar day of each month, commencing January 1, 2020, and shall be computed on the basis of a year of 360 days for the actual number of days elapsed.

Additional Required Payments under the Agreement.

The following shall be additional Required Payments under the Agreement:

(i) Upon an Event of Taxability, the Hospital and the Corporation shall pay to the Bank Holder any amounts that may be necessary to reimburse the Bank Holder for any interest, penalties or other charges assessed against the Bank Holder by reason of the Bank Holder not including interest on the Bonds in its federal gross income during the period following the Event of Taxability. The Hospital and the Corporation shall make reasonable arrangements satisfactory to the Commission and the Bank Holder for the payment of their reasonable expenses, including, but not limited to, reasonable legal expenses incurred in connection with any Event of Taxability. Notwithstanding any other provision of this Trust Agreement or the Agreement, the obligations of the Hospital and the Corporation pursuant to this paragraph shall continue following the expiration of the term of the Agreement; and

(ii) So long as any portion of the principal amount of the Bonds or interest thereon remains unpaid, if (i) any law, rule, regulation or executive order is or has been enacted or promulgated by any public body or governmental agency which changes the basis of taxation of payments to the Bank Holder of principal or interest payable pursuant to the Bonds, including without limitation the imposition of any excise tax or surcharge thereon, but excluding changes in the rates of tax applicable to the overall net income of the Bank Holder, or (ii) as a result of action by any public body or governmental agency, any payment is required to be made by, or any federal, state or local income tax deduction is denied to, the Bank Holder by reason of the ownership of, borrowing money to invest in, or receiving principal or interest from the Bonds, the Hospital and the Corporation agree to reimburse on

demand for, and do hereby indemnify the Bank Holder against, any loss, cost, charge or expense with respect to any such change, payment or loss of deduction.

Mandatory Purchase Dates.

"December 19, 2031" shall be substituted for "May 25, 2027" in clause (b) of the first paragraph under the caption "**Mandatory Purchase Date**s" in the Bonds.

Redemption of Bonds Before Maturity.

The terms and provisions under the caption "**Redemption of Bonds Before Maturity – Optional Redemption – Bank-Bought Rate**" in the Bonds shall be amended and restated in their entirety to read as follows:

> **"Optional Redemption – Bank-Bought Rate.** While the Bonds bear interest at the Bank-Bought Rate, the Bonds shall be subject to optional redemption prior to maturity at the option of the Commission, to be exercised as directed by the Group Representative, in whole on any Business Day or in part (in Authorized Denominations) on any Interest Payment Date at a redemption price equal to 100% of the principal amount being redeemed, plus interest accrued to the redemption date, plus prepayment compensation in the amount deemed necessary by the Majority Bank Holders to compensate the Bank Holder for any losses, costs or expenses which the Bank Holder may incur as a result of such prepayment (the "Prepayment Compensation") as set forth below. If the Hospital and the Corporation fail to pay the Prepayment Compensation when due, the amount of the Prepayment Compensation shall thereafter bear interest until paid at the Default Rate. Each optional redemption of the Bonds shall be applied to the principal installments due under the Bonds in inverse order of maturity. The determination of the amount of the Prepayment Compensation due the Bank Holder hereunder shall be made by the Majority Bank Holders in good faith and shall be conclusive and binding upon the Hospital and the Corporation absent manifest error; provided, however, that the Prepayment Compensation shall in no event exceed the maximum prepayment compensation permitted by applicable law and the Bonds shall be construed to give maximum effect to the provisions contained herein.

The Prepayment Compensation shall be the amount derived by subtracting (a) the Net Present Value of the Bonds or (in the case of a partial prepayment) the Net Present Value of the principal portion of the Bonds being prepaid determined at the Marginal Funding Rate at Prepayment from (b) the Net Present Value of the Bonds or (in the case of a partial prepayment) the Net Present Value of the principal portion of the Bonds being prepaid determined at the Initial Marginal Funding Rate. If the value is positive, the Prepayment Compensation shall be zero.

For purposes hereof:

> "Initial Marginal Funding Rate" shall mean the rate determined by the Majority Bank Holders as of the Modification Date as the rate at which the Majority Bank Holders would have been able to borrow funds in Money Markets for the outstanding principal amount of the Bonds with an interest payment frequency and principal repayment schedule equal to those contained in the Bonds, adjusted for any reserve requirement and for any subsequent costs arising from any change in government regulation. The Hospital and the

Corporation acknowledge that the Majority Bank Holders are under no obligation to actually purchase and/or match funds for the Initial Marginal Funding Rate of the Bonds.

"Marginal Funding Rate at Prepayment" shall mean the rate determined by the Majority Bank Holders no more than ten (10) Business Days prior to the date of redemption as the rate at which the Majority Bank Holders would be able to borrow funds in Money Markets for the prepayment amount matching the maturity of a specific prospective note payment, adjusted for any reserve requirement and any subsequent costs arising from any change in government regulation.

"Money Markets" shall mean one or more wholesale funding markets available to and selected by the Majority Bank Holders, including negotiable certificates of deposit, commercial paper, Eurodollar deposits, bank notes, federal funds, interest rate swaps or others.

"Net Present Value" shall mean the amount which is derived by summing the present values of each prospective payment of principal or principal and interest which, without such full or partial prepayment, would otherwise have been received by the Majority Bank Holders over the remaining term of the Bonds. The individual discount rate used to calculate the present value of each prospective payment of principal and/or interest shall be determined by the Marginal Funding Rate at Prepayment for the maturity matching that of each specific payment of principal and/or interest under the Bonds. In calculating the Prepayment Compensation, the Majority Bank Holders are authorized by the Hospital and the Corporation to make such assumptions regarding the source of funding, redeployment of funds and other related matters as the Majority Bank Holders may deem appropriate.

The Majority Bank Holders shall give written notice of the amount of the Prepayment Compensation (if any) to the Hospital and the Hospital, the Corporation and the Bond Trustee by not later than the Business Day next preceding the redemption date. The Bond Trustee shall have no duty to review or analyze the calculation of the Prepayment Compensation. Any Prepayment Compensation shall constitute redemption premium for purposes of the Trust Agreement, the Bonds and the Agreement.

Bonds to be optionally redeemed shall be in the minimum amount of the greater of (i) 10% of all Bonds outstanding at the time of redemption or (ii) $250,000."

STATE OF NORTH CAROLINA
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE OF THE COMMISSION
CONFERENCE TELEPHONE MEETING ORIGINATING
FROM THE OFFICES OF THE COMMISSION
January 31, 2020
11:00 A.M.

Members of the Commission Present:

John J. Meier, IV, M.D., Chairman
Joseph D. Crocker, Vice-Chairman
J. William Paugh
Jeffrey S. Wilson
Albert F. Lockamy, RPh

Members of the Commission Absent:

Sally B. Cone
Linwood B. Hollowell, III

Members of Staff Present:

S. Mark Payne, DHSR Director/MCC Secretary
Geary W. Knapp, Assistant Secretary
Kathy Larrison, Auditor
Crystal Abbott, Auditor
Alice Creech, Executive Assistant

Others Present:

Paul Billow, Womble Bond Dickinson (US) LLP
Margie Blackford, Ponder & Co.
John Cheney, Ponder & Co.
Phil Delvecchio, Bank of America Merrill Lynch
Jon Mize, Womble Bond Dickinson (US) LLP
Andy Zukowski, UNC Rex Healthcare

1. Purpose of Meeting

To consider a resolution authorizing the sale and issuance of bonds, the proceeds of which will be loaned to Rex Hospital, Inc.

2. Series Resolution Authorizing the Issuance of $199,725,000 North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (Rex Healthcare), Series 2020A (the "Bonds").

Remarks were made on the financing by Mr. Geary Knapp, Mr. Paul Billow, Mr. Joe Crocker, Mr. Mark Payne, Mr. Bill Paugh, Dr. John Meier, Ms. Margie Blackford, and Mr. Andy Zukowski.

Executive Committee Action: Motion was made by Mr. Joe Crocker, seconded by Mr. Al Lockamy, and unanimously adopted with the recusal of Dr. John Meier, IV.

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities; and

WHEREAS, Rex Hospital, Inc. (the "Corporation") is a private, nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina which owns and operates, by itself and through controlled affiliates, various health care facilities; and

WHEREAS, the Corporation has made application to the Commission for a loan to be made to the Corporation for the purpose of providing funds, together with other available funds, to (a) pay or reimburse the costs of acquiring, constructing and equipping certain hospital facilities and equipment, including, without limitation, (i) the UNC Rex Holly Springs Hospital (consisting of a hospital facility of approximately 230,000 square feet, a central energy plant of approximately 11,500 square feet, and associated site improvements, to be located in Holly Springs, North Carolina) and (ii) the UNC Rex Outpatient Cancer Center (consisting of a building of approximately 142,835 square feet and associated surface parking, to be located on the main campus of the Corporation in Raleigh, North Carolina) (collectively, the "Project") and (b) pay the fees and expenses incurred in connection with the sale and issuance of the Bonds; and

WHEREAS, the Commission has, by resolution adopted on August 21, 2019, approved the issuance of the Bonds, subject to compliance with the conditions set forth in such resolution, and the Corporation has complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented at this meeting drafts or copies, as applicable, of the following documents relating to the issuance of the Bonds:

(a) Trust Agreement, to be dated as of February 1, 2020 (the "Trust Agreement"), between the Commission and U.S. Bank National Association, as trustee (the "Bond Trustee"), together with the form of the Bonds attached thereto;

(b) Loan Agreement, to be dated as of February 1, 2020 (the "Loan Agreement"), between the Commission and the Corporation;

(c) Contract of Purchase, to be dated the date of delivery thereof (the "Contract of Purchase"), between the North Carolina Local Government Commission (the "LGC") and BofA Securities, Inc., Morgan Stanley & Co. LLC and Wells Fargo Bank, National Association (collectively, the "Underwriters"), and approved by the Commission, the Corporation and Rex Healthcare, Inc. (the "Parent Corporation");

(d) Supplemental Indenture for Obligation No. 9, to be dated as of February 1, 2020 (the "Supplemental Indenture"), between the Corporation and U.S. Bank National Association (in such capacity, the "Master Trustee"), supplementing an Amended and Restated Master Trust Indenture, dated as of October 1, 2010 (as amended or supplemented from time to time in accordance with its terms, the "Master Indenture"), by and among the Corporation, the Parent Corporation and the Master Trustee;

(e) the Master Indenture;

(f) Obligation No. 9, to be dated the date of delivery thereof ("Obligation No. 9"), to be issued by the Corporation to the Commission; and

(g) Preliminary Official Statement, dated the date of delivery thereof (as supplemented, the "Preliminary Official Statement"), relating to the offering and sale of the Bonds; and

WHEREAS, the Commission has determined that the Parent Corporation and the Corporation are financially responsible and capable of fulfilling their respective obligations, as applicable, under each of the documents described above to which the Parent Corporation and/or the Corporation is a party; and

WHEREAS, the Commission has determined that the public interest will be served by the proposed financing and that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW THEREFORE, BE IT RESOLVED by the Executive Committee of the North Carolina Medical Care Commission as follows:

Section 1. Capitalized terms used in this Series Resolution and not defined herein shall have the meanings given such terms in the Trust Agreement, the Loan Agreement and the Master Indenture.

Section 2. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes the issuance of the Bonds in the aggregate principal amount of $199,725,000. The Bonds shall be dated as of the date of delivery thereof and shall mature in such amounts and at

such times and shall bear interest at such rates as are set forth in Exhibit A attached hereto and made a part hereof.

The Bonds shall be issued as fully registered bonds in denominations of $5,000 or any whole multiple thereof. The Bonds shall be initially issued in book-entry only form as described in the Trust Agreement. Interest on the Bonds shall be payable semiannually on each January 1 and July 1, beginning July 1, 2020, until the Bonds are fully paid. Payments of principal of and interest on the Bonds shall be forwarded by the Bond Trustee to the registered owners of the Bonds in such manner as is set forth in the Trust Agreement.

Section 3. The Bonds shall be subject to optional, extraordinary and mandatory sinking fund redemption at the times, upon the terms and conditions and at the prices set forth in the Trust Agreement.

Section 4. The proceeds of the Bonds shall be applied as provided in Section 2.08 of the Trust Agreement.

Section 5. The forms, terms and provisions of the Loan Agreement and the Trust Agreement are hereby approved in all respects, and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such purpose and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Loan Agreement and the Trust Agreement in substantially the forms presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary or appropriate, including but not limited to changes, modifications and deletions necessary to incorporate the final terms of the Bonds as shall be set forth in the Contract of Purchase; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 6. The forms, terms and provisions of the Contract of Purchase are hereby approved in all respects and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such purpose is hereby authorized and directed to execute and deliver the Contract of Purchase in substantially the form presented at this meeting, together with such changes, modifications, insertions and deletions as such Chairman, the Vice Chairman or such member of the Commission, with the advice of counsel, may deem necessary or appropriate, including but not limited to changes, modifications and deletions necessary to incorporate the final terms of the Bonds; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The forms of the Bonds set forth in the Trust Agreement are hereby approved in all respects and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such purpose and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature as provided in such form of the Bonds, and to deliver to the Bond Trustee for authentication on behalf of the Commission, the Bonds in definitive form, which shall be in substantially the form presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary or appropriate and consistent

with the Trust Agreement; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. The forms, terms and provisions of the Supplemental Indenture and Obligation No. 9 are hereby approved in substantially the forms presented at this meeting, together with such changes, modifications and deletions as the Chairman or Vice Chairman, with the advice of counsel, may deem necessary and appropriate; and the execution and delivery of the Trust Agreement by the Commission shall be conclusive evidence of the approval of the Supplemental Indenture and Obligation No. 9 by the Commission.

Section 9. The Commission hereby approves the action of the LGC in awarding the Bonds to the Underwriters at the price of $226,903,981.10 (which price represents the aggregate principal amount of the Bonds, plus an original issue premium of $27,816,103.85 and less an underwriters' discount of $637,122.75).

Section 10. Upon execution of the Bonds in the form and manner set forth in the Trust Agreement, the Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Bonds and, upon compliance with the provisions of Section 2.08 of the Trust Agreement, the Bond Trustee shall deliver the Bonds to the Underwriters against payment therefor.

Section 11. The Commission hereby ratifies the use and distribution of the Preliminary Official Statement in connection with the offering and sale of the Bonds. The preparation and distribution of a final Official Statement (the "Official Statement"), in substantially the form of the Preliminary Official Statement, with such changes as are necessary to reflect the final terms of the Bonds, is hereby approved, and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such purpose is hereby authorized to execute and deliver, on behalf of the Commission, the Official Statement in substantially such form, together with such changes, modifications and deletions as the Chairman, the Vice Chairman or such member of the Commission, with the advice of counsel, may deem necessary or appropriate; and such execution and delivery shall be conclusive evidence of the approval thereof by the Commission. The Commission hereby approves and authorizes the distribution and use of copies of the Loan Agreement, the Trust Agreement, the Supplemental Indenture, Obligation No. 9 and the Master Indenture by the Underwriters in connection with the offering and sale of the Bonds.

Section 12. U.S. Bank National Association is hereby appointed as the Bond Trustee for the Bonds.

Section 13. The Depository Trust Company ("DTC") is hereby appointed as the initial Securities Depository for the Bonds, with Cede & Co., as nominee of DTC, being the initial Securities Depository Nominee and initial registered owner of the Bonds. The Commission has heretofore executed and delivered to DTC a Blanket Letter of Representations.

Section 14. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary, Kathy C. Larrison, Auditor, Crystal M. Watson-Abbott, Auditor, and Steven C. Lewis, Chief of the Construction Section of the Division of Health Service Regulation, for the

Commission, are each hereby appointed a Commission Representative (as that term is defined in the Loan Agreement) with full power to carry out the duties set forth therein and the Trust Agreement.

Section 15. The Chairman, the Vice Chairman, any member of the Commission designated in writing by the Chairman, the Secretary and any Assistant Secretary of the Commission are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the Loan Agreement, the Trust Agreement, the Contract of Purchase and the Official Statement.

Section 16. The Commission hereby recommends that the Governor of the State of North Carolina approve the issuance of the Bonds pursuant to Section 147(f) of the Internal Revenue Code of 1986, as amended, and hereby requests such approval.

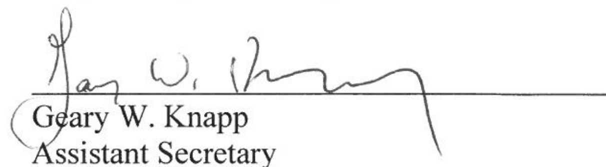
Section 17. A comparison of the professional fees as set forth in the resolution of the Commission granting preliminary approval of the Bonds with the actual professional fees incurred in connection with the Bonds is set forth as Exhibit B hereto.

Section 18. This Series Resolution shall take effect immediately upon its adoption.

3. Adjournment

There being no further business, the meeting was adjourned at 11:25 a.m.

Respectfully submitted,



Geary W. Knapp
Assistant Secretary

Date: January 31, 2020

EXHIBIT A

MATURITY SCHEDULE

Due July 1	Principal Amount	Interest Rate
2021	$1,185,000	5.00%
2022	1,265,000	5.00
2023	1,330,000	5.00
2024	2,360,000	5.00
2025	2,495,000	5.00
2026	2,640,000	5.00
2027	2,785,000	5.00
2028	2,935,000	5.00
2029	3,105,000	5.00
2030	3,250,000	5.00
2031	3,875,000	5.00
2032	4,065,000	5.00
2033	4,280,000	5.00
2034	4,490,000	5.00
2035	4,725,000	5.00
2036	4,910,000	3.00
2037	5,065,000	3.00
2038	5,215,000	3.00
2039	5,395,000	4.00
2040	5,610,000	4.00

$43,655,000 3.00% Term Bond due July 1, 2045

Due July 1	Sinking Fund Requirement
2041	$ 5,815,000
2042	5,990,000
2043	6,170,000
2044	6,355,000
2045*	19,325,000

* Maturity

$85,090,000 4.00% Term Bond due July 1, 2049

Due July 1	Sinking Fund Requirement
2046	$20,015,000
2047	20,830,000
2048	21,680,000
2049*	22,565,000

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* Maturity

EXHIBIT B

PROFESSIONAL FEES

Professional	Preliminary Approval	Actual
Financial Advisor	$150,000	$150,000
Underwriters	875,000	637,123
Accountant/Auditor	130,000	100,000
Bond Counsel	145,000	120,000
Underwriters' Counsel	110,000	120,000
Corporation Counsel	75,000	75,000
Trustee (including counsel)	11,000	7,000

NC MCC Bond Sale Approval Form
Facility Name: Rex Hospital, Inc.

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanation of Variance
SERIES: 2020A					
PAR Amount	$250,000,000.00	$200,000,000.00	$199,725,000.00	($50,275,000.00)	LGC Sizing Restriction, Improvement in Market Conditions
Estimated Interest Rate [1]	3.43%	3.16%	2.94%	-0.49%	Improvement in Market Conditions
All-in True Interest Cost	3.45%	3.22%	2.97%	-0.48%	Improvement in Market Conditions
Maturity Schedule (Interest) - Date	1/1/2020 - 7/1/2049	7/1/2020 - 7/1/2049	7/1/2020 - 7/1/2049	1st Interest Payment in July 2020	Financing Delays
Maturity Schedule (Principal) - Date	7/1/2020 - 7/1/2049	7/1/2021 - 7/1/2049	7/1/2021 - 7/1/2049	1st Principal Payment in July 2021	Financing Delays
Bank Holding Period (if applicable) - Date	N/A [2]	N/A [2]	N/A [2]	--	--
Estimated NPV Savings ($) (if refunded bonds)	N/A [2]	N/A [2]	N/A [2]	--	--
Estimated NPV Savings (%) (if refunded bonds)	N/A [2]	N/A [2]	N/A [2]	--	--

NOTES:
(1) True Interest Cost is shown for Estimated Interest Rate.
(2) The Series 2020A bonds are publicly-offered, fixed-rate, new money bonds.

10A NCAC 13F .0202 is amended as published in 34:06 NCR 481-485 as follows:

10A NCAC 13F .0202 THE LICENSE

(a) Except as otherwise provided in ~~Rule .0203 of this Section,~~ G.S. 131D-2.4, the Department shall issue an adult care home license to any person who submits the application material according to Rule .0204 of this Section and the Department determines that the applicant complies with the provisions of all ~~applicable~~ State adult care home licensure statutes and ~~rules.~~ rules of this Subchapter. All applications for a new license shall disclose the names of individuals who are co-owners, partners, or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.

(b) The license shall be conspicuously posted in a public place in the home.

(c) When a provisional license is ~~issued,~~ issued according to G.S. 131D-2.7, the administrator shall post the provisional license and a copy of the notice from the Division of Health Service Regulation identifying the reasons for it, conspicuously in a public place in the home and in place of the full license.

(d) The license is not transferable or assignable.

(e) An adult care home shall be licensed only as an adult care home and not for any other level of care or licensable entity or service. The license shall be terminated when the home is licensed to provide a higher level of care or a combination of a higher level of care and adult care home level of care.

History Note: *Authority G.S. 131D-2.4; 131D-2.7; 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. April 1, 2020.

1 10A NCAC 13F .0204 is amended as published in 34:06 NCR 481-485 as follows:

2

3 **10A NCAC 13F .0204 APPLYING FOR A LICENSE TO OPERATE A FACILITY NOT CURRENTLY**
4 **LICENSED**

5 (a) Prior to submission of a license application, all Certificate of Need requirements shall be met according to G.S.
6 131E, Article 9.

7 (b) In applying for a license to operate an adult care home to be constructed or ~~renovated~~ renovated, or in an existing
8 building that is not currently licensed, the applicant shall submit the following to the Division of Health Service
9 Regulation:

10 (1) the Initial License Application ~~which~~ that is available ~~on the internet website,~~ online at
11 ~~http://facility-services.state.nc.us/gcpage.htm~~ https://info.ncdhhs.gov/dhsr/acls/pdf/fcchgapp.pdf at
12 no cost and includes the following: ~~or the Division of Health Service Regulation, Adult Care~~
13 ~~Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708;~~

14 (A) contact person, facility site and mailing addresses, and administrator;

15 (B) operation disclosure including names and contact information of the licensee, management
16 company, and building owner;

17 (C) ownership disclosure including names and contact information of owners, principals,
18 affiliates, shareholders, and members; and

19 (D) bed capacity including that of any special care unit for Alzheimer's and Related Disorders;

20 (2) plans and specifications as required in Section .0300 of this Subchapter and a construction review
21 fee according to ~~G.S. 131E-267;~~ G.S. 131E-267 to be calculated and invoiced by the DHSR
22 Construction Section;

23 (3) an approved fire and building safety inspection report from the local fire marshal to be submitted
24 upon completion of construction or renovation;

25 (4) an approved sanitation report or a copy of the permit to begin operation from the sanitation division
26 of the county health department to be submitted upon completion of construction or renovation;

27 (5) a nonrefundable license fee as required by G.S. ~~131D-2(b)(1);~~ G.S. 131D-2.5; and

28 (6) a certificate of occupancy or certification of compliance from the local building official to be
29 submitted upon completion of construction or renovation.

30 Note: Rule .0207 of this Section applies to obtaining a license to operate a currently licensed facility.

31 (c) ~~A pre-licensing survey shall be made by program consultants of the Division of Health Service Regulation and an~~
32 ~~adult home specialist of the county department of social services.~~ Issuance of an adult care home license shall be
33 based on the following:

34 (1) successful completion and approval of Subparagraphs (b)(1) through (b)(6) of this Rule;

35 (2) the Division of Health Service Regulation's Construction Section's recommendation of licensure
36 based on compliance with rules in Section .0300 of this Subchapter;

1 (3) a compliance history review of the facility and its principals and affiliates according to G.S. 131D-
2 2.4;
3 (4) approval by the Adult Care Licensure Section of the facility's operational policies and procedures
4 based on compliance with the rules of this Subchapter; and
5 (5) the facility's demonstration of compliance with Adult Care Home statutes and rules of this
6 Subchapter as determined by a pre-licensing survey of the facility by the Adult Care Licensure
7 Section.
8 (d) ~~The Division of Health Service Regulation shall provide to the applicant written notification of the decision to~~
9 ~~license or not to license the adult care home.~~ The Adult Care Licensure Section shall notify in writing the applicant
10 licensee and the county department of social services of the decision to license or not to license the adult care home
11 based on compliance with adult care home statutes and the rules of this Subchapter within 14 days from the decision
12 to license or not to license the facility.
13
14 *History Note:* *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
15 *Readopted Eff. October 31, 1977;*
16 *Amended Eff. April 1, 1984;*
17 *Temporary Amendment Eff. September 1, 2003;*
18 *Amended Eff. June 1, 2004;*
19 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6,*
20 *~~2018.~~ 2018;*
21 *Amended Eff. April 1, 2020.*

10A NCAC 13F .0208 is amended as published in 34:06 NCR 481-485 as follows:

10A NCAC 13F .0208 RENEWAL OF LICENSE

(a) The ~~license shall be renewed annually,~~ licensee shall file a license renewal application annually on a calendar year basis ~~except as otherwise provided in Rule .0209 of this Subchapter, if the licensee submits an application for renewal~~ on the forms provided by the Department at no cost with a nonrefundable annual license fee according to ~~G.S. 131D-2(b)(1) and the Department determines that the licensee complies with the provisions of all applicable State adult care home licensure statutes and rules. When violations of licensure rules or statutes are documented and have not been corrected prior to expiration of license, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or revoke the license.~~ G.S. 131D-2.5. The renewal application form includes the following:

(1) contact person, facility site and mailing address, and administrator;
(2) operation disclosure including names and contact information of the licensee, management company, and building owner;
(3) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members holding an ownership or controlling interest of five percent or more of the applicant entity;
(4) bed capacity including that of any special care unit for Alzheimer's and Related Disorders; and
(5) population and census data.

~~(b) All applications for license renewal shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.~~

(b) In determining whether to renew a license under G.S. 131D-2.4, the Department shall take into consideration at least the following:

(1) the compliance history of the applicant facility with the provisions of all State adult care home licensure statutes and rules of this Subchapter;
(2) the compliance history of the owners, principals, and affiliates of the applicant facility in operating other adult care homes in the State;
(3) the extent to which the conduct of a related facility, its owners, principals, and affiliates is likely to affect the quality of care at the applicant facility; and
(4) the hardship on residents of the applicant facility if the license is not renewed.

(c) When violations of licensure rules or statutes are documented by the Department and have not been corrected by the facility prior to license expiration, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or deny the license.

History Note: *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;

1 *Temporary Amendment Eff. December 1, 1999;*
2 *Amended Eff. July 1, 2000;*
3 *Temporary Amendment Eff. July 1, 2003;*
4 *Amended Eff. June 1, 2004;*
5 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6,*
6 *~~2018.~~ 2018;*
7 *Amended Eff. April 1, 2020.*

1 10A NCAC 13F .0209 is repealed as published in 34:06 NCR 481-485 as follows:

2

3 **10A NCAC 13F .0209 CONDITIONS FOR LICENSE RENEWAL**

4

5 *History Note:* *Authority G.S. 131D-2.4; 131D-2.16; 143B-165;*

6 *Temporary Adoption Eff. December 1, 1999;*

7 *Eff. July 1, 2000;*

8 *Temporary Amendment Eff. July 1, 2003;*

9 *Amended Eff. June 1, 2004;*

10 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6,*

11 *~~2018.~~ 2018;*

12 *Repealed Eff. April 1, 2020.*

10A NCAC 13F .0212 is amended as published in 34:06 NCR 481-485 as follows:

10A NCAC 13F .0212 DENIAL OR REVOCATION OF LICENSE

(a) A license may be denied by the Division of Health Service Regulation for failure to comply with the rules of this Subchapter.

(b) Denial of a license by the Division of Health Service Regulation shall be effected by mailing to the ~~applicant,~~ applicant licensee, by registered mail, a notice setting forth the particular reasons for such action.

(c) A license may be revoked by the Division of Health Service Regulation in accordance with ~~G.S. 131D-2(b)~~ G.S. 131D-2.7(b) and G.S. 131D-29.

(d) When a facility receives a notice of revocation, the administrator shall inform each resident and the resident's responsible person in writing of the notice and the basis on which it was ~~issued.~~ issued within five calendar days of the notice of revocation being received by the licensee of the facility.

History Note: *Authority G.S. 131D-2.7; 131D-2.16; 131D-4.3; 131D-29; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. April 1, 2020.

10A NCAC 13G .0202 is readopted as published in 34:06 NCR 481-485 as follows:

10A NCAC 13G .0202 THE LICENSE

(a) Except as otherwise provided in ~~Rule .0203 of this Subchapter,~~ G.S. 131D-2.4, the Department of Health and Human Services shall issue a family care home license to any person who submits ~~an application on the forms provided by the Department with a non-refundable license fee as required by G.S. 131D-2(b)(1)~~ the application material according to Rule .0204 of this Section and the Department determines that the applicant complies with the provisions of all ~~applicable~~ State ~~family care~~ adult care home licensure statutes and ~~rules.~~ rules of this Subchapter. All applications for a new license shall disclose the names of individuals who are co-owners, partners, or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.

(b) The license shall be conspicuously posted in a public place in the home.

~~(c) The license shall be in effect for 12 months from the date of issuance unless revoked for cause, voluntarily or involuntarily terminated, or changed to provisional licensure status.~~

~~(d) A provisional license may be issued in accordance with G.S. 131D-2(b).~~

~~(e)~~(c) When a provisional license is ~~issued,~~ issued according to G.S. 131D-2.7, the administrator shall post the provisional license and a copy of the notice from the Division of Health Service Regulation identifying the reasons for it, conspicuously in a public place in the home in place of the full license.

~~(f)~~(d) The license is not transferable or assignable.

~~(g)~~(e) A family care home shall be licensed only as a family care home and not for any other level of care or licensable entity or service. The license shall be terminated when the home is licensed to provide a higher level of care or a combination of a higher level of care and family care home level of care.

History Note: *Authority G.S. 131D-2.4; 131D-2.7; 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. April 1. 2020.

10A NCAC 13G .0204 is readopted as published in 34:06 NCR 481-485 as follows:

10A NCAC 13G .0204 APPLYING FOR A LICENSE TO OPERATE A HOME NOT CURRENTLY LICENSED

(a) An application for a license to operate a family care home for adults in an existing building where no alterations are necessary as determined by the Construction Section of the Division of Health Service Regulation or a family care home ~~which~~ that is to be constructed, added ~~to~~ to, or renovated shall be made at the county department of social ~~services.~~ services in the county where the licensed family care home will be located.

~~(b) If during the study of the administrator and the home, it does not appear that the qualifications of the administrator or requirements for the home can be met, the county department of social services shall so inform the applicant, indicating in writing the reason and give the applicant an opportunity to withdraw the application. Upon the applicant's request, the application shall be completed and submitted to the Division of Health Service Regulation for consideration.~~

~~(c)~~(b) The applicant shall submit the following ~~forms and reports through~~ material to the county department of social services for submission to the Division of Health Service ~~Regulation:~~ Regulation within ten business days of receipt by the county department of social services:

(1) the Initial Licensure ~~Application;~~ Application that is available online at https://info.ncdhhs.gov/dhsr/acls/pdf/acchgapp.pdf at no cost and includes the following:
  (A) contact person, facility site and mailing addresses, and administrator;
  (B) operation disclosure including names and contact information of licensee, management company, and building owner;
  (C) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members; and
  (D) bed capacity;

(2) an approval letter from the local zoning jurisdiction for the proposed location;

(3) a photograph of each side of the existing structure and at least one of each of the interior spaces if an existing structure;

(4) a set of blueprints or a floor plan of each level indicating the following:
  (A) the layout of all ~~rooms,~~ rooms;
  (B) the room dimensions (including ~~closets),~~ closets);
  (C) the door widths (exterior, bedroom, ~~bathroom~~ bathroom, and kitchen ~~doors),~~ doors);
  (D) the window sizes and window sill ~~heights,~~ heights;
  (E) the type of ~~construction,~~ construction;
  (F) the use of the basement and ~~attic,~~ attic; and
  (G) the proposed resident bedroom locations including the number of occupants and the bedroom and number (including the ages) of any non-resident who will be residing within the home;

(5) a cover letter ~~or transmittal form~~ prepared by the adult home specialist of the county department of social services ~~identifying~~ stating the following:

(A) the prospective home site ~~address,~~ address;

(B) the name of the contact person (including address, telephone numbers, ~~fax numbers),~~ email address); and

(C) the name and address of the applicant (if different from the contact ~~person) and the total number and the expected evacuation capability of the residents;~~ person); and

(6) ~~a construction review fee according to G.S. 131E-267.~~ a non-refundable license fee as required by G.S. 131D-2.5.

~~(d) The Construction Section of the Division of Health Service Regulation shall review the information and notify the applicant and the county department of social services of any required changes that must be made to the building to meet the rules in Section .0300 of this Subchapter along with the North Carolina State Building Code. At the end of the letter there shall be a list of final documentation required from the local jurisdiction that must be submitted upon completion of any required changes to the building or completion of construction.~~

~~(e) Any changes to be made during construction that were not proposed during the initial review shall require the approval of the Construction Section to assure that licensing requirements are maintained.~~

~~(f) Upon receipt of the required final documentation from the local jurisdiction, the Construction Section shall review the information and may either make an on-site visit or approve the home for construction by documentation. If all items are met, the Construction Section shall notify the Adult Care Licensure Section of the Division of Health Service Regulation of its recommendation for licensure.~~

~~(g) Following review of the application, references, all forms and the Construction Section's recommendation for licensure, a pre-licensing visit shall be made by a consultant of the Adult Care Licensure Section. The consultant shall report findings to the Division of Health Service Regulation which shall notify, in writing, the applicant and the county department of social services of the decision to license or not to license the family care home.~~

(c) Issuance of a family care home license shall be based on the following:

(1) successful completion and approval of Subparagraphs (b)(1) through (b)(6) of this Rule;

(2) the Division of Health Service Regulation's Construction Section's recommendation of licensure based on compliance with rules in Section .0300 of this Subchapter;

(3) a compliance history review of the facility and its principals and affiliates according to G.S. 131D-2.4;

(4) approval by the Adult Care Licensure Section of the facility's operational policies and procedures based on compliance with the rules of this Subchapter; and

(5) the facility's demonstration of compliance with Adult Care Home statutes and rules of this Subchapter as determined by a pre-licensing survey of the facility by the Adult Care Licensure Section.

(d) The Adult Care Licensure Section shall notify in writing the applicant licensee and the county department of social services of the decision to license or not to license the adult care home based on compliance with adult care home statutes and the rules of this Subchapter within 14 days from the decision to license or not to license the facility.

History Note: *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
ARRC Objection Lodged November 14, 1990;
Amended Eff. May 1, 1991;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; July 1, ~~2004.~~ 2004;
Readopted Eff. April 1, 2020.

10A NCAC 13G .0208 is readopted as published in 34:06 NCR 481-485 as follows:

10A NCAC 13G .0208 RENEWAL OF LICENSE

(a) The ~~license shall be renewed annually,~~ licensee shall file a license renewal application annually on a calendar year basis ~~except as otherwise provided in Rule .0209 of this Subchapter, if the licensee submits an application for renewal~~ on the forms provided by the Department at no cost ~~and the Department determines that the licensee complies with the provisions of all applicable State adult care home licensure statutes and rules. When violations of licensure rules or statutes are documented and have not been corrected prior to expiration of license, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or revoke the license for cause.~~ with a nonrefundable annual license fee according to G.S. 131D-2.5. The renewal application includes the following:

(1) contact person, facility site and mailing address, and administrator;

(2) operation disclosure including names and contact information of the licensee, management company, and building owner;

(3) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members holding an ownership or controlling interest of five percent or more of the applicant entity;

(4) bed capacity; and

(5) population and census data.

~~(b) All applications for license renewal shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity.~~

(b) In determining whether to renew a license under G.S. 131D-2.4, the Department shall take into consideration at least the following:

(1) the compliance history of the applicant facility with the provisions of all State adult care home licensure statutes and rules of this Subchapter;

(2) the compliance history of the owners. principals and affiliates of the applicant facility in operating other adult care homes in the State;

(3) the extent to which the conduct of a related facility, its owners, principals, and affiliates is likely to affect the quality of care at the applicant facility; and

(4) the hardship on residents of the applicant facility if the license is not renewed.

(c) When violations of licensure rules or statutes are documented by the Department and have not been corrected by the facility prior to license expiration, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or deny the license.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1992; July 1, 1990; April 1, 1987; April 1, 1984;

1 *Temporary Amendment Eff. December 1, 1999;*

2 *Amended Eff. July 1, ~~2000.~~ 2000;*

3 *Readoption Eff. April 1, 2020.*

1 10A NCAC 13G .0209 is repealed through readoption as published in 34:06 NCR 481-485 as follows:
2
3 **10A NCAC 13G .0209 CONDITIONS FOR LICENSE RENEWAL**
4
5 *History Note:* *Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;*
6 *Temporary Adoption Eff. December 1, 1999;*
7 *Eff. July 1, ~~2000.~~ 2000;*
8 *Repealed Eff. April 1, 2020.*

1 10A NCAC 13G .0212 is readopted as published in 34:06 NCR 481-485 as follows:

2

3 **10A NCAC 13G .0212 DENIAL AND REVOCATION OF LICENSE**

4 (a) A license may be denied by the Division of Health Service Regulation for failure to comply with the rules of this
5 Subchapter.

6 (b) Denial of a license by the Division of Health Service Regulation shall be effected by mailing to the ~~applicant,~~
7 applicant licensee, by registered mail, a notice setting forth the particular reasons for such action.

8 (c) A license may be revoked by the Division of Health Service Regulation in accordance with ~~G.S. 131D-2(b)~~ G.S.
9 131D-2.7(b) and G.S. 131D-29.

10 (d) When a facility receives a notice of revocation, the administrator shall inform each resident and ~~his~~ the resident's
11 responsible person in writing of the notice and the basis on which it was ~~issued.~~ issued within five calendar days of
12 the notice of revocation being received by the licensee of the facility.

13

14 *History Note: Authority G.S. 131D-2.7; 131D-2.16; 131D-4.3; 131D-29; 143B-165;*
15 *Eff. January 1, 1977;*
16 *Readopted Eff. October 31, 1977;*
17 *Amended Eff. April 1, 1984; May 1, 1981;*
18 *Temporary Amendment Eff. January 1, 1998;*
19 *Amended Eff. April 1, ~~1999.~~ 1999;*
20 *Readopted Eff. April 1, 2020.*

1 10A NCAC 13G .0213 is repealed through readoption as published in 34:06 NCR 481-485 as follows:
2
3 **10A NCAC 13G .0213 APPEAL OF LICENSURE ACTION**
4
5 *History Note: Authority 131D-2.4; 131D-2.16; 143B-165; 150B-23;*
6 *Eff. January 1, 1977;*
7 *Readopted Eff. October 31, 1977;*
8 *Amended Eff. July 1, 1990; April 1, ~~1984.~~ 1984;*
9 *Repealed Eff. April 1, 2020.*

Exhibit C/3
Fiscal Note

DHSR Adult Care Licensure Section

Fiscal Impact Analysis

Permanent Rule Adoptions without Substantial Economic Impact

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, MCC/DHSR Rulemaking Coordinator, 919-855-3811

Megan Lamphere, Chief, Adult Care Licensure Section, 919-855-3784

Doug Barrick, Policy Coordinator, Adult Care Licensure Section, 919 - 855-3778

Impact:

Federal Government Impact:	No
State Government Impact:	Yes
Local Government Impact:	Yes
Private Entities	Yes
Substantial Economic Impact:	No

Titles of Rule Changes and N.C. Administrative Code citations

Rule Repeal:

10A NCAC 13F.0209 Conditions for License Renewal

10A NCAC 13G .0209 Conditions for License Renewal

10A NCAC 13G .0213 Appeal of Licensure Action

Rule Readoptions (*See proposed text of these rules in Appendix A):*

10A NCAC 13G .0202 The License

10A NCAC 13G .0204 Applying for a License to Operate a Home Not Currently Licensed

10A NCAC 13G .0208 Renewal of License

10A NCAC 13G .02012 Denial and Revocation of License

Rule Amendments *(See proposed text of these rules in Appendix B)*

10A NCAC 13F .0202 The License

10A NCAC 13F .0204 Applying for a License to Operate a Facility Not Currently Licensed

10A NCAC 13F .0208 Renewal of License

10A NCAC 13F .0212 Denial or Revocation of License

Authorizing Statutes: G.S. 131D-2.1; 131D- 2.4; 131D-2.5; 131D-2.7; 131D-4.3; 131D-4.5; 131D-2.16; 131D-29; 143B-165

Introduction and Background

Under the authority of G.S. 150B-21.3A, Periodic review and expiration of existing rules, the North Carolina Medical Care Commission and Rule Review Commission approved the Subchapter reports with classifications for the rules under 10A NCAC 13F Licensing of Adult Care Homes of Seven or More Beds and 10A NCAC 13G Licensing of Family Care Homes. The rules were classified in the reports as necessary with substantive public interest. Rules 10A NCAC 13G .0202, .0204, .0208 and .0212 are being presented for readoption with substantive changes. The following rules were not identified for readoption with substantive changes based on public comment but are being proposed for amendment to correlate with the 13G rules of same title and similar content being proposed for readoption: 10A NCAC 13F .0202, 13F .0204, 13F .0208 and 13F .0212. Most of the rules for both types of assisted living residences, adult care homes of seven beds or more and family care homes, are the same with the primary exception of staffing and physical plant requirements since they serve the same population based on need for care and services. Therefore, the 13F rules corresponding to the 13G rules being proposed for readoption with changes are being amended concurrently to assure this traditional consistency. Rules 10A NCAC 13F .0209, 13G .0209 and 13G .0213 are being readopted as repeals and will not be discussed in this analysis.

Rule Summary and Anticipated Fiscal Impact

10A NCAC 13G .0202/10A NCAC 13F .0202 The License: These rules address the issuance of licenses for family care homes and adult care homes of seven beds or more based on application and disclosure of specific information, the posting of the license and a provisional license if issued, and the nature of the license.

1. In Paragraph (a), the reference to Subchapter Rule .0203 is proposed for deletion since that rule is being repealed and reference is being made to the law regarding the issuance of a license and to Subchapter Rule .0204 that addresses the license application process.

Fiscal Impact: None

2. In proposed Paragraph (c), the requirement of posting a provisional license conspicuously in the facility is an addition to this rule.

Rationale: The addition is necessary to complement the posting requirement in Paragraph (b) of this Rule. Since the provisional license becomes the facility's current license until its expiration, the disclosure of the current status of the license should be made well-visible to residents and the public to the same extent as a standard license. The law addressing provisional licenses is cited here for reference purposes.

Fiscal Impact: This proposed change to posting "conspicuously" carries no determinable or quantifiable fiscal impact from current rule. Current rule already requires posting and the change simply assures posting in a clearly visible location to the public eye.

3. Proposed Paragraph (e) contains the statement indicating that the facility will be issued and hold only one license from the Division of Health Services Regulation (DHSR), being a family care home license or an adult care home license, and not hold any other license from a licensing entity.

Rationale: This has been the case in DHSR policy for at least 30 years with no other rules or law allowing for more than one license. There is no record of double licensing being allowed but this change formalizes the long-held policy to assure that there is no sharing of licensing and regulatory authority that may impact care of residents and create confusion across lines of authority and services. If a family care home or adult care home desires to change their level of services, a new license must be applied for and would replace the current license.

Fiscal Impact: There is no fiscal impact to this proposed change in rule since historically there has never been multiple licenses allowed for family care homes.

4. This section only applies to 10A NCAC 13G .0202. Current Paragraphs (c) and (d) are proposed for deletion because G.S. 131D-2.4 and G.S. 131D-2.7 address how long the license is in effect and the issuance of a provisional license, and so the citation for these is no longer correct.

Rationale: The reorganization of G.S. 131D-2 in 2009 requires new law references in rules being readopted that contain such references.

Fiscal Impact: There is no fiscal impact to the correct identification of the law based on its reorganization.

Notification of Applicant Licensee and County Department of Social Services

Proposed paragraph (d) of 10A NCAC 13G .0204 and proposed paragraph (d) of 10A NCAC 13F .0204 both require written notification of DHSR's decision regarding the licensing of the facility within 14 days of the licensing decision to the applicant licensee and the county department of social services in which the facility is located. The proposed addition to Paragraph (c) of 10A NCAC 13G .0204 is a listing of what is required for a facility to be licensed.

Rationale: These proposed requirements have been established DHSR policy and procedure for at least ten years and, therefore, the standard of licensure practice that has been consistently followed over that period. The incorporation into rule assures DHSR the authority to deny a

license if conditions are not met, objectivity in that decision-making process by DHSR, and clarity to applicant licensees on the process and consistency in its application. The 14-day written notification period is in line with both past and current practice. By adding the 14-day period to the rule, DHSR is providing the applicant awareness of an expected timeframe for DHSR's decision to license or not to license the facility. It has typically and traditionally been provided well within a 14-day time period.

Fiscal Impact: The incorporation of long-established licensure practice into rule does not involve additional cost for affected parties since it has been the accepted standard of licensure practice for many years and forms the baseline. Email is and has been an acceptable form of written notification.

10A NCAC 13G .0204: This section discusses the rule impacts regarding the license application process for family care homes not currently licensed by specifying how and what information needs to be submitted to the Adult Care Licensure Section (ACLS) and the basis on which the Section can issue a license.

1. Paragraph (a) contains strictly clarifying information with no fiscal impact. Current Paragraph (b) is proposed for deletion because it is outdated by not reflecting current practice.

Rationale: While the county departments of social services still collect the information to forward to ACLS, they do not make any determination about applicant administrators since they are pre-approved by ACLS and county staff should not be in the position of determining if the requirements of the home can be met. That is determined by the Construction Section in its review of physical plant and ACLS in its review of policies and procedures as has been customary for many years per licensure rules regarding construction and facility policies and procedures. The shift in policies and procedures for review of all licensure application through the counties occurred over ten years ago

Fiscal Impact: There is positive fiscal impact due to cost savings by the county department of social services not reviewing/studying license application material to either return to applicant or submit to DHSR. However, those savings are indeterminable because of the inability to project the number of family care home applications that will be received in the future each year by the 97 county departments of social. This number varies considerably by county and any data related to the time required on such a process has not been followed for over ten years. Currently there are 633 licensed family care homes across the state. There is also no data on any applications returned to applicants instead of forwarding to DHSR for review and processing. Neither is there any data on any possible non-recommended applications by the county that the applicant may have requested to be forwarded to DHSR in spite of a lack of recommendation by the county. There would be no additional cost to the State in DHSR staff time since it has always been the responsibility of DHSR to review and process all licensure applications it receives. There may have been some minimal cost savings to the State in not having to review any applications that were not forwarded from counties, but again, these savings cannot be determined due to the lack of any data from so many years ago.

2. Paragraph (b) adds the requirement of submission of application material by the county departments of social services to DHSR within a 10-business-day time period and specifies information to be provided by the applicant on the application.

Rationale: While most applications are submitted within that time frame, this specified time frame will help assure timely submittal by all counties so that the licensing process is not delayed which happens occasionally and results in inquiries by applicants of the county and DHSR and by the Division of Social Services in the counties. Failure to submit applications within a specified time frame may negatively impact the annual evaluation of the county department of social services because the Division has oversight of the county's work in the area of adult and family care home regulation under the direction and leadership of DHSR. Part 1 of this paragraph lists what information the license application requires which is what has been on the application currently being used. Part (4) lists what has been in narrative format to make it easier and clearer to follow. The same holds true for Part (5) plus deletion of phrase in Subpart (c) regarding number of residents and evacuation capability which has to be evaluated and approved by the Construction Section of DHSR. Part (6) references the license fee required by law and deletes references to the Construction review fee which is being proposed for inclusion in Section .0300 of this Subchapter which contains the physical plant rules being readopted.

Fiscal Impact: The organizational changes in content have no fiscal impact. The 10-day period for submission of license application by the county to the Division is within the normal time range of submission. Failure to meet that would not result in any fiscal impact since the county is not fined for singular failures such as this. Any negative impact would be in the Division's periodic evaluation of the county's work.

3. Paragraphs (d), (e), and (f) addressing responsibilities of DHSR's Construction are proposed for deletion.

Rationale: The physical plant rules in Section .0300 of this Subchapter will be readopted to incorporate the requirements in Paragraphs (d), (e) and (f) with possible revisions by the Construction Section which is responsible for building plan reviews.

10A NCAC 13F .0204: This rule directs the license application process for adult care homes of seven or more beds not currently licensed by specifying how and what information needs to be submitted to the Adult Care Licensure Section (ACLS) and the basis on which the Section can issue a license.

1. Paragraph (b)(1) lists what information the license application requires. This information has been on the application currently being used but is now being proposed for disclosure in rule for the purposes of transparency and clarity. Contact information is also updated. Part (2) references the fee requirement in law and the responsibility of the Construction Section to calculate and invoice the fee, which has been and is currently Division policy.

Rationale: Updating of information is required and the inclusion of operational policy in current and traditional practice for several years and as referenced in law is added to assure conformity with current and traditional policy implementation and practice.

Fiscal Note: Since these requirements uphold past and current policy with no change in implementation, there is no additional cost to implementation of the requirements and general statute.

10A NCAC 13G .0208/10A NCAC 13F .0208: This rule addresses when and how a home's license is to be renewed, including information about the licensee and home to be considered for renewal. Rules 13G .0208 and .0209 are proposed for consolidation since contents of both are about license renewal and having just one rule for renewal streamlines the regulatory requirements in a cohesive, logical and non-repetitive manner. Rules 13F .0208 and .0209 are also proposed for consolidation for the same reasons as Rules 13G .0208 and .0209. Therefore, Rule 13G .0208 and Rule 13F .0208 are proposed for readoption to incorporate the requirements of Rule 13G .0209 and Rule 13F .0209, respectively, which are both being proposed for repeal as to being unnecessary with readoption of 13G .0208 and 13F .0208.

1. Paragraph (a) has deletion of reference to Rule .0209 which is proposed for repeal due to its proposed consolidation into this Rule, .0208. Forms have always been provided at no cost but it is stated directly so for readoption. The other deletions in this paragraph are a result of the requirements being moved to Paragraphs (b) and (c) of this Rule for reorganization purposes to be inclusive of requirements in repealed Rule .0209 and for greater clarity. The non-refundable license fee has been mandated by G.S. 131D-2.5 for many years. The contents of the renewal application are listed for greater clarity and disclosure purposes.

Rationale: The changes are proposed for clarity and organizational purposes to allow for the incorporation of repealed Rule .0209 for consolidation of two rules addressing license renewal. The content of both rules lends itself to this reorganization and consolidation.

Fiscal Impact: No costs are associated with these changes.

2. Paragraph (b) of current rule is proposed for deletion to have its contents included in the proposed Paragraph (b), which incorporates the requirements in Rule .0208 and .0209 that are currently proposed for repeal.

Rationale: The changes are a result of incorporating requirements from current Rule .0208 and Rule .0209 that are proposed for repeal for consolidation purposes. The requirement of (b) as proposed for deletion is proposed as (a)(3) of this rule for organizational purposes.

Fiscal Note: Changes are reorganizational to allow for incorporation of repealed Rule .0209 and have no fiscal impact.

3. Paragraph (c) is a repeat of requirement being deleted in Paragraph (a).

Rationale: This change reorganizes the language in the previous rule and provides for clarity as Rules .0208 and .0209 are consolidated.

Fiscal Impact: None

10A NCAC 13G .0212/10A NCAC 13F .1212: These rules address the regulatory action of DHSR in denying and revoking facility licenses.

Paragraphs (b) and (c) contain technical changes for clarity and an updated statutory reference with no fiscal impact.

Paragraph (d) is proposed to require a facility's written notification of resident and responsible person of the notice of revocation of the facility's license. The notification is to be within five calendar days of facility's receipt of the revocation notice.

Rationale: Residents and their responsible persons should be clearly made aware of the revocation of the license of the facility, the residents' home, within a reasonable amount of time so that plans can be made accordingly for relocation. Furthermore, notification in writing provides its own documentation for regulatory compliance purposes as opposed to just verbal communication.

Fiscal Note: Notification is already required in current rule, just not in written form. Since verbal notification itself needs documentation to assure compliance with the rule, the fiscal impact on the facility of written notification is negligible.

Conclusion:

The proposed rule readoptions and amendments in this report are intended to update rules to bring them into line with current licensure processes and procedures, update statutory references, clarify wording and unify family care home and adult care home rules as much as possible for efficient and effective regulation since both types of assisted living facilities are licensed and intended by law to serve residents with similar needs for care and services. This ensures consistency of regulation of facility types determined by capacity in regard to issuing and renewing facility licenses. The proposed changes also include notification timeframes of residents by facilities and of the county departments and applicant licensees by DHSR thereby formalizing DHSR's traditional standards of practice and assuring full transparency and disclosure.

These rule readoptions and amendments concur with licensing and license renewal practices of the past 10 years resulting from law and policy changes impacting process and procedures of the Adult Care Licensure Section of the Division of Health Service Regulation. The changes provide clear guidance and expectations based on current licensure practice to adult care home and family care home licensees to ensure a more streamlined and efficient licensure process. Fiscal impact is minimal in most cases and indeterminable in another where historical and current data is not available or inaccessible.

10A NCAC 13G .0202 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0202 THE LICENSE

(a) Except as otherwise provided in ~~Rule .0203 of this Subchapter,~~ G.S. 131D-2.4, the Department of Health and Human Services shall issue a family care home license to any person who submits ~~an application on the forms provided by the Department with a non-refundable license fee as required by G.S. 131D-2(b)(1)~~ the application material according to Rule .0204 of this Section and the Department determines that the applicant complies with the provisions of all ~~applicable~~ State ~~family care~~ adult care home licensure statutes and ~~rules.~~ rules of this Subchapter. All applications for a new license shall disclose the names of individuals who are co-owners, partners, or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.

(b) The license shall be conspicuously posted in a public place in the home.

~~(c) The license shall be in effect for 12 months from the date of issuance unless revoked for cause, voluntarily or involuntarily terminated, or changed to provisional licensure status.~~

~~(d) A provisional license may be issued in accordance with G.S. 131D-2(b).~~

~~(e)~~(c) When a provisional license is ~~issued,~~ issued according to G.S. 131D-2.7, the administrator shall post the provisional license and a copy of the notice from the Division of Health Service Regulation identifying the reasons for it, conspicuously in a public place in the home in place of the full license.

~~(f)~~(d) The license is not transferable or assignable.

~~(g)~~(e) A family care home shall be licensed only as a family care home and not for any other level of care or licensable entity or service. The license shall be terminated when the home is licensed to provide a higher level of care or a combination of a higher level of care and family care home level of care.

History Note: *Authority G.S. 131D-2.4; 131D-2.7; 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. April 1. 2020.

10A NCAC 13F .0202 is proposed for amendment as follows:

10A NCAC 13F .0202 THE LICENSE

(a) Except as otherwise provided in ~~Rule .0203 of this Section,~~ G.S. 131D-2.4, the Department shall issue an adult care home license to any person who submits the application material according to Rule .0204 of this Section and the Department determines that the applicant complies with the provisions of all ~~applicable~~ State adult care home licensure statutes and ~~rules.~~ rules of this Subchapter. All applications for a new license shall disclose the names of individuals who are co-owners, partners, or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.

(b) The license shall be conspicuously posted in a public place in the home.

(c) When a provisional license is ~~issued,~~ issued according to G.S. 131D-2.7, the administrator shall post the provisional license and a copy of the notice from the Division of Health Service Regulation identifying the reasons for it, conspicuously in a public place in the home and in place of the full license.

(d) The license is not transferable or assignable.

(e) An adult care home shall be licensed only as an adult care home and not for any other level of care or licensable entity or service. The license shall be terminated when the home is licensed to provide a higher level of care or a combination of a higher level of care and adult care home level of care.

History Note: Authority G.S. 131D-2.4; 131D-2.7; 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. April 1, 2020.

Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; July 1, ~~2004.~~ 2004;
Readopted Eff. April 1, 2020.

10A NCAC 13G .0204 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0204 APPLYING FOR A LICENSE TO OPERATE A HOME NOT CURRENTLY LICENSED

(a) An application for a license to operate a family care home for adults in an existing building where no alterations are necessary as determined by the Construction Section of the Division of Health Service Regulation or a family care home ~~which~~ that is to be constructed, added ~~to~~ to, or renovated shall be made at the county department of social ~~services.~~ in the county where the licensed family care home will be located.

~~(b) If during the study of the administrator and the home, it does not appear that the qualifications of the administrator or requirements for the home can be met, the county department of social services shall so inform the applicant, indicating in writing the reason and give the applicant an opportunity to withdraw the application. Upon the applicant's request, the application shall be completed and submitted to the Division of Health Service Regulation for consideration.~~

~~(c)~~(b) The applicant shall submit the following ~~forms and reports through~~ material to the county department of social services for submission to the Division of Health Service ~~Regulation:~~ Regulation within ten business days of receipt by the county department of social services:

(1) the Initial Licensure ~~Application;~~ Application that is available online at https://info.ncdhhs.gov/dhsr/acls/pdf/acchgapp.pdf at no cost and includes the following:

(A) contact person, facility site and mailing addresses, and administrator;

(B) operation disclosure including names and contact information of licensee, management company, and building owner;

(C) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members; and

(D) bed capacity;

(2) an approval letter from the local zoning jurisdiction for the proposed location;

(3) a photograph of each side of the existing structure and at least one of each of the interior spaces if an existing structure;

(4) a set of blueprints or a floor plan of each level indicating the following:

(A) the layout of all ~~rooms,~~ rooms;

(B) the room dimensions (including ~~closets),~~ closets);

(C) the door widths (exterior, bedroom, ~~bathroom~~ bathroom, and kitchen ~~doors),~~ doors);

(D) the window sizes and window sill ~~heights,~~ heights;

(E) the type of ~~construction,~~ construction;

(F) the use of the basement and ~~attic,~~ attic; and

(G) the proposed resident bedroom locations including the number of occupants and the bedroom and number (including the ages) of any non-resident who will be residing within the home;

(5) a cover letter ~~or transmittal form~~ prepared by the adult home specialist of the county department of social services ~~identifying~~ stating the following:

(A) the prospective home site ~~address,~~ address;

(B) the name of the contact person (including address, telephone numbers, ~~fax numbers),~~ email address); and

(C) the name and address of the applicant (if different from the contact ~~person) and the total number and the expected evacuation capability of the residents;~~ person); and

(6) ~~a construction review fee according to G.S. 131E-267.~~ a non-refundable license fee as required by G.S. 131D-2.5.

~~(d) The Construction Section of the Division of Health Service Regulation shall review the information and notify the applicant and the county department of social services of any required changes that must be made to the building to meet the rules in Section .0300 of this Subchapter along with the North Carolina State Building Code. At the end of the letter there shall be a list of final documentation required from the local jurisdiction that must be submitted upon completion of any required changes to the building or completion of construction.~~

~~(e) Any changes to be made during construction that were not proposed during the initial review shall require the approval of the Construction Section to assure that licensing requirements are maintained.~~

~~(f) Upon receipt of the required final documentation from the local jurisdiction, the Construction Section shall review the information and may either make an on-site visit or approve the home for construction by documentation. If all items are met, the Construction Section shall notify the Adult Care Licensure Section of the Division of Health Service Regulation of its recommendation for licensure.~~

~~(g) Following review of the application, references, all forms and the Construction Section's recommendation for licensure, a pre-licensing visit shall be made by a consultant of the Adult Care Licensure Section. The consultant shall report findings to the Division of Health Service Regulation which shall notify, in writing, the applicant and the county department of social services of the decision to license or not to license the family care home.~~

(c) Issuance of a family care home license shall be based on the following:

(1) successful completion and approval of Subparagraphs 1 through 6 of Paragraph (b) of this Rule;

(2) the Division of Health Service Regulation's Construction Section's recommendation of licensure based on compliance with rules in Section .0300 of this Subchapter;

(3) a compliance history review of the facility and its principals and affiliates according to G.S. 131D-2.4;

(4) approval by the Adult Care Licensure Section of the facility's operational policies and procedures based on compliance with the rules of this Subchapter; and

(5) the facility's demonstration of compliance with Adult Care Home statutes and rules of this Subchapter as determined by a pre-licensing survey of the facility by the Adult Care Licensure Section.

(d) The Adult Care Licensure Section shall notify in writing the applicant licensee and the county department of social services of the decision to license or not to license the adult care home based on compliance with adult care home statutes and the rules of this Subchapter within 14 days from the decision to license or not to license the facility.

History Note: *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
ARRC Objection Lodged November 14, 1990;
Amended Eff. May 1, 1991;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; July 1, ~~2004.~~ 2004;
Readopted Eff. April 1, 2020.

10A NCAC 13F .0204 is proposed for amendment as follows:

10A NCAC 13F .0204 APPLYING FOR A LICENSE TO OPERATE A FACILITY NOT CURRENTLY LICENSED

(a) Prior to submission of a license application, all Certificate of Need requirements shall be met according to G.S. 131E, Article 9.

(b) In applying for a license to operate an adult care home to be constructed or ~~renovated~~ renovated, or in an existing building that is not currently licensed, the applicant shall submit the following to the Division of Health Service Regulation:

(1) the Initial License Application ~~which~~ that is available ~~on the internet website,~~ online at ~~http://facility-services.state.nc.us/gcpage.htm~~ https://info.ncdhhs.gov/dhsr/acls/pdf/fcchgapp.pdf at no cost and includes the following: ~~or the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708;~~

(A) contact person, facility site and mailing addresses, and administrator;

(B) operation disclosure including names and contact information of the licensee, management company, and building owner;

(C) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members; and

(D) bed capacity including that of any special care unit for Alzheimer's and Related Disorders;

(2) plans and specifications as required in Section .0300 of this Subchapter and a construction review fee according to ~~G.S. 131E-267;~~ G.S. 131E-267 to be calculated and invoiced by the DHSR Construction Section;

(3) an approved fire and building safety inspection report from the local fire marshal to be submitted upon completion of construction or renovation;

(4) an approved sanitation report or a copy of the permit to begin operation from the sanitation division of the county health department to be submitted upon completion of construction or renovation;

(5) a nonrefundable license fee as required by G.S. ~~131D-2(b)(1);~~ G.S. 131D-2.5; and

(6) a certificate of occupancy or certification of compliance from the local building official to be submitted upon completion of construction or renovation.

Note: Rule .0207 of this Section applies to obtaining a license to operate a currently licensed facility.

(c) ~~A pre-licensing survey shall be made by program consultants of the Division of Health Service Regulation and an adult home specialist of the county department of social services.~~ Issuance of an adult care home license shall be based on the following:

(1) successful completion and approval of Subparagraphs 1 through 6 of Paragraph (b) of this Rule;

(2) the Division of Health Service Regulation's Construction Section's recommendation of licensure based on compliance with rules in Section .0300 of this Subchapter;

(3) a compliance history review of the facility and its principals and affiliates according to G.S. 131D-2.4;

(4) approval by the Adult Care Licensure Section of the facility's operational policies and procedures based on compliance with the rules of this Subchapter; and

(5) the facility's demonstration of compliance with Adult Care Home statutes and rules of this Subchapter as determined by a pre-licensing survey of the facility by the Adult Care Licensure Section.

(d) ~~The Division of Health Service Regulation shall provide to the applicant written notification of the decision to license or not to license the adult care home.~~ The Adult Care Licensure Section shall notify in writing the applicant licensee and the county department of social services of the decision to license or not to license the adult care home based on compliance with adult care home statutes and the rules of this Subchapter within 14 days from the decision to license or not to license the facility.

History Note: *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~*2018.*~~ *2018;*

Amended Eff. April 1, 2020.

10A NCAC 13G .0208 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0208 RENEWAL OF LICENSE

(a) The ~~license shall be renewed annually,~~ licensee shall file a license renewal application annually on a calendar year basis ~~except as otherwise provided in Rule .0209 of this Subchapter, if the licensee submits an application for renewal~~ on the forms provided by the Department at no cost ~~and the Department determines that the licensee complies with the provisions of all applicable State adult care home licensure statutes and rules. When violations of licensure rules or statutes are documented and have not been corrected prior to expiration of license, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or revoke the license for cause.~~ with a nonrefundable annual license fee according to G.S. 131D-2.5. The renewal application includes the following:

(1) contact person, facility site and mailing address, and administrator;

(2) operation disclosure including names and contact information of the licensee, management company, and building owner;

(3) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members holding an ownership or controlling interest of five percent or more of the applicant entity;

(4) bed capacity; and

(5) population and census data.

~~(b) All applications for license renewal shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity.~~

(b) In determining whether to renew a license under G.S. 131D-2.4, the Department shall take into consideration at least the following:

(1) the compliance history of the applicant facility with the provisions of all State adult care home licensure statutes and rules of this Subchapter;

(2) the compliance history of the owners. principals and affiliates of the applicant facility in operating other adult care homes in the State;

(3) the extent to which the conduct of a related facility, its owners, principals, and affiliates is likely to affect the quality of care at the applicant facility; and

(4) the hardship on residents of the applicant facility if the license is not renewed.

(c) When violations of licensure rules or statutes are documented by the Department and have not been corrected by the facility prior to license expiration, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or deny the license.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;

Eff. January 1, 1977;

Readopted Eff. October 31, 1977;

Amended Eff. December 1, 1992; July 1, 1990; April 1, 1987; April 1, 1984;

Temporary Amendment Eff. December 1, 1999;

Amended Eff. July 1, ~~2000.~~ 2000;

Readoption Eff. April 1, 2020.

10A NCAC 13F .0208 is proposed for amendment as follows:

10A NCAC 13F .0208 RENEWAL OF LICENSE

(a) The ~~license shall be renewed annually,~~ licensee shall file a license renewal application annually on a calendar year basis ~~except as otherwise provided in Rule .0209 of this Subchapter, if the licensee submits an application for renewal~~ on the forms provided by the Department at no cost with a nonrefundable annual license fee according to ~~G.S. 131D-2(b)(1) and the Department determines that the licensee complies with the provisions of all applicable State adult care home licensure statutes and rules. When violations of licensure rules or statutes are documented and have not been corrected prior to expiration of license, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or revoke the license.~~ G.S. 131D-2.5. The renewal application form includes the following:

(1) contact person, facility site and mailing address, and administrator;

(2) operation disclosure including names and contact information of the licensee, management company, and building owner;

(3) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members holding an ownership or controlling interest of five percent or more of the applicant entity;

(4) bed capacity including that of any special care unit for Alzheimer's and Related Disorders; and

(5) population and census data.

~~(b) All applications for license renewal shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.~~

(b) In determining whether to renew a license under G.S. 131D-2.4, the Department shall take into consideration at least the following:

(1) the compliance history of the applicant facility with the provisions of all State adult care home licensure statutes and rules of this Subchapter;

(2) the compliance history of the owners, principals, and affiliates of the applicant facility in operating other adult care homes in the State;

(3) the extent to which the conduct of a related facility, its owners, principals, and affiliates is likely to affect the quality of care at the applicant facility; and

(4) the hardship on residents of the applicant facility if the license is not renewed.

(c) When violations of licensure rules or statutes are documented by the Department and have not been corrected by the facility prior to license expiration, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or deny the license.

History Note: *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. April1, 2020.

10A NCAC 13G .0212 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0212 DENIAL AND REVOCATION OF LICENSE

(a) A license may be denied by the Division of Health Service Regulation for failure to comply with the rules of this Subchapter.

(b) Denial of a license by the Division of Health Service Regulation shall be effected by mailing to the ~~applicant,~~ applicant licensee, by registered mail, a notice setting forth the particular reasons for such action.

(c) A license may be revoked by the Division of Health Service Regulation in accordance with ~~G.S. 131D-2(b)~~ G.S. 131D-2.7(b) and G.S. 131D-29.

(d) When a facility receives a notice of revocation, the administrator shall inform each resident and ~~his~~ the resident's responsible person in writing of the notice and the basis on which it was ~~issued.~~ issued within five calendar days of the notice of revocation being received by the licensee of the facility.

History Note: *Authority G.S. 131D-2.7; 131D-2.16; 131D-4.3; 131D-29; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984; May 1, 1981;

Temporary Amendment Eff. January 1, 1998;

Amended Eff. April 1, ~~1999.~~ 1999;

Readopted Eff. April 1, 2020.

10A NCAC 13F .0212 is proposed for amendment as follows:

10A NCAC 13F .0212 DENIAL OR REVOCATION OF LICENSE

(a) A license may be denied by the Division of Health Service Regulation for failure to comply with the rules of this Subchapter.

(b) Denial of a license by the Division of Health Service Regulation shall be effected by mailing to the ~~applicant,~~ applicant licensee, by registered mail, a notice setting forth the particular reasons for such action.

(c) A license may be revoked by the Division of Health Service Regulation in accordance with ~~G.S. 131D-2(b)~~ G.S. 131D-2.7(b) and G.S. 131D-29.

(d) When a facility receives a notice of revocation, the administrator shall inform each resident and the resident's responsible person in writing of the notice and the basis on which it was ~~issued.~~ issued within five calendar days of the notice of revocation being received by the licensee of the facility.

History Note: *Authority G.S. 131D-2.7; 131D-2.16; 131D-4.3; 131D-29; 143B-165;*

Eff. January 1, 1977;

Readopted Eff. October 31, 1977;

Temporary Amendment Eff. July 1, 2003;

Amended Eff. June 1, 2004;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;

Amended Eff. April 1, 2020.

10A NCAC 13B .1902 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .1902 DEFINITIONS

The following definitions shall apply throughout this Section, unless text otherwise clearly indicates to the contrary:

(1) "Accident" means something occurring by chance or without intention ~~which~~ that has caused physical or mental harm to a patient, ~~resident~~ resident, or employee.

(2) "Administer" means ~~the direct application of a drug to the body of a patient by injection, inhalation, ingestion or other means.~~ as defined in G.S. 90-87.

(3) "Administrator" means the person who has authority for and is responsible to the governing board for the overall operation of a facility.

(4) "Brain injury long-term care" is defined as an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process and are directed toward maintaining the individual at the optimal level of physical, ~~cognitive~~ cognitive, and behavioral functioning.

~~(5) "Capacity" means the maximum number of patient or resident beds which the facility is licensed to maintain at any given time. This number shall be determined as follows:~~

~~(a) Bedrooms shall have minimum square footage of 100 square feet for a single bedroom and 80 square feet per patient or resident in multi-bedded rooms. This minimum square footage shall not include space in toilet rooms, washrooms, closets, vestibules, corridors, and built-in furniture.~~

~~(b) Dining, recreation and common use areas available shall total no less than 25 square feet per bed for skilled nursing and intermediate care beds and no less than 30 square feet per bed for adult care home beds. Such space must be contiguous to patient and resident bedrooms.~~

~~(6)~~(5) "Combination Facility" means any hospital with nursing home beds ~~which~~ that is licensed to provide more than one level of care such as a combination of intermediate care ~~and/or~~ and skilled nursing care and adult care home care.

~~(7) "Convalescent Care" means care given for the purpose of assisting the patient or resident to regain health or strength.~~

~~(8)~~(6) "Department" means the North Carolina Department of Health and Human Services.

~~(9)~~(7) "Director of Nursing" means the nurse who has authority and ~~direct~~ responsibility for all nursing services and nursing care.

~~(10)~~(8) "Dispense" means ~~preparing and packaging a prescription drug or device in a container and labeling the container with information required by state and federal law. Filling or refilling drug containers~~

~~with prescription drugs for subsequent use by a patient is "dispensing". Providing quantities of unit dose prescription drugs for subsequent administration is "dispensing".~~ as defined in G.S. 90-87.

~~(11)~~(9) "Drug" means ~~substances:~~

~~(a) recognized in the official United States Pharmacopoeia, official National Formulary, or any supplement to any of them;~~

~~(b) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;~~

~~(c) intended to affect the structure or any function of the body of man or other animals, i.e., substances other than food; and~~

~~(d) intended for use as a component of any article specified in (a), (b), or (c) of this Subparagraph; but does not include devices or their components, parts, or accessories.~~ as defined in G.S. 90-87.

~~(12)~~(10) "Duly Licensed" means holding a current and valid license as required under the General Statues of North Carolina.

~~(13) "Existing Facility" means a licensed facility; or a proposed facility, proposed addition to a licensed facility or proposed remodeled licensed facility that will be built according to plans and specifications which have been approved by the department through the preliminary working drawings stage prior to the effective date of this Rule.~~

~~(14) "Exit Conference" means the conference held at the end of a survey, inspection or investigation, but prior to finalizing the same, between the department's representatives who conducted the survey, inspection or investigation and the facility administration representative(s).~~

~~(15)~~(11) "Incident" means an intentional or unintentional action, occurrence or happening ~~which~~ that is likely to cause or lead to physical or mental harm to a patient, ~~resident~~ resident, or employee.

~~(16)~~(12) "Licensed Practical Nurse" means ~~a nurse who is duly licensed as a practical nurse under G.S. 90, Article 9A.~~ as defined in G.S. 90-171.30 or G.S. 90-171.32.

~~(17) "Licensee" means the person, firm, partnership, association, corporation or organization to whom a license has been issued.~~

~~(18)~~(13) "Medication" means drug as defined in ~~(12)~~ Item (9) of this Rule.

~~(19) "New Facility" means a proposed facility, a proposed addition to an existing facility or a proposed remodeled portion of an existing facility that is constructed according to plans and specifications approved by the department subsequent to the effective date of this Rule. If determined by the department that more than one half of an existing facility is remodeled, the entire existing facility shall be considered a new facility.~~

~~(20)~~(14) "Nurse Aide" means any individual providing nursing or nursing-related services to patients in a facility, and is not a licensed health professional, a qualified dietitian or someone who volunteers to provide such services without pay, and who is listed in a nurse aide registry approved by the Department.

~~(21)~~(15) "Nurse Aide Trainee" means an individual who has not completed an approved nurse aide training course and competency evaluation and is demonstrating knowledge, while performing tasks ~~for which~~ that they have been found proficient in by an instructor. These tasks shall be performed under the ~~direct~~ supervision of a registered nurse. The term does not apply to volunteers.

~~(22)~~(16) "Nursing Facility" means that portion of a nursing home certified under Title XIX of the Social Security Act (Medicaid) as in compliance with federal program standards for nursing facilities. It is often used ~~as~~ synonymous with the term "nursing ~~home"~~ home," ~~which is~~ the usual prerequisite level for state licensure for nursing facility (NF) certification and Medicare skilled nursing facility (SNF) certification.

~~(23)~~(17) "Nurse in Charge" means the nurse to whom duties for a specified number of patients and staff for a specified period of time have been delegated, such as for Unit A on the 7-3 or 3-11 shift.

~~(24)~~(18) "On Duty" means personnel who are awake, dressed, and responsive to patient needs and ~~physically~~ present in the facility performing assigned duties.

~~(25)~~(19) "Patient" means any person admitted for care to a skilled nursing or intermediate care facility.

~~(26)~~(20) "Physician" means ~~a person licensed under G.S. Chapter 90, Article 1 to practice medicine in North Carolina.~~ as defined in G.S. 90-9.1 or G.S. 90-9.2.

~~(27)~~(21) "Qualified Dietitian" means ~~a person who meets the standards and qualifications established by the Committee on Professional Registration of the American Dietetic Association included in "Standards of Practice" seven dollars and twenty-five cents ($7.25) or "Code of Ethics for the Profession of Dietetics" two dollars and fifteen cents ($2.15), American Dietetic Association, 216 W. Jackson Blvd., Chicago, IL 60606-6995.~~ as defined in 42 CFR 483.60(a)(1), herein incorporated by reference including subsequent amendments and editions. Electronic copies of 42 CFR 483.60 can be obtained free of charge at https://www.ecfr.gov/cgi-bin/text-idx?SID=1260800a39929487f0ca55b0ab5e710b&mc=true&tpl=/ecfrbrowse/Title42/42cfrv5_02.tpl#0.

~~(28)~~(22) "Registered Nurse" means ~~a nurse who is duly licensed as a registered nurse under~~ as defined in G.S. 90, Article 9A.

~~(29)~~(23) "Resident" means ~~any person admitted for care to an adult care home.~~ as defined in G.S.131D-2.1.

~~(30) "Sitter" means an individual employed to provide companionship and social interaction to a particular resident or patient, usually on a private duty basis.~~

~~(31)~~(24) "Supervisor-in-Charge" means a duly licensed nurse to whom supervisory duties have been delegated by the Director of Nursing.

~~(32)~~(25) "Ventilator dependence" means physiological dependency by a patient on the use of a ventilator for more than eight hours a day.

History Note: *Filed as a Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;*

1 *Authority G.S. 131E-79;*

2 *Eff. February 1, 1986;*

3 *Amended Eff. February 1, 1993; December 1, 1991; March 1, 1991; March 1, ~~1990.~~ 1990;*

4 *Readopted Eff. April 1, 2020.*

1 10A NCAC 13B .1915 is readopted as published in 34:06 NCR 473-481 as follows:
2
3 **10A NCAC 13B .1915 ADULT CARE HOME PERSONNEL REQUIREMENTS**
4 (a) The administrator shall designate a person to be in charge of the adult care home residents at all times. The nurse
5 in charge of nursing services may also serve as supervisor-in-charge of the adult care home beds.
6 (b) If adult care home beds are located in a separate building or a separate level of the same building, there ~~must~~ shall
7 be a person on duty in the adult care home areas at all times.
8 (c) A licensed facility shall provide ~~sufficient~~ staff to assure that activities of daily living, personal grooming, and
9 assistance with eating are provided to each resident. Medication administration as indicated by each resident's
10 condition or physician's orders shall be carried out as identified in each resident's plan of care.
11 (d) Adult care home facilities ~~(Home for the Aged beds)~~ licensed as a part of a combination facility shall comply with
12 the staffing requirements ~~of 10A NCAC 42D .1407 as adopted by the Social Services Commission for freestanding~~
13 ~~adult care homes.~~ in 10A NCAC 13F .0605 herein incorporated by reference including subsequent amendments and
14 editions.
15
16 *History Note: Filed as a Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on*
17 *February 28, 1991;*
18 *Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);*
19 *Eff. February 1, 1986;*
20 *Amended Eff. March 1, ~~1991.~~ 1991;*
21 *Readopted Eff. April 1, 2020.*

10A NCAC 13B .1918 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .1918 TRAINING

(a) A licensed facility shall provide ~~for all~~ patient or resident care employees a planned orientation and continuing education program emphasizing patient or resident assessment and planning, activities of daily living, personal grooming, rehabilitative nursing or restorative care, other patient or resident care policies and procedures, patients' rights, and staff performance expectations. Attendance and subject matter covered shall be documented for each ~~session~~ session, retained in accordance with policy established by the facility, and available for licensure inspections.

(b) The administrator shall assure that ~~each employee is~~ employees are oriented within the first week of employment to the facility's philosophy and goals.

(c) ~~Each employee~~ Employees shall have specific on-the-job training as necessary ~~for the employee~~ to ~~properly~~ perform ~~his~~ their individual job assignment.

(d) Unless otherwise prohibited, a nurse aide trainee may be employed to perform the duties of a nurse aide for a period of time not to exceed four months. During this period of time the nurse aide trainee shall be permitted to perform only those tasks ~~for which minimum acceptable~~ that competence has been demonstrated and documented on a skills check-off record. ~~Job applicants for nurse aide positions who were formerly qualified nurse aides but have not been gainfully employed as such for a period of 24 consecutive months or more shall be employed only as nurse aide trainees and must re-qualify as nurse aides within four months of hire by successfully passing an approved competency evaluation. Any individual, nursing home, or education facility may offer Department approved vocational education for nursing home nurse aides. An accurate record~~ Nurse aide I shall meet the training and competency evaluation standards in 10A NCAC 13O .0301, incorporated herein by reference including subsequent amendments and editions. A record of nurse aide qualifications shall be maintained for each nurse aide used by a facility and shall be retained in the general personnel files of the ~~facility.~~ facility in accordance with policy established by the facility.

(e) ~~The curriculum content required for nurse aide education programs shall be subject to approval by the Division of Health Service Regulation and shall include, as a minimum, basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and patients' rights. Successful course completion shall be determined by passing a competency evaluation test. The minimum number of course hours shall be 75 of which at least 20 hours shall be classroom and at least 40 hours of supervised practical experience.~~ The initial orientation to the facility shall be exclusive of the 75 hour training program. Competency evaluation shall be conducted in each of the following areas:

(1) Observation and documentation,
(2) Basic nursing skills,
(3) Personal care skills,
(4) Mental health and social service needs,
(5) Basic restorative services, and
(6) Residents' Rights.

1 ~~(f) Successful course completion and skill competency shall be determined by competency evaluation approved by~~
2 ~~the Department. Commencing July 1, 1989, nurse aides who had formerly been fully qualified under nurse aide~~
3 ~~training requirements may re-establish their qualifications by successfully passing a competency evaluation test~~.
4
5 *History Note:* *Filed as a Temporary Rule Eff. October 1, 1990 For a Period of 142 Days to Expire on February*
6 *28, 1991;*
7 *Authority G.S. 131E-79; 42 U.S.C. 1396 r (b)(5);*
8 *Eff. February 1, 1986;*
9 *Amended Eff. March 1, 1991; March 1, ~~1990.~~ 1990;*
10 *Readopted Eff. April 1, 2020.*

10A NCAC 13B .1925 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .1925 REQUIRED SPACES

~~The total space requirements shall be those set forth in Rule .1902(5) of this Section. Physical therapy and occupational therapy space shall not be included in these totals.~~

(a) A combination or nursing facility shall meet the following requirements for bedrooms, dining, recreation, and common use areas:

(1) single bedrooms shall be provided with not less than 100 square feet of floor area;

(2) bedrooms with more than one bed shall be provided with not less than 80 square feet of floor area per bed;

(3) dining, recreation, and common use areas shall:

(A) total not less than 25 square feet of floor area per bed for skilled nursing and intermediate care beds;

(B) total not less than 30 square feet of floor area per bed for adult care home beds; and

(C) be contiguous to patient and resident bedrooms.

(b) Floor space for the following rooms, areas, and furniture shall not be included in the floor areas required by Paragraph (a) of this Rule:

(1) toilet rooms;

(2) vestibules;

(3) bath areas;

(4) closets;

(5) lockers;

(6) built-in furniture;

(7) movable wardrobes;

(6) corridors; and

(7) areas for physical and occupational therapy.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, ~~1986.~~ 1986;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3001 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .3001 DEFINITIONS

Notwithstanding Section .1900 of this Subchapter, ~~The~~ the following definitions shall apply throughout this ~~Section~~ Subchapter unless the context clearly indicates to the contrary:

(1) "Appropriate" means suitable or fitting, or conforming to standards of care as established by professional organizations.

(2) "Authority having jurisdiction" means the Division of Health Service Regulation.

(3) "Certified Dietary Manager" or "CDM" means an individual who is certified by the Certifying Board of the Dietary Managers and meets the standards and qualification as referenced in the "Dietary Manager Training Program Requirements." These standards include any subsequent amendments and editions of the referenced manual. Copies of the "Dietary Manager Training Program Requirements" may be ~~purchased for fifteen dollars ($15.00) from the Dietary Managers Association, 406 Surry Woods Dr., St. Charles, IL 60174.~~ obtained free of charge at https://www.cbdmonline.org/.

(4) "Competence" means the state or quality of being able to perform specific functions well; skill; ability.

(5) "Comprehensive" means covering completely, inclusive; large in scope or content.

(6) "Construction documents" means final building plans and specifications for the construction of a facility that a governing body submits to the Construction Section for approval as specified in Rule .3102 of this Subchapter.

(7) "Construction Section" means the Construction Section of the Division of Health Service Regulation.

~~(6)~~(8) "Continuous" means ongoing or uninterrupted, 24 hours per day.

~~(7)~~(9) "CRNA" means a Certified Registered Nurse Anesthetist as ~~credentialed by the Council on Certification of Nurse Anesthetists and recognized by the Board of Nursing in 21 NCAC 36 .0226.~~ defined in G.S. 90-171.21(d)(4).

~~(8)~~(10) "Credentialed" means that the individual having a given title or position has been credited with the right to exercise official responsibilities to provide specific patient care and treatment services, within defined limits, based primarily upon the individual's license, education, training, experience, competence, and judgment.

~~(9)~~(11) "Department" means the Department of Health and Human Services.

~~(10)~~(12) "Dietetics" means ~~the integration and application of principles derived from the science of nutrition, biochemistry, physiology, food and management and from behavioral and social sciences to achieve and maintain optimal nutritional status.~~ as defined in G.S. 90-352.

~~(11)~~(13) "Dietitian" means ~~an individual who is licensed according to~~ as defined in G.S. 90, ~~Article 25, or is registered by the Commission on Dietetic Registration (CDR) of the American Dietetic Association~~

~~(ADA) according to the standards and qualifications as referenced in the second edition of the "Accreditation/Approval Manual for Dietetic Education Programs", "The Registration Eligibility Application for Dietitians" and the "Continuing Professional Education" and subsequent amendments or editions of the reference material. Copies of the "Accreditation/Approval Manual for Dietetic Education Programs" may be purchased for twenty-one dollars and ninety-five cents ($21.95) plus three dollars ($3.00) minimum shipping and handling from ADA 216 W. Jackson Blvd., Chicago, IL 60606-9-6995.~~ Article 25.

~~(12)~~(14) "Dietetic Technician Registered" or "DTR" means ~~an individual who is registered by the Commission on Dietetic Registration (CDR) of the American Dietetic Association (ADA) according to the standards and qualifications as referenced in the second edition of the "Accreditation/Approval Manual for Dietetic Education Programs" which is incorporated by reference including any subsequent amendments and editions. Copies of the "Accreditation/Approval Manual for Dietetic Education Programs" may be purchased for twenty-one dollars and ninety-five cents ($21.95) plus three dollars ($3.00) minimum for shipping and handling from the ADA 216 W. Jackson Blvd., Chicago, IL 60606-9-6995.~~ as defined in G.S. 90-352.

~~(13)~~(15) "Direct Supervision" means the state of being under the immediate control of a supervisor, manager, or other person of authority.

~~(14)~~(16) "Division" means the Division of Health Service Regulation.

~~(15)~~(17) "Facility" means a hospital as defined in G.S. 131E-76.

~~(16)~~(18) "Free standing facility" means a facility that is physically separated from the primary hospital building or separated by a three hour fire containment wall.

~~(17)~~(19) "Full-time equivalent" means a unit of measure of employee work time that is equal to the number of hours that one full-time employee would work during one calendar year if the employee worked eight hours a day, five days a week, and 52 weeks a year; i.e. 2,080 hours per year.

~~(18)~~(20) "Governing body" means the authority as defined in G.S. 131E-76.

~~(19)~~(21) "Imaging" means a reproduction or representation of a body or body part for diagnostic purposes by radiologic intervention that may include conventional fluoroscopic exam, magnetic resonance, nuclear or radio-isotope scan.

~~(20)~~(22) "Invasive procedure" means a procedure involving puncture or incision of the skin, insertion of an instrument or foreign material into the body (excluding venipuncture and intravenous therapy).

~~(21)~~(23) "LDRP" (labor, delivery, recovery, post-partum) means a specific single occupancy obstetrical use room counted as a licensed bed.

~~(22)~~(24) "License" means formal permission to provide services as granted by the State.

~~(23)~~(25) "Medical staff" means the formal organization that is comprised of ~~all of those~~ individuals who have sought and obtained clinical privileges in a facility. Those members of the medical staff who regularly and routinely admit patients to a facility constitute the active medical staff.

~~(24)~~(26) "Mission statement" means a written statement of the philosophy and beliefs of the organization or hospital as approved by the governing body.

~~(25)~~(27) "Neonate" means the newborn from birth to one month.

~~(26)~~(28) "NP" means a Nurse Practitioner as defined in ~~G.S. 90-6;~~ G.S. 90-8.2, ~~90-18(14)~~ 90-18(14), and 90-18.2.

~~(27)~~(29) "Nurse executive" means ~~a registered nurse who is the director of nursing services or a representative of decentralized nursing management staff.~~ as defined in Rule 21 NCAC 36 .0109.

~~(28)~~(30) "Nurse midwife" means ~~a Certified Nurse Midwife~~ as defined in ~~G.S. 90, Article 10.~~ G.S.90-171.21 (4).

~~(29)~~(31) "Nursing facility" means ~~that portion of a hospital that is approved to provide skilled nursing care.~~ as defined in G.S. 131E-116 (2).

~~(30)~~(32) "Nursing staff" means the registered nurses, licensed practical nurses, nurse aides, and others under nurse supervision, who provide ~~direct~~ patient care. The term also includes clerical personnel who work in clinical areas under nurse supervision.

(33) "Nutrition and Dietetic Technician Registered" means as defined by the Academy of Nutrition and Dietetics. A copy of the requirements can be obtained at https://www.eatrightpro.org/about-us/what-is-an-rdn-and-dtr/what-is-a-nutrition-and-dietetics-technician-registered at no cost.

~~(31)~~(34) "Nutrition therapy" ranges from intervention and counseling on diet modification to administration of specialized nutrition therapies as determined necessary to manage a condition or treat illness or injury. Specialized nutrition therapies include supplementation with medical foods, enteral and parenteral nutrition. Nutrition therapy integrates information from the nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status.

~~(32)~~(35) "Observation bed" means a bed used for no more than 24-hours, to evaluate and determine the condition and disposition of a patient and is not considered a part of the hospital's licensed bed capacity.

~~(33)~~(36) "Patient" means any person receiving diagnostic or medical services at a hospital.

~~(34)~~(37) "Pharmacist" means ~~a person licensed according to G.S. 90, Article 4A, by the N.C. Board of Pharmacy to practice pharmacy.~~ as defined in G.S. 90-85.3.

~~(35)~~(38) "Physical Rehabilitation Services" means any combination of physical therapy, occupational therapy, speech ~~therapy~~ therapy, or vocational rehabilitation.

~~(36)~~(39) "Physician" means ~~a person licensed according to G.S. 90, Article 1, by the N.C. Board of Medical Examiners to practice medicine.~~ as defined in G.S.90-9.1 or G.S. 90-9.2.

~~(37)~~(40) "Provisional license" means a hospital license recognizing ~~significantly~~ less than full compliance with the licensure rules.

~~(38)~~(41) "Qualified" means having complied with the specific conditions for employment or the performance of a function.

~~(39)~~(42) "Reference" means to use in consultation to obtain information.

~~(40)~~(43) "Special Care Unit" means a ~~designated~~ unit or area of a hospital ~~with a concentration of qualified professional staff and support services that provide intensive or extra ordinary care on a 24-hour basis to critically ill patients; these units may include but are not limited to Cardiac Care, Medical or Surgical Intensive Care Unit, Cardiothoracic Intensive Care Unit, Burn Intensive Care Unit, Neurologic Intensive Care Unit or Pediatric Intensive Care Unit.~~ that includes a critical care unit, an intermediate care unit, or a pediatric care unit.

~~(41)~~(44) "Unit" means a designated area of the hospital for the delivery of patient care services.

History Note: *Authority G.S. 131E-79;*
RRC Objection due to lack of Statutory Authority Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3101 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .3101 GENERAL REQUIREMENTS

(a) An application for licensure shall be submitted to the Division prior to a license being issued or patients admitted.

(b) An existing facility shall not sell, ~~lease~~ <u>lease,</u> or subdivide a portion of its bed capacity without the approval of the Division.

(c) Application forms may be obtained by contacting the Division.

(d) The Division shall be notified in writing <u>30 days</u> prior to the occurrence of any of the following:

(1) addition or deletion of a licensable service;
(2) increase or decrease in bed capacity;
(3) change of chief executive officer;
(4) change of mailing address;
(5) ownership change; or
(6) name change.

(e) Each application shall contain the following information:

(1) legal identity of applicant;
(2) name or names ~~under which~~ <u>used to present</u> the hospital or services ~~are presented~~ to the public;
(3) name of the chief executive officer;
(4) ownership disclosure;
(5) bed complement;
(6) bed utilization data;
(7) accreditation data;
(8) physical plant inspection data; and
(9) service data.

(f) A license shall include only facilities or premises within a single county.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Amended Eff. April 1, ~~2003.~~ <u>2003;</u>
<u>Readopted Eff. April 1, 2020.</u>

10A NCAC 13B .3110 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .3110 ITEMIZED CHARGES

(a) The facility shall ~~either~~ present an itemized list of charges to ~~all~~ discharged patients or the facility shall include on patients' bills that are not itemized, notification of the right to request an itemized bill within three years of receipt of the non-itemized bill or so long as the hospital, a collections agency, or other assignee asserts the patient has an obligation to pay the bill.

(b) If requested, the facility shall present an itemized list of charges to ~~each~~ the patient or the patient's representative. This list shall detail in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient.

(c) The itemized listing shall include each specific chargeable item or service in the following service areas:

(1) room ~~rate~~ rate;
(2) laboratory;
(3) radiology and nuclear medicine;
(4) surgery;
(5) anesthesiology;
(6) pharmacy;
(7) emergency services;
(8) outpatient services;
(9) specialized care;
(10) extended care;
(11) prosthetic and orthopedic appliances; and
(12) professional services provided by the facility.

History Note: *Authority G.S. 131E-79; 131E-91; ~~S.L. 2013-382, s. 13.1;~~*
Eff. January 1, 1996;
Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, ~~2014.~~ 2014;
Readopted Eff. April 1, 2020.

1 10A NCAC 13B .3204 is readopted as published in 34:06 NCR 473-481 as follows:

2

3 **10A NCAC 13B .3204 TRANSFER AGREEMENT**

4 (a) Any facility ~~which~~ that does not provide hospital based nursing facility service shall maintain written agreements
5 with institutions offering this kind of care. Such agreements shall provide for the transfer and admission of patients
6 who no longer require the services of the hospital but do require nursing facility services.
7 (b) A patient shall not be transferred to another medical care facility unless prior arrangements for admission have
8 been made. Clinical records ~~of sufficient content~~ to provide continuity of care shall accompany the patient.

9

10 *History Note: Authority G.S. 131E-79;*
11 *Eff. January 1, ~~1996.~~ 1996;*
12 *Readopted Eff. April 1, 2020.*

10A NCAC 13B .3205 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .3205 DISCHARGE OF MINOR OR INCOMPETENT

~~Any individual~~ Individuals who cannot legally consent to his or her own care shall be discharged ~~only~~ to the custody of parents, legal guardian, person standing in loco parentis, or another competent adult unless otherwise directed by the parent or ~~guardian~~ guardian, or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, ~~he~~ they shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3302 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .3302 MINIMUM PROVISIONS OF PATIENT'S BILL OF RIGHTS

This Rule does not apply to patients in licensed nursing facility beds since these individuals are granted rights pursuant to G.S. 131E-117. A patient in a facility subject to this Rule has the following rights:

(1) A patient has the right to respectful care given by competent personnel.

(2) A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his or her care, and the names and functions of other health care persons having direct contact with the patient.

(3) A patient has the right to privacy concerning his or her own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly.

~~(4) A patient has the right to have all records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.~~

~~(5)~~(4) A patient has the right to know what facility rules and regulations apply to his or her conduct as a patient.

~~(6)~~(5) A patient has the right to expect emergency procedures to be implemented without ~~unnecessary~~ delay.

~~(7)~~(6) A patient has the right to ~~good~~ quality care and ~~high~~ professional standards that are ~~continually~~ maintained and reviewed.

~~(8)~~(7) A patient has the right to full information in laymen's terms, concerning his diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his or her behalf to the patient's designee.

~~(9)~~ (8) Except for emergencies, a physician must obtain ~~necessary~~ informed consent prior to the start of any procedure or ~~treatment, or both.~~ treatment.

~~(10)~~ (9) A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent ~~must~~ shall be obtained prior to ~~actual~~ participation in such a ~~program and the~~ program. The patient or legally responsible ~~party, may, at any time,~~ party may refuse to continue in any ~~such~~ program ~~to which~~ that he or she has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in ~~accord~~ accordance with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations under 21 CFR Parts 50 and 56. For any research study proposed for conduct under an FDA "Exception from Informed Consent Requirements for Emergency Research" or an HHS "Emergency Research Consent Waiver" ~~in which~~ that waives informed consent ~~is waived~~ but

community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study shall also ~~must~~ verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB ~~reviewing the research study~~ has authorized the start of the community consultation process required ~~by the federal regulations~~ for emergency research, but before the beginning of that process, notice of the proposed research study ~~by the facility~~ shall be provided to the North Carolina Medical Care Commission. The notice shall include:

(a) the title of the research study;

(b) a description of the research study, including a description of the population to be enrolled;

(c) a description of the planned community consultation process, including ~~currently~~ proposed meeting dates and times;

(d) ~~an explanation of the way that people choosing not to participate in~~ instructions for opting out of the research ~~study may opt out;~~ study; and

(e) contact information including mailing address and phone number for the IRB and the principal investigator.

The Medical Care Commission may publish all or part of the above information in the North Carolina Register, and may require the institution proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.

~~(11)~~ (10) A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to the extent permitted by law, and a physician shall inform the patient of his or her right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.

~~(12)~~ (11) A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.

~~(13)~~ (12) A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual orientation, gender identity, national origin or source of payment.

~~(14)~~ (13) A patient who does not speak English shall have ~~access, when possible,~~ access to an interpreter.

~~(15)~~ (14) ~~A facility shall provide a patient, or patient designee, upon request, access to all information contained in the patient's medical records.~~ A patient or his or her designee has the right to have all records pertaining to his or her medical care treated as confidential except as otherwise provided by law or third party contractual arrangements. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason. A patient's designee may have access to

the information in the patient's medical records even if the attending physician restricts the patient's access to those records.

~~(16)~~ (15)A patient has the right not to be awakened by hospital staff unless it is medically necessary.

~~(17)~~ (16)The patient has the right to be free from duplication of medical and nursing procedures as determined by the attending physician.

~~(18)~~ (17)The patient has the right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.

~~(19)~~ (18)When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility ~~to which~~ that the patient is to be transferred must first have accepted the patient for transfer.

~~(20)~~ (19)The patient has the right to examine and receive a detailed explanation of his bill.

~~(21)~~ (20)The patient has a right to full information and counseling on the availability of known financial resources for his health care.

~~(22)~~ (21)A patient has the right to be informed upon discharge of his or her continuing health care requirements following discharge and the means for meeting them.

~~(23)~~ (22)A patient shall not be denied the right of access to an individual or agency who is authorized to act on his or her behalf to assert or protect the rights set out in this Section.

~~(24)~~ (23)A patient has the right to be informed of his rights at the earliest possible time in the course of his or her hospitalization.

~~(25)~~ (24)A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient.

History Note: *Authority G.S. 131E-75; 131E-79; 143B-165;*
RRC Objection due to ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Temporary Amendment Eff. April 1, 2005;
Amended Eff. January 1, 2011; May 1, 2008; November 1, ~~2005.~~ 2005;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3303 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .3303 PROCEDURE

(a) The facility shall develop and implement procedures to inform ~~each patient~~ patients of his or her rights. Copies of the facilities' Patient's Bill of Rights shall be made available through one of the following ways:

(1) displayed in prominent ~~displays in appropriate~~ locations in addition to copies available upon request; or

(2) provision of a copy to each patient or responsible party upon admission or as soon after admission as is feasible.

(b) The address and telephone number of the section in the Department responsible for the enforcement of the provisions of this part shall be posted.

(c) The facility shall adopt procedures to ensure ~~effective and fair~~ a comprehensive investigation of violations of patients' rights and to ensure their enforcement. These procedures shall ensure that:

(1) a system is established to identify formal written complaints;

(2) formal written complaints are recorded and investigated;

(3) investigation and resolution of formal complaints shall be conducted; and

(4) disciplinary and education procedures shall be developed for members of the hospital and medical staff who are noncompliant with facility policies.

(d) The Division shall investigate or refer to ~~appropriate~~ other State agencies all complaints within the jurisdiction of the rules in this Subchapter.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .5412 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .5412 ADDITIONAL REQUIREMENTS FOR TRAUMATIC BRAIN INJURY PATIENTS

Inpatient rehabilitation facilities providing services to ~~persons~~ patients with traumatic brain injuries shall ~~meet the requirements in this Rule in addition to those identified in this Section.~~ provide staff to meet the needs of patients in accordance with the patient assessment, treatment plan, and physician orders.

~~(1) Direct care nursing personnel staffing ratios established in Rule .5408 of this Section shall not be applied to nursing services for traumatic brain injury patients in the inpatient, rehabilitation facility or unit. The minimum nursing hours per traumatic brain injury patient in the unit shall be 6.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which shall be a registered nurse.~~

~~(2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.5 hours of specific or combined rehabilitation therapy services per traumatic brain injury patient day.~~

~~(3)~~ (1) The facility shall ~~provide special facility or~~ have access to special equipment to meet the needs ~~for patients~~ of patients with traumatic brain ~~injury, including specially designed wheelchairs, tilt tables and standing tables.~~ injury.

~~(4) The medical director of an inpatient traumatic brain injury program shall have two years management in a brain injury program, one of which may be in a clinical fellowship program and board eligibility or certification in the medical specialty of the physician's training.~~

~~(5)~~ (2) The facility shall provide the consulting services of a neuropsychologist.

~~(6)~~ (3) The facility shall provide continuing education in the care and treatment of brain injury patients for all staff.

~~(7)~~ (4) The size of the brain injury program shall ~~be adequate to~~ support a comprehensive, dedicated ongoing brain injury program.

History Note: *Authority G.S. 131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .5413 is readopted as published in 34:06 NCR 473-481 as follows:

10A NCAC 13B .5413 ADDITIONAL REQUIREMENTS FOR SPINAL CORD INJURY PATIENTS

Inpatient rehabilitation facilities providing services to ~~persons~~ patients with spinal cord injuries shall ~~meet the requirements in this Rule in addition to those identified in this Section.~~ provide staff to meet the needs of patients in accordance with the patient assessment, treatment plan, and physician orders.

~~(1) Direct care nursing personnel staffing ratios established in Rule .5408 of this Section shall not be applied to nursing services for spinal cord injury patients in the inpatient rehabilitation facility or unit. The minimum nursing hours per spinal cord injury patient in the unit shall be 6.0 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which shall be a registered nurse.~~

~~(2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.0 hours of specific or combined rehabilitation therapy services per spinal cord injury patient day.~~

~~(3)~~ (1) The facility shall ~~provide special facility or~~ have access to special equipment to meet the needs of patients with spinal cord ~~injury, including specially designed wheelchairs, tilt tables and standing tables.~~ injury.

~~(4) The medical director of an inpatient spinal cord injury program shall have either two years experience in the medical care of persons with spinal cord injuries or six months minimum in a spinal cord injury fellowship.~~

~~(5)~~ (2) The facility shall provide continuing education in the care and treatment of spinal cord injury patients for all staff.

~~(6)~~ (3) The facility shall provide specific staff training and education in the care and treatment of spinal cord injury.

~~(7)~~ (4) The size of the spinal cord injury program shall ~~be adequate to~~ support a comprehensive, dedicated ongoing spinal cord injury program.

History Note: *Authority G.S. 131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. April 1, 2020.

Exhibit C/5
Fiscal Note

Fiscal Impact Analysis of
Permanent Rule Readoption without Substantial Economic Impact

Agency Proposing Rule Change
North Carolina Medical Care Commission

Contact Persons
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Impact Summary

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Title of Rules Changes and Statutory Citations

10A NCAC 13B

Section .1900 – Supplemental Rules for the Licensure of the Skilled: Intermediate: Adult Care Home Beds in a Hospital
- Definitions 10A NCAC 13B .1902 (Readopt)
- Adult Care Home Personnel Requirements 10A NCAC 13B .1915 (Readopt)
- Training 10A NCAC 13B .1918 (Readopt)
- Required Spaces 10A NCAC 13B .1925 (Readopt)

Section .3000 – General Information
- Definitions 10A NCAC 13B .3001 (Readopt)
- General Requirements 10A NCAC 13B .3101 (Readopt)
- Itemized Charges 10A NCAC 13B .3110 (Readopt)

Section .3200 -- General Hospital Requirements
- Transfer Agreement 10A NCAC 13B .3204 (Readopt)
- Discharge of Minor or Incompetent 10A NCAC 13B .3205 (Readopt)

Section .3300 – Patient's Bill of Rights
- Minimum Provisions of Patient's Bill of Rights 10A NCAC 13B .3302 (Readopt)
- Procedure 10A NCAC 13B .3303 (Readopt)

Section .5400 –Comprehensive Inpatient Rehabilitation
- Additional Requirements for Traumatic Brain Injury Patients 10A NCAC 13B .5412 (Readopt)
- Additional Requirements for Spinal Cord Injury Patients 10A NCAC 13B .5413 (Readopt)

See proposed text of these rules in Appendix 1

Statutory Authority

G.S. 131E-79-169

Background and Purpose

Under authority of G.S. 150B-21-3A, Periodic review and expiration of existing rules, the Medical Care Commission, Rules Review Commission and the Joint Legislative Administrative Procedure Oversight Committee approved the Subchapter report with classifications for the rules located at 10A NCAC 13B—Rules for the Licensing of Hospitals on February 10, 2017, May 18, 2017, and July 22, 2017, respectively. A total of 13 rules were determined necessary with substantive public interest and therefore subject to readoptions as new rules. The Medical Care Commission is proposing to readopt 13 hospital licensure rules. These rules are a collection of the supplemental rules for the licensure of skilled nursing, intermediate, and adult care home beds in a hospital, comprehensive rehabilitation, and general information regarding hospital licensure. Of those 13 rules, eight are proposed for readoption with substantive changes. (10A NCAC 13B .1902, .1918, .1925, .3001, .3101, .3302, .5412, and .5413).

Five rules are proposed for readoption without substantive changes and will not be discussed in this analysis. (10A NCAC 13B .1915, .3110, .3204, .3205, and .3303).

There are 119 licensed hospitals in North Carolina, of which 21 are combination facilities licensed for Skilled Nursing Beds. There are also five licensed Comprehensive Inpatient Rehabilitation Hospitals and 21 Rehabilitation Units within Acute Care Hospital facilities. The rule readoptions presented in this fiscal analysis will be the third phase of the hospital rule readoptions required by G.S. 150B-21.3.A. The readoptions will update rules that, in some cases, have not been updated in 29 years. The readoptions will update practices and language, address previous Rules Review Commission objections, and implement technical changes. Changes will also allow reference to the General Statute. When a hospital offers nursing facility or adult care home long-term care services, the services shall be included under one hospital license. The general requirements included in this Subchapter shall apply when applicable but in addition the nursing facility care and adult care home care unit must meet the supplemental requirements of this Section. A hospital stakeholder group was put together to assist in rule readoption by providing expertise on hospital processes, current standards of practice, and to ensure hospitals have an opportunity to provide input as we move forward with the readoption process.

Rules Summary and Anticipated Fiscal Impact

Rule 13B .1902 – Definitions

The agency is proposing to readopt this rule with substantive changes. This rule lists definitions that apply throughout the Subchapter and is being changed to update definitions, delete definitions that are no longer used in the Subchapter, to relocate definitions to other existing rules, and to reference definitions in the General Statute. Generally, the definitions in the statute are the same as those used in the rule. There are several minor differences that are noted in the General Statute definitions, but those minor differences do not materially change the scope of the definition and are not any more stringent than the definitions in the current rule. The definitions in the General Statute will always prevail. Two definitions are not utilized in the Subchapter and were deleted.

In addition, the agency removed redundancy by deleting definitions for Existing Facility and New Facility. Those definitions are in Rule 10A NCAC 13B .6102 and .6105 of this Subchapter.

Fiscal Impact:

Federal Government Entities: No Impact

State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Rule 13B .1918 – Training
The agency is proposing to readopt this rule with substantive changes. The rule was last amended in 1991. This rule identifies training requirements for Nurse Aide I patient care employees. This rule previously specified curriculum content for nurse aide training programs and subjected the programs to approval by DHSR. It also specified the breakdown of educational hours between classroom hours and supervised practical experience. The rule also allowed nurse aides who had formerly been fully qualified under the nurse aide training requirements to re-instate their requirements by passing an approved competency evaluation test.

The new changes incorporate the training and competency evaluation standards for Nurse Aide 1 that are contained in 42 CFR 483, Subpart D. The referenced standards establish the requirements for the state approved Nurse Aide 1 training and evaluation program. Regardless of the facility of employment, all Nurse Aide 1s who meet the required training and evaluation are eligible to be put on the Nurse Aide 1 Registry. Therefore, the current baseline incorporates the changes already made to the Nurse Aide 1 registry requirements. The fiscal note for Nurse Aide Registry changes, 10A NCAC 13 .0301 is available at https://ncosbm.s3.amazonaws.com/s3fs-public/documents/files/DHHS07082015.pdf, details the cost associated with the initial switch to the current program. The new rules, 10A NCAC 13 .0301, were designed to result in the public receiving safer/more competent hands-on, direct patient/resident/client care.

DHSR does not require any additional training above the minimum and therefore does not expect any additional costs for training above the current minimum standards. However, a facility or program may go above the minimum training standards for Nurse Aide Is, if they so desire. In the event a new training topic needs to the added to the Nurse Aide I trainings curriculum, approved trainers will not change class time. While new training objectives would be added to the existing class time, there is a possibility that new materials would be required to be purchased in order to teach new skills. However, these are unknown at this time and would be expected to be minimal.
Facilities are responsible for providing their initial facility specific orientation exclusive of the 75-hour training requirement and for checking the Nurse Aide Registry to ensure potential Nurse Aide Is are on the registry prior to employment.

In addition, changes to the rule require training programs to establish a policy for retention of attendance and subject matter covered during the training. This information is currently retained by the training programs. We are instructing them to document their policy for doing so for compliance purposes. Dependent on current practices, there may be some minimal staff time/cost involved in establishing a retention schedule regarding attendance and subject matter covered during the training. There are currently 261 state-approved Nurse Aide I training programs. Changes to this rule won't result in any modification to the training program or process.

Fiscal Impact:

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Rule 13B .1925 – Required Spaces
The agency is proposing to readopt this rule with substantive changes. This rule lists the space requirements for a combination facility (nursing facility within a hospital) and is changed to update requirements, make technical changes, and to reorganize text. Space requirements are being relocated from Rule 10A NCAC 13B .1902 to this Rule. This change will pull similar information together in one location.

Technical changes include changing language to update "washrooms" to "bath areas" and deleting the reference to 10 A NCAC 13B .1902 as it was no longer applicable. This was a technical change and is not expected to have an impact. Lockers and movable wardrobes were added to the rule as additional options in lieu of closets. Closets, lockers or wardrobes space are not counted against the space requirements for bedrooms. The current requirement is one closet or wardrobe per bed. The lockers will give facilities an additional option they can use in lieu of closets or wardrobes. Some of the old facilities may still utilize lockers instead of closets or wardrobes. The nursing home wing in a hospital is required to follow the nursing facility standards regarding space identified in 10A NCAC 13D .3201. It is unknown how many facilities, if any, will take advantage of the additional options. The overall requirements regarding space, closets, or wardrobes in combination facilities remains unchanged. These changes will not expand the scope of this rule or result in any additional administrative or staff time and is unlikely to have financial implications for combination facilities.

Fiscal Impact:

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Rule 13B .3001 -- Definitions
The agency is proposing to readopt this rule with substantive changes. This rule lists definitions that apply throughout the Subchapter and are being changed to satisfy previous Rules Review Commission objections, to update definitions and terminology, and to reference the General Statute. Changes were also made to remove repealed statutes and update statute location. There were nine definitions the Rules Review Commission objected to regarding lack of authority. All were definitions that were defined in the general statute. The nine definitions were replaced with references to the general statute. Changing the definition to referencing the statute does not make any material changes to the definitions or expand or decrease the scope of the definition. Furthermore, the definitions in the statutes constitute the current baseline because the definitions in the general statutes take legal precedence over the current definitions written in rules because the statute is the higher-level authority. Two definitions were relocated from an existing rule to eliminate redundancy. The definition of Special Care units was condensed into three categories. Those three categories are inclusive of all the items identified in the current rule.

As the current baseline includes the definitions as found in the general statutes, there is no impact to this rule change and it does not require any additional actions by the facility or staff.

Fiscal Impact:

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact

Substantial Impact: No Impact

Rule 13B .3101 – General Requirements
The agency is proposing to readopt this rule with substantive changes. This rule lays out general requirements regarding licensure, lease, and bed changes. Changes to the rule establish 30 days as the standard for prior notification of licensure changes. Facilities are currently required to notify the agency in writing at any time prior to the occurrence of licensure changes. The change to the rule will establish a consistent timeframe to make notification. There were also several technical changes. These changes will not result in any increase in administrative or staff time and are unlikely to have any fiscal implications.

Fiscal Impact:

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Rule 13B .3302 – Minimum Provisions of Patient's Bill of Rights
The agency is proposing to readopt this rule with substantive changes. This rule establishes minimal provisions of patient's bill of rights. The rule is changed to consolidate language regarding the patients right to information with the patients access to medical records. This change will combine related information and eliminate redundancy. In addition, the agency made several technical changes to take out ambiguous language. There was no expansion or reduction to the provision of the patient bill of rights and the changes won't result in any administrative or facility costs.

Fiscal Impact:

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Rule 13B .5412 – Additional Requirements for Traumatic Brain Injury Patients
The agency is proposing to readopt this rule with substantive changes. This rule establishes additional requirements for inpatient rehabilitation facilities providing services to persons with traumatic brain injuries. It is being changed to resolve the conflict between the rule and the current standards of practice, and to reflect current standards of care regarding nursing, physical, occupational, and speech therapy hours. The current rule was last amended in 1996 and is highly prescriptive without offering flexibility for hospitals to encourage the efficient use of resources. The rule also does not have any basis in evidence based practice standards that contribute to better patient outcomes.

During the readoption process for these rules, DHSR asked stakeholder groups for input regarding current rules. The stakeholder group was composed of staff from rehabilitation units at acute care hospitals as well as staff from rehabilitation hospitals. Two members of the stakeholder group, both staff at rehabilitation facilities, acknowledged that the standard of practice regarding nursing, physical, occupational, and speech therapy for traumatic brain injury patients is to provide nursing, physical, occupational, and speech therapy hours to meet the needs of the patient in accordance with the patient assessment, treatment plan, and physician orders.

The current rules required a minimum of 6.5 nursing hours per patient day and that direct care nursing staff required at least 2 FTEs, one of which is a registered nurse. According to the CMS Measures Inventory Tool, nursing care hours per patient day is the number of productive hours worked by nursing staff, including RNs, LPN/LVNs, and UAP (unlicensed assistive personnel) with direct patient care responsibilities per patient day for each in-patient unit in a calendar month.[1] While evidence suggests that higher nursing staffing ratios can have impacts on patient outcomes including patient readmission rates[2], preventable events such as falls and pressure ulcers, and medical and medication errors[3], other factors also must be taken into account when developing optimal nursing hours per patient day levels such as patient complexity and acuity and nursing skill mix. Due to these reasons, the rule as currently written does not ensure efficient, high quality care for traumatic brain injury patients, which is the intent of the rule. According to reports from stakeholder groups, this rule is both incredibly onerous and does not represent current practices and has not been followed for some time due to these reasons.

The range of traumatic brain injuries (TBI) is wide and the severity of the injury may vary widely from a mild concussion to severe memory loss and extended period of unconsciousness after injuries. However, this condition is wide ranging – in 2014, there were about "2.87 million TBI-related emergency department (ED) visits, hospitalizations, and deaths[4]" that occurred in the United States. The leading cause of TBIs were falls, which disproportionately affect children aged 0-4 and older adults aged 75 years and older. "Motor vehicle crashes were the leading cause of hospitalizations for adolescents and adults aged 15 to 44 years of age.[5]"

"Inpatient TBI rehabilitation practice remains highly variable, which, in part, reflects lack of empirical evidence of how the complex interweaving of rehabilitations from different professionals, in conjunction with patient prognostic factors (e.g. comorbidities, injury severity), influences recovery.[6]" More research is necessary to determine standardized rehabilitation options across traumatic brain injury patients. Due to the range of symptoms that may occur in TBI patients, each patient should have a care plan that is individualized to them based on their specific needs. However, there is evidence to suggest that similar treatment options based on cognitive functions and other assessments such as the Comprehensive Severity Index that takes into account a patient's comorbidities and severity of illness are more able to be standardized.[7] However, due to the complexity of these factors for every patient, these decisions are generally individualized to each patient based on their cognitive function level and comorbidities as part of their care plan developed by their medical team.

As part of current practice and federal regulations for conditions of payment under the inpatient rehabilitation facility prospective payment system for Medicare and Medicaid, rehabilitation facilities are to furnish through the use of qualified personnel, rehabilitation nursing, physician therapy, and occupational therapy, plus as needed, speech-language pathology, social services, psychological services

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1 https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=12&cad=rja&uact=8&ved=2ahUKEwjH7fvK0sbjAhWLv1kKHdOSA-4QFjALegQIABAC&url=https%3A%2F%2Fcmit.cms.gov%2FCMIT_public%2FReportMeasure%3FmeasureRevisionId%3D1580&usg=AOvVaw2txLIy8zRwRfRNN4tkpDlV

2 https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0613

3 https://www.pteqicon.org/wp-content/uploads/2019/01/NurseStaffingWhitePaper_Final.pdf?name=Mary%20Evans&email=mary.evans%40osbm.nc.gov&organization=NC%20Office%20of%20State%20Budget%20and%20Management&job_title=Not%20currently%20working%20in%20nursing&what_best_describes_where_you_work=Other&top_interest_area_1_=Excellence&top_interest_area_2=Care%20Management&top_interest_area_3=Accreditation

4 https://www.cdc.gov/traumaticbraininjury/get_the_facts.html

5 https://www.cdc.gov/traumaticbraininjury/get_the_facts.html

6 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4516907/

7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4516907/

(including neuropsychological services), and orthotic and prosthetic services. In addition, federal regulation 42 CFR 412.622 (ii) requires intensive rehabilitation therapy programs to generally consist of at least three hours of therapy per day, at least five days per week. However, as noted in stakeholder meetings, meeting these targets also depends on the patient's ability to tolerate these therapies.

A change was also made to eliminate the medical director qualifications because of an existing Rules Review Commission objection. The Rules Review Commission determined that the agency has no authority to set the medical director qualifications. In order to receive reimbursement for Medicare and Medicaid patients, facilities are responsible for providing the appropriate director of rehabilitation per 42 CFR 412.29(g).

As federal regulations already require hospitals to be organized and staffed to provide care according to a patient's assessment and plan of care developed by their medical team as well as the fact that existing rules have not been practiced for some time as they are outdated, the current baseline already reflects the new rules. The new rule also allows hospitals the flexibility to provide care without negatively impacting in any way the wellbeing of the patient. It is unlikely that there will be any additional fiscal impact from this rule update. This readoption also will not result in any changes to current practices or processes and is unlikely to have any fiscal implications for administrative/professional staff, state, or local staff.

Fiscal Impact:

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Rule 13B .5413 – Additional Requirements for Spinal Cord Injury Patients

The agency is proposing to readopt this rule with substantive changes. This rule establishes additional requirements for inpatient rehabilitation facilities providing services to persons with spinal cord injury. It is being changed to resolve the conflict between the outdated rule and the current standards of practice, as well as reflect current standards of care regarding nursing, physical, occupational, and speech therapy hours. Current industry standards for intensive rehabilitation therapy programs generally consist of at least three hours of therapy per day at least five days per week.

An estimated 291,000 people are living with SCI in the United States today. In the United States alone, approximately 17,730 new SCI cases occur each year. Most new spinal cord injuries affect men, who account for 78% of new cases. The average age at the time of injury is 43 years. Most spinal cord injuries are caused by car crashes, followed closely by falls and violent acts. The average Acute Care hospital stay is 11 days. Rehabilitation facility stays average 31 days.[8]

The previously mentioned stakeholder group also provided expertise regarding spinal cord patient care standards. They acknowledged that the standard of practice regarding nursing care and physical, occupational, and speech therapy for spinal cord patients is to provide physical, occupational, and speech therapy hours to meet the needs of the patient in accordance with the patient assessment, treatment plan, and physician orders.

8 https://www.spineuniverse.com/conditions/spinal-cord-injury/traumatic-spinal-cord-injury-facts-figures

Doctors determine the appropriate level of care and treatment plan for SCI patients. Hospitals determine the appropriate level of staffing to meet treatment plan. The current rules required a minimum of 6.0 nursing hours per patient day and that direct care nursing staff required at least 2 FTEs, one of which is a registered nurse. Similarly to the reasons listed for the traumatic brain injury patients, the care of spinal cord patients is also extremely varied based on their individual injuries and comorbidities. Therefore, it is not an efficient or effective practice to mandate minimum numbers of nursing hours per patient day for such a general population. The current rule standards are also not supported by evidence-based practice.

The following current federal regulations set the current industry standards. 42 CFR 482.56 requires hospitals that provide rehabilitation to be organized and staffed to ensure the health and safety of patients. Federal regulation 42 CFR 412.29 as a condition for payment for Medicare and Medicaid patients under the inpatient rehabilitation facility prospective payment system, rehabilitation facilities are to furnish through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

In addition, a change was made to eliminate the medical director qualifications because of an existing Rules Review Commission objection. The Rules Review Commission determined that the agency has no authority to set the medical director qualifications. Similarly to traumatic brain injury patients, facilities are responsible for providing the appropriate medical director to meet the needs of patients per 42 CFR 412.29(g).

While changes to rules reflect current practices, it is unlikely that there will be any fiscal impact. Acute care hospitals with rehabilitation units and rehabilitation facilities are currently complying with the federal regulations. Hospitals are required to be in compliance with the federal requirements set forth in the Medicare Conditions of Participation (CoP) in order to receive Medicare/Medicaid payment. This readoption will not result in any changes to current standards, practices, or processes and is unlikely to have any fiscal implications for administrative/professional staff, state, or local staff.

Fiscal Impact:

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Impact Summary

These readoptions update rules to account for current practices and language, remove ambiguity, address previous Rule Review Commission objections, and implement technical changes. Changes also allow reference to the General Statute where appropriate. The changes reflect current practices and eliminates the conflict between current standards of practice and rules 13B .5412 and .5413. It is unlikely that there will be any fiscal impact. Updates to current standards or processes is unlikely to have any fiscal implications for facilities since rehabilitation facilities currently adhere to the standards. Changes made to reference the statute will have no impact, as the statutes will always prevail. There were no new requirements added, or changes in scope. It is unlikely changes will have any fiscal impact on facility cost, administrative cost, patient costs, or impact state or local staff.

10A NCAC 13B .1902 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .1902 DEFINITIONS

The following definitions shall apply throughout this Section, unless text otherwise clearly indicates to the contrary:

(1) "Accident" means something occurring by chance or without intention ~~which~~ that has caused physical or mental harm to a patient, ~~resident~~ resident, or employee.

(2) "Administer" means ~~the direct application of a drug to the body of a patient by injection, inhalation, ingestion or other means.~~ as defined in G.S. 90-87.

(3) "Administrator" means the person who has authority for and is responsible to the governing board for the overall operation of a facility.

(4) "Brain injury long-term care" is defined as an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process and are directed toward maintaining the individual at the optimal level of physical, ~~cognitive~~ cognitive, and behavioral functioning.

~~(5) "Capacity" means the maximum number of patient or resident beds which the facility is licensed to maintain at any given time. This number shall be determined as follows:~~

~~(a) Bedrooms shall have minimum square footage of 100 square feet for a single bedroom and 80 square feet per patient or resident in multi-bedded rooms. This minimum square footage shall not include space in toilet rooms, washrooms, closets, vestibules, corridors, and built-in furniture.~~

~~(b) Dining, recreation and common use areas available shall total no less than 25 square feet per bed for skilled nursing and intermediate care beds and no less than 30 square feet per bed for adult care home beds. Such space must be contiguous to patient and resident bedrooms.~~

~~(6)~~(5) "Combination Facility" means any hospital with nursing home beds ~~which~~ that is licensed to provide more than one level of care such as a combination of intermediate care ~~and/or~~ and skilled nursing care and adult care home care.

~~(7) "Convalescent Care" means care given for the purpose of assisting the patient or resident to regain health or strength.~~

~~(8)~~(6) "Department" means the North Carolina Department of Health and Human Services.

~~(9)~~(7) "Director of Nursing" means the nurse who has authority and ~~direct~~ responsibility for all nursing services and nursing care.

~~(10)~~(8) "Dispense" means ~~preparing and packaging a prescription drug or device in a container and labeling the container with information required by state and federal law. Filling or refilling drug containers~~

~~with prescription drugs for subsequent use by a patient is "dispensing". Providing quantities of unit dose prescription drugs for subsequent administration is "dispensing".~~ as defined in G.S. 90-87.

~~(11)~~(9) "Drug" means ~~substances:~~

~~(a) recognized in the official United States Pharmacopoeia, official National Formulary, or any supplement to any of them;~~

~~(b) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;~~

~~(c) intended to affect the structure or any function of the body of man or other animals, i.e., substances other than food; and~~

~~(d) intended for use as a component of any article specified in (a), (b), or (c) of this Subparagraph; but does not include devices or their components, parts, or accessories.~~

as defined in G.S. 90-87.

~~(12)~~(10) "Duly Licensed" means holding a current and valid license as required under the General Statues of North Carolina.

~~(13) "Existing Facility" means a licensed facility; or a proposed facility, proposed addition to a licensed facility or proposed remodeled licensed facility that will be built according to plans and specifications which have been approved by the department through the preliminary working drawings stage prior to the effective date of this Rule.~~

~~(14) "Exit Conference" means the conference held at the end of a survey, inspection or investigation, but prior to finalizing the same, between the department's representatives who conducted the survey, inspection or investigation and the facility administration representative(s).~~

~~(15)~~(11) "Incident" means an intentional or unintentional action, occurrence or happening ~~which~~ that is likely to cause or lead to physical or mental harm to a patient, ~~resident~~ resident, or employee.

~~(16)~~(12) "Licensed Practical Nurse" means ~~a nurse who is duly licensed as a practical nurse under G.S. 90, Article 9A.~~ as defined in G.S. 90-171.30 or G.S. 90-171.32.

~~(17) "Licensee" means the person, firm, partnership, association, corporation or organization to whom a license has been issued.~~

~~(18)~~(13) "Medication" means drug as defined in ~~(12)~~ Item (9) of this Rule.

~~(19) "New Facility" means a proposed facility, a proposed addition to an existing facility or a proposed remodeled portion of an existing facility that is constructed according to plans and specifications approved by the department subsequent to the effective date of this Rule. If determined by the department that more than one half of an existing facility is remodeled, the entire existing facility shall be considered a new facility.~~

~~(20)~~(14) "Nurse Aide" means any individual providing nursing or nursing-related services to patients in a facility, and is not a licensed health professional, a qualified dietitian or someone who volunteers to provide such services without pay, and who is listed in a nurse aide registry approved by the Department.

~~(21)~~(15) "Nurse Aide Trainee" means an individual who has not completed an approved nurse aide training course and competency evaluation and is demonstrating knowledge, while performing tasks ~~for which~~ that they have been found proficient in by an instructor. These tasks shall be performed under the ~~direct~~ supervision of a registered nurse. The term does not apply to volunteers.

~~(22)~~(16) "Nursing Facility" means that portion of a nursing home certified under Title XIX of the Social Security Act (Medicaid) as in compliance with federal program standards for nursing facilities. It is often used ~~as~~ synonymous with the term "nursing ~~home"~~ home," ~~which is~~ the usual prerequisite level for state licensure for nursing facility (NF) certification and Medicare skilled nursing facility (SNF) certification.

~~(23)~~(17) "Nurse in Charge" means the nurse to whom duties for a specified number of patients and staff for a specified period of time have been delegated, such as for Unit A on the 7-3 or 3-11 shift.

~~(24)~~(18) "On Duty" means personnel who are awake, dressed, and responsive to patient needs and ~~physically~~ present in the facility performing assigned duties.

~~(25)~~(19) "Patient" means any person admitted for care to a skilled nursing or intermediate care facility.

~~(26)~~(20) "Physician" means ~~a person licensed under G.S. Chapter 90, Article 1 to practice medicine in North Carolina.~~ as defined in G.S. 90-9.1 or G.S. 90-9.2.

~~(27)~~(21) "Qualified Dietitian" means ~~a person who meets the standards and qualifications established by the Committee on Professional Registration of the American Dietetic Association included in "Standards of Practice" seven dollars and twenty-five cents ($7.25) or "Code of Ethics for the Profession of Dietetics" two dollars and fifteen cents ($2.15), American Dietetic Association, 216 W. Jackson Blvd., Chicago, IL 60606-6995.~~ as defined in 42 CFR 483.60(a)(1), herein incorporated by reference including subsequent amendments and editions. Electronic copies of 42 CFR 483.60 can be obtained free of charge at https://www.ecfr.gov/cgi-bin/text-idx?SID=1260800a39929487f0ca55b0ab5e710b&mc=true&tpl=/ecfrbrowse/Title42/42cfrv5_02.tpl#0.

~~(28)~~(22) "Registered Nurse" means ~~a nurse who is duly licensed as a registered nurse under~~ as defined in G.S. 90, Article 9A.

~~(29)~~(23) "Resident" means ~~any person admitted for care to an adult care home.~~ as defined in G.S.131D-2.1.

~~(30) "Sitter" means an individual employed to provide companionship and social interaction to a particular resident or patient, usually on a private duty basis.~~

~~(31)~~(24) "Supervisor-in-Charge" means a duly licensed nurse to whom supervisory duties have been delegated by the Director of Nursing.

~~(32)~~(25) "Ventilator dependence" means physiological dependency by a patient on the use of a ventilator for more than eight hours a day.

History Note: *Filed as a Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;*

Authority G.S. 131E-79;
Eff. February 1, 1986;
Amended Eff. February 1, 1993; December 1, 1991; March 1, 1991; March 1, ~~1990.~~ 1990;
Readopted Eff. April 1, 2020.

10A NCAC 13B .1918 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .1918 TRAINING

(a) A licensed facility shall provide ~~for all~~ patient or resident care employees a planned orientation and continuing education program emphasizing patient or resident assessment and planning, activities of daily living, personal grooming, rehabilitative nursing or restorative care, other patient or resident care policies and procedures, patients' rights, and staff performance expectations. Attendance and subject matter covered shall be documented for each ~~session~~ session, retained in accordance with policy established by the facility, and available for licensure inspections.

(b) The administrator shall assure that ~~each employee is~~ employees are oriented within the first week of employment to the facility's philosophy and goals.

(c) ~~Each employee~~ Employees shall have specific on-the-job training as necessary ~~for the employee~~ to ~~properly~~ perform ~~his~~ their individual job assignment.

(d) Unless otherwise prohibited, a nurse aide trainee may be employed to perform the duties of a nurse aide for a period of time not to exceed four months. During this period of time the nurse aide trainee shall be permitted to perform only those tasks ~~for which minimum acceptable~~ that competence has been demonstrated and documented on a skills check-off record. ~~Job applicants for nurse aide positions who were formerly qualified nurse aides but have not been gainfully employed as such for a period of 24 consecutive months or more shall be employed only as nurse aide trainees and must re-qualify as nurse aides within four months of hire by successfully passing an approved competency evaluation. Any individual, nursing home, or education facility may offer Department approved vocational education for nursing home nurse aides. An accurate record~~ Nurse aide I shall meet the training and competency evaluation requirements in 42 CFR 483, Subpart D incorporated herein by reference including subsequent amendments and editions. A record of nurse aide qualifications shall be maintained for each nurse aide used by a facility and shall be retained in the general personnel files of the ~~facility.~~ facility in accordance with policy established by the facility.

(e) ~~The curriculum content required for nurse aide education programs shall be subject to approval by the Division of Health Service Regulation and shall include, as a minimum, basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and patients' rights. Successful course completion shall be determined by passing a competency evaluation test. The minimum number of course hours shall be 75 of which at least 20 hours shall be classroom and at least 40 hours of supervised practical experience.~~ The initial orientation to the facility shall be exclusive of the 75 hour training program. Competency evaluation shall be conducted in each of the following areas:

(1) Observation and documentation,

(2) Basic nursing skills,

(3) Personal care skills,

(4) Mental health and social service needs,

(5) Basic restorative services, and

(6) Residents' Rights.

~~(f) Successful course completion and skill competency shall be determined by competency evaluation approved by the Department. Commencing July 1, 1989, nurse aides who had formerly been fully qualified under nurse aide training requirements may re-establish their qualifications by successfully passing a competency evaluation test~~.

History Note: Filed as a Temporary Rule Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Authority G.S. 131E-79; 42 U.S.C. 1396 r (b)(5);
Eff. February 1, 1986;
Amended Eff. March 1, 1991; March 1, ~~1990.~~ 1990;
Readopted Eff. April 1, 2020.

10A NCAC 13B .1925 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .1925 REQUIRED SPACES

~~The total space requirements shall be those set forth in Rule .1902(5) of this Section~~. Physical therapy and occupational therapy space shall not be included in these totals. (a) A combination or nursing facility shall meet the following requirements for bedrooms, dining, recreation, and common use areas:

(1) single bedrooms shall be provided with not less than 100 square feet of floor area;

(2) bedrooms with more than one bed shall be provided with not less than 80 square feet of floor area per bed;

(3) dining, recreation, and common use areas shall:

(A) total not less than 25 square feet of floor area per bed for skilled nursing and intermediate care beds;

(B) total not less than 30 square feet of floor area per bed for adult care home beds; and

(C) be contiguous to patient and resident bedrooms.

(b) Floor space for the following rooms, areas, and furniture shall not be included in the floor areas required by Paragraph (a) of this Rule:

(1) toilet rooms;

(2) vestibules;

(3) bath areas;

(4) closets, lockers, or moveable wardrobes;

(5) built-in furniture; and
(6) corridors.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, ~~1986.~~ 1986;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3001 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3001 DEFINITIONS

Notwithstanding Section .1900 of this Subchapter, ~~The~~ the following definitions shall apply throughout this ~~Section~~ Subchapter unless the context clearly indicates to the contrary:

(1) "Appropriate" means suitable or fitting, or conforming to standards of care as established by professional organizations.
(2) "Authority having jurisdiction" means the Division of Health Service Regulation.
(3) "Certified Dietary Manager" or "CDM" means an individual who is certified by the Certifying Board of the Dietary Managers and meets the standards and qualification as referenced in the "Dietary Manager Training Program Requirements." These standards include any subsequent amendments and editions of the referenced manual. Copies of the "Dietary Manager Training Program Requirements" may be ~~purchased for fifteen dollars ($15.00) from the Dietary Managers Association, 406 Surry Woods Dr., St. Charles, IL 60174.~~ obtained free of charge at https://www.cbdmonline.org/.
(4) "Competence" means the state or quality of being able to perform specific functions well; skill; ability.
(5) "Comprehensive" means covering completely, inclusive; large in scope or content.
(6) “Construction documents” means final building plans and specifications for the construction of a facility that a governing body submits to the Construction Section for approval as specified in Rule .3102 of this Subchapter.
(7) “Construction Section” means the Construction Section of the Division of Health Service Regulation.
~~(6)~~(8) "Continuous" means ongoing or uninterrupted, 24 hours per day.
~~(7)~~(9) "CRNA" means a Certified Registered Nurse Anesthetist as ~~credentialed by the Council on Certification of Nurse Anesthetists and recognized by the Board of Nursing in 21 NCAC 36 .0226.~~ defined in G.S. 90-171.21(d)(4).
~~(8)~~(10) "Credentialed" means that the individual having a given title or position has been credited with the right to exercise official responsibilities to provide specific patient care and treatment services, within defined limits, based primarily upon the individual's license, education, training, experience, competence, and judgment.

~~(9)~~(11) "Department" means the Department of Health and Human Services.

~~(10)~~(12) "Dietetics" means ~~the integration and application of principles derived from the science of nutrition, biochemistry, physiology, food and management and from behavioral and social sciences to achieve and maintain optimal nutritional status.~~ as defined in G.S. 90-352.

~~(11)~~(13) "Dietitian" means ~~an individual who is licensed according to~~ as defined in G.S. 90, ~~Article 25, or is registered by the Commission on Dietetic Registration (CDR) of the American Dietetic Association (ADA) according to the standards and qualifications as referenced in the second edition of the "Accreditation/Approval Manual for Dietetic Education Programs", "The Registration Eligibility Application for Dietitians" and the "Continuing Professional Education" and subsequent amendments or editions of the reference material. Copies of the "Accreditation/Approval Manual for Dietetic Education Programs" may be purchased for twenty-one dollars and ninety-five cents ($21.95) plus three dollars ($3.00) minimum shipping and handling from ADA 216 W. Jackson Blvd., Chicago, IL 60606-9-6995.~~ Article 25.

~~(12)~~(14) "Dietetic Technician Registered" or "DTR" means ~~an individual who is registered by the Commission on Dietetic Registration (CDR) of the American Dietetic Association (ADA) according to the standards and qualifications as referenced in the second edition of the "Accreditation/Approval Manual for Dietetic Education Programs" which is incorporated by reference including any subsequent amendments and editions. Copies of the "Accreditation/Approval Manual for Dietetic Education Programs" may be purchased for twenty-one dollars and ninety-five cents ($21.95) plus three dollars ($3.00) minimum for shipping and handling from the ADA 216 W. Jackson Blvd., Chicago, IL 60606-9-6995.~~ as defined in G.S. 90-352.

~~(13)~~(15) "Direct Supervision" means the state of being under the immediate control of a supervisor, manager, or other person of authority.

~~(14)~~(16) "Division" means the Division of Health Service Regulation.

~~(15)~~(17) "Facility" means a hospital as defined in G.S. 131E-76.

~~(16)~~(18) "Free standing facility" means a facility that is physically separated from the primary hospital building or separated by a three hour fire containment wall.

~~(17)~~(19) "Full-time equivalent" means a unit of measure of employee work time that is equal to the number of hours that one full-time employee would work during one calendar year if the employee worked eight hours a day, five days a week, and 52 weeks a year; i.e. 2,080 hours per year.

~~(18)~~(20) "Governing body" means the authority as defined in G.S. 131E-76.

~~(19)~~(21) "Imaging" means a reproduction or representation of a body or body part for diagnostic purposes by radiologic intervention that may include conventional fluoroscopic exam, magnetic resonance, nuclear or radio-isotope scan.

~~(20)~~(22) "Invasive procedure" means a procedure involving puncture or incision of the skin, insertion of an instrument or foreign material into the body (excluding venipuncture and intravenous therapy).

~~(21)~~(23) "LDRP" (labor, delivery, recovery, post-partum) means a specific single occupancy obstetrical use room counted as a licensed bed.

~~(22)~~(24) "License" means formal permission to provide services as granted by the State.

~~(23)~~(25) "Medical staff" means the formal organization that is comprised of ~~all of those~~ individuals who have sought and obtained clinical privileges in a facility. Those members of the medical staff who regularly and routinely admit patients to a facility constitute the active medical staff.

~~(24)~~(26) "Mission statement" means a written statement of the philosophy and beliefs of the organization or hospital as approved by the governing body.

~~(25)~~(27) "Neonate" means the newborn from birth to one month.

~~(26)~~(28) "NP" means a Nurse Practitioner as defined in ~~G.S. 90-6;~~ G.S. 90-8.2, ~~90-18(14)~~ 90-18(14), and 90-18.2.

~~(27)~~(29) "Nurse executive" means ~~a registered nurse who is the director of nursing services or a representative of decentralized nursing management staff.~~ as defined in Rule 21 NCAC 36 .0109.

~~(28)~~(30) "Nurse midwife" means ~~a Certified Nurse Midwife~~ as defined in ~~G.S. 90, Article 10.~~ G.S.90-171.21 (4).

~~(29)~~(31) "Nursing facility" means ~~that portion of a hospital that is approved to provide skilled nursing care.~~ as defined in G.S. 131E-116 (2).

~~(30)~~(32) "Nursing staff" means the registered nurses, licensed practical nurses, nurse aides, and others under nurse supervision, who provide ~~direct~~ patient care. The term also includes clerical personnel who work in clinical areas under nurse supervision.

(33) "Nutrition and Dietetic Technician Registered" means as defined by the Academy of Nutrition and Dietetics. A copy of the requirements can be obtained at https://www.eatrightpro.org/about-us/what-is-an-rdn-and-dtr/what-is-a-nutrition-and-dietetics-technician-registered at no cost.

~~(31)~~(34) "Nutrition therapy" ranges from intervention and counseling on diet modification to administration of specialized nutrition therapies as determined necessary to manage a condition or treat illness or injury. Specialized nutrition therapies include supplementation with medical foods, enteral and parenteral nutrition. Nutrition therapy integrates information from the nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status.

~~(32)~~(35) "Observation bed" means a bed used for no more than 24-hours, to evaluate and determine the condition and disposition of a patient and is not considered a part of the hospital's licensed bed capacity.

~~(33)~~(36) "Patient" means any person receiving diagnostic or medical services at a hospital.

~~(34)~~(37) "Pharmacist" means ~~a person licensed according to G.S. 90, Article 4A, by the N.C. Board of Pharmacy to practice pharmacy.~~ as defined in G.S. 90-85.3.

~~(35)~~(38) "Physical Rehabilitation Services" means any combination of physical therapy, occupational therapy, speech ~~therapy~~ therapy, or vocational rehabilitation.

~~(36)~~(39) "Physician" means ~~a person licensed according to G.S. 90, Article 1, by the N.C. Board of Medical Examiners to practice medicine.~~ as defined in G.S.90-9.1 or G.S. 90-9.2.

~~(37)~~(40) "Provisional license" means a hospital license recognizing ~~significantly~~ less than full compliance with the licensure rules.

~~(38)~~(41) "Qualified" means having complied with the specific conditions for employment or the performance of a function.

~~(39)~~(42) "Reference" means to use in consultation to obtain information.

~~(40)~~(43) "Special Care Unit" means a ~~designated~~ unit or area of a hospital ~~with a concentration of qualified professional staff and support services that provide intensive or extra ordinary care on a 24-hour basis to critically ill patients; these units may include but are not limited to Cardiac Care, Medical or Surgical Intensive Care Unit, Cardiothoracic Intensive Care Unit, Burn Intensive Care Unit, Neurologic Intensive Care Unit or Pediatric Intensive Care Unit.~~ that includes a critical care unit, an intermediate care unit, or a pediatric care unit.

~~(41)~~(44) "Unit" means a designated area of the hospital for the delivery of patient care services.

History Note: *Authority G.S. 131E-79;*
RRC Objection due to lack of Statutory Authority Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3101 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3101 GENERAL REQUIREMENTS

(a) An application for licensure shall be submitted to the Division prior to a license being issued or patients admitted.

(b) An existing facility shall not sell, ~~lease~~ lease, or subdivide a portion of its bed capacity without the approval of the Division.

(c) Application forms may be obtained by contacting the Division.

(d) The Division shall be notified in writing 30 days prior to the occurrence of any of the following:

(1) addition or deletion of a licensable service;

(2) increase or decrease in bed capacity;

(3) change of chief executive officer;

(4) change of mailing address;

(5) ownership change; or

(6) name change.

(e) Each application shall contain the following information:

(1) legal identity of applicant;

(2) name or names ~~under which~~ <u>used to present</u> the hospital or services ~~are presented~~ to the public;
(3) name of the chief executive officer;
(4) ownership disclosure;
(5) bed complement;
(6) bed utilization data;
(7) accreditation data;
(8) physical plant inspection data; and
(9) service data.

(f) A license shall include only facilities or premises within a single county.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Amended Eff. April 1, ~~2003.~~ <u>2003;</u>
<u>Readopted Eff. April 1, 2020.</u>

10A NCAC 13B .3302 is proposed for readoption <u>with substantive changes</u> as follows:

10A NCAC 13B .3302 MINIMUM PROVISIONS OF PATIENT'S BILL OF RIGHTS

This Rule does not apply to patients in licensed nursing facility beds since these individuals are granted rights pursuant to G.S. 131E-117. A patient in a facility subject to this Rule has the following rights:

(1) A patient has the right to respectful care given by competent personnel.
(2) A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his <u>or her</u> care, and the names and functions of other health care persons having direct contact with the patient.
(3) A patient has the right to privacy concerning his <u>or her</u> own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly.
~~(4) A patient has the right to have all records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.~~
~~(5)~~<u>(4)</u> A patient has the right to know what facility rules and regulations apply to his <u>or her</u> conduct as a patient.
~~(6)~~<u>(5)</u> A patient has the right to expect emergency procedures to be implemented without ~~unnecessary~~ delay.
~~(7)~~<u>(6)</u> A patient has the right to ~~good~~ quality care and ~~high~~ professional standards that are ~~continually~~ maintained and reviewed.

~~(8)~~(7) A patient has the right to full information in laymen's terms, concerning his diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his or her behalf to the patient's designee.

~~(9)~~ (8) Except for emergencies, a physician must obtain ~~necessary~~ informed consent prior to the start of any procedure or ~~treatment, or both.~~ treatment.

~~(10)~~ (9) A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent ~~must~~ shall be obtained prior to ~~actual~~ participation in such a ~~program and the~~ program. The patient or legally responsible party~~, may, at any time,~~ may refuse to continue in any ~~such~~ program ~~to which~~ that he or she has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in ~~accord~~ accordance with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations under 21 CFR Parts 50 and 56. For any research study proposed for conduct under an FDA "Exception from Informed Consent Requirements for Emergency Research" or an HHS "Emergency Research Consent Waiver" ~~in which~~ that waives informed consent ~~is waived~~ but community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study shall also ~~must~~ verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB ~~reviewing the research study~~ has authorized the start of the community consultation process required ~~by the federal regulations~~ for emergency research, but before the beginning of that process, notice of the proposed research study ~~by the facility~~ shall be provided to the North Carolina Medical Care Commission. The notice shall include:

(a) the title of the research study;

(b) a description of the research study, including a description of the population to be enrolled;

(c) a description of the planned community consultation process, including ~~currently~~ proposed meeting dates and times;

(d) ~~an explanation of the way that people choosing not to participate in~~ instructions for opting out of the research ~~study may opt out;~~ study; and

(e) contact information including mailing address and phone number for the IRB and the principal investigator.

The Medical Care Commission may publish all or part of the above information in the North Carolina Register, and may require the institution proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.

~~(11)~~ (10)A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to the extent permitted by law, and a physician shall inform the patient of his or her right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.

~~(12)~~ (11)A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.

~~(13)~~ (12)A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual orientation, gender identity, national origin or source of payment.

~~(14)~~ (13)A patient who does not speak English shall have ~~access, when possible,~~ access to an interpreter.

~~(15)~~ (14)~~A facility shall provide a patient, or patient designee, upon request, access to all information contained in the patient's medical records.~~ A patient or his or her designee has the right to have all records pertaining to his or her medical care treated as confidential except as otherwise provided by law or third party contractual arrangements. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason. A patient's designee may have access to the information in the patient's medical records even if the attending physician restricts the patient's access to those records.

~~(16)~~ (15)A patient has the right not to be awakened by hospital staff unless it is medically necessary.

~~(17)~~ (16)The patient has the right to be free from duplication of medical and nursing procedures as determined by the attending physician.

~~(18)~~ (17)The patient has the right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.

~~(19)~~ (18)When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility ~~to which~~ that the patient is to be transferred must first have accepted the patient for transfer.

~~(20)~~ (19)The patient has the right to examine and receive a detailed explanation of his bill.

~~(21)~~ (20)The patient has a right to full information and counseling on the availability of known financial resources for his health care.

~~(22)~~ (21)A patient has the right to be informed upon discharge of his or her continuing health care requirements following discharge and the means for meeting them.

~~(23)~~ (22)A patient shall not be denied the right of access to an individual or agency who is authorized to act on his or her behalf to assert or protect the rights set out in this Section.

~~(24)~~ (23)A patient has the right to be informed of his rights at the earliest possible time in the course of his or her hospitalization.

~~(25)~~ (24) A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient.

History Note: *Authority G.S. 131E-75; 131E-79; 143B-165;*
RRC Objection due to ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Temporary Amendment Eff. April 1, 2005;
Amended Eff. January 1, 2011; May 1, 2008; November 1, ~~2005.~~ 2005;
Readopted Eff. April 1, 2020.

10A NCAC 13B .5412 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .5412 ADDITIONAL REQUIREMENTS FOR TRAUMATIC BRAIN INJURY PATIENTS

Inpatient rehabilitation facilities providing services to ~~persons~~ patients with traumatic brain injuries shall ~~meet the requirements in this Rule in addition to those identified in this Section.~~ provide staff to meet the needs of patients in accordance with the patient assessment, treatment plan, and physician orders.

~~(1) Direct-care nursing personnel staffing ratios established in Rule .5408 of this Section shall not be applied to nursing services for traumatic brain injury patients in the inpatient, rehabilitation facility or unit. The minimum nursing hours per traumatic brain injury patient in the unit shall be 6.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which shall be a registered nurse.~~

~~(2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.5 hours of specific or combined rehabilitation therapy services per traumatic brain injury patient day.~~

~~(3)~~ (1) The facility shall ~~provide special facility or~~ have access to special equipment to meet the needs ~~for patients~~ of patients with traumatic brain ~~injury, including specially designed wheelchairs, tilt tables and standing tables.~~ injury.

~~(4) The medical director of an inpatient traumatic brain injury program shall have two years management in a brain injury program, one of which may be in a clinical fellowship program and board eligibility or certification in the medical specialty of the physician's training.~~

~~(5)~~ (2) The facility shall provide the consulting services of a neuropsychologist.

~~(6)~~ (3) The facility shall provide continuing education in the care and treatment of brain injury patients for all staff.

~~(7)~~ (4) The size of the brain injury program shall ~~be adequate to~~ support a comprehensive, dedicated ongoing brain injury program.

History Note: *Authority G.S. 131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .5413 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .5413 ADDITIONAL REQUIREMENTS FOR SPINAL CORD INJURY PATIENTS

Inpatient rehabilitation facilities providing services to ~~persons~~ patients with spinal cord injuries shall ~~meet the requirements in this Rule in addition to those identified in this Section.~~ provide staff to meet the needs of patients in accordance with the patient assessment, treatment plan, and physician orders.

~~(1) Direct care nursing personnel staffing ratios established in Rule .5408 of this Section shall not be applied to nursing services for spinal cord injury patients in the inpatient rehabilitation facility or unit. The minimum nursing hours per spinal cord injury patient in the unit shall be 6.0 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which shall be a registered nurse.~~

~~(2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.0 hours of specific or combined rehabilitation therapy services per spinal cord injury patient day.~~

~~(3)~~ (1) The facility shall ~~provide special facility or~~ have access to special equipment to meet the needs of patients with spinal cord ~~injury, including specially designed wheelchairs, tilt tables and standing tables.~~ injury.

~~(4) The medical director of an inpatient spinal cord injury program shall have either two years experience in the medical care of persons with spinal cord injuries or six months minimum in a spinal cord injury fellowship.~~

~~(5)~~ (2) The facility shall provide continuing education in the care and treatment of spinal cord injury patients for all staff.

~~(6)~~ (3) The facility shall provide specific staff training and education in the care and treatment of spinal cord injury.

~~(7)~~ (4) The size of the spinal cord injury program shall ~~be adequate to~~ support a comprehensive, dedicated ongoing spinal cord injury program.

History Note: *Authority G.S. 131E-79;*

RRC Objection due to lack of statutory authority Eff. January 18, 1996;

Eff. May 1, ~~1996.~~ 1996;

Readopted Eff. April 1, 2020.

Licensing of Hospitals Rules Readoption – Public Comments
10A NCAC 13 B .1902, .1915, .1918, .1925, .3001, .3131, .3110, .3204, .3205, .3302, .3303, .5412, and .5413
Comment Period 9/16/19 – 11/15/19

Introduction:

Two individuals submitted comments during the public comment period on the readoption of Licensing of Hospital rules 10A NCAC 13 B .1902, .1915, .1918, .1925, .3001, .3131, .3110, .3204, .3205, .3302, .3303, .5412, and .5413. Of these comments, no member of the public was present during the public hearing conducted on October 1, 2019. These comments were submitted by a representative from the North Carolina Healthcare Association and summarized below:

Comments Received and Agency's Consideration of Comments for Readoption Rule 13B .5412 – Additional Requirements for Traumatic Brain Injury Patients:

Commenter	Comment Summary
North Carolina Healthcare Association	(in (2)) Providing the consulting services of neuropsychologist is almost impossible in rural areas due to the lack in and access to these providers. These areas may use licensed clinical counselors instead. This wording may preclude rural and community based inpatient rehabs from providing this service line to and for their community. As this is another of the rules that are ideally addressed by CMS and/or Accreditation bodies, is this a change that can be considered under the current timetable for the periodic rule review?
North Carolina Healthcare Association	The requirement in Section .5412 (2) *"shall provide the consulting services of a neuropsychologist"* is not consistent with CMS requirements for inpatient comprehensive inpatient providers of TBI services. Obtaining these services in rural areas may be difficult due to lack of access to neuropsychologists. Suggest: remove the requirement or modify to require "the provision of clinical counseling" without mandating a credential for the provider of the service.

Agency Response to Comments Above:

DHSR does not support deleting "consulting services of a neuropsychologist" in the rule.

NC General Assembly Session Law 2019 – 240; Senate Bill 537
(38a) Traumatic brain injury. – An injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment, or both, and meets all of the following criteria: a. Involves an open or closed head injury. b. Resulted from a single event or resulted from a series of events which may include multiple concussions. c. Occurs with or without a loss of consciousness at the time of injury. d. Results in impairments in one or more areas of the following functions: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. e. Does not include brain injuries that are congenital or degenerative. …." Approved November 6, 2019

Hospital rule: 10A NCAC 13B .1902 DEFINITIONS
The following definitions shall apply throughout this Section, unless text otherwise clearly indicates to the contrary:
(1) (2) (3) .

(4) "Brain injury long-term care" is defined as an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process and are directed toward maintaining the individual at the optimal level of physical, cognitive and behavioral functioning.

NCHA references the following CMS rule:
42 CFR 482.56 Condition of Participation: Rehabilitation Services
Addresses the provision of rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services in an organized manner to ensure the health and safety of patients. The provision of rehab services in this particular regulation clearly addresses the physical needs of patients. However, this regulation is not intended to be an all-inclusive listing of all the care, treatment and services warranted by a traumatic brain injury patient in an acute inpatient rehabilitation bed or outpatient setting. Examples of care needs may include sensory problems, emotional problems, and/or thinking problems of which the services of a psychologist/neuropsychologist are needed to assess and treat problems with thinking, memory, mood, and behavior. Provision of services via technology-assisted media or telemedicine is an optional mean of assessing and serving the needs of patients.

A position statement from the North Carolina Psychology Board from March, 2005, titled “Provision of Services via electronic means” stated that deleting the services of a neuropsychologist has the potential of diminishing the delivery of quality care and meeting he needs of TBI patients.

At this time, we do not have the support of NC Psychology Board and/or NC DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services Traumatic Brain Injury Team, NC DHSR Mental Health Licensure Section to delete the reference in the rule. DHSR recommends no change to the reference in the rule on “consulting services of a neuropsychologist.”

EXHIBIT D

Friends Homes

Compliance Summary:

- **<u>Violation of MCC Compliance policy (Section A Only)</u>**

  1) Violation of 12 month compliance requirement (Section B of MCC Compliance Policy):

     - NONE

  2) Violation of multi-year history of non-compliance requirement (Section A of MCC Compliance Policy):

     - VIOLATION (FYE 2018 & FYE 2016)
       - FYE 2019 (Review of Routine Annual & Quarterly Filings) – No Findings
       - FYE 2018 (Review of Routine Annual & Quarterly Filings)
         - Late filing of Opinion of Counsel regarding financing statements
       - FYE 2017 (Review of Routine Annual & Quarterly Filings) – No Findings
       - FYE 2016
         - Late filing of Opinion of Counsel regarding financing statements
         - Late filing of Schedule K

Selected Application Information:

1) Information from FYE 2019 (9/30 Year End) Audit of Friends Homes:

Operating Income	$ 2,476,937
Resident Service Revenue	$ 29,590,499
Change in Unrestricted Net Assets	$ 613,870
Change in Net Assets	$ 655,528
Net Cash provided by Operating Activities	$ 2,793,296
Unrestricted Cash	$ 1,143,803
Change in Cash	$ (78,922)

Note: Decrease in cash due to purchase of investments and property.

2) Ratings: None

3) Community Benefits (FYE 2019):

Per N.C.G.S § 105 – 5.16% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $1,428,075

4) Long-Term Debt Service Coverage Ratios:

Actual	FYE	2019	2.73
Forecasted	FYE	2020	1.94
Forecasted	FYE	2021	2.03
Forecasted	FYE	2022	2.50
Forecasted	FYE	2023	1.32
Forecasted	FYE	2024	1.35

5) Transaction Participants:

Underwriter	BB&T Capital Markets
Feasibility Consultant	*TBD*
Bond Counsel	Parker Poe Adams & Bernstein LLP
Corporation Counsel	Hill Evans Jordan & Beatty PLLC
Underwriter Counsel	McGuireWoods LLP
Trustee	U.S. Bank National Association
Trustee Counsel	Troutman Sanders LLP

6) Other Information:

(a) Board diversity

Male:	13
Female:	7
Total:	20

Caucasian:	18
African American:	2
	20

(b) Diversity of residents

Guilford / West

Male:	75 / 90
Female:	235 / 202
Total:	310 / 292

Caucasian:	309 / 291
African American:	1 / 1
	310 / 292

(c) Fee Schedule – Attached (D-3)

(d) MCC Bond Sale Approval Policy Form – Attached (D-4)

2020 Schedule of Fees

EXPANSION RESIDENCES

DESCRIPTION	SQUARE FOOTAGE	ENTRANCE FEE	SINGLE OCCUPANCY MONTHLY SERVICE FEE	DOUBLE OCCUPANCY MONTHLY SERVICE FEE
GUILFORD				
2 Bedroom Townhome	1419	$264,000	$3,348	$4,172
2 Bedroom / Den Townhome	1625	$295,000	$3,502	$4,326
2 Bedroom Townhome	1627	$295,000	$3,502	$4,326
WEST				
2 Bedroom Townhome	1453	$264,000	$3,348	$4,172
2 Bedroom / Den Townhome	1659	$295,000	$3,502	$4,326
3 Bedroom Cottage	1910	$352,000	$3,708	$4,532
3 Bedroom Cottage	1919	$352,000	$3,708	$4,532
WEST VILLA APARTMENTS				
2 Bedroom Villa Apartment	1492	$284,000	$3,605	$4,429
2 Bedroom Villa Apartment	1697	$322,000	$3,811	$4,635
2 Bedroom / Den Villa Apartment	1872	$372,000	$4,017	$4,841

***Townhomes and Cottages** - Monthly Service Fee includes one meal per day and monthly housekeeping. Telephone, cable and Wi-Fi (additional $50 per month).*

***Villa Apartments** - Monthly Service Fee includes one meal per day, monthly housekeeping and all utilities except telephone, cable and Wi-Fi (additional $50 per month).*

Entrance Fee amortizes by 1.6% per month over 60 months less a 4% non-refundable fee.

All square footage is approximate. Floor plans are subject to change.

NC MCC Bond Sale Approval Form	
Facility Name: Friends Homes	
	Time of Preliminary Approval
SERIES: 2020	
PAR Amount	$68,185,000.00
Estimated Interest Rate	5.00%
All-in True Interest Cost	5.00%
Maturity Schedule (Interest) - Date	9/1/2050
Maturity Schedule (Principal) - Date	9/1/2050
Bank Holding Period (if applicable) - Date	N/A
Estimated NPV Savings ($) (if refunded bonds)	N/A
Estimated NPV Savings (%) (if refunded bonds)	N/A
NOTES:	

EXHIBIT E

NORTH CAROLINA MEDICAL CARE COMMISSION QUARTERLY MEETING

DIVISION OF HEALTH SERVICE REGULATION
801 BIGGS DRIVE
RALEIGH, NORTH CAROLINA 27603

FEBRUARY 14, 2020
9:00 A.M.

NAME	AGENCY
Jennifer Wimmer	DST
Jeff Poley	Parker Poe
Arnie Thompson	Friends Homes Inc
Julia Hanover	Friends Homes
Seth Wagner	BB&T Capital Markets
Madeline Hurley	NCOSA
Mike Vicario	NCHA
Jeff Horton	NCSLA
Sally Cone	At-Large Member
AMANDA FINELLI	SEANC
ANDREW KOHA	PRINCIPLECTC

EXHIBIT F

NC Medical Care Commission

Compliance Policy

NC MCC Compliance Policy

- Two-pronged Approach
  - Multi-Year History
    - NC MCC will not issue debt if entity has exhibited multi-year history on noncompliance
  - Noncompliance in past 12 Months
    - NC MCC will not issue debt if entity has not been in compliance for at least the past 12 months prior to filing an application
- Authority to Grant Exemption to the Policy
  - 6 Month Compliance Prong
    - NC MCC can grant an Exemption if entity has been in compliance for past 6 months prior to filing an application **and** documents mitigating circumstances for noncompliance
  - Overall Exemption Prong (Exemption to the Exemption)
    - NC MCC can, at its discretion, grant an complete exemption to the policy

Compliance Determinants

- Bond Documents
  - Master Trust Agreement
    - Approximately 25 covenants/requirements
  - Trust Agreement
    - Approximately 20 covenants/requirements
  - Loan Agreement
    - Approximately 45 - 50 covenants/requirements
  - Tax Certificate
    - Approximately 10 - 12 covenants/requirements
  - Bank Agreements (Bank-Bought Bond Deals)
    - NC MCC gets certification they are in compliance with Bank's requirements

Compliance Process

- Compliance "Checklist" prepared by Bond Counsel
  - Contains both routine and non-routine requirements
  - Staff provides training/reviews on the Bond Documents
- Full Compliance Review by Staff (Annual)
  - Staff provides questionnaire covering non-routine events
  - "Checklist" for routine events provided/available
  - No assessment of Materiality
- Compliance Results Provided to Entity

Current Compliance Status

- 40 Health Care Facilities Finance Act Participants
  - 21 Hospitals/Health Care Systems
  - 17 CCRCs
  - 2 "Other" (DePaul – Assisted Living & LSA – Assisted Living (1 CCRC))
- 8 Participants are "Problems"
  - Repeat offenders
  - Difficulty in getting consistency in filings / Poor Communication
  - Common theme among group: Constant change of who is in charge of compliance
- 32 Participants are "Good"
  - Make compliance a priority
  - Good communication
  - Majority would still need an "exemption" to our current compliance policy

Feedback From Participants

- Materiality Assessment
- Always Ask for Exemption?
- Exemption Ruling on a Quarterly Basis
- Excessive Amount of Covenants/Requirements
- No Violation of SEC & IRS Rules/Filing Requirements
- No Opportunity to Remedy/Adjustments w/out Penalty

Materiality

- Public Company Audit Oversight Board (PCAOB)
  - Set Audit/Attestation Standards for CPA/CPA Firms
  - For Compliance Attestation Engagements: Materiality must be assessed even if engagement is for complete compliance review of all terms (AT § 601.36 - .37)
- Materiality Assessment for Tax-Exempt Bond Compliance Includes:
  - Entities Compliance Culture
  - Consequential and Significant Events
  - Goals/Needs of Compliance

Goal and Needs of Compliance

- MSRB (SEC) rules and regulations are met
  - 16 Filing Requirement to EMMA (MSRB's website for investors)
- Market-driven covenants are met (Bond Holders)
  - Bond-holders require certain metrics/disclosures as part of the buying process
- Bonds maintain tax-exempt status (IRS)
  - 2 main categories for IRS requirements
    - Arbitrage & Rebate
    - Use of Bond Proceeds & Bond-Financed Facilities
- Facility is maintaining financial viability (NC MCC)
  - Approximately 5 key items NC MCC needs
    - Quarterly Financials; Annual Audited Financial Statements; Covenant to Maintain Debt Service Ratio; Certificates from Officers regarding Compliance; Various Restrictions on Future Debt

Role of NC MCC in Compliance Policy

- Regulatory Function vs. Protection Function
  - Regulatory = Focus on Penalty
  - Protection = Focus on Steps to Remain Compliant
- Facilitate Communication
  - Time component
- Ensure Appropriate Compliance Environment
  - Designated Compliance Officer
  - Training / Succession Plan
  - Reporting mechanisms for noncompliance
  - Record Retention

Compliance Policy Considerations

- Make Facility Demonstrate an Adequate Compliance Environment (Application / Preliminary Approval)
  - Written Policy
  - Designated Compliance Officer
  - Monitoring Plan
  - Reporting Mechanism to Leadership
- Material Noncompliance Triggers Penalty
- Immaterial Noncompliance Can Be Remedied
  - Failure to respond within 30 days results in penalty
- Eliminate Multi-Year History
  - Establish a "look back" period (24 - 36 months)

EXHIBIT G

Capital Markets

North Carolina Medical Care Commission Meeting

Friends Homes

ESTABLISHED 1958

February 14, 2020

Friends Homes, Inc.

Arnie Thompson 336.292.8187 athompson@friendshomes.org
Executive Director
Friends Homes, Inc.

Julia Hanover 336.886.6553 ext. 5109 jhanover@presbyhomesinc.org
Chief Financial Officer
The Presbyterian Homes, Inc.

BB&T Capital Markets

Seth Wagner 804.782.8895 swagner@bbandtcm.com
Vice President

- Overview of Friends Homes, Inc.
- Overview of Project
- Preliminary Plan of Finance
- Questions

- Life Plan Communities in Greensboro, North Carolina
  - Guilford and West Campus (approximate 1.5 miles apart; act as one campus)
- Friends Homes was chartered in 1958 as a North Carolina not for profit organization by the North Carolina Yearly Meeting of the Religious Society of Friends
- Presbyterian Management Services, LLC is contracted by the Board of Trustees of Friends Homes to manage Friends Homes (contract valid through 2023)
- Presbyterian Management Services, LLC is wholly owned by Presbyterian Homes, Inc. ("PHI")
- PHI currently manages/operates Scotia Village (Laurinburg), Glenaire (Cary), and River Landing (High Point) in the state of North Carolina

Guilford

Unit Type	Number of Units
Independent Living	184
Assisted Living	52
Skilled Nursing	69
Total	305

West

Unit Type	Number of Units
Independent Living	171
Assisted Living	40
Skilled Nursing	40
Total	251

- Current Residents at both campuses are approximately 73% female and 27% male

- The Friends Homes Board has a strategic plan in place for Diversity and Inclusion

- The Board consists of 13 males and 7 females with two members of the Board of African American ethnicity

- Friends Homes provides at least 5% of its operating income in the form of charity care and both campuses have Medicaid certified nursing beds

Combined – Average Historical Occupancy

	FYE Years Ended September 30			
	2016	2017	2018	2019
Independent Living	91%	93%	95%	96%
Assisted Living	86%	88%	80%	86%
Skilled Nursing	92%	90%	91%	96%

Combined – Skilled Payor Mix

	Fiscal Years Ended September 30			
	2016	2017	2018	2019
Private Pay	79.9%	79.1%	80.6%	88.5%
Medicare	9.7%	9.3%	9.7%	4.2%
Medicaid	10.4%	11.6%	9.7%	7.3%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**

FY Ending September 30,	2016	2017	2018	2019
Operating Income	$2.5mm	$1.1mm	$3.3mm	$2.4mm
Debt Service Coverage Ratio	2.38x	2.49x	3.15x	2.73x
Days Cash on Hand	543	605	614	576

- 2020 Financing will be for the 73 Independent Living Unit ("ILU") expansion, bistro addition, wellness addition, and dining renovations on the West campus

- The 73 ILU's consist of:
  - 54 villa apartments
  - 8 duplex cottages
  - 11 single family cottages

Friends Homes
ESTABLISHED 1958

ROBLYN RD.
ELIZABETH DR.
W FRIENDLY AVE
KEY
DINING
RENOVATION ADDITION
WELLNESS & 1000 BUILDING CONNECTOR
COTTAGE A
COTTAGE B
TOWNHOUSE C
TOWNHOUSE D
VILLA
APARTMENT BUILDING
SCA
STEWART & CONNERS ARCHITECTS, PLLC
FRIENDS HOME - WEST CAMPUS
SCALE : 1" = 60'
AUGUST 9, 2019
Friends Homes

Unit Mix (Combined)

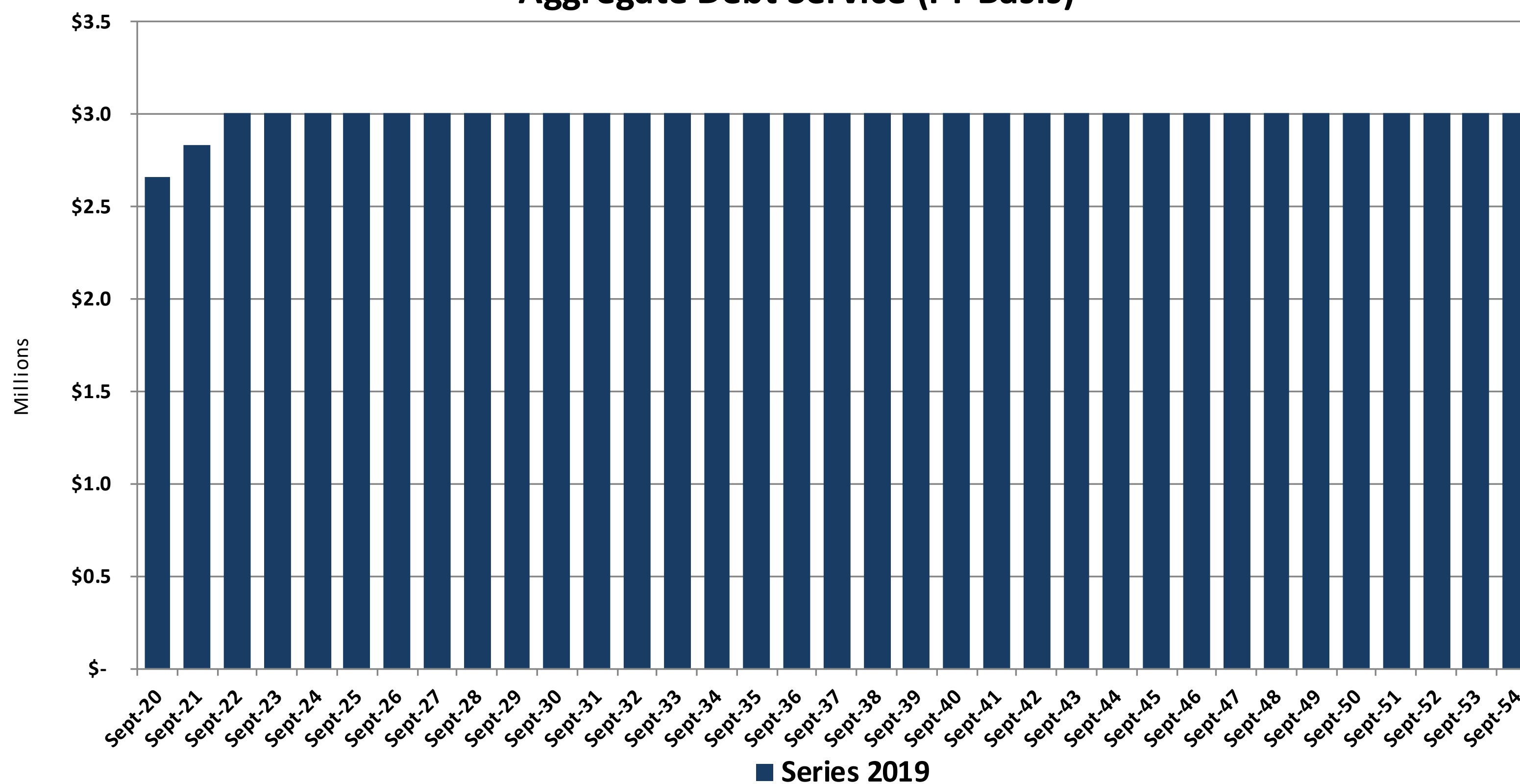
Unit Type	Current	Guilford[1]	West	After
Independent Living	355	20	73	448
Assisted Living	92	-	-	92
Skilled Nursing	109	-	-	109
Total	**556**	**20**	**73**	**649**

[1]Friends Homes issued Bonds through the PFA in 2019 for 20 ILU Addition on the Guilford Campus (Phase 1A)

Friends Homes
ESTABLISHED 1958

Friends Homes, Inc. (02/01/2020)

Component	Outstanding	Structure	Coupons	Maturity Date	Call Provisions
Series 2019	$ 49,320,000	Fixed Rate Bonds	4.00-5.00%	September 1, 2054	7-year @ 103%
Total	**$ 49,320,000**				



- Project Financing:
  - Long-Term Tax-Exempt Fixed Rate Bonds
- Interest Rate Assumptions:
  - Fixed Rate Bond Interest Rates: 5.00%

Note: FHI received a term sheet from Truist Bank for an Entrance Fee Bank Loan not to exceed $29.5mm

The Current Plan of Finance assumes all Long Term Fixed Rate Bonds but is likely to include a short term Entrance Fee Bank Loan:

Sources		
Par Amount	$	68,185,000
Total Sources	**$**	**68,185,000**

Uses		
Project Fund	$	57,750,000
Funded Interest		5,072,541
Debt Service Reserve Fund		4,304,100
Cost of Issuance		1,058,359
Total Uses	**$**	**68,185,000**

Note: FHI received a term sheet from Truist Bank for an Entrance Fee Bank Loan not to exceed $29.5mm

MANAGEMENT PROJECTED FINANCIAL RESULTS

Friends Homes
ESTABLISHED 1958

FY Ending September 30,	2020	2021	2022	2023	2024
Debt Service Coverage Ratio (All Fixed Rate Bonds)	1.94x	2.03x	2.50x	1.32x	1.35x
Debt Service Coverage Ratio (Hybrid Transaction)	1.94x	2.03x	2.43x	1.76x	1.80x

- **Week of June 1:**
  - Print Preliminary Official Statement after receiving LGC Approval

- **Week of June 22:**
  - Priced Fixed Rate Bonds and execute Bond Purchase Agreement (receive final NCMCC Approval day after pricing)

- **Week of July 6:**
  - Close 2020 Financing

QUESTIONS AND ANSWERS

Friends Homes
ESTABLISHED 1958

BB&T Capital Markets

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 3rd Quarter FYE 2020)

Program Measures	FYE 2019 Ending: 6/30/2019	FYE 2020 Ending: 3/31/2019
Outstanding Debt	**$5,878,126,412**	**$6,051,179,529**
Outstanding Series	**131**	**129**[1]

Detail of Program Measures	Ending: 6/30/2019	Ending: 3/31/2019
Outstanding Debt per Hospitals and Healthcare Systems	$4,672,572,057	$4,832,588,399
Outstanding Debt per CCRCs	$1,147,209,355	$1,162,191,130
Outstanding Debt per Other Healthcare Service Providers	$58,345,000	$56,400,000
Outstanding Debt Total	**$5,878,126,412**	**$6,051,179,529**
Outstanding Series per Hospitals and Healthcare Systems	76	76
Outstanding Series per CCRCs	53	51
Outstanding Series per Other Healthcare Service Providers	2	2
Series Total	**131**	**129**
Number of Hospitals and Healthcare Systems with Outstanding Debt	19	19
Number of CCRCs with Outstanding Debt	20	16
Number of Other Healthcare Service Providers with Outstanding Debt	2	2
Facility Total	41	37

Note 1: For FYE 2020, NCMCC closed 14 **Bond Series** thru the 2nd Quarter. Out of the 14 closed Bond Series: 5 were conversions, 4 were new money projects, 3 were a combination of refundings and new money projets, and 2 were refundings. The loss of 2 Bond Series outstanding from FYE 2019 to current represents all new money projects, refundings, conversions, and redemptions.

GENERAL NOTES: Facility Totals represent a parent entity total and do not represent each individual facility owned by the parent entity. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities. The following parent entities represent the current "other healthcare service providers" with outstanding NC MCC debt: DePaul (Assisted Living); Lutheran Services (Assisted

Exhibit B (Outstanding Balance)

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 3rd Quarter FYE 2020)

Program Measures	FYE 2019 Ending: 6/30/2019	FYE 2020 Ending: 3/31/2019
Total PAR Amount of Debt Issued	**$25,538,623,155**	**$26,541,826,344**
Total Project Debt Issued (excludes refunding/conversion proceeds) [1]	**$12,288,054,987**	**$12,931,361,439**
Total Series Issued	**629**	**643**

Detail of Program Measures	Ending: 6/30/2019	Ending: 3/31/2019
PAR Amount of Debt per Hospitals and Healthcare Systems	$20,794,927,185	$21,575,249,855
PAR Amount of Debt per CCRCs	$4,369,400,740	$4,592,281,259
PAR Amount of Debt per Other Healthcare Service Providers	$374,295,230	$374,295,230
Par Amount Total	**$25,538,623,155**	**$26,541,826,344**
Project Debt per Hospitals and Healthcare Systems	$9,643,788,740	$10,167,759,674
Project Debt per CCRCs	$2,397,252,332	$2,516,587,851
Project Debt per Other Healthcare Service Providers	$247,013,915	$247,013,915
Project Debt Total	**$12,288,054,987**	**$12,931,361,439**
Series per Hospitals and Healthcare Systems	397	404
Series per CCRCs	193	200
Series per Other Healthcare Service Providers	39	39
Series Total	**629**	**643**
Number of Hospitals and Healthcare Systems issuing debt	99	99
Number of CCRCs issuing debt	40	40
Number of Other Healthcare Service Providers issuing debt	46	46
Facility Total	185	185

Note 1: Project Debt excludes bond proceeds that directly refunded prior NCMCC outstanding issues and conversion par amounts. Project Debt is an accumulation of all new project money, issuance costs (including issuance costs for refundings/conversions (if any)), and refundings of non-NCMCC debt.

GENERAL NOTES: Facility Totals represent each individual facility and do not represent parent entity totals. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE MARCH 26, 2020 11:00 A.M.

Members of the Executive Committee Present:

John J. Meier, IV, M.D., Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Linwood B. Hollowell, III
Albert F. Lockamy, Jr., RPh
William J. Paugh
Jeffrey S. Wilson

Members of the Executive Committee Absent:

None

Members of Staff Present:

Geary W. Knapp, JD, CPA, Assistant Secretary
Kathy C. Larrison, MCC Auditor
Crystal Watson-Abbott, MCC Auditor
Alice S. Creech, Executive Assistant

Others Present:

Alice Adams, Robinson Bradshaw & Hinson, PA
Lynn DeJaco, FirstHealth of the Carolinas, Inc.
Allen Robertson, Robinson Bradshaw & Hinson, PA

1. **Purpose of Meeting**

To authorize the execution and delivery of First Supplemental Trust Agreements for the 2014A Bonds and 2017D Bonds issued for the benefit of FirstHealth of the Carolinas, Inc.

2. **Resolution of the North Carolina Medical Care Commission Approving and Authorizing Execution and Delivery of a First Supplemental Trust Agreement Relating to the North Carolina Medical Care Commission Variable Rate Health Care Facilities Revenue Refunding Bonds (FirstHealth of the Carolinas Project), Series 2014A (the "Bonds").**

Remarks were made on the Trust Agreements by Geary Knapp, Allen Robertson, Dr. John Meier, and Joe Crocker.

Executive Committee Action: Motion was made to approve the execution and delivery of First Supplemental Trust Agreement for the 2014A Bonds by Mr. Joe Crocker, seconded by Mrs. Sally Cone, and unanimously approved.

WHEREAS, the North Carolina Medical Care Commission (the "Commission"), a commission of the Department of Health and Human Services of the State of North Carolina, has issued $18,160,000 aggregate principal amount of its Variable Rate Health Care Facilities Revenue Refunding Bonds (FirstHealth of the Carolinas Project), Series 2014A (the "Bonds"), all of which are outstanding, pursuant to the terms of a Trust Agreement, dated as of July 1, 2014 (the "Trust Agreement"), between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"); and

WHEREAS, the Commission loaned the proceeds from the sale of the Bonds to FirstHealth of the Carolinas, Inc. (the "Corporation") pursuant to a Loan Agreement, dated as of July 1, 2014 (the "Loan Agreement"), between the Commission and the Corporation; and

WHEREAS, the Bonds were purchased upon their initial issuance, and continue to be held, by PNC Bank, National Association (the "Bank Holder"); and

WHEREAS, since their initial issuance, the Bonds have been bearing interest at a Bank-Bought Rate equal to 2.61% per annum, which is subject to adjustment based on the debt ratings of the Corporation; and

WHEREAS, the Corporation has requested that the definition of "Bank-Bought Rate" be amended to reflect that, beginning on April 2, 2020 (when the 2008A Bonds issued by the Commission for the benefit of the Corporation will be retired), the Corporation will maintain one or more issuer credit ratings instead of debt ratings for specific borrowings; and

WHEREAS, Section 11.02 of the Trust Agreement permits the Commission and the Bond Trustee, with the consent of the Bank Holder as the Holder (as defined in the Trust Agreement) of 100% of the Bonds, to enter into agreements supplemental to the Trust Agreement to make any change to the Trust Agreement; and

WHEREAS, there has been presented at this meeting a draft copy of a First Supplemental Trust Agreement, to be dated the date of delivery thereof (the "Supplement") between the Commission and the Bond Trustee, that would amend the Trust Agreement to make the changes requested by the Corporation (See EXHIBIT A); and

WHEREAS, the Corporation has requested that the Commission approve the Supplement and authorize its execution and delivery;

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. The form, terms and provisions of the Supplement are hereby approved in all respects, and the Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are hereby authorized and directed to execute and deliver the Supplement in substantially the form presented at this meeting, together with such changes, modifications and deletions as they, with the advice of bond counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 2. The Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) or any duly authorized Commission Representative under the Trust Agreement are authorized and directed to execute and deliver a replacement Bond reflecting the terms of the Supplement to the Bank Holder and to take such other action and to execute and deliver any such other documents, certificates, undertakings, agreements or other instruments as they, with the advice of bond counsel, may deem necessary or appropriate to effect the changes made in the Supplement.

Section 3. This Resolution shall take effect immediately upon its passage.

3. Resolution of the North Carolina Medical Care Commission Approving and Authorizing Execution and Delivery of a First Supplemental Trust Agreement Relating to the North Carolina Medical Care Commission Variable Rate Health Care Facilities Revenue Refunding Bonds (FirstHealth of the Carolinas Project), Series 2017D (the "Bonds").

Executive Committee Action: Motion was made to approve the execution and delivery of First Supplemental Trust Agreement for the 2017D Bonds by Mr. Al Lockamy, seconded by Mr. Joe Crocker, and unanimously approved.

WHEREAS, the North Carolina Medical Care Commission (the "Commission"), a commission of the Department of Health and Human Services of the State of North Carolina, has issued $28,590,000 aggregate principal amount of its Variable Rate Health Care Facilities Revenue Refunding Bonds (FirstHealth of the Carolinas Project), Series 2017D (the "Bonds"), all of which are outstanding, pursuant to the terms of a Trust Agreement, dated as of September 1, 2017 (the "Trust Agreement"), between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"); and

WHEREAS, the Commission loaned the proceeds from the sale of the Bonds to FirstHealth of the Carolinas, Inc. (the "Corporation") pursuant to a Loan Agreement, dated as of September 1, 2017 (the "Loan Agreement"), between the Commission and the Corporation; and

WHEREAS, the Bonds were purchased upon their initial issuance, and continue to be held, by Wells Fargo Municipal Capital Strategies, LLC (the "Bank Holder"); and

WHEREAS, since their initial issuance, the Bonds have been bearing interest at a LIBOR Index Rate equal to the product of (a) the sum of (i) the Applicable Spread plus (ii) the product of (1) the LIBOR Index as multiplied by (2) the Applicable Factor, multiplied by (b) the Margin Rate Factor; and

WHEREAS, the Applicable Spread varies based on the debt ratings of the Corporation; and

WHEREAS, the Corporation has requested that the definition of "Applicable Spread" be amended to reflect that, beginning on April 2, 2020 (when the 2008A Bonds issued by the Commission for the benefit of the Corporation will be retired), the Corporation will maintain one or more issuer credit ratings instead of debt ratings for specific borrowings; and

WHEREAS, Section 11.02 of the Trust Agreement permits the Commission and the Bond Trustee, with the consent of the Bank Holder as the Holder (as defined in the Trust Agreement) of 100% of the Bonds, to enter into agreements supplemental to the Trust Agreement to make any change to the Trust Agreement; and

WHEREAS, there has been presented at this meeting a draft copy of a First Supplemental Trust Agreement, to be dated the date of delivery thereof (the "Supplement") between the Commission and the Bond Trustee, that would amend the Trust Agreement to make the changes proposed by the Bank Holder (See EXHIBIT B); and

WHEREAS, the Corporation has requested that the Commission approve the Supplement and authorize its execution and delivery;

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. The form, terms and provisions of the Supplement are hereby approved in all respects, and the Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are hereby authorized and directed to execute and deliver the Supplement in substantially the form presented at this meeting, together with such changes, modifications and deletions as they, with the advice of bond counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

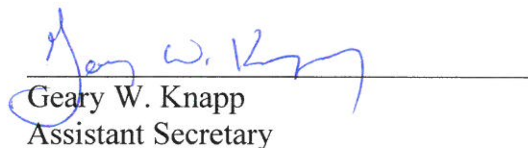
Section 2. The Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) or any duly authorized Commission Representative under the Trust Agreement are authorized and directed to execute and deliver a replacement Bond reflecting the terms of the Supplement to the Bank Holder and to take such other action and to execute and deliver any such other documents, certificates, undertakings, agreements or other instruments as they, with the advice of bond counsel, may deem necessary or appropriate to effect the changes made in the Supplement.

Section 3. This Resolution shall take effect immediately upon its passage.

4. Adjournment

There being no further business, the meeting was adjourned at 11:19 a.m.

Respectfully submitted,



Geary W. Knapp
Assistant Secretary

EXHIBIT A

Changes to 2014A Trust Agreement

(a) The definition of "Bank-Bought Rate" in Exhibit D to the Trust Agreement is hereby deleted and the following is substituted therefor:

> "Bank-Bought Rate" means 2.61% per annum; provided, however, that in the event, and for so long as, (1) the long-term unenhanced rating assigned by Moody's, S&P or Fitch to any obligation of the Restricted Group evidenced by a bond, note or similar instrument ranking senior to or on parity with the Bonds and secured by a Master Obligation (a "debt rating") or (2) if there are no such debt ratings, the long-term "issuer credit rating," "issuer default rating" or any similar issuer rating assigned by Moody's, S&P or Fitch to (i) the Borrower, (ii) the Restricted Group or (iii) the Borrower and all affiliates included in its Audited Financial Statements, as the case may be (each, a "Rating"), is below "A2," "A," or "A," respectively, "Bank-Bought Rate" shall mean the respective rate shown below. In the event of split ratings, the lowest rating will apply.

Rating	Bank-Bought Rate
A3/A-	2.71%
Baa1/BBB+	2.91%
Baa2/BBB	3.11%
Baa3/BBB- or below	3.51%

(b) The first paragraph under the heading "Optional Redemption" in Exhibit D to the Trust Agreement is hereby deleted and the following is substituted therefor:

> In the event, and for so long as, any Rating is reduced to or below "Baa2," "BBB," or "BBB" by Moody's, Fitch or S&P, respectively, the Corporation shall cause the Bonds to be optionally redeemed, at a Redemption Price equal to 100% of the principal amount of the Bonds to be redeemed plus accrued interest to, but not including the redemption date, on each subsequent October 1 (each, a "Mandatory Optional Redemption Date") in amounts equal to the Mandatory Optional Redemption Requirement. The Mandatory Optional Redemption Requirement, for each Mandatory Optional Redemption Date, shall be equal to the amount obtained by dividing the Outstanding principal amount of the Bonds by the number of Mandatory Optional Redemption Dates (including the then current Mandatory Optional Redemption Date) remaining until and including October 1, 2029 (rounded to the nearest Authorized Denomination). This obligation shall automatically cease in the event no Rating is at or below "Baa2," "BBB," or "BBB" by Moody's, Fitch or S&P, respectively.

EXHIBIT B

Changes in 2017D Trust Agreement

(a) The definition of "Applicable Spread" in Exhibit D to the Trust Agreement is hereby deleted and the following is substituted therefor:

"Applicable Spread" means a rate per annum associated with the Level corresponding to (1) the lowest long-term unenhanced rating assigned by any of Moody's, S&P or Fitch to any obligation of the Restricted Group evidenced by a bond, note or similar instrument ranking senior to or on parity with the Bonds and secured by a Master Obligation (a "debt rating"), or (2) if there are no such debt ratings, the lowest long-term "issuer credit rating," "issuer default rating" or any similar issuer rating assigned by Moody's, S&P or Fitch to (i) the Borrower, (ii) the Restricted Group or (iii) the Borrower and all affiliates included in its Audited Financial Statements, as the case may be (each a "Rating"), as specified below:

LEVEL	MOODY'S RATING	S&P RATING	FITCH RATING	APPLICABLE SPREAD
Level 1	Aa2 or above	AA or above	AA or above	0.35%
Level 2	Aa3	AA-	AA-	0.40%
Level 3	A1	A+	A+	0.45%
Level 4	A2	A	A	0.60%
Level 5	A3	A-	A-	0.75%
Level 6	Baa1	BBB+	BBB+	0.90%
Level 7	Baa2 or below	BBB or below	BBB or below	1.05%

In the event that Ratings are assigned by all three Rating Agencies and there is a split among Ratings (*i.e.*, one of the Rating Agencies' Rating is at a different Level than the Rating of another Rating Agency), (i) if two of such Ratings are at the same Level, the Applicable Spread shall be based upon that Level, and (ii) if no two Ratings are at the same Level, the Applicable Spread shall be based upon the Level in which the middle Rating appears. In the event that Ratings are assigned by only two Rating Agencies and one of the Rating Agencies' Rating is at a different Level than the Rating of the other Rating Agency, the Applicable Spread shall be based upon the Level in which the lower Rating appears. References to Ratings above are references to rating categories as presently determined by the Rating Agencies and in the event of adoption of any new or changed rating system or a "global" rating scale, the ratings from the Rating Agency in question referred to above shall be deemed to refer to the rating category under the new rating system that most closely approximates the applicable rating category as currently in effect. Any change in the Applicable Spread shall apply to the LIBOR Index Reset Date next succeeding the date on which the change occurs. The Corporation acknowledges that as of the Closing Date the Applicable Spread is that specified above for Level 2.

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION EMERGENCY TELECONFERENCE MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
EDGERTON BUILDING
CONFERENCE ROOM - 026A

Thursday, April 9, 2020

10:00 a.m.

Minutes

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Sally B. Cone Paul R.G. Cunningham, M.D. John A. Fagg, M.D. Bryant C. Foriest Linwood B. Hollowell, III Eileen C. Kugler, RN, MSN, MPH, FNP Albert F. Lockamy, Jr., RPh Stephen T. Morton J. William Paugh Patrick D. Sebastian Jeffrey S. Wilson	Charles H. Hauser Ashley H. Lloyd, D.D.S. Karen E. Moriarty Robert E. Schaaf, M.D.
DIVISION OF HEALTH SERVICE REGULATION STAFF Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Jana Busick, Chief, Health Care Personnel Registry Section Bethany Burgon, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC	**DHSR STAFF ABSENT** Mark Payne, DHSR Director/MCC Secretary Emery Milliken, DHSR Deputy Director
OTHERS PRESENT Adam Sholar, NC Health Care Facilities Association	

II. Chairman's Comments..Dr. John Meier

Dr. John Meier thanked everyone for being on the emergency conference call and serving the patients/citizens of North Carolina. Dr. Meier encouraged everyone to stay safe and practice social distancing. Dr. Meier emphasized the meeting of the Medical Care Commission is a public **meeting**, open to the public, but is not a public **hearing**. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone on the call.

III. Ethics Statement..Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

IV. New Business

A. Rule for Adoption (Discuss Rule)

1. Healthcare Personnel Registry Rule..Nadine Pfeiffer & Jana Busick

Emergency rulemaking for nurse aid certification or registration reciprocity due to COVID-19

- Rule: 10A NCAC 13O .0301 (See Exhibits A & A/1)

B. Rule for Initiating Rulemaking Approval (Discuss rule)

2. Healthcare Personnel Registry Rule..............................Nadine Pfeiffer & Jana Busick

Temporary rulemaking for nurse aid certification or registration reciprocity due to COVID-19

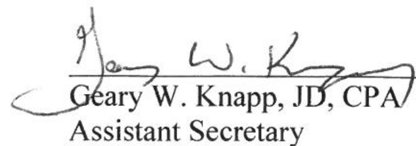
- Rule: 10A NCAC 13O .0301 (See Exhibits B & B/1)

Remarks were made on the Healthcare Personnel Registry Rule by Dr. John Meier, Jeff Wilson, Dr. John Fagg, Nadine Pfeiffer, Jana Busick, Bryant Foriest, Linwood Hollowell, Bethany Burgon, Bill Paugh, Eileen Kugler, Sally Cone, Dr. Paul Cunningham, and Joe Crocker.

<u>COMMISSION ACTION</u>: Motion to approve an emergency and temporary rule for the Nurse Aide I Registry was made by Dr. Paul Cunningham, seconded by Mrs. Eileen Kugler, and unanimously approved.

V. Adjournment- There being no further business, the meeting was adjourned at 10:55 a.m.

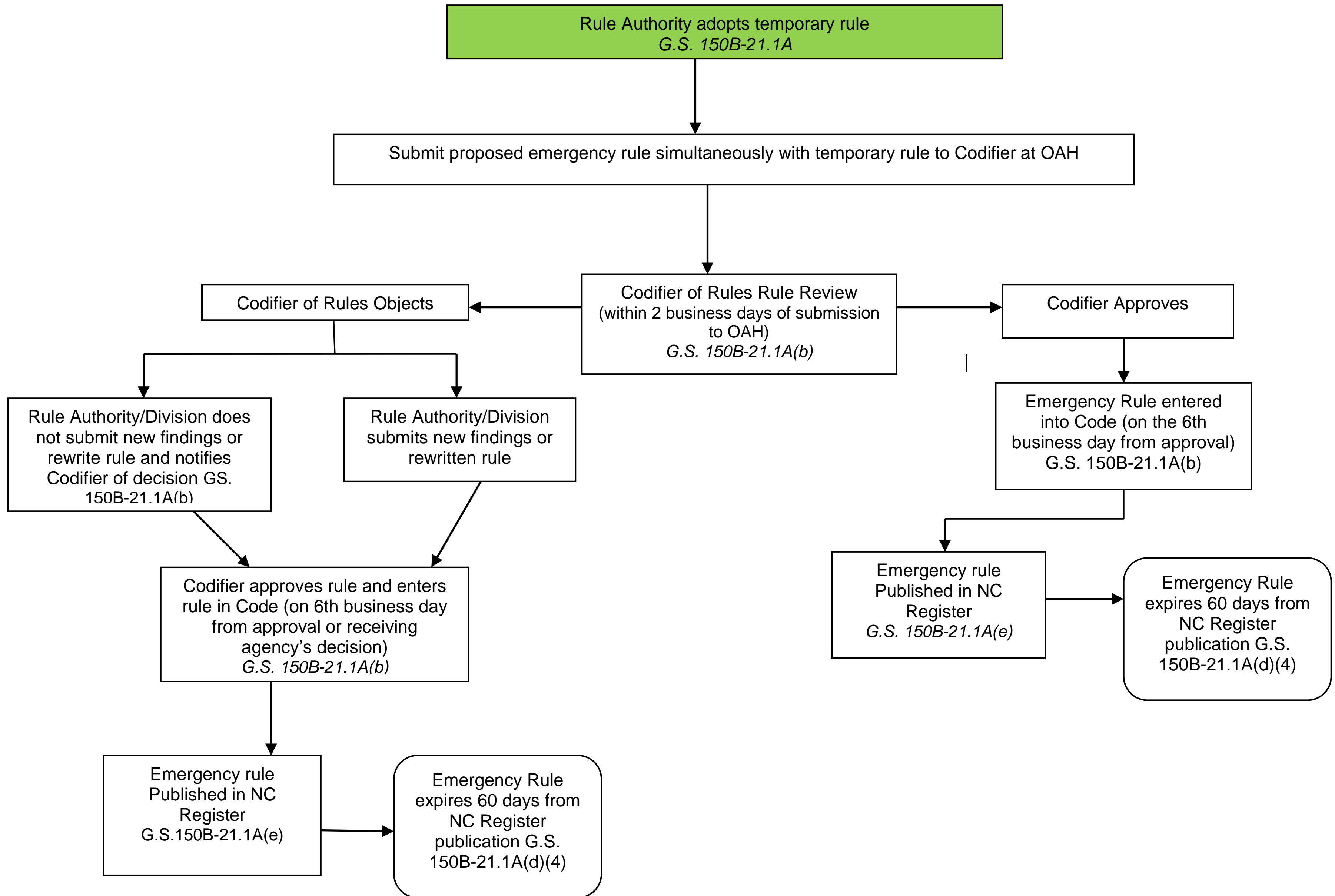
Respectfully Submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

Emergency Rulemaking Process

Exhibit A
4/2020



10A NCAC 13O .0301 is proposed for amendment under emergency procedures as follows:

SECTION .0300 - NURSE AIDE I REGISTRY

10A NCAC 13O .0301 NURSE AIDE I TRAINING AND COMPETENCY EVALUATION

(a) To be eligible to be listed on the NC Nurse Aide I Registry by the Health Care Personnel Education and Credentialing Section, a person ~~shall~~ shall:

(1) pass a Nurse Aide I training program approved by the Department in accordance with 42 CFR Part 483.151 through Part 483.152 and the State of North Carolina's Nurse Aide I competency ~~exam.~~ exam; or

(2) apply to the Department for approval to be listed on the NC Nurse Aide I Registry by reciprocity transfer of a nurse aide certification or registration from another State to North Carolina.

(b) In applying for reciprocity transfer of a nurse aide certification or registration to be listed on the NC Nurse Aide I Registry pursuant to Subparagraph (a)(2) of this Rule, the applicant shall meet the following criteria:

(1) submit a completed application to the Department that includes the following:

(A) first, middle, and last name;

(B) the applicant's prior name(s), if any;

(C) mother's maiden name;

(D) gender;

(E) social security number;

(F) date of birth;

(G) mailing address;

(H) email address;

(I) home telephone number;

(J) any other State registries of nurse aides upon which the applicant is listed;

(K) certification or registration numbers for any State nurse aide registries identified in Part (b)(1)(J) of this Rule;

(L) original issue dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule;

(M) expiration dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule;

(N) training program name(s);

(O) training program locations(s);

(P) training program completion date(s) with a passing score; and

(Q) employment history;

(2) provide documentation verifying that his or her registry listing is active and in good standing in the State(s) of transfer, dated no earlier than 30 calendar days prior to the date the application is received by the Department; and

(3) provide a copy of his or her Social Security card and a valid government-issued identification containing a photograph and signature.

(c) For the applicant to be approved for reciprocity transfer of a nurse aide certification or registration to be listed on the NC Nurse Aide I Registry, the Department shall verify the following:

(1) the applicant has completed an application in accordance with Subparagraph (b)(1) of this Rule;

(2) the applicant is listed on another State's registry of nurse aides with an active status;

(3) the applicant has no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on another State's registry of nurse aides;

(4) the applicant has been employed as a nurse aide for monetary compensation consisting of at least eight hours of time worked performing nursing or nursing-related tasks delegated and supervised by a Registered Nurse for the previous 24 consecutive months;

(5) the name listed on the Social Security card and government-issued identification containing a photograph and signature submitted with the application matches the name listed on another State's registry of nurse aides or that the applicant has submitted additional documentation verifying any name changes; and

(6) that the applicant completed a State-approved nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483 Part 152 or a State-approved competency evaluation program that meets the requirements of 42 CFR 483 Part 154.

(d) The Department shall within 15 business days of receipt of an application for reciprocity transfer of a nurse aide certification or registration or receipt of additional information from the applicant:

(1) inform the applicant by letter whether he or she has been approved; or

(2) request additional information from the applicant.

The applicant shall be added to the NC Nurse Aide I Registry within three business days of Department approval.

~~(b)~~ (e) This Rule incorporates 42 CFR Part 483 Subpart D by reference, including all subsequent amendments and editions. Copies of the Code of Federal Regulations may be accessed electronically free of charge from www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR.

~~(c)~~ (f) The State of North Carolina's Nurse Aide I competency exam shall include each course requirement specified in the Department-approved Nurse Aide I training program as provided for in 42 CFR Part 483.152.

~~(d)~~ (g) The State of North Carolina's Nurse Aide I competency exam shall be administered and evaluated only by the Department or its contracted testing agent as provided for in 42 CFR Part 483.154.

~~(e)~~ (h) The Department shall include a record of completion of the State of North Carolina's Nurse Aide I competency exam in the NC Nurse Aide I Registry within 30 business days of passing the written or oral exam and the skills demonstration as provided for in 42 CFR Part 483.154.

(f) (i) If the State of North Carolina's Nurse Aide I competency exam candidate does not pass the written or oral exam and the skills demonstration as provided for in 42 CFR Part 483.154, the candidate shall be advised by the Department of the areas that the individual did not pass.

(g) (j) Every North Carolina's Nurse Aide I competency exam candidate shall have, as provided for in 42 CFR Part 483.154, the opportunity to take the exam three times before being required to retake and pass a Nurse Aide I training program.

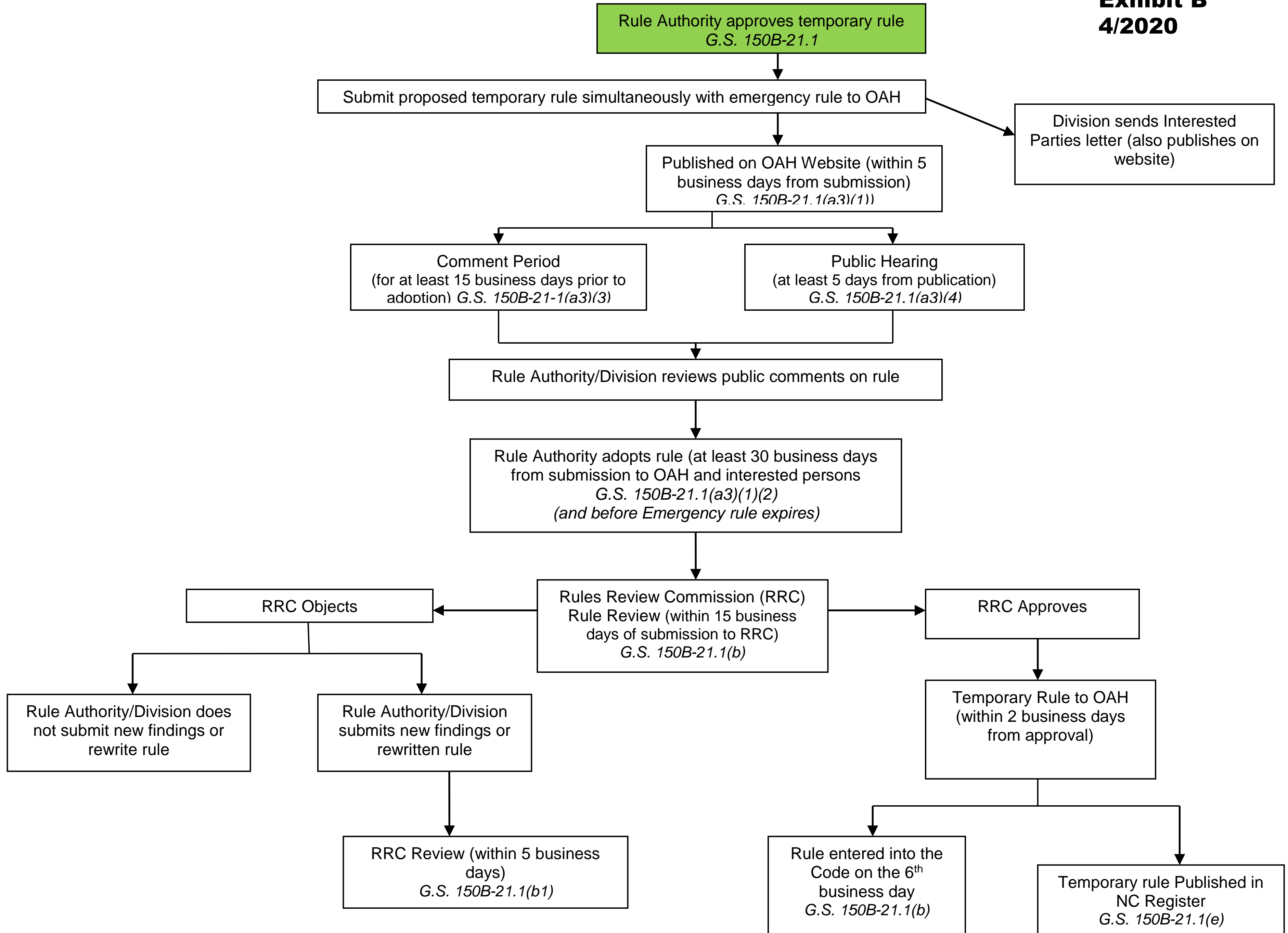
(h) (k) A person who is currently listed on any state's Nurse Aide I Registry shall not be required to take the Department-approved Nurse Aide I training program to be listed or, if his or her 24-month listing period has expired, relisted on the NC Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam after three attempts.

(i) (l) U.S. military personnel who have completed medical corpsman training and retired or non-practicing nurses shall not be required to take the Department-approved Nurse Aide I training program to be listed or relisted on the Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam after three attempts.

History Note: *Authority G.S. 131E-255; 42 CFR Part 483;*
Eff. January 1, 2016. 2016;
Emergency Rule Eff. April 20, 2020.

Temporary Rulemaking Process

Exhibit B
4/2020



1 10A NCAC 13O .0301 is proposed for amendment under temporary procedures as follows:
2
3 **SECTION .0300 - NURSE AIDE I REGISTRY**
4
5 **10A NCAC 13O .0301 NURSE AIDE I TRAINING AND COMPETENCY EVALUATION**
6 (a) To be eligible to be listed on the NC Nurse Aide I Registry by the Health Care Personnel Education and
7 Credentialing Section, a person ~~shall~~ shall:
8 (1) pass a Nurse Aide I training program approved by the Department in accordance with 42 CFR Part
9 483.151 through Part 483.152 and the State of North Carolina's Nurse Aide I competency ~~exam.~~
10 exam; or
11 (2) apply to the Department for approval to be listed on the NC Nurse Aide I Registry by reciprocity
12 transfer of a nurse aide certification or registration from another State to North Carolina.
13 (b) In applying for reciprocity transfer of a nurse aide certification or registration to be listed on the NC Nurse Aide
14 I Registry pursuant to Subparagraph (a)(2) of this Rule, the applicant shall meet the following criteria:
15 (1) submit a completed application to the Department that includes the following:
16 (A) first, middle, and last name;
17 (B) the applicant's prior name(s), if any;
18 (C) mother's maiden name;
19 (D) gender;
20 (E) social security number;
21 (F) date of birth;
22 (G) mailing address;
23 (H) email address;
24 (I) home telephone number;
25 (J) any other State registries of nurse aides upon which the applicant is listed;
26 (K) certification or registration numbers for any State nurse aide registries identified in Part
27 (b)(1)(J) of this Rule;
28 (L) original issue dates for any certifications or registrations identified in Part (b)(1)(K) of this
29 Rule;
30 (M) expiration dates for any certifications or registrations identified in Part (b)(1)(K) of this
31 Rule;
32 (N) training program name(s);
33 (O) training program locations(s);
34 (P) training program completion date(s) with a passing score; and
35 (Q) employment history;

(2) provide documentation verifying that his or her registry listing is active and in good standing in the State(s) of transfer, dated no earlier than 30 calendar days prior to the date the application is received by the Department; and

(3) provide a copy of his or her Social Security card and a valid government-issued identification containing a photograph and signature.

(c) For the applicant to be approved for reciprocity transfer of a nurse aide certification or registration to be listed on the NC Nurse Aide I Registry, the Department shall verify the following:

(1) the applicant has completed an application in accordance with Subparagraph (b)(1) of this Rule;

(2) the applicant is listed on another State's registry of nurse aides with an active status;

(3) the applicant has no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on another State's registry of nurse aides;

(4) the applicant has been employed as a nurse aide for monetary compensation consisting of at least eight hours of time worked performing nursing or nursing-related tasks delegated and supervised by a Registered Nurse for the previous 24 consecutive months;

(5) the name listed on the Social Security card and government-issued identification containing a photograph and signature submitted with the application matches the name listed on another State's registry of nurse aides or that the applicant has submitted additional documentation verifying any name changes; and

(6) that the applicant completed a State-approved nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483 Part 152 or a State-approved competency evaluation program that meets the requirements of 42 CFR 483 Part 154.

(d) The Department shall within 15 business days of receipt of an application for reciprocity transfer of a nurse aide certification or registration or receipt of additional information from the applicant:

(1) inform the applicant by letter whether he or she has been approved; or

(2) request additional information from the applicant.

The applicant shall be added to the NC Nurse Aide I Registry within three business days of Department approval.

~~(b)~~ (e) This Rule incorporates 42 CFR Part 483 Subpart D by reference, including all subsequent amendments and editions. Copies of the Code of Federal Regulations may be accessed electronically free of charge from www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR.

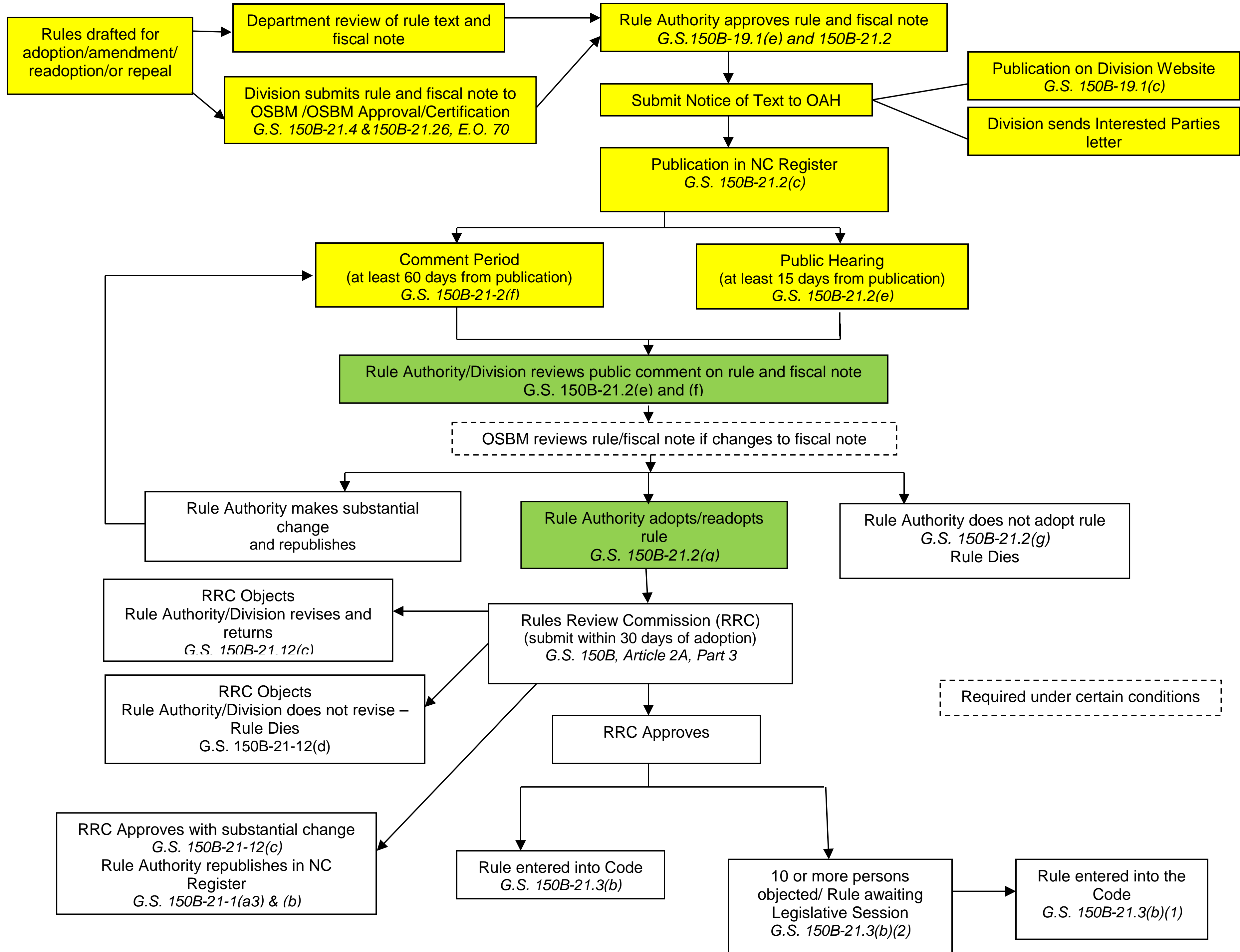
~~(c)~~ (f) The State of North Carolina's Nurse Aide I competency exam shall include each course requirement specified in the Department-approved Nurse Aide I training program as provided for in 42 CFR Part 483.152.

~~(d)~~ (g) The State of North Carolina's Nurse Aide I competency exam shall be administered and evaluated only by the Department or its contracted testing agent as provided for in 42 CFR Part 483.154.

~~(e)~~ (h) The Department shall include a record of completion of the State of North Carolina's Nurse Aide I competency exam in the NC Nurse Aide I Registry within 30 business days of passing the written or oral exam and the skills demonstration as provided for in 42 CFR Part 483.154.

1 ~~(f)~~ (i) If the State of North Carolina's Nurse Aide I competency exam candidate does not pass the written or oral exam
2 and the skills demonstration as provided for in 42 CFR Part 483.154, the candidate shall be advised by the Department
3 of the areas that the individual did not pass.
4 ~~(g)~~ (j) Every North Carolina's Nurse Aide I competency exam candidate shall have, as provided for in 42 CFR Part
5 483.154, the opportunity to take the exam three times before being required to retake and pass a Nurse Aide I training
6 program.
7 ~~(h)~~ (k) A person who is currently listed on any state's Nurse Aide I Registry shall not be required to take the
8 Department-approved Nurse Aide I training program to be listed or, if his or her 24-month listing period has expired,
9 relisted on the NC Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I
10 competency exam after three attempts.
11 ~~(i)~~ (l) U.S. military personnel who have completed medical corpsman training and retired or non-practicing nurses
12 shall not be required to take the Department-approved Nurse Aide I training program to be listed or relisted on the
13 Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam
14 after three attempts.
15
16 *History Note:* *Authority G.S. 131E-255; 42 CFR Part 483;*
17 *Eff. January 1, ~~2016.~~ 2016;*
18 *Temporary Amendment Eff. June 26, 2020.*

Exhibit C



1 10A NCAC 13B .3501 is amended as published in 34:12 NCR 1104-1110 as follows:
2
3 **SECTION .3500 - GOVERNANCE AND MANAGEMENT**
4
5 **10A NCAC 13B .3501 GOVERNING BODY**
6 (a) The governing body, ~~owner~~ owner, or the person or persons designated by the owner as the governing ~~authority~~
7 body shall be responsible for ~~seeing~~ ensuring that the objectives specified in the ~~charter (or resolution if publicly~~
8 ~~owned)~~ facility's governing documents are attained.
9 (b) The governing body shall be the final authority ~~in the facility~~ ~~to which~~ ~~the administrator,~~ for decisions for which
10 the facility administration, the medical staff, and the facility personnel ~~and all auxiliary organizations~~ are directly or
11 indirectly ~~responsible.~~ responsible within the facility.
12 (c) A local advisory board shall be established if the facility is owned ~~or controlled~~ by an organization or persons
13 outside of North Carolina. A local advisory board shall include members from the county where the facility is located.
14 The local advisory board will provide non-binding advice to the governing body.
15
16 *History Note:* *Authority G.S. 131E-75; 131E-79;*
17 *Eff. January 1, 1996;*
18 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22,*
19 *~~2017.~~ 2017;*
20 *Amended Eff. July 1, 2020.*

10A NCAC 13B .3502 is readopted as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3502 REQUIRED FACILITY BYLAWS, POLICIES, RULES, AND REGULATIONS

(a) The governing body shall adopt written bylaws, policies, rules, and regulations in accordance with all requirements contained in this Subchapter and in accordance with the community responsibility of the facility. The written bylaws, policies, rules, and regulations shall:

(1) state the purpose of the facility;

(2) describe the powers and duties of the governing body officers and committees and the responsibilities of the chief executive officer;

(3) state the qualifications for governing body membership, the procedures for selecting members, and the terms of service for members, officers and committee chairmen;

(4) describe the authority delegated to the chief executive officer and to the medical staff. No assignment, referral, or delegation of authority by the governing body shall relieve the governing body of its responsibility for the conduct of the facility. The governing body shall retain the right to rescind any such delegation;

(5) require ~~Board~~ governing body approval of the bylaws of any auxiliary organizations established by the ~~hospital;~~ facility;

(6) require the governing body to review and approve the bylaws of the medical ~~staff organization;~~ staff;

(7) establish ~~a procedure~~ procedures for processing and evaluating the applications for medical staff membership and for the granting of clinical privileges;

(8) establish a procedure for implementing, disseminating, and enforcing a Patient's Bill of Rights as set forth in Rule .3302 of this Subchapter and in compliance with G.S. 131E-117; and

(9) require the governing body to institute procedures to provide for:

(A) orientation of newly elected ~~board~~ governing body members to ~~specific~~ board functions and procedures;

(B) the development of procedures for periodic reexamination of the relationship of the ~~board~~ governing body to the total facility community; and

(C) the recording of minutes of all governing body and executive committee meetings and the dissemination of those minutes, or summaries thereof, on a regular basis to all members of the governing body.

(b) The governing body shall ~~assure~~ provide written policies and procedures to assure billing and collection practices in accordance with G.S. 131E-91. These policies and procedures shall include:

(1) a financial assistance policy as defined in G.S. 131E-214.14(b)(3);

(2) how a patient may obtain an estimate of the charges for the statewide 100 most frequently reported Diagnostic Related Groups (DRGs), where applicable, 20 most common outpatient imaging procedures, and 20 most common outpatient surgical procedures. The policy shall require that the

information be provided to the patient in writing, either electronically or by mail, within three business days;

(3) how a patient or patient's representative may dispute a bill;

(4) issuance of a refund within 45 days of the patient receiving notice of the overpayment when a patient has overpaid the amount due to the ~~hospital;~~ facility;

(5) providing written notification to the patient or patient's representative at least 30 days prior to submitting a delinquent bill to a collections agency;

(6) providing the patient or patient's representative with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990;

(7) the requirement that a collections agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or patient's representative;

(8) a policy for handling debts arising from the provision of care by the ~~hospital~~ facility involving the doctrine of necessaries, in accordance with G.S. 131E-91(d)(5); and

(9) a policy for handling debts arising from the provision of care by the ~~hospital~~ facility to a minor, in accordance with G.S. 131E-91(d)(6).

(c) The governing body shall ensure that the bylaws, rules, and regulations of the medical staff and the bylaws, rules, policies, and regulations of the facility shall not be in conflict.

~~(c)~~(d) The written policies, rules, and regulations shall be reviewed every three years, revised as necessary, and dated to indicate when last reviewed or revised.

~~(d)~~(e) To qualify for licensure or license renewal, each facility must provide to the Division, upon application, an attestation statement in a form provided by the Division verifying compliance with the requirements of this Rule.

~~(e)~~(f) On an annual basis, on the license renewal application provided by the Division, the facility shall provide to the Division the direct website address to the facility's financial assistance policy. This ~~Rule~~ requirement applies only to facilities required to file a Schedule H, federal form 990.

History Note: *Authority G.S. 131E-79; 131E-91; 131E-214.8; 131E-214.13(f); 131E-214.14; ~~S.L. 2013-382, s. 10.1; S.L. 2013-382, s. 13.1;~~*
Eff. January 1, 1996;
Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, ~~2014.~~ 2014;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3503 is readopted as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3503 FUNCTIONS

(a) The governing body shall:

(1) provide management, physical ~~resources~~ resources, and personnel determined by the governing body to be required to meet the needs of ~~the~~ patients for ~~which it is licensed;~~ treatment as authorized by the facility's license;

(2) require ~~management~~ facility administration to establish a quality control mechanism ~~which~~ that includes ~~as an integral part~~ a risk management component and an infection control program;

(3) formulate short-range and long-range plans ~~for the development of the facility;~~ as defined in the facility bylaws, policies, rules, and regulations;

(4) conform to all applicable ~~federal,~~ State and federal laws, rules, and regulations, and applicable local ~~laws and regulations;~~ ordinances;

(5) provide for the control and use of the physical and financial resources of the facility;

(6) review the annual audit, ~~budget~~ budget, and periodic reports of the financial operations of the facility;

(7) consider the ~~advice~~ recommendation of the medical staff in granting and defining the scope of clinical privileges to ~~individuals. When the governing body does not concur in the medical staff recommendation regarding the clinical privileges of an individual, there shall be a review of the recommendation by a joint committee of the medical staff and governing body before a final decision is reached by the governing body;~~ individuals in accordance with medical staff bylaws requirements for making such recommendations and the facility bylaws established by the governing body for the review and final determination of such recommendations;

(8) require that applicants be informed of the disposition of their application for medical staff membership or clinical ~~privileges, or both, within an established period of time after their~~ privileges in accordance with the facility bylaws established by the governing body, after an application has been submitted;

(9) review and approve the medical staff bylaws, ~~rules~~ rules, and ~~regulations body;~~ regulations;

(10) delegate to the medical staff the authority ~~to~~ to:

(A) evaluate the professional competence of medical staff members and applicants for ~~staff privileges~~ medical staff membership and clinical privileges; and

(B) ~~hold the medical staff responsible for recommending~~ recommend to the governing body initial medical staff appointments, ~~reappointments~~ reappointments, and assignments or curtailments of privileges;

(11) require that resources be made available to address the emotional and spiritual needs of patients either directly or through referral or arrangement with community agencies;

(12) maintain ~~effective~~ communication with the medical staff which ~~shall~~ may be ~~established,~~ established through:

~~(a)~~(A) meetings with the ~~Executive Committee~~ executive committee of the ~~Medical Staff;~~ medical staff;

~~(b)~~(B) service by the president of the medical staff as a member of the governing body with or without a vote;

~~(c)~~(C) appointment of individual medical staff members to ~~governing body committees; or~~ the medical review committee; or

~~(d)~~(D) a joint conference ~~committee;~~ committee that will be a committee of the governing body and the medical staff composed of equal representatives of each of the governing body, the chairman of the board or designee, the medical staff, and the chief of the medical staff or designee, respectively;

(13) require the medical staff to establish controls that are designed to provide that standards of ethical professional practices are met;

(14) provide ~~the necessary~~ administrative staff support to facilitate utilization review and infection control within the ~~facility and~~ facility, to support quality ~~control,~~ control and any other medical staff functions required by this Subchapter or by the facility bylaws;

(15) meet the following disclosure requirements:

~~(a)~~(A) provide data required by the Division;

~~(b)~~(B) disclose the facility's average daily inpatient charge upon request of the Division; and

~~(c)~~(C) disclose the identity of persons owning ~~5.0~~ five percent or more of the facility as well as the facility's officers and members of the governing body upon request;

(16) establish a procedure for reporting the occurrence and disposition of ~~any unusual incidents.~~ allegations of abuse or neglect of patients and incidents involving quality of care or physical environment at the facility. These procedures shall require that:

~~(a)~~(A) incident reports are analyzed and ~~summarized;~~ summarized by a designated party; and

~~(b)~~(B) corrective action is taken ~~as indicated by~~ based upon the analysis of incident reports;

(17) in a facility with one or more units, or portions of units, however described, utilized for psychiatric or substance abuse treatment, adopt policies implementing the provisions of G.S. 122C, Article 3, and Article 5, Parts, 2, 3, 4, 5, 7, and 8;

(18) develop arrangements for the provision of extended care and other long-term healthcare services. Such services shall be provided in the facility or by outside resources through a transfer agreement or referrals;

(19) provide and implement a written plan for the care or for the referral, or ~~for~~ both, of patients who require mental health or substance abuse services while in the ~~hospital;~~ facility;

(20) develop a conflict of interest policy which shall apply to all governing body members and ~~corporate officers.~~ facility administration. All governing body members shall execute a conflict of interest ~~statement;~~ statement; and

~~(21) prohibit members of the governing body from engaging in the following forms of self-dealing:~~

~~(a) the sale, exchange or leasing of property or services between the facility and a governing board member, his employer or an organization substantially controlled by him on a basis less favorable to the facility than that on which such property or service is made available to the general public;~~

~~(b) furnishing of goods, services or facilities by a facility to a governing board member, unless such furnishing is made on a basis not more favorable than that on which such goods, services, or facilities are made available to the general public or employees of the facility; or~~

~~(c) any transfer to or use by or for the benefit of a governing board member of the income or assets of a facility, except by purchase for fair market value; and~~

~~(22) prohibit the lease, sale, or exclusive use of any facility buildings or facilities receiving a license in accordance with this Subchapter to any entity which provides medical or other health services to the facility's patients, unless there is full, complete disclosure to and approval from the Division.~~

(21) conduct direct consultations with the medical staff at least twice during the year.

(b) For the purposes of this Rule, “direct consultations” means the governing body, or a subcommittee of the governing body, meets with the leader(s) of the medical staff(s), or his or her designee(s) either face-to-face or via a telecommunications system permitting immediate, synchronous communication.

(c) The direct consultations shall consist of discussions of matters related to the quality of medical care provided to the hospital’s patients, including quality matters arising out of the following:

(1) the scope and complexity of services offered by the facility;

(2) specific clinical populations served by the facility;

(3) limitations on medical staff membership other than peer review or corrective action in individual cases;

(4) circumstances relating to medical staff access to a facility resource; or

(5) any issues of patient safety and quality of care that a hospital’s quality assessment and performance improvement program might identify as needing the attention of the governing body in consultation with the medical staff.

(d) For the purposes of this Rule, “specific clinical populations” includes those individuals who may be treated at the facility by the medical staff in place at the time of the consultation.

History Note: *Authority G.S. 131E-14.2; 131E-79; 42 CFR 482.12; 42 CFR 482.22;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3701 is readopted as published in 34:12 NCR 1104-1110 as follows:

SECTION .3700 - MEDICAL STAFF

10A NCAC 13B .3701 GENERAL PROVISIONS

a) The facility shall have a self-governed medical staff ~~organized in accordance with the facility's by-laws which~~ that shall be accountable to the governing body ~~and which shall have responsibility~~ for the quality of ~~professional services~~ care provided by individuals with medical staff membership and clinical ~~privileges.~~ privileges to provide medical services in the facility. Facility policy shall provide that individuals with clinical privileges shall perform only services within the scope of individual privileges granted.

b) Minutes required by the rules of this Section shall reflect all transactions, conclusions, and recommendations of meetings. Minutes shall be prepared and retained in accordance with a policy established by the facility and medical staff, and available for inspection by members of the medical staff and governing body, respectively, unless such minutes include confidential peer review information that is not accessible to others in accordance with applicable law, or as otherwise protected by law.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2020.

1 10A NCAC 13B .3702 is repealed through readoption as published in 34:12 NCR 1104-1110 as follows:

2

3 **10A NCAC 13B .3702 ESTABLISHMENT**

4

5 *History Note: Authority G.S. 131E-79;*

6 *Eff. January 1, ~~1996.~~ 1996;*

7 *Repealed Eff. July 1, 2020.*

10A NCAC 13B .3703 is amended as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3703 APPOINTMENT

(a) The governing body may grant, deny, renew, modify, suspend, or terminate medical staff membership and clinical privileges after consideration of the recommendation made by the medical staff in accordance with the bylaws established by the medical staff and approved by the governing body for making such recommendations, and the facility bylaws established by the governing body for review and final determination of such recommendations.

(b) ~~Formal appointment~~ Review of an applicant for medical staff membership and the granting of clinical privileges shall follow procedures set forth in the ~~by-laws, rules or~~ bylaws, rules, and regulations of the medical staff. These procedures shall require the following:

(1) a signed application for medical staff membership, specifying ~~age,~~ date of birth, year and school of graduation, date of licensure, statement of postgraduate or special training and ~~experience with~~ experience, and a statement of the scope of the clinical privileges sought by the applicant;

(2) verification by the ~~hospital~~ facility of the applicant's qualifications ~~of the applicant~~ as stated in the application, including ~~evidence of~~ any required continuing education; and

(3) written notice to the applicant from ~~the medical staff and~~ the governing ~~body,~~ body regarding appointment or ~~reappointment~~ reappointment, which specifies the approval or denial of clinical privileges and the scope of the privileges ~~granted; and~~ if granted.

~~(4) members of the medical staff and others granted clinical privileges in the facility shall hold current licenses to practice in North Carolina.~~

(c) Members of the medical staff and others granted clinical privileges in the facility shall hold current licenses to practice in North Carolina.

(d) Medical staff appointments shall be reviewed at least once every two years by the medical staff in accordance with the bylaws established by the medical staff and approved by the governing body, and shall be followed with recommendations made to the governing body for review and a final determination.

(e) The facility shall maintain a file containing performance information for each medical staff member. Representatives of the Division shall have access to these files in accordance with, and subject to the limitations and restrictions set forth in, G.S. 131E-80; however, to the extent that the same includes confidential medical review information, such information shall be reviewable and confidential in accordance with G.S. 131E-80(d) and other applicable law.

(f) Minutes shall be taken and maintained of all meetings of the medical staff and governing body that concern the granting, denying, renewing, modifying, suspending or terminating of clinical privileges.

History Note: *Authority G.S. 131E-79; 42 CFR 482.12(a)(10); 42 CFR 482.22(a)(1);*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, ~~2017.~~ 2017;

1 *Amended Eff. July 1, 2020;*

10A NCAC 13B .3704 is readopted as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3704 ~~STATUS~~ ESTABLISHMENT AND CATEGORIES OF MEDICAL STAFF MEMBERSHIP

(a) The medical staff shall be established in accordance with the bylaws of the facility and organized in accordance with the bylaws, rules, and regulations of the medical staff. The governing body of the facility, after considering the recommendations of the medical staff, may grant medical staff membership and clinical privileges to qualified, licensed practitioners in accordance with their training, experience, and demonstrated competence and judgment in accordance with the medical staff bylaws, rules, and regulations.

~~(a)~~(b) Every facility shall have an active medical ~~staff~~ staff, as defined by the medical staff bylaws, rules, and regulations, to deliver medical services within the ~~facility. The active medical staff shall be responsible for the organization and administration of the medical staff. Every member~~ facility and to administer medical staff functions. The members of the active medical staff shall be eligible to vote at medical staff meetings and to hold ~~office.~~ medical staff office positions as determined by the medical staff bylaws, rules, and regulations and shall be responsible for recommendations made to the governing body regarding the organization and administration of the medical staff. Medical staff office positions shall be determined in the medical staff bylaws, rules, and regulations.

~~(b)~~(c) The active medical staff may establish other categories for membership in the medical staff. These categories for membership shall be identified and defined in the medical staff ~~bylaws, rules or regulations adopted by the active medical staff.~~ bylaws. Examples of ~~these other~~ membership categories ~~for membership are:~~ include:

(1) active medical staff;
~~(1)~~ (2) associate medical staff;
~~(2)~~ (3) courtesy medical staff;
~~(3)~~ (4) temporary medical staff;
~~(4)~~ (5) consulting medical staff;
~~(5)~~ (6) honorary medical staff; or
~~(6)~~ (7) other staff classifications.

The medical staff ~~bylaws, rules or regulations may grant limited or full~~ bylaws shall describe the authority, duties, privileges, and voting rights ~~to any one or more of these other~~ for each membership ~~categories.~~ category consistent with applicable law, rules, and regulations and requirements of facility accrediting bodies.

~~(c) Medical staff appointments shall be reviewed at least once every two years by the governing board.~~

~~(d) The facility shall maintain an individual file for each medical staff member. Representatives of the Department shall have access to these files in accordance with G.S. 131E-80.~~

~~(e) Minutes of all actions taken by the medical staff and the governing board concerning clinical privileges shall be maintained by the medical staff and the governing board, respectively.~~

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;

1 *Readopted Eff. July 1, 2020.*

10A NCAC 13B .3705 is readopted as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3705 MEDICAL STAFF BYLAWS, ~~RULES~~ RULES, ~~OR~~ AND REGULATIONS

(a) The active medical staff shall develop and adopt, subject to the approval of the governing body, a set of bylaws, ~~rules or~~ rules, and ~~regulations,~~ regulations to establish a framework for ~~self governance~~ self-governance of medical staff activities and accountability to the governing body.

(b) The medical staff bylaws, ~~rules~~ rules, and regulations shall provide for ~~at least~~ the following:

(1) organizational structure;

(2) qualifications for medical staff membership;

(3) procedures for ~~admission, retention, assignment, and reduction or withdrawal of~~ granting or renewing, denying, modifying, suspending, and revoking clinical privileges;

(4) procedures for disciplinary or corrective actions;

~~(4)~~ (5) procedures for fair hearing and appellate review mechanisms for ~~denial of staff appointments, reappointments, suspension, or revocation of~~ denying, modifying, suspending, and revoking clinical privileges;

~~(5)~~ (6) composition, functions and attendance of standing committees;

~~(6)~~ (7) policies for completion of medical ~~records and procedures for disciplinary actions;~~ records;

~~(7)~~ (8) formal liaison between the medical staff and the governing body;

~~(8)~~ (9) methods developed to formally verify that each medical staff member on appointment or reappointment agrees to abide by current medical staff ~~bylaws~~ bylaws, rules, and regulations, and the facility ~~bylaws; and~~ bylaws, rules, policies, and regulations;

~~(9)~~ (10) procedures for ~~members of medical staff~~ participation in quality assurance ~~functions.~~ functions by medical staff members;

(11) the process for the selection and election and removal of medical staff officers; and

(12) procedures for the proposal, adoption, and amendment, and approval of medical staff bylaws, rules, and regulations.

(c) Neither the medical staff, the governing body, nor the facility administration may unilaterally amend the medical staff bylaws, rules, and regulations.

(d) Neither the medical staff, the governing body, nor the facility administration may waive any provision of the medical staff bylaws, rules, and regulations, except in an emergency circumstance. For purposes of this Rule, an "emergency circumstance" means a situation of urgency that justifies immediate action and when there is not sufficient time to follow the applicable provisions and procedures of the medical staff bylaws. Examples of an emergency circumstance include an immediate threat to the life or health of an individual or the public, a natural disaster, or a judicial or regulatory order. The duration of a waiver permitted by this Rule will be only so long as the emergency circumstance exists.

History Note: Authority G.S. 131E-79;

1 *Eff. January 1, ~~1996.~~ 1996;*

2 *Readopted Eff. July 1, 2020.*

10A NCAC 13B .3706 is readopted as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3706 ORGANIZATION AND RESPONSIBILITIES OF THE MEDICAL STAFF

(a) The medical staff shall be organized to accomplish its required functions as established by the governing body and medical staff bylaws, rules, and regulations and provide for the election or appointment of its own officers.

(b) There shall be an executive committee, or its equivalent, which represents the medical staff, ~~which~~ that has responsibility for the effectiveness of all medical activities of the staff, and ~~which~~ that acts for the medical staff.

~~(c) All minutes of proceedings of medical staff committees shall be recorded and available for inspections by members of the medical staff and the governing body.~~

~~(d)~~ (c) The following ~~reviews and~~ functions shall be performed by the medical staff:

(1) credentialing review;
~~(2) surgical case review;~~
~~(3)~~ (2) medical records review;
~~(4) medical care evaluation review;~~
~~(5)~~ (3) drug utilization review;
~~(6)~~ (4) radiation safety review;
~~(7)~~ (5) blood usage review; ~~and~~
~~(8)~~ (6) bylaws ~~review.~~ review;
(7) medical review;
(8) peer review; and
(9) recommendations for discipline or corrective action of medical staff members.

~~(e)~~ (d) ~~There shall be medical staff and departmental meetings for the purpose of reviewing the performance of the medical staff, departments or services, and reports and recommendations of medical staff and multi-disciplinary committees.~~ The medical staff shall ensure that minutes are ~~taken at~~ prepared for each ~~meeting and retained in accordance with the policy of the facility. These minutes shall reflect the transactions, conclusions and recommendations of the meetings~~. medical staff, departmental, and committee meeting.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3707 is readopted as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3707 MEDICAL ORDERS

(a) No medication or treatment shall be administered or discontinued except in response to the order of a member of the medical staff in accordance with ~~established rules~~ policies, rules, and regulations established by the facility and medical staff and as provided in Paragraph (f) ~~below.~~ of this Rule.

(b) Such orders shall be dated and recorded directly in the patient ~~chart or in a computer or data processing system which provides a hard copy printout of the order for the patient chart.~~ medical record. A method shall be established to safeguard against fraudulent recordings.

(c) All orders for medication or treatment shall be authenticated according to ~~hospital policies.~~ medical staff and facility policies, rules, or regulations. The order shall be taken by personnel qualified by medical staff ~~rules~~ bylaws, rules, and regulations, and shall include the date, time, and name of persons who gave the order, and the full signature of the person taking the order.

(d) The names of drugs shall be recorded in full and not abbreviated except where approved by the medical staff.

(e) The medical staff shall establish a written policy in conjunction with the pharmacy committee or its equivalent for all medications not specifically prescribed as to time or number of doses to be automatically stopped after a reasonable time limit, but no more than 14 days. The prescriber shall be notified according to established policies and procedures at least 24 hours before an order is automatically stopped.

(f) For patients who are under the continuing care of an out-of-state physician but are temporarily located in North Carolina, a ~~hospital~~ facility may process the out-of-state physician's prescriptions or orders for diagnostic or therapeutic studies which maintain and support the patient's continued program of care, where the authenticity and currency of the prescriptions or orders can be verified by the physician who prescribed or ordered the treatment requested by the patient, and where the ~~hospital~~ facility verifies that the out-of-state physician is licensed to prescribe or order the treatment.

History Note: *Authority G.S. 131E-75; 131E-79; ~~143B-165;~~*
Eff. January 1, 1996;
Amended Eff. April 1, 2005; August 1, ~~1998.~~ 1998;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3708 is amended as published in 34:12 NCR 1104-1110 as follows:

10A NCAC 13B .3708 MEDICAL STAFF RESPONSIBILITIES FOR QUALITY IMPROVEMENT REVIEW

(a) The medical staff shall have in effect a system to review ~~medical services rendered,~~ care provided at the facility by members of the medical staff, to assess quality, to provide a process for ~~improving performance when indicated~~ quality improvement, and to monitor the ~~outcome.~~ outcome of quality improvement activities.

(b) The medical staff shall establish criteria for the evaluation of the quality of ~~medical~~ care.

(c) The facility shall have a written plan ~~approved by the medical staff, administration and governing body which~~ that generates reports to permit identification of patient care ~~problems. The plan shall establish~~ problems and that establishes a system to use this data to document and identify interventions. The plan shall be approved by the medical staff, facility administration, and the governing body.

(d) The medical staff shall establish ~~and~~ a policy to maintain a ~~continuous~~ review process of the care ~~rendered to both inpatients and outpatients~~ provided by members of the medical staff to all patients in every medical department of the facility. ~~At least quarterly, the~~ The medical staff shall have a ~~meeting~~ policy to schedule meetings to examine the review process and results. The review process shall include both practitioners and allied health professionals from the ~~facility~~ medical staff.

(e) Minutes shall be ~~taken at~~ prepared for all meetings reviewing quality ~~improvement, and these minutes shall be made available to the medical staff on a regular basis in accordance with established policy. These minutes shall be retained as determined by the facility.~~ improvement and shall reflect all of the transactions, conclusions, and recommendations of the meeting.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, ~~2017.~~ 2017;
Amended Eff. July 1, 2020.

Fiscal Impact Analysis of
Permanent Rule Readoption with No Substantial Economic Impact

Agency Proposing Rule Change
North Carolina Medical Care Commission

Contact Persons
Nadine Pfeiffer, DHSR Rules Review Manager -- (919) 855-3811
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Impact Summary

Federal Government Entities:	No Impact
State Government entities:	No Impact
Local Government Entities:	No Impact
Small Business:	No Impact
Substantial Impact:	No Impact

Title of Rules Changes and Statutory Citations

10A NCAC 13B

Section .3500 – Governance and Management
- Governing Body 10A NCAC 13B .3501 (Amend)
- Required Facility Policies, Rules, and Regulations 10A NCAC 13B .3502 (Readopt)
- Functions 10A NCAC 13B .3503 (Readopt)

Section .3700 – Medical Staff
- General Provisions 10A NCAC 13B .3701 (Readopt)
- Establishment 10A NCAC 13B .3702 (Repeal)
- Appointment 10A NCAC 13B .3703 (Amend)
- Categories of Medical Staff Membership 10A NCAC 13B .3704 (Readopt)
- Medical Staff Bylaws, Rules and Regulations 10A NCAC 13B .3705 (Readopt)
- Organization and Responsibilities of the Medical Staff 10A NCAC 13B .3706 (Readopt)
- Medical Orders 10A NCAC 13B .3707 (Readopt)
- Medical Staff Responsibilities for Quality Improvement Review 10A NCAC 13B .3708 (Amend)

***See proposed text of these rules in Appendix 1**

Statutory Authority

N.C.G.S. 131E-79

Background and Purpose

The Medical Care Commission is proposing changes to eleven hospital licensure rules related to the responsibilities of the governing body and medical staff. Under authority of N.C.G.S. 150B-21-3A, Periodic review and expiration of existing rules, the Medical Care Commission, Rules Review Commission and the Joint Legislative Administrative Procedure Oversight Committee approved the

subchapter report with classifications for the rules located at 10A NCAC 13B—Rules for the Licensing of Hospitals on February 10, 2017, May 18, 2017, and July 22, 2017, respectively. Eight rules were determined as necessary with substantive change and therefore subject to readoptions as new rules (10A NCAC 13B .3502, .3503, .3701, 3702, .3704, .3705, .3706, and .3707).

Three rules are proposed for amendment (10A NCAC 13B .3501, .3703, and.3708).

There are 119 licensed Hospitals in North Carolina, each operated by a governing body with final decision-making authority regarding conduct of the facility, including granting clinical privileges to medical staff and defining the scope of services offered at the facility. The Commission believes that medical staff offer a unique perspective on the needs of the community served, and current state, federal, and Joint Commission rules require the governing body to consider input from the medical staff. However, the Commission is concerned about the effect of recent decisions by some governing body to discontinue or greatly reduce certain service lines, affecting access to care and continuity of care for residents. Access to care can be particularly challenging in some rural parts of the state where patients may be required to travel for miles to get to a hospital facility. Some of the major hospitals, such as UNC is working to help improve access to care by partnering with affiliate hospitals and hospital systems across the state. The rule readoptions presented in this fiscal analysis are intended to improve safety, quality and access to care by promoting improved communication between facilities and medical staff. Readoptions will also update language, provide clarity, remove ambiguity, address previous Rules Review objections, and implement several technical changes. Changes will also clarify authorities granted in federal regulations and allow reference to the statute where appropriate.

It is unknown whether the changes will result in different management decisions and therefore different patient outcomes, however, the changes are intended to ensure that medical staff are consulted and kept informed. The Commission believes that the proposed changes will establish a structure for information sharing that may increase medical staff awareness of their opportunity to make recommendations on proposed decisions and increase feedback on the potential impact of those changes on medical staff, patient, and health outcomes. Ultimate responsibility for the hospital from a corporate, legal, accreditation, licensure, and compliance standpoint will continue to reside with the governing body.

Rules Summary and Anticipated Fiscal Impact

Rule .3501 – Governing Body
The agency is proposing to amend this rule. This rule established criteria for the Governing Body. Changes clarify that the governing body is the entity responsible for ensuring charter objectives are attained and is the authority for decisions in the facility. This is and continues to be the standard.

Changes clarify that the local advisory board should contain members from the county where the facility is located. This is a current occurrence. Local advisory boards are established to advise facilities regarding community needs, ensure locals are involved in decision making, which will ultimately improve quality of care, safety and access to care. Local advisory boards are a current requirement for facilities that have out of state owners. There are three such facilities in North Carolina - Kindred Hospital, Frye Regional, and Martin General Hospital. Current healthcare administration research advocates for the use of patient advisory boards and community advisory boards but research is limited as to their impact on hospital leadership decision-making.

A review of Kindred's website revealed that Kindred Hospital has an advisory board of physicians who care for patients within the patients' community. A similar internet search of Martin General Hospital did not reveal a specific reference to an advisory board; however, it did express a commitment to sharing information with employees, patients and the community, to include working with the community to

provide quality healthcare that fits their lifestyle.[1] They do endorse several national and regional organizations of this nature. For Kindred, the advisory board already has members from the county and thus the new requirement will have no additional impact. Martin General currently doesn't specifically identify an advisory board on it's website. There could potentially be a minimal cost regarding administrative staff time and space required to hold meetings. Generally, advisory boards don't include reimbursement. In addition, the Centers for Disease Control requires hospitals every three years to communicate with the community and conduct a community health assessment. A community health assessment gives organizations comprehensive information about the community's current health status, needs, and issues. In turn, this information can help with developing a community health improvement plan by justifying how and where resources should be allocated to best meet community needs.[2] Frye Regional completes the Community Needs Health Assessment in which it defines priorities for health improvement, creates a collaborative community environment to engage stakeholders, and an open and transparent process to listen and understand the health needs of the community served by Frye Regional medical center. It brings together all the care providers, citizens, government, schools, churches, not for profit organizations and business and industry around an effective plan of action. In state hospital facilities also have advisor boards. Community advisory boards advise on important outreach initiatives and provide a vital link between the facility and the community. Facilities with out of state owners already have advisory boards/committees with members from the county. This rule change will have minimal impact on communication and information sharing between the local community and the governing board and impose minimal additional costs. Local advisory boards' advice is nonbinding, and it is unknown whether any additional input will result in different decisions and outcomes.[3]

Rule .3502-- Required Policies, Rules, and Regulations & Rule .3705 – Medical Staff Bylaws, Rules, or Regulations

The agency is proposing to readopt these rules with substantive changes. Rule .3502 and .3705 includes a new requirement that facility policies, rules, and regulations shall not conflict with the medical staff bylaws, rules, and regulations. The governing body, medical staff, or facility administration may not unilaterally change the medical staff bylaws, rules and regulations except in emergency circumstances. In addition, the rules further specify the required content of the medical staff bylaws. The remainder of the changes clarify governing body responsibilities regarding facility policies, rules, and regulations. The rule was changed to clarify language regarding the governing body and to make technical changes.

By requiring the medical staff bylaws and facility bylaws to be congruent, these rules are possibly changing the process that medical staff and facility staff will use when developing their bylaws. The governing body and the medical staff will have to review and update their bylaws, rules, and regulations to ensure they are congruent, requiring an investment of time by both medical staff and governing body members. However, it is unclear whether this requirement is likely to result in more collaboration or more effective communication. Under current rules, both the governing body and the medical staff must have bylaws, and the governing body must review and approve medical staff bylaws. Given the existing approval process, the extent of any changes to medical staff bylaws, rules, and regulations resulting from this new requirement is unknown.

More detail was added to clarify what subjects the medical staff bylaws, rules, and regulations shall cover. The rule requires medical staff bylaws to include a process for selection/election or removal of medical staff officers and for the adoption and amendment of medical staff bylaws. The North Carolina Medical Society Model Medical Staff Bylaws document currently includes a process for

[1] https://www.kindredhealthcare.com/resources/blog-kindred-continuum/2012/03/29/medical-advisory-boards-help-kindred-improve-quality-of-patient-care

[2] https://www.cdc.gov/publichealthgateway/cha/index.html

[3] https://www.fryemedctr.com/community-health/community-health-needs-assessment

selection/election or removal of medical staff officers, and amendment of bylaws. However, this document only serves as an example and is not mandated for use, so it is unclear how many entities will need to update their bylaws, or how much staff time may need to be devoted to updating the bylaws. Remaining changes to these rules are primarily technical in nature and will not affect processes currently used by hospitals.

Rule .3503 – Functions

The agency is proposing to readopt this rule with substantive changes. This rule establishes functions for the governing body. Proposed changes would require the facility and medical staff to develop a policy for how it will make recommendations to the governing body regarding granting and defining the scope of clinical privileges. Because the agency has no authority to establish a process when the governing body does not concur with medical staff recommendations, that language was deleted.

Current rules also provide several means for maintaining communications with medical staff. The governing body may establish meetings with the executive committee of the medical staff or appoint individual medical staff members to the medical review committee (previously "governing body committees"). In addition, a provision was added that requires the governing body to have consultation with medical staff twice during the year regarding quality of care provided, and limitations placed on medical staff.

The agency is also further interpreting policies established by federal regulations, to include updating authorities delegated and not delegated to the state agency as they relate to the functions of the governing body. Finally, these changes also updated language to current terminology and include other technical and clarifying changes.

The governing body is currently required to consider recommendations of staff regarding appointments. Language was added to require facilities to establish a policy for making recommendations. This language was added in an attempt to address any potential information asymmetry problems. Comments were submitted to the Medical Care Commission regarding areas of concern include the ability for physician privileges to be eliminated without peer physicians on the hospital staff being involved. Having a policy in place for this process may increase awareness and engagement in the process.

This requirement to establish policy for making recommendations may have no effect on medical staff and patient outcomes, or it may have some effect of unknown magnitude. While organizational research generally agrees that communication is essential to informed decision making, it is unclear whether this requirement will result in the governing body receiving different information from the medical staff compared to current practices or how additional information may change decision-making. The ultimate authority for granting and defining the scope of clinical privileges resides with the governing body.

The facility and medical staff may incur staff time costs to develop their policy for making recommendations about clinical privileges, depending upon the existing process in the facility. The governing body is currently required to consider recommendations of staff regarding appointments. While the number of affected facilities is unknown, facilities may need to establish formal policies for the first time or revise existing policies to satisfy both parties. The time required is likely to be highly variable for each facility.

Changes also require facilities to formulate short and long range plans as defined in their bylaws, policies, rules, and regulations. Facilities currently have short and long range plans. It is unclear how timeframes are chosen. Medical staff are currently required to participate in strategic planning as described in their bylaws. Changes will require facilities to formulate long range plans according to their bylaws, policies,

rules or regulations. It is likely that some facilities currently meet the requirement, but it is unknown to what extent. Strategic plans improve the ability to manage and control resources, which are critical to the organization's survival. This is especially true in rural hospitals that are struggling to maintain operations. Strategic planning offers a proactive way to foresee and prepare for the future and increase operational efficiency. If facilities do not currently have short and long range plans defined in their bylaws, policies, rules, and regulations, there will likely be some marginal staff time costs involved in revising the timeframe of the plans, but the agency expects the costs to be minimal. The MCC is also further interpreting policies established by federal regulations, to include updating authorities delegated and not delegated to the state agency as they relate to the functions of the governing body. These changes also updated language to current terminology.

As the governing body is the final authority regarding what happens in a facility, there is no authority to establish a process when the governing body does not concur with medical staff recommendations. That language was deleted.

This rule amendment also includes changes made to the language around the reporting of "unusual incidents." The term "unusual incidents" was removed, and replaced with "allegations of abuse and neglect of patients." Abuse and neglect are currently reported and investigated. Improving the definition of the intent of this rule helps to provide clarity as to the expectations for reporting.

In addition, detail regarding conflict of interest was removed and language was added requiring governing body members to execute a conflict of interest statement. General Statute 131E-14.2 address conflicts of interest in public hospitals. Pursuant to the Internal Revenue Manual,[4] 26 CFR § 53 addresses the prohibition on self-dealing in private hospitals. These provisions makes it unnecessary to discuss self dealings regarding the governing body in rule, so this language has been removed. These changes have no fiscal impact.

Rule .3701 – General Provisions & Rule .3704 – Categories of Medical Staff Membership
The agency is proposing to readopt these rules with substantive changes. Rule .3701 establishes general provision for medical staff. The rule is changed to interpret language in the federal regulation regarding medical staff. Changes clarify that medical staff are self-governed, responsible for working in collaboration with facility administration, and accountable to the governing body. Federal regulation requires medical staff to make recommendations to the governing body regarding medical staff appointments[5]. The governing body has approval authority for medical staff bylaws, rules, and other medical staff regulations. This rule change does not require any additional actions by the facility or staff.

Rule .3704 also establishes categories of medical staff membership, expand who is eligible to vote and hold medical staff office positions and informs facilities that they are to determine medical staff office positions in their bylaws, rules, and regulations. This is a current requirement in the Conditions of Participation (COP) and is a current practice. Together the rules grant the medical staff the authority to determine the organization and office positions of the medical staff. While we believe the changes will improve the communication process by better informing medical staff and facilities regarding responsibilities, it will be difficult to quantify its effectiveness.

The requirement for taking minutes was relocated from .3704 and .3706 to this rule to eliminate redundancy and clarifying language was added to identify what the minutes should reflect and the retention schedule. This was done to eliminate ambiguity. As minutes are currently taken at Medical

[4] https://www.irs.gov/irm/part7/irm_07-027-030
[5] See 42 CFR 482.22

Staff meetings, (following Parliamentary procedures of Roberts Rules of Order) there is not expected to be a change in procedure or cost related to additional time spent.
This rule also includes several technical changes. Language regarding staff appointments, review, file retention, and minutes was relocated to Rule.3703. Relocating this information to .3703 grouped similar guidance together. The changes will result in zero to minimal fiscal impact.

Rule .3703 – Appointment
The agency is proposing to amend this rule that establishes staff appointment requirements.

In accordance with G.S. 131E-85 and 42 CFR 482.12, the rule identifies the governing body as the final decision maker regarding appointment of staff and clinical privileges. Changes also clarify what appointment of staff means and requires facilities and medical staff to develop a policy for making recommendations to grant, deny, renew, modify, suspend, or terminate medical staff membership and clinical privileges to the governing body.

Although current state and federal requirements direct the governing body to consider the recommendations of the medical staff regarding appointments, the proposed rules expand the scope of topics on which the governing body must consult with the medical staff. Medical staff will make recommendations to the governing body regarding appointment or reappointment which specifies the approval or denial of clinical privileges and the scope of privileges, excluding qualified providers from medical service lines; or limiting facility access to medical staff. In addition, the rules require medical staff appointments to be reviewed once every two years.

The intent of these rule changes is to increase communication between the governing body and medical staff regarding quality of care issues. This requirement may increase the frequency of communication between the governing body and medical staff. However, the magnitude of the impact on medical staff and patient outcomes is unknown. While organizational research generally agrees that communication is essential to informed decision making, it is unclear whether this requirement will result in the governing body receiving different information from the medical staff compared to current practices, or how additional information may change decision-making. The ultimate authority for decisions related to staffing and service lines resides with the governing body.

Other amendments remove ambiguity, clarify rule language and make technical changes. They also include relocating certain existing requirements from other sections of rule.

The requirement for medical staff and others granted clinical privileges to hold a current license was relocated and is a current requirement in federal and state regulation. Regulations also address medical staff and access to the facility's medical resources which is a normal part of facility protocol. The remaining requirements that were added to e, f, and g were relocated from existing rules.

Rule .3706 – Organization and Responsibilities of the Medical Staff
The agency is proposing to readopt this rule with substantive changes. This rule established organization and responsibilities of the medical staff. The rule is being changed to reference the federal requirement that medical staff have bylaws that describe the organization of the medical staff.[6] This is a current practice.

The requirement to keep minutes of proceedings was relocated to .3701 (General Provision) to eliminate redundancy. The functions listed as those performed by medical staff are a current requirement in the federal regulations as a condition of participation in the Medicare and Medicaid programs. Changes were

[6] See 42 CFR 482.22

made to combine similar items, and add medical review and peer review as identified in the federal regulations. Surgical case reviews and medical care evaluation reviews was deleted as a result of adding medical review and peer review which are more encompassing.

Medical staff are currently required to make recommendation regarding granting of privileges to staff. The rule was changed to include recommendations for discipline or corrective action. The rule also, identified what meetings require minutes. It is unlikely that there is any fiscal impact associated with this rule change, as the rule generally incorporates federal requirements that are currently being done. A potential cost could result from a change in which meetings require someone to record minutes, versus what meetings are currently appropriate for minutes. However, any cost will likely be minor.

Rule .3707 – Medical Orders

This rule is being readopted with technical changes to reflect more current terminology but does not require any changes in current practices. This rule addresses guidelines for medical orders. The electronic health record did not exist at the time this rule was last amended, thus the requirement relating to the patient chart, computer or data processing system was removed and replaced with a reference to the medical record. Two additional technical changes/clarifications were made to replace hospital policies with facility polices, rules, and regulations and to replace rules with bylaws, rules, or regulations. All changes are technical in nature and do not have cost implications.

Rule .3708 – Medical Staff Responsibilities for Quality Improvement Review

The agency is proposing to amend this rule to clarify rule language and meeting requirements for medical staff. This rule established medical staff responsibilities for quality improvement review. The rule is being amended to change the requirements for quarterly meetings to having a policy to schedule meetings. Medical staff, together with the governing body, may choose to change the frequency of quality improvement meetings.

Other amendments clarify rule language and make technical changes. Medical staff are currently required to have a plan for review of services. Plans must currently be approved by the facility administration and ultimately the governing body. The governing body has the final authority. Meeting minutes are a current requirement, but language was added to clarify what the minutes should reflect and to impose a retention schedule as identified by the facility and medical staff. The only possible cost will involve the time required for facilities and medical staff to establish a policy for maintaining the minutes as well as the additional time required if additional details are added to the minutes. With the change, facilities will be required to retain minutes as determined by the facility. It is expected that any costs will be minimal.

Impact Summary

Taken together, the total impact of these rule amendments on access and quality of care is unknown. There may be no change, or, the rule provisions could increase communication between the medical staff and the governing body and may inform management decision-making - particularly the requirements to establish a formal policy for medical staff to make recommendations to the governing body, and for twice annual consultations on quality of care matters, medical staff membership, and medical staff access to facility resources. However, any effect on medical staff and patient outcomes depends upon three unknown factors: the extent to which these new provisions differ from current practices, whether governing bodies are likely to receive more or different information from the medical staff compared to current practices, and how any additional information may change final management decisions. The governing body retains final decision-making authority regarding conduct of the facility.

Similarly, hospitals may incur administrative costs to implement these changes dependent upon each facility's current practices. Although, resource requirements cannot be quantified, any changes to current

processes or an increase in the frequency of communication may require additional staff time from hospital leadership and staff across the state's 119 licensed facilities. It is unknown to what extent hospitals may be affected.

It is highly unlikely that there will be a State government impact. Changes may improve the communication process and transparency, but it is almost impossible to determine what impact those changes may have on facilities. The changes won't add any additional tasks or responsibilities to State staff. State staff will continue to provide oversight of hospitals, which is a part of their current responsibilities.

Appendix 1

10A NCAC 13B .3501 is proposed for amendment as follows:

SECTION .3500 - GOVERNANCE AND MANAGEMENT

10A NCAC 13B .3501 GOVERNING BODY

(a) The governing body, ~~owner~~ owner, or the person or persons designated by the owner as the governing ~~authority~~ body shall be responsible for ~~seeing~~ ensuring that the objectives specified in the ~~charter (or resolution if publicly owned)~~ facility's governing documents are attained.

(b) The governing body shall be the final authority ~~in the facility~~ ~~to which~~ ~~the administrator,~~ for decisions for which the facility administration, the medical staff, and the facility personnel ~~and all auxiliary organizations~~ are directly or indirectly ~~responsible.~~ responsible within the facility.

(c) A local advisory board shall be established if the facility is owned ~~or controlled~~ by an organization or persons outside of North Carolina. A local advisory board shall include members from the county where the facility is located. The local advisory board will provide non-binding advice to the governing body.

History Note: Authority G.S. 131E-75; 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, ~~2017.~~ 2017;
Amended Eff. July 1, 2020.

10A NCAC 13B .3502 is proposed for readoption <u>with substantive changes</u> as follows:

10A NCAC 13B .3502 REQUIRED <u>FACILITY BYLAWS,</u> POLICIES, RULES, AND REGULATIONS

(a) The governing body shall adopt written <u>bylaws,</u> policies, rules, and regulations in accordance with all requirements contained in this Subchapter and in accordance with the community responsibility of the facility. The written <u>bylaws,</u> policies, rules, and regulations shall:

(1) state the purpose of the facility;

(2) describe the powers and duties of the governing body officers and committees and the responsibilities of the chief executive officer;

(3) state the qualifications for governing body membership, the procedures for selecting members, and the terms of service for members, officers and committee chairmen;

(4) describe the authority delegated to the chief executive officer and to the medical staff. No assignment, referral, or delegation of authority by the governing body shall relieve the governing body of its responsibility for the conduct of the facility. The governing body shall retain the right to rescind any such delegation;

(5) require ~~Board~~ <u>governing body</u> approval of the bylaws of any auxiliary organizations established by the ~~hospital;~~ <u>facility;</u>

(6) require the governing body to review and approve the bylaws of the medical ~~staff organization;~~ <u>staff;</u>

(7) establish ~~a procedure~~ <u>procedures</u> for processing and evaluating the applications for medical staff membership and for the granting of clinical privileges;

(8) establish a procedure for implementing, disseminating, and enforcing a Patient's Bill of Rights as set forth in Rule .3302 of this Subchapter and in compliance with G.S. 131E-117; and

(9) require the governing body to institute procedures to provide for:

(A) orientation of newly elected ~~board~~ <u>governing body</u> members to ~~specific~~ board functions and procedures;

(B) the development of procedures for periodic reexamination of the relationship of the ~~board~~ <u>governing body</u> to the total facility community; and

(C) the recording of minutes of all governing body and executive committee meetings and the dissemination of those minutes, or summaries thereof, on a regular basis to all members of the governing body.

(b) The governing body shall ~~assure~~ <u>provide</u> written policies and procedures to assure billing and collection practices in accordance with G.S. 131E-91. These policies and procedures shall include:

(1) a financial assistance policy as defined in G.S. 131E-214.14(b)(3);

(2) how a patient may obtain an estimate of the charges for the statewide 100 most frequently reported Diagnostic Related Groups (DRGs), where applicable, 20 most common outpatient imaging procedures, and 20 most common outpatient surgical procedures. The policy shall require that the

information be provided to the patient in writing, either electronically or by mail, within three business days;

(3) how a patient or patient's representative may dispute a bill;

(4) issuance of a refund within 45 days of the patient receiving notice of the overpayment when a patient has overpaid the amount due to the ~~hospital;~~ facility;

(5) providing written notification to the patient or patient's representative at least 30 days prior to submitting a delinquent bill to a collections agency;

(6) providing the patient or patient's representative with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990;

(7) the requirement that a collections agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or patient's representative;

(8) a policy for handling debts arising from the provision of care by the ~~hospital~~ facility involving the doctrine of necessaries, in accordance with G.S. 131E-91(d)(5); and

(9) a policy for handling debts arising from the provision of care by the ~~hospital~~ facility to a minor, in accordance with G.S. 131E-91(d)(6).

(c) The governing body shall ensure that the bylaws, rules, and regulations of the medical staff and the bylaws, rules, policies, and regulations of the facility shall not be in conflict.

~~(c)~~(d) The written policies, rules, and regulations shall be reviewed every three years, revised as necessary, and dated to indicate when last reviewed or revised.

~~(d)~~(e) To qualify for licensure or license renewal, each facility must provide to the Division, upon application, an attestation statement in a form provided by the Division verifying compliance with the requirements of this Rule.

~~(e)~~(f) On an annual basis, on the license renewal application provided by the Division, the facility shall provide to the Division the direct website address to the facility's financial assistance policy. This ~~Rule~~ requirement applies only to facilities required to file a Schedule H, federal form 990.

History Note: *Authority G.S. 131E-79; 131E-91; 131E-214.8; 131E-214.13(f); 131E-214.14; ~~S.L. 2013-382, s. 10.1; S.L. 2013-382, s. 13.1;~~*
Eff. January 1, 1996;
Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, ~~2014.~~ 2014;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3503 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3503 FUNCTIONS

(a) The governing body shall:

(1) provide management, physical ~~resources~~ resources, and personnel determined by the governing body to be required to meet the needs of ~~the~~ patients for ~~which it is licensed;~~ treatment as authorized by the facility's license;

(2) require ~~management~~ facility administration to establish a quality control mechanism ~~which~~ that includes ~~as an integral part~~ a risk management component and an infection control program;

(3) formulate short-range and long-range plans ~~for the development of the facility;~~ as defined in the facility bylaws, policies, rules, and regulations;

(4) conform to all applicable ~~federal,~~ State and federal laws, rules, and regulations, and applicable local ~~laws and regulations;~~ ordinances;

(5) provide for the control and use of the physical and financial resources of the facility;

(6) review the annual audit, ~~budget~~ budget, and periodic reports of the financial operations of the facility;

(7) consider the ~~advice~~ recommendation of the medical staff in granting and defining the scope of clinical privileges to ~~individuals. When the governing body does not concur in the medical staff recommendation regarding the clinical privileges of an individual, there shall be a review of the recommendation by a joint committee of the medical staff and governing body before a final decision is reached by the governing body;~~ individuals in accordance with medical staff bylaws requirements for making such recommendations and the facility bylaws established by the governing body for the review and final determination of such recommendations;

(8) require that applicants be informed of the disposition of their application for medical staff membership or clinical ~~privileges, or both, within an established period of time after their~~ privileges in accordance with the facility bylaws established by the governing body, after an application has been submitted;

(9) review and approve the medical staff bylaws, ~~rules~~ rules, and ~~regulations body;~~ regulations;

(10) delegate to the medical staff the authority ~~to~~ to:

(A) evaluate the professional competence of medical staff members and applicants for ~~staff privileges~~ medical staff membership and clinical privileges; and

(B) ~~hold the medical staff responsible for recommending~~ recommend to the governing body initial medical staff appointments, ~~reappointments~~ reappointments, and assignments or curtailments of privileges;

(11) require that resources be made available to address the emotional and spiritual needs of patients either directly or through referral or arrangement with community agencies;

(12) maintain ~~effective~~ communication with the medical staff which ~~shall~~ may be ~~established,~~ established through:

~~(a)~~(A) meetings with the ~~Executive Committee~~ executive committee of the ~~Medical Staff;~~ medical staff;

~~(b)~~(B) service by the president of the medical staff as a member of the governing body with or without a vote;

~~(c)~~(C) appointment of individual medical staff members to ~~governing body committees; or~~ the medical review committee; or

~~(d)~~(D) a joint conference ~~committee;~~ committee that will be a committee of the governing body and the medical staff composed of equal representatives of each of the governing body, the chairman of the board or designee, the medical staff, and the chief of the medical staff or designee, respectively;

(13) require the medical staff to establish controls that are designed to provide that standards of ethical professional practices are met;

(14) provide ~~the necessary~~ administrative staff support to facilitate utilization review and infection control within the ~~facility and~~ facility, to support quality ~~control,~~ control and any other medical staff functions required by this Subchapter or by the facility bylaws;

(15) meet the following disclosure requirements:

~~(a)~~(A) provide data required by the Division;

~~(b)~~(B) disclose the facility's average daily inpatient charge upon request of the Division; and

~~(c)~~(C) disclose the identity of persons owning ~~5.0~~ five percent or more of the facility as well as the facility's officers and members of the governing body upon request;

(16) establish a procedure for reporting the occurrence and disposition of ~~any unusual incidents.~~ allegations of abuse or neglect of patients and incidents involving quality of care or physical environment at the facility. These procedures shall require that:

~~(a)~~(A) incident reports are analyzed and ~~summarized;~~ summarized by a designated party; and

~~(b)~~(B) corrective action is taken ~~as indicated by~~ based upon the analysis of incident reports;

(17) in a facility with one or more units, or portions of units, however described, utilized for psychiatric or substance abuse treatment, adopt policies implementing the provisions of G.S. 122C, Article 3, and Article 5, Parts, 2, 3, 4, 5, 7, and 8;

(18) develop arrangements for the provision of extended care and other long-term healthcare services. Such services shall be provided in the facility or by outside resources through a transfer agreement or referrals;

(19) provide and implement a written plan for the care or for the referral, or ~~for~~ both, of patients who require mental health or substance abuse services while in the ~~hospital;~~ facility;

(20) develop a conflict of interest policy which shall apply to all governing body members and ~~corporate officers.~~ facility administration. All governing body members shall execute a conflict of interest ~~statement;~~ statement; and

~~(21) prohibit members of the governing body from engaging in the following forms of self-dealing:~~

~~(a) the sale, exchange or leasing of property or services between the facility and a governing board member, his employer or an organization substantially controlled by him on a basis less favorable to the facility than that on which such property or service is made available to the general public;~~

~~(b) furnishing of goods, services or facilities by a facility to a governing board member, unless such furnishing is made on a basis not more favorable than that on which such goods, services, or facilities are made available to the general public or employees of the facility; or~~

~~(c) any transfer to or use by or for the benefit of a governing board member of the income or assets of a facility, except by purchase for fair market value; and~~

~~(22) prohibit the lease, sale, or exclusive use of any facility buildings or facilities receiving a license in accordance with this Subchapter to any entity which provides medical or other health services to the facility's patients, unless there is full, complete disclosure to and approval from the Division.~~

(21) conduct direct consultations with the medical staff at least twice during the year.

(b) For the purposes of this Rule, "direct consultations" means the governing body, or a subcommittee of the governing body, meets with the leader(s) of the medical staff(s), or his or her designee(s) either face-to-face or via a telecommunications system permitting immediate, synchronous communication.

(c) The direct consultations shall consist of discussions of matters related to the quality of medical care provided to the hospital's patients, including quality matters arising out of the following:

(1) the scope and complexity of services offered by the facility;

(2) specific clinical populations served by the facility;

(3) limitations on medical staff membership other than peer review or corrective action in individual cases;

(4) circumstances relating to medical staff access to a facility resource; or

(5) any issues of patient safety and quality of care that a hospital's quality assessment and performance improvement program might identify as needing the attention of the governing body in consultation with the medical staff.

(d) For the purposes of this Rule, "specific clinical populations" includes those individuals who may be treated at the facility by the medical staff in place at the time of the consultation.

History Note: *Authority G.S. 131E-14.2; 131E-79; 42 CFR 482.12; 42 CFR 482.22;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3701 is proposed for readoption with substantive changes as follows:

SECTION .3700 - MEDICAL STAFF

10A NCAC 13B .3701 GENERAL PROVISIONS

a) The facility shall have a self-governed medical staff ~~organized in accordance with the facility's by-laws which~~ that shall be accountable to the governing body ~~and which shall have responsibility~~ for the quality of ~~professional services~~ care provided by individuals with medical staff membership and clinical ~~privileges.~~ privileges to provide medical services in the facility. Facility policy shall provide that individuals with clinical privileges shall perform only services within the scope of individual privileges granted.

b) Minutes required by the rules of this Section shall reflect all transactions, conclusions, and recommendations of meetings. Minutes shall be prepared and retained in accordance with a policy established by the facility and medical staff, and available for inspection by members of the medical staff and governing body, respectively, unless such minutes include confidential peer review information that is not accessible to others in accordance with applicable law, or as otherwise protected by law.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3702 is proposed for readoption as a repeal as follows:

10A NCAC 13B .3702 ESTABLISHMENT

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Repealed Eff. July 1, 2020.

10A NCAC 13B .3703 is proposed for amendment as follows:

10A NCAC 13B .3703 APPOINTMENT

(a) The governing body may grant, deny, renew, modify, suspend, or terminate medical staff membership and clinical privileges after consideration of the recommendation made by the medical staff in accordance with the bylaws established by the medical staff and approved by the governing body for making such recommendations, and the facility bylaws established by the governing body for review and final determination of such recommendations.

(b) ~~Formal appointment~~ Review of an applicant for medical staff membership and the granting of clinical privileges shall follow procedures set forth in the ~~by-laws, rules or~~ bylaws, rules, and regulations of the medical staff. These procedures shall require the following:

(1) a signed application for medical staff membership, specifying ~~age,~~ date of birth, year and school of graduation, date of licensure, statement of postgraduate or special training and ~~experience with~~ experience, and a statement of the scope of the clinical privileges sought by the applicant;

(2) verification by the ~~hospital~~ facility of the applicant's qualifications ~~of the applicant~~ as stated in the application, including ~~evidence of~~ any required continuing education; and

(3) written notice to the applicant from ~~the medical staff and~~ the governing ~~body,~~ body regarding appointment or ~~reappointment~~ reappointment, which specifies the approval or denial of clinical privileges and the scope of the privileges ~~granted; and~~ if granted.

~~(4) members of the medical staff and others granted clinical privileges in the facility shall hold current licenses to practice in North Carolina.~~

(c) Members of the medical staff and others granted clinical privileges in the facility shall hold current licenses to practice in North Carolina.

(d) Medical staff appointments shall be reviewed at least once every two years by the medical staff in accordance with the bylaws established by the medical staff and approved by the governing body, and shall be followed with recommendations made to the governing body for review and a final determination.

(e) The facility shall maintain a file containing performance information for each medical staff member. Representatives of the Division shall have access to these files in accordance with, and subject to the limitations and restrictions set forth in, G.S. 131E-80; however, to the extent that the same includes confidential medical review information, such information shall be reviewable and confidential in accordance with G.S. 131E-80(d) and other applicable law.

(f) Minutes shall be taken and maintained of all meetings of the medical staff and governing body that concern the granting, denying, renewing, modifying, suspending or terminating of clinical privileges.

History Note: *Authority G.S. 131E-79; 42 CFR 482.12(a)(10); 42 CFR 482.22(a)(1);*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, ~~2017.~~ 2017;

1 *Amended Eff. July 1, 2020;*

10A NCAC 13B .3704 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3704 ~~STATUS~~ ESTABLISHMENT AND CATEGORIES OF MEDICAL STAFF MEMBERSHIP

(a) The medical staff shall be established in accordance with the bylaws of the facility and organized in accordance with the bylaws, rules, and regulations of the medical staff. The governing body of the facility, after considering the recommendations of the medical staff, may grant medical staff membership and clinical privileges to qualified, licensed practitioners in accordance with their training, experience, and demonstrated competence and judgment in accordance with the medical staff bylaws, rules, and regulations.

~~(a)~~(b) Every facility shall have an active medical ~~staff~~ staff, as defined by the medical staff bylaws, rules, and regulations, to deliver medical services within the ~~facility. The active medical staff shall be responsible for the organization and administration of the medical staff. Every member~~ facility and to administer medical staff functions. The members of the active medical staff shall be eligible to vote at medical staff meetings and to hold ~~office.~~ medical staff office positions as determined by the medical staff bylaws, rules, and regulations and shall be responsible for recommendations made to the governing body regarding the organization and administration of the medical staff. Medical staff office positions shall be determined in the medical staff bylaws, rules, and regulations.

~~(b)~~(c) The active medical staff may establish other categories for membership in the medical staff. These categories for membership shall be identified and defined in the medical staff ~~bylaws, rules or regulations adopted by the active medical staff.~~ bylaws. Examples of ~~these other~~ membership categories ~~for membership are:~~ include:

(1) active medical staff;
~~(1)~~ (2) associate medical staff;
~~(2)~~ (3) courtesy medical staff;
~~(3)~~ (4) temporary medical staff;
~~(4)~~ (5) consulting medical staff;
~~(5)~~ (6) honorary medical staff; or
~~(6)~~ (7) other staff classifications.

The medical staff ~~bylaws, rules or regulations may grant limited or full~~ bylaws shall describe the authority, duties, privileges, and voting rights ~~to any one or more of these other~~ for each membership ~~categories.~~ category consistent with applicable law, rules, and regulations and requirements of facility accrediting bodies.

~~(c) Medical staff appointments shall be reviewed at least once every two years by the governing board.~~

~~(d) The facility shall maintain an individual file for each medical staff member. Representatives of the Department shall have access to these files in accordance with G.S. 131E-80.~~

~~(e) Minutes of all actions taken by the medical staff and the governing board concerning clinical privileges shall be maintained by the medical staff and the governing board, respectively.~~

History Note: Authority G.S. 131E-79;
Eff. January 1, ~~1996.~~ 1996;

1 *Readopted Eff. July 1, 2020.*

10A NCAC 13B .3705 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3705 MEDICAL STAFF BYLAWS, ~~RULES~~ RULES, ~~OR~~ AND REGULATIONS

(a) The active medical staff shall develop and adopt, subject to the approval of the governing body, a set of bylaws, ~~rules or~~ rules, and ~~regulations,~~ regulations to establish a framework for ~~self governance~~ self-governance of medical staff activities and accountability to the governing body.

(b) The medical staff bylaws, ~~rules~~ rules, and regulations shall provide for ~~at least~~ the following:

(1) organizational structure;

(2) qualifications for medical staff membership;

(3) procedures for ~~admission, retention, assignment, and reduction or withdrawal of~~ granting or renewing, denying, modifying, suspending, and revoking clinical privileges;

(4) procedures for disciplinary or corrective actions;

~~(4)~~ (5) procedures for fair hearing and appellate review mechanisms for ~~denial of staff appointments, reappointments, suspension, or revocation of~~ denying, modifying, suspending, and revoking clinical privileges;

~~(5)~~ (6) composition, functions and attendance of standing committees;

~~(6)~~ (7) policies for completion of medical ~~records and procedures for disciplinary actions;~~ records;

~~(7)~~ (8) formal liaison between the medical staff and the governing body;

~~(8)~~ (9) methods developed to formally verify that each medical staff member on appointment or reappointment agrees to abide by current medical staff ~~bylaws~~ bylaws, rules, and regulations, and the facility ~~bylaws; and~~ bylaws, rules, policies, and regulations;

~~(9)~~ (10) procedures for ~~members of medical staff~~ participation in quality assurance ~~functions.~~ functions by medical staff members;

(11) the process for the selection and election and removal of medical staff officers; and

(12) procedures for the proposal, adoption, and amendment, and approval of medical staff bylaws, rules, and regulations.

(c) Neither the medical staff, the governing body, nor the facility administration may unilaterally amend the medical staff bylaws, rules, and regulations.

(d) Neither the medical staff, the governing body, nor the facility administration may waive any provision of the medical staff bylaws, rules, and regulations, except in an emergency circumstance. For purposes of this Rule, an "emergency circumstance" means a situation of urgency that justifies immediate action and when there is not sufficient time to follow the applicable provisions and procedures of the medical staff bylaws. Examples of an emergency circumstance include an immediate threat to the life or health of an individual or the public, a natural disaster, or a judicial or regulatory order. The duration of a waiver permitted by this Rule will be only so long as the emergency circumstance exists.

History Note: Authority G.S. 131E-79;

1 *Eff. January 1, ~~1996.~~ 1996;*

2 *Readopted Eff. July 1, 2020.*

10A NCAC 13B .3706 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3706 ORGANIZATION AND RESPONSIBILITIES OF THE MEDICAL STAFF

(a) The medical staff shall be organized to accomplish its required functions as established by the governing body and medical staff bylaws, rules, and regulations and provide for the election or appointment of its own officers.

(b) There shall be an executive committee, or its equivalent, which represents the medical staff, ~~which~~ that has responsibility for the effectiveness of all medical activities of the staff, and ~~which~~ that acts for the medical staff.

~~(c) All minutes of proceedings of medical staff committees shall be recorded and available for inspections by members of the medical staff and the governing body.~~

~~(d)~~ (c) The following ~~reviews and~~ functions shall be performed by the medical staff:

(1) credentialing review;
~~(2) surgical case review;~~
~~(3)~~ (2) medical records review;
~~(4) medical care evaluation review;~~
~~(5)~~ (3) drug utilization review;
~~(6)~~ (4) radiation safety review;
~~(7)~~ (5) blood usage review; ~~and~~
~~(8)~~ (6) bylaws ~~review.~~ review;
(7) medical review;
(8) peer review; and
(9) recommendations for discipline or corrective action of medical staff members.

~~(e)~~ (d) ~~There shall be medical staff and departmental meetings for the purpose of reviewing the performance of the medical staff, departments or services, and reports and recommendations of medical staff and multi-disciplinary committees.~~ The medical staff shall ensure that minutes are ~~taken at~~ prepared for each ~~meeting and retained in accordance with the policy of the facility. These minutes shall reflect the transactions, conclusions and recommendations of the meetings~~. medical staff, departmental, and committee meeting.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3707 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3707 MEDICAL ORDERS

(a) No medication or treatment shall be administered or discontinued except in response to the order of a member of the medical staff in accordance with ~~established rules~~ policies, rules, and regulations established by the facility and medical staff and as provided in Paragraph (f) ~~below.~~ of this Rule.

(b) Such orders shall be dated and recorded directly in the patient ~~chart or in a computer or data processing system which provides a hard copy printout of the order for the patient chart.~~ medical record. A method shall be established to safeguard against fraudulent recordings.

(c) All orders for medication or treatment shall be authenticated according to ~~hospital policies.~~ medical staff and facility policies, rules, or regulations. The order shall be taken by personnel qualified by medical staff ~~rules~~ bylaws, rules, and regulations, and shall include the date, time, and name of persons who gave the order, and the full signature of the person taking the order.

(d) The names of drugs shall be recorded in full and not abbreviated except where approved by the medical staff.

(e) The medical staff shall establish a written policy in conjunction with the pharmacy committee or its equivalent for all medications not specifically prescribed as to time or number of doses to be automatically stopped after a reasonable time limit, but no more than 14 days. The prescriber shall be notified according to established policies and procedures at least 24 hours before an order is automatically stopped.

(f) For patients who are under the continuing care of an out-of-state physician but are temporarily located in North Carolina, a ~~hospital~~ facility may process the out-of-state physician's prescriptions or orders for diagnostic or therapeutic studies which maintain and support the patient's continued program of care, where the authenticity and currency of the prescriptions or orders can be verified by the physician who prescribed or ordered the treatment requested by the patient, and where the ~~hospital~~ facility verifies that the out-of-state physician is licensed to prescribe or order the treatment.

History Note: *Authority G.S. 131E-75; 131E-79; ~~143B-165;~~*
Eff. January 1, 1996;
Amended Eff. April 1, 2005; August 1, ~~1998.~~ 1998;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3708 is proposed for amendment as follows:

10A NCAC 13B .3708 MEDICAL STAFF RESPONSIBILITIES FOR QUALITY IMPROVEMENT REVIEW

(a) The medical staff shall have in effect a system to review ~~medical services rendered,~~ care provided at the facility by members of the medical staff, to assess quality, to provide a process for ~~improving performance when indicated~~ quality improvement, and to monitor the ~~outcome.~~ outcome of quality improvement activities.

(b) The medical staff shall establish criteria for the evaluation of the quality of ~~medical~~ care.

(c) The facility shall have a written plan ~~approved by the medical staff, administration and governing body which~~ that generates reports to permit identification of patient care ~~problems. The plan shall establish~~ problems and that establishes a system to use this data to document and identify interventions. The plan shall be approved by the medical staff, facility administration, and the governing body.

(d) The medical staff shall establish ~~and~~ a policy to maintain a ~~continuous~~ review process of the care ~~rendered to both inpatients and outpatients~~ provided by members of the medical staff to all patients in every medical department of the facility. ~~At least quarterly, the~~ The medical staff shall have a ~~meeting~~ policy to schedule meetings to examine the review process and results. The review process shall include both practitioners and allied health professionals from the ~~facility~~ medical staff.

(e) Minutes shall be ~~taken at~~ prepared for all meetings reviewing quality ~~improvement, and these minutes shall be made available to the medical staff on a regular basis in accordance with established policy. These minutes shall be retained as determined by the facility.~~ improvement and shall reflect all of the transactions, conclusions, and recommendations of the meeting.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, ~~2017.~~ 2017;
Amended Eff. July 1, 2020.

DHSR Received 2/14/20
Exhibit C/3

Uniting hospitals, health systems and
care providers for healthier communities

February 14, 2020

Ms. Nadine Pfeiffer
DHSR Rules Coordinator
809 Ruggles Drive
2701 Mail Service Center
Raleigh, NC 27699-2701

DHSR.RulesCoordinator@dhhs.nc.gov

Re: 10A NCAC 13B Licensing of Hospitals – Governance and Management (Section .3500) and Medical Staff (Section .3700)

Dear Ms. Pfeiffer:

NCHA represents 130 hospitals and health systems in North Carolina and we thank you for the opportunity to comment on the Proposed Rule changes to Chapter 13B, Licensing of Hospitals, as found in the December 16, 2019 issue of the North Carolina Register.

As you know the December 16, 2019 published rule changes result from a rule review process that was initiated in 2016 and that, in some cases represented the first proposed change to the rules in decades. Those proposals resulted in discussions and negotiations over more than two years with the North Carolina Medical Society and a Medical Care Commission Subcommittee.

The December 16, 2019 published version of these rules are consistent with the Medicare/Medicaid Conditions of Participation for Hospitals, as well as with Joint Commission and other accrediting body requirements. The rules also recognize the roles of the hospital governing board and its medical staff in working together to provide quality healthcare in the community. For this reason, NCHA is supportive of these proposed rules and invites their adoption as permanent rules.

Thank you for your consideration of our comments. Please contact Mike Vicario (mvicario@ncha.org) or me if you have questions or concerns.

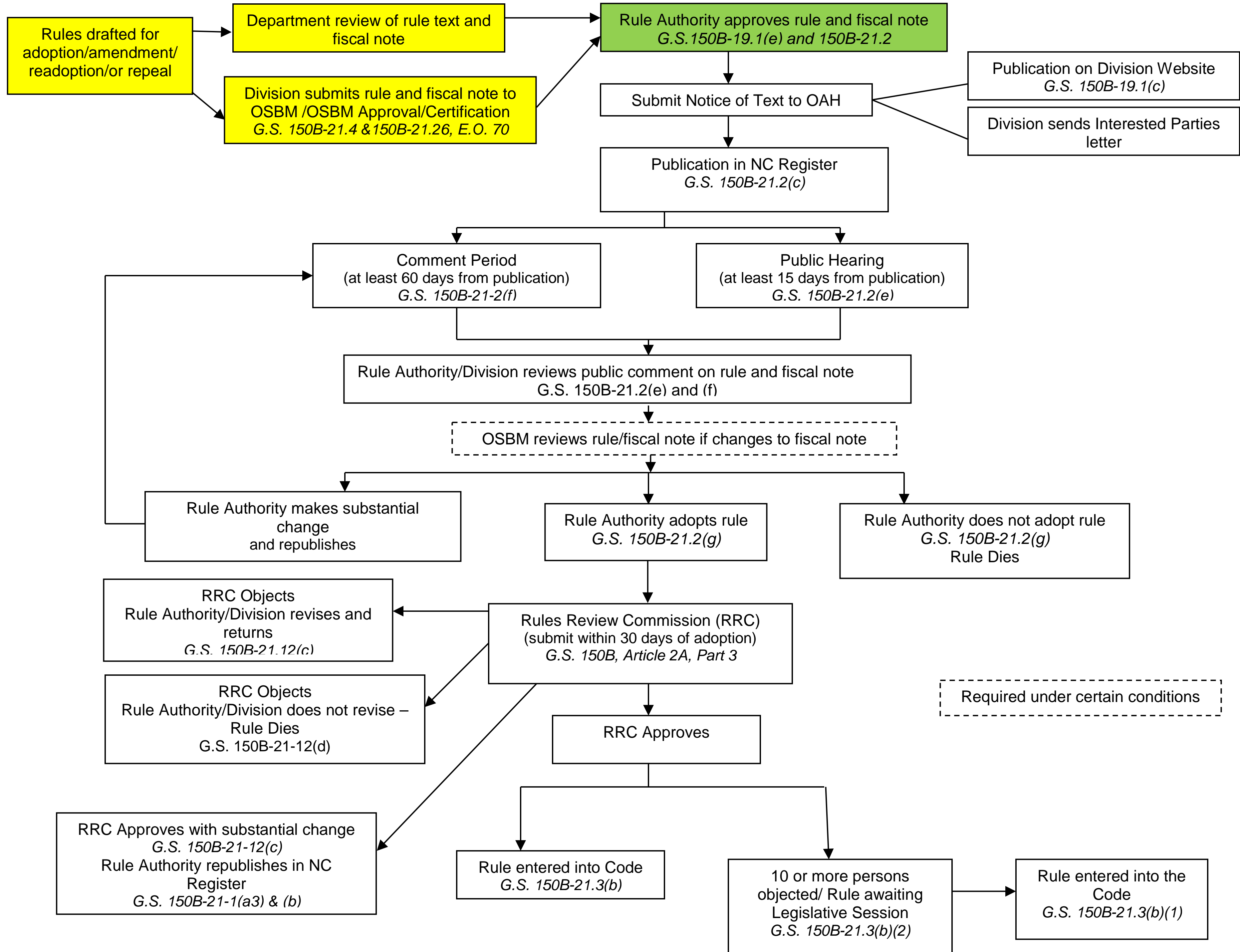
Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association

2400 Weston Parkway, Cary, NC 27513 | 919.677.2400 (main) | 919.677.4200 (fax) | ncha.org

Process for Medical Care Commission to Initiate Rulemaking

Exhibit D



1 10A NCAC 13C .0202 is proposed for readoption with substantive changes as follows:

2

3 **10A NCAC 13C .0202 REQUIREMENTS FOR ISSUANCE OF LICENSE**

4 (a) Upon application for a license from a facility never before licensed, a representative of the Department shall make
5 an inspection of that facility. Every building, institution, or establishment ~~for which a license~~ that has been issued a
6 license shall be inspected for compliance with the ~~rules~~ Rules found in this Subchapter. An ambulatory surgery facility
7 shall be deemed to meet licensure requirements if the ambulatory surgery facility is accredited by The Joint
8 ~~Commission (formerly known as "JCAHO"),~~ Commission, AAAHC or AAAASF. Accreditation ~~does~~ shall not
9 exempt a facility from statutory or rule requirements for licensure nor ~~does~~ shall it prohibit the Department from
10 conducting inspections as provided in this Rule to determine compliance with all requirements.
11 (b) If the applicant has been issued a Certificate of Need and is found to be in compliance with the Rules found in
12 this Subchapter, then the Department shall issue a license to expire on December 31 of each year.
13 (c) The Department shall be notified at the time of:
14 (1) any change of the owner or operator;
15 (2) any change of location;
16 (3) any change as to a lease; and
17 (4) any transfer, assignment, or other disposition or change of ownership or control of 20 percent or
18 more of the capital stock or voting rights thereunder of a corporation that is the operator or owner
19 of an ambulatory surgical facility, or any transfer, assignment, or other disposition of the stock or
20 voting rights thereunder of such corporation that results in the ownership or control of more than 20
21 percent of the stock or voting rights thereunder of such corporation by any person.
22 A new application shall be submitted to the Department in the event of such a change or changes.
23 (d) The Department shall not grant a license until the plans and specifications that are stated in Section .1400 of this
24 Subchapter, covering the construction of new buildings, additions, or material alterations to existing buildings are
25 approved by the Department.
26 (e) The facility design and construction shall be in accordance with the licensure rules for ambulatory surgical
27 facilities found in this Subchapter, the North Carolina State Building Code, and local municipal codes.
28 (f) Submission of Plans.
29 (1) ~~Before construction is begun, schematic plans and specifications and final plans and specifications~~
30 ~~covering construction of the new buildings, alterations, renovations, or additions to existing~~
31 ~~buildings shall be submitted to the Division for approval.~~ When construction or remodeling of a
32 facility is planned, one copy of construction documents and specifications shall be submitted by the
33 owner or owner's appointed representative to the Department for review and approval. As a
34 preliminary step to avoid last minute difficulty with construction documents approval, schematic
35 design drawings and design development drawings may be submitted for approval prior to the
36 required submission of construction documents.

(2) ~~The Division shall review the plans and notify the licensee that said buildings, alterations, additions, or changes are approved or disapproved. If plans are disapproved the Division shall give the applicant notice of deficiencies identified by the Division.~~ Approval of construction documents and specifications shall be obtained from the Department prior to licensure. Approval of construction documents and specifications shall expire one year after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.

(3) The plans shall include a plot plan showing the size and shape of the entire site and the location of all existing and proposed facilities.

~~(4) Plans shall be submitted in duplicate. The Division shall distribute a copy to the Department of Insurance for review of the North Carolina State Building Code requirements if required by the North Carolina State Building Code which is hereby incorporated by reference, including all subsequent amendments. Copies of the Code may be accessed electronically free of charge at: http://www.ecodes.biz/ecodes_support/Free_Resources/2012NorthCarolina/12NorthCarolina_main.html.~~

(g) To qualify for licensure or license renewal, each facility shall provide to the Division, with its application, an attestation statement in a form provided by the Division verifying compliance with the requirements defined in Rule .0301(d) of this Subchapter.

History Note: *Authority G.S. 131E-91; 131E-147; 131E-149; ~~S.L. 2013-382, s. 13.1;~~*
Eff. October 14, 1978;
Amended Eff. April 1, 2003;
Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, ~~2014.~~ 2014;
Readopted Eff. January 1, 2021.

10A NCAC 13C .0203 is proposed for amendment as follows:

10A NCAC 13C .0203 SUSPENSION OR REVOCATION: AMBULATORY SURGICAL FACILITY

(a) The license may be suspended or revoked at any time for noncompliance with the ~~regulations~~ rules of the Department.

(b) Suspension or revocation of the license shall be covered by the rules regarding contested cases as found in ~~10 NCAC 3B .0200.~~ G.S. 150B-23.

(c) Notwithstanding ~~Subsection~~ Paragraph (a) and (b) of this Rule, the Department may summarily suspend the license pursuant to ~~General Statute~~ G.S. 150B-3(c).

History Note: *Authority G.S. 131E-148; 131E-149; 143B-165; 150B-3(c); 150B-23;*
Eff. October 14, 1978;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, ~~2017.~~ 2017;
Amended Eff. January 1, 2021.

10A NCAC 13C .0301 is proposed for readoption without substantive changes as follows:

SECTION .0300 – GOVERNING AUTHORITY MANAGEMENT

10A NCAC 13C .0301 GOVERNING AUTHORITY

(a) The facility's governing authority shall adopt bylaws or other operating policies and procedures to assure that:

(1) a named individual is identified who is responsible for the overall operation and maintenance of the facility. The governing authority shall have methods in place for the oversight of the individual's performance;

(2) ~~at least~~ annual meetings of the governing authority ~~are~~ shall be conducted if the governing authority consists of two or more individuals. Minutes shall be maintained of such meetings;

(3) a policy and procedure manual is created that is designed to ensure professional and safe care for the patients. The manual shall be reviewed annually and revised ~~when necessary.~~ in accordance with facility policy. The manual shall include provisions for administration and use of the facility, compliance, personnel quality assurance, procurement of outside services and consultations, patient care ~~policies~~ policies, and services offered; and

(4) annual reviews and evaluations of the facility's policies, management, and operation are conducted.

(b) When services such as dietary, laundry, or therapy services are purchased from others, the governing authority shall be responsible ~~to assure~~ for assuring the supplier meets the same local and ~~state~~ State standards the facility would have to meet if it were providing those services ~~itself~~ using its own staff.

(c) The governing authority shall provide for the selection and appointment of the professional staff and the granting of clinical privileges and shall be responsible for the professional conduct of these persons.

(d) The governing authority shall establish written policies and procedures to assure billing and collection practices in accordance with G.S. 131E-91. These policies and procedures shall include:

(1) a financial assistance policy as defined in G.S. 131E-214.14(b)(3);

(2) how a patient may obtain an estimate of the charges for the statewide 20 most common outpatient imaging procedures and 20 most common outpatient surgical procedures based on the primary Current Procedure Terminology Code (CPT). The policy shall require that the information be provided to the patient in writing, either electronically or by mail, within three business days;

(3) how a patient or patient's representative may dispute a bill;

(4) issuance of a refund within 45 days of the patient receiving notice of the overpayment when a patient has overpaid the amount due to the facility;

(5) providing written notification to the patient or patient's representative, ~~at least~~ 30 days prior to submitting a delinquent bill to a collections agency;

(6) providing the patient or patient's representative with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990;

1 (7) the requirement that a collections agency, entity, or other assignee obtain written consent from the
2 facility prior to initiating litigation against the patient or patient's representative;
3 (8) a policy for handling debts arising from the provision of care by the ambulatory surgical facility
4 involving the doctrine of necessaries, in accordance with G.S. 131E-91(d)(5); and
5 (9) a policy for handling debts arising from the provision of care by the ambulatory surgical facility to
6 a minor, in accordance with G.S. 131E-91(d)(6).
7
8 *History Note:* *Authority G.S. 131E-91; 131E-147.1; 131E-149; 131E-214.13(f); 131E-214.14; ~~S.L. 2013-382, s.~~*
9 *~~10.1; S.L. 2013-382, s. 13.1;~~*
10 *Eff. October 14, 1978;*
11 *Amended Eff. November 1, 1989; November 1, 1985; December 24, 1979;*
12 *Temporary Amendment Eff. May 1, 2014;*
13 *Amended Eff. November 1, ~~2014.~~ 2014;*
14 *Readopted Eff. January 1, 2021.*

10A NCAC 13C .0501 is proposed for readoption with substantive changes as follows:

SECTION .0500 - ANESTHESIA SERVICES

10A NCAC 13C .0501 PROVIDING ANESTHESIA SERVICES

Only a physician, ~~dentist~~ dentist, or qualified anesthetist or qualified anesthesiologist as defined in Rule .0103 of this Subchapter, shall administer anesthetic ~~agents (general and regional).~~ agents. Podiatrists shall administer only local anesthesia. The governing authority shall establish written policies and procedures concerning the provision of anesthesia services, including the designation of those persons authorized to administer ~~anesthetics.~~ anesthetics in accordance with State law.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, ~~1978.~~ 1978;
Readopted Eff. January 1, 2021.

1 10A NCAC 13C .0702 is proposed for amendment as follows:
2
3 **10A NCAC 13C .0702 REGULATIONS FOR PERFORMED SERVICES**
4 Radiation protection shall be provided in accordance with the rules and regulations adopted by the Radiation
5 Protection Commission found in ~~10 NCAC 3G, and the recommendations of the National Council on Radiation~~
6 ~~Protection and Measurements.~~ 10A NCAC 15. Records shall be kept of at least annual checks and calibration of all
7 ionizing radiation therapy equipment used in the facility.
8
9 *History Note: Authority G.S. 131E-149;*
10 *Eff. October 14, 1978;*
11 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December*
12 *23, ~~2017.~~ 2017;*
13 *Amended Eff. January 1, 2021.*

10A NCAC 13C .0902 is proposed for readoption with substantive changes as follows:

10A NCAC 13C .0902 NURSING PERSONNEL

(a) ~~An adequate number of licensed~~ Licensed and ancillary nursing personnel shall be on duty to assure that staffing levels meet the ~~total~~ nursing needs of patients ~~based on the number of patients~~ in the facility and their individual nursing care needs.

(b) At least one registered nurse shall be in the facility during the hours ~~it is in~~ of operation. Nursing personnel shall be assigned to duties consistent with their training and experience.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, ~~1978.~~ 1978;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0102 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .0102 DEFINITIONS

In addition to the definitions set forth in G.S. ~~131E-201~~ 131E-201, the following definitions shall apply throughout this ~~Subchapter following:~~ Subchapter:

(1) "Agency" means a licensed hospice as defined in ~~Article 10~~ G.S. 131E-201(3).

~~(2) "Attending Physician" means the physician licensed to practice medicine in North Carolina who is identified by the patient at the time of hospice admission as having the most significant role in the determination and delivery of medical care for the patient.~~

~~(3)~~(2) "Care Plan" means the proposed method developed in writing by the interdisciplinary care team through which the hospice seeks to provide services ~~which~~ that meet the patient's and family's medical, ~~psychosocial~~ psychosocial, and spiritual needs.

~~(4)~~(3) "Clergy Member" means an individual who has received a degree ~~from an~~ from a theological school and has fulfilled ~~appropriate~~ denominational seminary requirements; or an individual who, by ordination or authorization from the individual's denomination, has been approved to function in a pastoral capacity. Each hospice shall designate a clergy member responsible for coordinating spiritual care to hospice patients and families.

~~(5)~~(4) "Coordinator of Patient Family Volunteers" means an individual on the hospice ~~staff~~ team who coordinates and supervises the activities of all patient family volunteers.

~~(6)~~(5) "Dietary Counseling" means counseling given by a licensed ~~dietitian~~ dietitian, licensed dietitian/nutritionist, or licensed nutritionist as defined in ~~G.S. 90-357.~~ G.S. 90-352.

~~(7)~~(6) "Director" means the person having administrative responsibility for the operation of the hospice.

(7) “Division” means the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

(8) "Governing Body" means the group of persons responsible for overseeing ~~the~~ operations of the hospice, ~~specifically for~~ including the development and monitoring of policies and procedures related to all aspects of the operations of the hospice program. The governing body ensures that all services provided are consistent with accepted standards of hospice practice.

(9) "Hospice" means a coordinated program of services as defined in G.S. ~~131E-176(13a).~~ 131E-201.

(10) "Hospice Caregiver" means an individual on the hospice ~~staff~~ team who has completed hospice caregiver training as defined in ~~10A NCAC 13K~~ Rule .0402 of this Subchapter and is assigned to a hospice residential facility or hospice inpatient unit.

(11) "Hospice Inpatient Facility or Hospice Inpatient Unit" means ~~a licensed facility~~ as defined in ~~G.S. 131E-201(3).~~ G.S.131E-201(3a).

(12) "Hospice Residential Facility" means as defined in ~~G.S. 131E-201(5) is a facility licensed to provide hospice care to hospice patients as defined in G.S. 131E-201(4) and their families in a group residential setting.~~ G.S. 131E-201(5a).

(13) "Hospice ~~Staff"~~ Team" means ~~members of the interdisciplinary team~~ as defined in ~~G.S. 131E-201(7), nurse aides, administrative and support personnel and patient family volunteers.~~ G.S. 131E-201(6).

(14) "Informed Consent" means the agreement to receive hospice care made by the patient and family ~~which~~ that specifies in writing the type of care and services to be provided. The informed consent form shall be signed by the patient prior to service. If the patient's medical condition is such that a signature cannot be obtained, a signature shall be obtained from the individual having legal guardianship, applicable durable or health care power of attorney, or the family member or individual assuming the responsibility of primary caregiver.

~~(15) "Inpatient Beds" means beds licensed as such by the Department of Health and Human Services for use by hospice patients, for medical management of symptoms or for respite care.~~

~~(16)~~(15) "Interdisciplinary Team" means ~~a group of hospice staff~~ as defined in ~~G.S. 131E-201(7).~~ G.S. 131E-201(6).

~~(17)~~(16) "Licensed Practical Nurse" means ~~a nurse holding a valid current license as required by G.S. 90, Article 9A.~~ as defined in G.S. 90-171.30 or G.S. 171.32.

~~(18)~~(17) "Medical Director" means a physician licensed to practice medicine in North Carolina who directs the medical aspects of the hospice's patient care program.

(18) "Nurse Practitioner" means as defined in G.S. 90-18.2(a).

~~(19)~~(19) "Nurse Aide" means an individual who is authorized to provide nursing care under the supervision of a licensed nurse, has completed a training and competency evaluation program or competency evaluation program and is listed on the Nurse Aide Registry, at the Division of Health Service Regulation. If the nurse aide performs Nurse Aide II tasks, ~~he or she~~ the nurse aide ~~must~~ shall also meet the requirements established by the N.C. Board of Nursing as defined in 21 NCAC 36 ~~.0405.~~ .0405, incorporated by reference including subsequent amendments and editions. This rule may be accessed at http://reports.oah.state.nc.us/ncac.asp at no charge.

~~(20) "Occupational Therapist" means a person duly licensed as such, holding a current license as required by G.S. 90-270.29.~~

~~(21)~~(20) "Patient and Family Care Coordinator" means a registered nurse designated by the hospice to coordinate the provision of hospice services for each patient and family.

~~(22)~~(21) "Patient Family Volunteer" means an individual who has received orientation and training as defined in Rule .0402 of this Subchapter, and provides volunteer services to a patient and the patient's family in the patient's home or in a hospice inpatient facility or hospice inpatient unit, or a hospice residential facility.

~~(23)~~(22) "Pharmacist" means ~~an individual licensed to practice pharmacy in North Carolina as required in G.S. 90-85(15).~~ as defined in G.S. 90-85.3.

~~(24) "Physical Therapist" means an individual holding a valid current license as required by G.S. 90, Article 18B.~~

~~(25)~~(23) "Physician" means ~~an individual licensed to practice medicine in North Carolina.~~ as defined in G.S. 90-9.1 or G.S. 90-9.2.

~~(26)~~(24) "Premises" means the location or licensed site ~~from which~~ where the agency provides hospice services or maintains patient service records or advertises itself as a hospice agency.

~~(27)~~(25) "Primary Caregiver" means the family member or other person who assumes the overall responsibility for the care of the patient in the patient's home.

~~(28)~~(26) "Registered Nurse" means ~~a nurse holding a valid current license as required by G.S. 90, Article 9A.~~ as defined in G.S. 90-171.30 or G.S. 90-171.32.

~~(29)~~(27) "Respite Care" means care provided to a patient for temporary relief to family members or others caring for the patient at home.

~~(30) "Social Worker" means an individual who performs social work and holds a bachelor's or advanced degree in social work from a school accredited by the Council of Social Work Education or a bachelor's or an advanced degree in psychology, counseling or psychiatric nursing.~~

~~(31) "Speech and Language Pathologist" means an individual holding a valid current license as required by G.S. 90, Article 22.~~

~~(32)~~(28) "Spiritual Caregiver" means an individual authorized by the patient and family to provide for their spiritual ~~direction.~~ needs.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; February 1, 1995; June 1, 1991; November 1, ~~1989.~~ 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0401 is proposed for readoption with substantive changes as follows:

SECTION .0400 - PERSONNEL

10A NCAC 13K .0401 PERSONNEL

(a) Written policies shall be established and implemented by the agency regarding infection control and exposure to communicable diseases consistent with the rules set forth in 10A NCAC ~~41A.~~ 41A, which is incorporated by reference, including subsequent amendments and editions. These policies and procedures shall include provisions for compliance with 29 CFR 1910 ~~(Occupational~~ Occupational Safety and Health ~~Standards)~~ Standards, which is incorporated by reference including subsequent ~~amendments.~~ amendments and editions. ~~Emphasis shall be placed on compliance with~~ These editions shall include 29 CFR 1910.1030 ~~(Airborne and Bloodborne Pathogens).~~ Bloodborne Pathogens. Copies of Title 29 Part 1910 can be ~~purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7954 or by calling Washington, D.C. (202) 512-1800. The cost is twenty one dollars ($21.00) and may be purchased with a credit card.~~ obtained online at no charge at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS.

(b) Hands-on care employees ~~must~~ shall have a baseline ~~skin~~ test for tuberculosis. Individuals who test positive ~~must~~ shall demonstrate non-infectious status prior to assignment in a patient's home. Individuals who have previously tested positive to the tuberculosis ~~skin~~ test shall obtain a baseline and subsequent annual verification that they are free of tuberculosis symptoms. The verification shall be obtained from the local health department, a private ~~physician~~ physician, or health nurse employed by the agency. The ~~Tuberculosis Control~~ Communicable Disease Branch of the North Carolina Department of Health and Human Services, Division of Public Health, ~~1902~~ 1905 Mail Service Center, Raleigh, NC ~~27699-1902~~ 27699-1905 will ~~provide,~~ provide free of charge guidelines for conducting and verification utilizing ~~and~~ Form ~~DEHNR~~ DHHS 3405 (Record of Tuberculosis Screening). Employees identified by agency risk assessment to be at risk for exposure ~~are required to~~ shall be subsequently tested ~~at intervals prescribed by OSHA standards.~~ in accordance with Centers for Disease Control (CDC) guidelines, which is incorporated by reference with subsequent amendments and editions. A copy of the CDC guidelines can be obtained online at no charge at https://search.cdc.gov/search/?query=TB+testing+intervals&sitelimit=&utf8=%E2%9C%93&affiliate=cdc-main.

~~(b)~~(c) Written policies shall be established and implemented ~~which~~ by the agency that include personnel record content, orientation, patient family volunteer training, and in-service education. Records on the subject of in-service education and attendance shall be maintained by the agency and retained for ~~at least~~ one year.

~~(c)~~(d) Job descriptions for every position, including volunteers involved in direct patient/family services, shall be established ~~in writing which~~ by the agency and shall include the position's qualifications and specific responsibilities. ~~Individuals~~ Hospice team member(s) shall be assigned only to duties ~~for which~~ that they are trained and competent to ~~perform and when applicable for which they are properly licensed.~~ perform, or licensed to perform.

~~(d)~~(e) Personnel records shall be established and maintained for ~~all~~ hospice ~~staff,~~ team, both paid and direct patient/family services volunteers. These records shall be maintained ~~at least~~ for one year after ~~termination from~~

~~agency employment.~~ employment or volunteer service ends. When ~~requested,~~ requested by the State surveyors, the records shall be available on the agency premises for inspection by the Department. The records shall include:

(1) an application or resume ~~which~~ that lists education, ~~training~~ training, and previous employment that can be verified, including job title;

(2) a job description with record of acknowledgment by the ~~staff;~~ team member(s);

(3) reference checks or verification of previous employment;

(4) records of tuberculosis annual screening for ~~those employees for whom the test is necessary as described in Paragraph (a) of this Rule;~~ hands-on care team;

(5) documentation of Hepatitis B immunization or declination for hands on care ~~staff;~~ team;

(6) ~~airborne and~~ bloodborne pathogen training for ~~hands on~~ hands-on care ~~staff,~~ team, including annual updates, in compliance with 29 CFR 1910 and in accordance with the agency's exposure control plan;

(7) performance evaluations according to agency ~~policy and~~ policy, or at least annually;

(8) verification of ~~staff credentials as applicable;~~ team member(s) credentials;

(9) records of the verification of competencies by agency supervisory personnel of ~~all~~ skills required of hospice services personnel to carry out patient care ~~tasks to which the staff is assigned.~~ tasks. The method of verification shall be defined in agency policy.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, ~~1989~~ 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0604 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .0604 PATIENT'S RIGHTS AND RESPONSIBILITIES

(a) A hospice agency shall provide each patient with a written notice of the patient's rights and responsibilities in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of services. The agency ~~must~~ shall maintain documentation showing that each patient has received a copy of ~~his~~ their rights and ~~responsibilities.~~ responsibilities as defined in G.S. 131E-144.3.

~~(b) The notice shall include at a minimum the patient's right to:~~

~~(1) be informed and participate in the patient's plan of care;~~

~~(2) voice grievances about the patient's care and not be subjected to discrimination or reprisal for doing so;~~

~~(3) confidentiality of the patient's records;~~

~~(4) be informed of the patient's liability for payment for services;~~

~~(5) be informed of the process for acceptance and continuance of service and eligibility determination;~~

~~(6) accept or refuse services;~~

~~(7) be informed of the agency's on-call service;~~

~~(8) be advised of the agency's procedures for discharge; and~~

~~(9) be informed of supervisory accessibility and availability~~

~~(c)~~(b) A hospice agency shall provide ~~all~~ patients with a business hours telephone number for information, ~~questions~~ questions, or complaints about services provided by the agency. The agency shall also provide the Division of Health Service Regulation's complaints ~~number and the Department of Health and Human Services Careline number.~~ intake telephone numbers: within N.C. (800) 624-3004; outside of N.C. (919) 855-4500. The Division of Health Service Regulation shall investigate all allegations of non-compliance with the ~~rules.~~ rules of this Subchapter.

~~(d)~~(c) A hospice agency shall initiate an investigation within ~~72-hours~~ 72 hours of complaints made by a patient or his or her family. Documentation of both the existence of the complaint and the resolution of the complaint shall be maintained by the ~~agency.~~ agency, at a minimum of one-year, in accordance with hospice agency policy and procedures.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0701 is proposed for readoption without substantive changes as follows:

SECTION .0700 - PATIENT/FAMILY CARE PLAN

10A NCAC 13K .0701 CARE PLAN

(a) The ~~hospice~~ agency shall develop and implement policies and procedures ~~which~~ that ensure ~~that~~ a written care plan is developed and maintained for each patient and family. The plan shall be established by the interdisciplinary ~~care~~ team in accordance with the orders of the attending physician and be based on the ~~complete~~ assessment of the patient's and family's medical, ~~psychosocial~~ psychosocial, and spiritual needs. The patient and family care coordinator shall have the primary responsibility for assuring the implementation of the patient's care plan. The care plan shall include the following:

(1) the patient's diagnosis and prognosis;

(2) the identification of problems or needs and the establishment of ~~appropriate goals;~~ goals that are appropriate for the patient;

(3) the types and frequency of services required to meet the goals; and

(4) the identification of personnel and disciplines responsible for each service.

(b) The care plan shall be reviewed by ~~appropriate~~ the interdisciplinary ~~care~~ team members and updated ~~at least once~~ monthly. The interdisciplinary ~~care~~ team and other ~~appropriate~~ personnel shall meet at ~~least once~~ a minimum every ~~two weeks~~ 15 days for the purpose of care plan review and staff support. Minutes shall be kept of these meetings that include the date, names of those in ~~attendance~~ attendance, and the names of the patients discussed. Additionally, entries shall be recorded in the medical records of those patients whose care plans are reviewed.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, ~~1989.~~ 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .1104 is proposed for readoption <u>without substantive changes</u> as follows:

10A NCAC 13K .1104 DIETARY SERVICES

(a) The hospice shall develop and maintain written policies and procedures for dietary services.

(b) Dietary services shall be provided directly or ~~may be provided~~ through written agreement with a food service company. The written agreement, ~~if applicable,~~ shall meet the provisions of Rule .0505 of this Subchapter.

(c) The hospice shall assure that residents' favorite foods are included in their diets whenever possible.

(d) The food service shall be planned and staffed to serve three balanced meals at regular intervals or at a variety of times depending upon the needs of the residents. No more than 14 hours shall elapse between a substantial evening meal and breakfast.

(e) The hospice shall appoint a staff member trained or experienced in food management to:

(1) plan menus to meet the nutritional needs of the ~~residents.~~ <u>residents; and</u>

(2) supervise meal preparation and service.

(f) Therapeutic diets shall be prescribed by the physician and planned by a registered dietitian.

(g) Between-meal snacks of nourishing quality shall be offered and be available on a ~~24 hour~~ <u>24-hour</u> basis.

(h) The procurement, ~~storage~~ <u>storage,</u> and refrigeration of food, refuse ~~handling~~ <u>handling,</u> and pest control shall comply with ~~the most current sanitation rules~~ <u>15A NCAC 18A which are hereby incorporated by reference, including subsequent amendments and editions</u> promulgated by the ~~Division of~~ ~~Environmental~~ <u>Commission for Public</u> Health. <u>These rules may be accessed at http://reports.oah.state.nc.us/ncac.asp free of charge.</u>

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ <u>1996;</u>
<u>Readopted Eff. January 1, 2021.</u>

Fiscal Impact Analysis
Readoption Rules without Substantial Economic Impact

Agency Proposing Rule Change
North Carolina Medical Care Commission

Contact Persons
Nadine Pfeiffer, DHSR Rules Review Manager -- (919) 855-3811
Azzie Conley, Section Chief, Acute and Home Care Licensure & Certification – (919) 855-4646
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Impact Summary
Federal Government Entities: No Impact
State Government entities: No Impact
Local Government Entities: No Impact
Small Business: No Impact
Substantial Impact: No Impact

Title of Rules Changes and Statutory Citation

Rule Readoptions:
10A NCAC 13K .0102 Definitions
10A NCAC 13K .0401 Personnel
10A NCAC 13K .0604 Patient's Rights and Responsibilities
10A NCAC 13K .0701 Patient/Family Care Plan
10A NCAC 13K .1104 Dietary Services

*See Appendix for rule text

Statutory Authority
G.S. 131E-202

Background and Purpose
The Medical Care Commission is proposing to update Hospice licensure rules that, in some cases, have not been updated in 24 years. There are 209 licensed Hospice Agencies in North Carolina. The amendments will update practices and language to current industry standards, address previous Rules Review Commission objections, and implement technical changes for clarification. Changes will also allow reference to the General Statute.

Under authority of G.S. 150B-21-3A, Periodic review and expiration of existing rules, the Medical Care Commission, Rules Review Commission and the Joint Legislative Administrative Procedure Oversight Committee approved the Subchapter report with classifications for the rules located at 10A NCAC 13K Rules Hospice Licensing Rules: on August 10, 2018, October 18, 2018, and December 22, 2018 respectively. A total of five (5) rules were determined necessary with substantive public interest and therefore subject to readoption as new rules. The rule readoptions presented in this fiscal analysis will be for the Hospice Rules readoptions required by G.S. 150B-21.3.A.A Hospice stakeholder group was put together to assist in the rule readoption by providing expertise and providing input on Hospice processes, current standards of practice, and to ensure Hospices have an opportunity to provide input as we move forward with the readoption process.

Rules Summary and Anticipated Fiscal Impact

Rule 13K .0102 – Definitions
The agency is proposing to readopt this rule with substantive changes. This rule lists definitions that apply throughout the Subchapter and is being changed to update definitions, delete definitions that are no longer used in the Subchapter, to relocate definitions to other existing rules, and to reference definitions in the General Statute. Generally, the definitions in the statute are the same as those used in the rule. There are several minor differences that are noted in the General Statute definitions, but those minor differences do not materially change the scope of the definition and are not any more stringent than the definitions in the current rule; therefore, the agency does not expect these changes to have any fiscal impact. The definitions in the General Statute will always prevail. Six definitions are not utilized in the Subchapter and were deleted.

Rule 13K.0401 - Personnel:
The agency is proposing to readopt this rule with substantive changes. The rule was last amended in 1996. This rule changes in parts (a) and (c)-(e) include technical and grammatical corrections to outdated language and nomenclature. Substantive changes in part (b) update the reference for TB testing guidelines for at-risk employees. These changes have no economic impact as TB testing following the new CDC guidelines is already required by the existing public health rule 10A NCAC 13J .1003 for staff working in health care and going into individuals' homes to provide care. Furthermore, the TB testing costs under the new CDC guidelines are not significantly different than testing under the previous OSHA guidelines.

Rule 13K .0604 - Patients Rights and Responsibilities:
The agency is proposing to readopt this rule with substantive changes. The rule was last updated in 1996. It had outdated language and references to out dated patients' rights. These changes provide that clarity and updated information by referencing the patients' rights requirements in the General Statutes. The requirements in statute are already independently enforceable; these conforming rule amendments are simply technical corrections for clarity with no fiscal impact.

Rule 13K .0701 - Care Plan and Rule 13K 1104 - Dietary Services
The agency is proposing to readopt these rules without substantive changes other than correcting grammar and removing ambiguous words. These rules have not been updated since 1996.

Appendix

10A NCAC 13K .0102 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .0102 DEFINITIONS

In addition to the definitions set forth in G.S. ~~131E-201~~ 131E-201, the following definitions shall apply throughout this ~~Subchapter following:~~ Subchapter:

(1) "Agency" means a licensed hospice as defined in ~~Article 10~~ G.S. 131E-201(3).

~~(2) "Attending Physician" means the physician licensed to practice medicine in North Carolina who is identified by the patient at the time of hospice admission as having the most significant role in the determination and delivery of medical care for the patient.~~

~~(3)~~(2) "Care Plan" means the proposed method developed in writing by the interdisciplinary care team through which the hospice seeks to provide services ~~which~~ that meet the patient's and family's medical, ~~psychosocial~~ psychosocial, and spiritual needs.

~~(4)~~(3) "Clergy Member" means an individual who has received a degree ~~from an~~ from a theological school and has fulfilled ~~appropriate~~ denominational seminary requirements; or an individual who, by ordination or authorization from the individual's denomination, has been approved to function in a pastoral capacity. Each hospice shall designate a clergy member responsible for coordinating spiritual care to hospice patients and families.

~~(5)~~(4) "Coordinator of Patient Family Volunteers" means an individual on the hospice ~~staff~~ team who coordinates and supervises the activities of all patient family volunteers.

~~(6)~~(5) "Dietary Counseling" means counseling given by a licensed ~~dietitian~~ dietitian, licensed dietitian/nutritionist, or licensed nutritionist as defined in ~~G.S. 90-357.~~ G.S. 90-352.

~~(7)~~(6) "Director" means the person having administrative responsibility for the operation of the hospice.

(7) “Division” means the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

(8) "Governing Body" means the group of persons responsible for overseeing ~~the~~ operations of the hospice, ~~specifically for~~ including the development and monitoring of policies and procedures related to all aspects of the operations of the hospice program. The governing body ensures that all services provided are consistent with accepted standards of hospice practice.

(9) "Hospice" means a coordinated program of services as defined in G.S. ~~131E-176(13a).~~ 131E-201.

(10) "Hospice Caregiver" means an individual on the hospice ~~staff~~ team who has completed hospice caregiver training as defined in ~~10A NCAC 13K~~ Rule .0402 of this Subchapter and is assigned to a hospice residential facility or hospice inpatient unit.

(11) "Hospice Inpatient Facility or Hospice Inpatient Unit" means ~~a licensed facility~~ as defined in ~~G.S. 131E-201(3).~~ G.S.131E-201(3a).

(12) "Hospice Residential Facility" means as defined in ~~G.S. 131E-201(5) is a facility licensed to provide hospice care to hospice patients as defined in G.S. 131E-201(4) and their families in a group residential setting.~~ G.S. 131E-201(5a).

(13) "Hospice ~~Staff"~~ Team" means ~~members of the interdisciplinary team~~ as defined in ~~G.S. 131E-201(7), nurse aides, administrative and support personnel and patient family volunteers.~~ G.S. 131E-201(6).

(14) "Informed Consent" means the agreement to receive hospice care made by the patient and family ~~which~~ that specifies in writing the type of care and services to be provided. The informed consent form shall be signed by the patient prior to service. If the patient's medical condition is such that a signature cannot be obtained, a signature shall be obtained from the individual having legal guardianship, applicable durable or health care power of attorney, or the family member or individual assuming the responsibility of primary caregiver.

~~(15) "Inpatient Beds" means beds licensed as such by the Department of Health and Human Services for use by hospice patients, for medical management of symptoms or for respite care.~~

~~(16)~~(15) "Interdisciplinary Team" means ~~a group of hospice staff~~ as defined in ~~G.S. 131E-201(7).~~ G.S. 131E-201(6).

~~(17)~~(16) "Licensed Practical Nurse" means ~~a nurse holding a valid current license as required by G.S. 90, Article 9A.~~ as defined in G.S. 90-171.30 or G.S. 171.32.

~~(18)~~(17) "Medical Director" means a physician licensed to practice medicine in North Carolina who directs the medical aspects of the hospice's patient care program.

(18) "Nurse Practitioner" means as defined in G.S. 90-18.2(a).

~~(19)~~(19) "Nurse Aide" means an individual who is authorized to provide nursing care under the supervision of a licensed nurse, has completed a training and competency evaluation program or competency evaluation program and is listed on the Nurse Aide Registry, at the Division of Health Service Regulation. If the nurse aide performs Nurse Aide II tasks, ~~he or she~~ the nurse aide ~~must~~ shall also meet the requirements established by the N.C. Board of Nursing as defined in 21 NCAC 36 ~~.0405.~~ .0405, incorporated by reference including subsequent amendments and editions. This rule may be accessed at http://reports.oah.state.nc.us/ncac.asp at no charge.

~~(20) "Occupational Therapist" means a person duly licensed as such, holding a current license as required by G.S. 90-270.29.~~

~~(21)~~(20) "Patient and Family Care Coordinator" means a registered nurse designated by the hospice to coordinate the provision of hospice services for each patient and family.

~~(22)~~(21) "Patient Family Volunteer" means an individual who has received orientation and training as defined in Rule .0402 of this Subchapter, and provides volunteer services to a patient and the patient's family in the patient's home or in a hospice inpatient facility or hospice inpatient unit, or a hospice residential facility.

~~(23)~~(22) "Pharmacist" means ~~an individual licensed to practice pharmacy in North Carolina as required in G.S. 90-85(15).~~ as defined in G.S. 90-85.3.

~~(24) "Physical Therapist" means an individual holding a valid current license as required by G.S. 90, Article 18B.~~

~~(25)~~(23) "Physician" means ~~an individual licensed to practice medicine in North Carolina.~~ as defined in G.S. 90-9.1 or G.S. 90-9.2.

~~(26)~~(24) "Premises" means the location or licensed site ~~from which~~ where the agency provides hospice services or maintains patient service records or advertises itself as a hospice agency.

~~(27)~~(25) "Primary Caregiver" means the family member or other person who assumes the overall responsibility for the care of the patient in the patient's home.

~~(28)~~(26) "Registered Nurse" means ~~a nurse holding a valid current license as required by G.S. 90, Article 9A.~~ as defined in G.S. 90-171.30 or G.S. 90-171.32.

~~(29)~~(27) "Respite Care" means care provided to a patient for temporary relief to family members or others caring for the patient at home.

~~(30) "Social Worker" means an individual who performs social work and holds a bachelor's or advanced degree in social work from a school accredited by the Council of Social Work Education or a bachelor's or an advanced degree in psychology, counseling or psychiatric nursing.~~

~~(31) "Speech and Language Pathologist" means an individual holding a valid current license as required by G.S. 90, Article 22.~~

~~(32)~~(28) "Spiritual Caregiver" means an individual authorized by the patient and family to provide for their spiritual ~~direction.~~ needs.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; February 1, 1995; June 1, 1991; November 1, ~~1989.~~ 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0401 is proposed for readoption with substantive changes as follows:

SECTION .0400 - PERSONNEL

10A NCAC 13K .0401 PERSONNEL

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with 29 CFR 1910 ~~(Occupational~~ Occupational Safety and Health ~~Standards)~~ Standards, which is incorporated by reference including subsequent ~~amendments.~~ amendments and editions. ~~Emphasis shall be placed on compliance with~~ These editions shall include 29 CFR 1910.1030 ~~(Airborne and Bloodborne Pathogens).~~ Bloodborne Pathogens. Copies of Title 29 Part 1910 can be ~~purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7954 or by calling Washington, D.C. (202) 512-1800. The cost is twenty one dollars ($21.00) and may be purchased with a credit card.~~ obtained online at no charge at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS.

(b) Hands-on care employees ~~must~~ shall have a baseline ~~skin~~ test for tuberculosis. Individuals who test positive ~~must~~ shall demonstrate non-infectious status prior to assignment in a patient's home. Individuals who have previously tested positive to the tuberculosis ~~skin~~ test shall obtain a baseline and subsequent annual verification that they are free of tuberculosis symptoms. The verification shall be obtained from the local health department, a private ~~physician~~ physician, or health nurse employed by the agency. The ~~Tuberculosis Control~~ Communicable Disease Branch of the North Carolina Department of Health and Human Services, Division of Public Health, ~~1902~~ 1905 Mail Service Center, Raleigh, NC ~~27699-1902~~ 27699-1905 will ~~provide,~~ provide free of charge guidelines for conducting and verification utilizing ~~and~~ Form ~~DEHNR~~ DHHS 3405 (Record of Tuberculosis Screening). Employees identified by agency risk assessment to be at risk for exposure ~~are required to~~ shall be subsequently tested ~~at intervals prescribed by OSHA standards.~~ in accordance with Centers for Disease Control (CDC) guidelines, which is incorporated by reference with subsequent amendments and editions. A copy of the CDC guidelines can be obtained online at no charge at https://search.cdc.gov/search/?query=TB+testing+intervals&sitelimit=&utf8=%E2%9C%93&affiliate=cdc-main.

~~(b)~~(c) Written policies shall be established and implemented ~~which~~ by the agency that include personnel record content, orientation, patient family volunteer training, and in-service education. Records on the subject of in-service education and attendance shall be maintained by the agency and retained for ~~at least~~ one year.

~~(c)~~(d) Job descriptions for every position, including volunteers involved in direct patient/family services, shall be established ~~in writing which~~ by the agency and shall include the position's qualifications and specific responsibilities. ~~Individuals~~ Hospice team member(s) shall be assigned only to duties ~~for which~~ that they are trained and competent to ~~perform and when applicable for which they are properly licensed.~~ perform, or licensed to perform.

~~(d)~~(e) Personnel records shall be established and maintained for ~~all~~ hospice ~~staff,~~ team, both paid and direct patient/family services volunteers. These records shall be maintained ~~at least~~ for one year after ~~termination from agency employment.~~ employment or volunteer service ends. When ~~requested,~~ requested by the State surveyors, the records shall be available on the agency premises for inspection by the Department. The records shall include:

(1) an application or resume ~~which~~ that lists education, ~~training~~ training, and previous employment that can be verified, including job title;

(2) a job description with record of acknowledgment by the ~~staff;~~ team member(s);

(3) reference checks or verification of previous employment;

(4) records of tuberculosis annual screening for ~~those employees for whom the test is necessary as described in Paragraph (a) of this Rule;~~ hands-on care team;

(5) documentation of Hepatitis B immunization or declination for hands on care ~~staff;~~ team;

(6) ~~airborne and~~ bloodborne pathogen training for ~~hands on~~ hands-on care ~~staff,~~ team, including annual updates, in compliance with 29 CFR 1910 and in accordance with the agency's exposure control plan;

(7) performance evaluations according to agency ~~policy and~~ policy, or at least annually;

(8) verification of ~~staff credentials as applicable;~~ team member(s) credentials;

(9) records of the verification of competencies by agency supervisory personnel of ~~all~~ skills required of hospice services personnel to carry out patient care ~~tasks to which the staff is assigned.~~ tasks. The method of verification shall be defined in agency policy.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, ~~1989~~ 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0604 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .0604 PATIENT'S RIGHTS AND RESPONSIBILITIES

(a) A hospice agency shall provide each patient with a written notice of the patient's rights and responsibilities in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of services. The agency ~~must~~ shall maintain documentation showing that each patient has received a copy of ~~his~~ their rights and ~~responsibilities.~~ responsibilities as defined in G.S. 131E-144.3.

~~(b) The notice shall include at a minimum the patient's right to:~~

~~(1) be informed and participate in the patient's plan of care;~~

~~(2) voice grievances about the patient's care and not be subjected to discrimination or reprisal for doing so;~~

~~(3) confidentiality of the patient's records;~~

~~(4) be informed of the patient's liability for payment for services;~~

~~(5) be informed of the process for acceptance and continuance of service and eligibility determination;~~

~~(6) accept or refuse services;~~

~~(7) be informed of the agency's on-call service;~~

~~(8) be advised of the agency's procedures for discharge; and~~

~~(9) be informed of supervisory accessibility and availability~~

~~(c)~~(b) A hospice agency shall provide ~~all~~ patients with a business hours telephone number for information, ~~questions~~ questions, or complaints about services provided by the agency. The agency shall also provide the Division of Health Service Regulation's complaints ~~number and the Department of Health and Human Services Careline number.~~ intake

telephone numbers: within N.C. (800) 624-3004; outside of N.C. (919) 855-4500. The Division of Health Service Regulation shall investigate all allegations of non-compliance with the ~~rules.~~ rules of this Subchapter.

~~(d)~~(c) A hospice agency shall initiate an investigation within ~~72 hours~~ 72 hours of complaints made by a patient or his or her family. Documentation of both the existence of the complaint and the resolution of the complaint shall be maintained by the ~~agency.~~ agency, at a minimum of one-year, in accordance with hospice agency policy and procedures.

History Note: Authority G.S. 131E-202;
Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0701 is proposed for readoption without substantive changes as follows:

SECTION .0700 - PATIENT/FAMILY CARE PLAN

10A NCAC 13K .0701 CARE PLAN

(a) The ~~hospice~~ agency shall develop and implement policies and procedures ~~which~~ that ensure ~~that~~ a written care plan is developed and maintained for each patient and family. The plan shall be established by the interdisciplinary ~~care~~ team in accordance with the orders of the attending physician and be based on the ~~complete~~ assessment of the patient's and family's medical, ~~psychosocial~~ psychosocial, and spiritual needs. The patient and family care coordinator shall have the primary responsibility for assuring the implementation of the patient's care plan. The care plan shall include the following:

(1) the patient's diagnosis and prognosis;
(2) the identification of problems or needs and the establishment of ~~appropriate goals;~~ goals that are appropriate for the patient;
(3) the types and frequency of services required to meet the goals; and
(4) the identification of personnel and disciplines responsible for each service.

(b) The care plan shall be reviewed by ~~appropriate~~ the interdisciplinary ~~care~~ team members and updated ~~at least once~~ monthly. The interdisciplinary ~~care~~ team and other ~~appropriate~~ personnel shall meet at ~~least once~~ a minimum every ~~two weeks~~ 15 days for the purpose of care plan review and staff support. Minutes shall be kept of these meetings that include the date, names of those in ~~attendance~~ attendance, and the names of the patients discussed. Additionally, entries shall be recorded in the medical records of those patients whose care plans are reviewed.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;

Amended Eff. February 1, 1996; November 1, ~~1989.~~ 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .1104 is proposed for readoption without substantive changes as follows:

10A NCAC 13K .1104 DIETARY SERVICES

(a) The hospice shall develop and maintain written policies and procedures for dietary services.

(b) Dietary services shall be provided directly or ~~may be provided~~ through written agreement with a food service company. The written agreement, ~~if applicable,~~ shall meet the provisions of Rule .0505 of this Subchapter.

(c) The hospice shall assure that residents' favorite foods are included in their diets whenever possible.

(d) The food service shall be planned and staffed to serve three balanced meals at regular intervals or at a variety of times depending upon the needs of the residents. No more than 14 hours shall elapse between a substantial evening meal and breakfast.

(e) The hospice shall appoint a staff member trained or experienced in food management to:

(1) plan menus to meet the nutritional needs of the ~~residents.~~ residents; and

(2) supervise meal preparation and service.

(f) Therapeutic diets shall be prescribed by the physician and planned by a registered dietitian.

(g) Between-meal snacks of nourishing quality shall be offered and be available on a ~~24 hour~~ 24-hour basis.

(h) The procurement, ~~storage~~ storage, and refrigeration of food, refuse ~~handling~~ handling, and pest control shall comply with ~~the most current sanitation rules~~ 15A NCAC 18A which are hereby incorporated by reference, including subsequent amendments and editions promulgated by the ~~Division of~~ ~~Environmental~~ Commission for Public Health. These rules may be accessed at http://reports.oah.state.nc.us/ncac.asp free of charge.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1996;
Readopted Eff. January 1, 2021.

1 10A NCAC 13D .2001 is proposed for amendment as follows:

2

3 **SECTION .2000 – GENERAL INFORMATION**

4

5 **10A NCAC 13D .2001 DEFINITIONS**

6 In addition to the definitions set forth in 131E-101, the ~~The~~ following definitions ~~will~~ shall apply throughout this
7 Subchapter:

8 (1) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or
9 punishment with resulting physical harm, pain, or mental anguish.

10 (2) "Accident" means an unplanned event resulting in the injury or wounding, no matter how slight, of
11 a patient or other individual.

12 (3) "Addition" means an extension or increase in floor area or height of a building.

13 (4) "Administrator" as defined in G.S. 90-276(4).

14 (5) "Alteration" means any construction or renovation to an existing structure other than repair,
15 maintenance, or addition.

16 (6) "Brain injury long term care" means an interdisciplinary, intensive maintenance program for patients
17 who have incurred brain damage caused by external physical trauma and who have completed a
18 primary course of rehabilitative treatment and have reached a point of no gain or progress for more
19 than three consecutive months. Brain injury long term care is provided through a medically
20 supervised interdisciplinary process and is directed toward maintaining the individual at the optimal
21 level of physical, cognitive, and behavioral functions.

22 (7) "Capacity" means the maximum number of patient or resident beds for which the facility is licensed
23 to maintain at any given time.

24 (8) "Combination facility" means a combination home as defined in G.S. 131E-101.

25 (9) "Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons
26 with functional limitations or chronic disabling conditions who have the potential to achieve a
27 significant improvement in activities of daily living, including bathing, dressing, grooming,
28 transferring, eating, and using speech, language, or other communication systems. A
29 comprehensive, inpatient rehabilitation program utilizes a coordinated and integrated,
30 interdisciplinary approach, directed by a physician, to assess patient needs and to provide treatment
31 and evaluation of physical, psychosocial, and cognitive deficits.

32 (10) "Department" means the North Carolina Department of Health and Human Services.

33 (11) "Director of nursing" means a registered nurse who has authority and ~~direct~~ responsibility for all
34 nursing services and nursing care.

35 (12) "Discharge" means a physical relocation of a patient to another health care setting, the discharge of
36 a patient to his or her home, or the relocation of a patient from a nursing bed to an adult care home
37 bed, or from an adult care home bed to a nursing bed.

(13) "Existing facility" means a facility currently licensed, a proposed facility, a proposed addition to a licensed facility, or a proposed remodeled licensed facility that will be built according to design development drawings and specifications approved by the Department for compliance with the standards established in Sections .3100, .3200, and .3400 of this Subchapter, to the effective date of this Rule.

(14) "Facility" means a nursing facility or combination facility as defined in this Rule.

(15) "Incident" means any accident, event, or occurrence that is unplanned, or unusual, and has ~~actually~~ caused harm to a patient, or has the potential for harm.

(16) "Inpatient rehabilitation facility or unit" means a free-standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) within an existing licensed health service facility approved in accordance with G.S. 131E, Article 9 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program.

(17) "Interdisciplinary" means an integrated process involving representatives from disciplines of the health care team.

(18) "Licensee" means the person, firm, partnership, association, corporation, or organization to whom a license to operate the facility has been issued. The licensee is the legal entity that is responsible for the operation of the business.

(19) "Medication error rate" means the measure of discrepancies between medication that was ordered for a patient by the health care provider and medication that is ~~actually~~ administered to the patient. The medication error rate is calculated by dividing the number of errors observed by the surveyor by the opportunities for error, multiplied times 100.

(20) "Misappropriation of property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.

(21) "Neglect" means a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

(22) "New facility" means a proposed facility, a proposed addition to an existing facility, or a proposed remodeled portion of an existing facility that will be built according to design development drawings and specifications approved by the Department for compliance with the standards established in Sections .3100, .3200, and .3400 of this Subchapter after the effective date of this Rule.

(23) "Nurse Aide" means a person who is listed on the N.C. Nurse Aide Registry and provides nursing or nursing-related services to patients in a nursing home. A nurse aide is not a licensed health professional. Nursing homes that participate in Medicare or Medicaid shall comply with 42 CFR Part 483.75(e), which is incorporated by reference, including subsequent amendments. The Code of Federal Regulations may be accessed at ~~http://www.access.gpo.gov/nara/cfr/waisidx_08/42cfr483_08.~~ https://www.ecfr.gov.

(24) "Nursing facility" means a nursing home as defined in G.S. 131E-101.

(25) "Patient" means any person admitted for nursing care.

(26) "Remodeling" means alterations, renovations, rehabilitation work, repairs to structural systems, and replacement of building systems at a nursing or combination facility.

(27) "Repair" means reconstruction or renewal of any part of an existing building for the purpose of its maintenance.

(28) "Resident" means any person admitted for care to an adult care home part of a combination ~~facility as defined in G.S. 131E-101.~~ facility.

(29) "Respite care" means services provided for a patient on a temporary basis, not to exceed 30 days.

(30) "Surveyor" means ~~an authorized~~ a representative of the Department who inspects nursing facilities and combination facilities to determine compliance with ~~rules~~ rules, laws, and regulations as set forth in G.S. 131E-117; Subchapters 13D and 13F of this Chapter; and 42 CFR Part 483, Requirements for States and Long Term Care Facilities.

~~(31) "Ventilator dependence" means a physiological dependency by a patient on the use of a ventilator for more than eight hours a day.~~

~~(32)~~(31) "Violation" means a failure to comply with ~~the regulations, standards, and requirements~~ rules, laws, and regulations as set forth in G.S. 131E-117 and 131D–21; Subchapters 13D and 13F of this Chapter; or 42 CFR Part 483, Requirements for States and Long Term Care Facilities, that ~~directly~~ relates to a patient's or resident's health, safety, or welfare, or ~~which~~ that creates a ~~substantial~~ risk that death, or ~~serious~~ physical harm ~~will~~ may occur.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Readopted Eff. July 1, ~~2016.~~ 2016;
Amended Eff. January 1, 2021.

10A NCAC 13D .2506 is proposed for repeal as follows:

10A NCAC 13D .2506 PHYSICIAN SERVICES FOR VENTILATOR DEPENDENT PATIENTS

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, ~~2015.~~ 2015;
Repealed Eff. January 1, 2021.

10A NCAC 13D .3003 is proposed for amendment as follows:

10A NCAC 13D .3003 VENTILATOR ~~DEPENDENCE~~ ASSISTED CARE

(a) ~~The general requirements in this Subchapter shall apply when applicable. In addition, facilities having patients requiring the use of ventilators for more than eight hours a day shall meet the following requirements:~~ For the purpose of this Rule, ventilator assisted individuals, means as defined in 42 CFR Part 483.25(i), F695, herein incorporated by reference including subsequent amendments and editions. Copies of the Code of Federal Regulations, Title 42, Public Health, Part 482-End, 2019 may be accessed free of charge online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

(b) Facilities having patients who are ventilator assisted individuals shall:

(1) ~~The facility shall be located within 30 minutes of an acute care facility.~~ administer respiratory care in accordance with 42 CFR Part 483.25(i), F695;

(2) ~~Respiratory therapy shall be provided and supervised by a respiratory therapist currently registered by the National Board for Respiratory Care.~~ administer respiratory care in accordance with the scope of practice for respiratory therapists defined in G.S. 90-648; and ~~The respiratory therapist shall:~~

~~(a) make, as a minimum, weekly on-site assessments of each patient receiving ventilator support with corresponding progress notes;~~

~~(b) be on-call 24 hours daily; and~~

~~(c) assist the pulmonologist and nursing staff in establishing ventilator policies and procedures, including emergency policies and procedures.~~

(3) ~~Direct nursing care staffing shall be in accordance with Rule .3005 of this Section.~~ provide pulmonary services from a physician who has training in pulmonary medicine according to The American Board of Internal Medicine. The physician shall be responsible for respiratory services and shall:

(A) establish with the respiratory therapist and nursing staff, ventilator policies and procedures, including emergency procedures;

(B) assess each ventilator assisted patient's status at least monthly with corresponding progress notes;

(C) respond to emergency communications 24-hours a day; and

(D) participate in individual care planning.

(c) Direct care nursing personnel staffing ratios established in Rule .2303 of this Subchapter shall not be applied to nursing services for patients who are ventilator assisted at life support settings. The minimum direct care nursing staff shall be 5.5 hours per patient day, allocated on a per shift basis as the facility chooses; however, in no event shall the direct care nursing staff fall below a registered nurse and a nurse aide I at any time during a 24-hour period.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;

1 *Eff. January 1, 1996;*

2 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22,*

3 ~~*2015.*~~ *2015;*

4 *Amended Eff. January 1, 2021.*

Fiscal Impact Analysis of

Nursing Home Ventilator Rules Permanent Rule Amendments

Agency Proposing Rule Change

North Carolina Medical Care Commission

Contact Persons

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Impact Summary

State Government: Yes
Local Government: No Impact
Private Business: Yes
Patients: Yes
Substantial Impact: None

Title of Rules

10A NCAC 13D .2001 Definitions (Amend)
10A NCAC 13D .2506 Physician Services for Ventilator Dependent Patients (Repeal)
10A NCAC 13D .3003 Ventilator ~~Dependence~~ Assisted Care (Amend)

*See proposed text of these rules in Appendix

Statutory Authority

G.S. 131E-104

Summary

North Carolina does not have enough beds distributed across the state to meet the need for patients requiring life supporting ventilator care. To address this issue, the N.C. Medical Care Commission is proposing to amend the Rules for the Licensing of Nursing Homes in 10A NCAC 13D for ventilator assisted care. The proposed rules expand the definition of ventilator assisted care according to patient needs and remove location requirements based on proximity to an acute care facility. The changes also require administration of respiratory care in accordance with federal guidance (F695) for individuals with this type of care need.

The agency expects these rule amendments to reduce regulatory barriers associated with proximity to an acute care facility and adherence to the current definition for ventilator dependence for providers and encourage more availability of ventilator assisted care services in Nursing Homes, benefiting patients and their families. Nursing Homes serving Medicare and/or Medicaid-eligible individuals must already adhere to the federal requirements for administering ventilator assisted care. If these facilities choose to expand respiratory care services due to the rule amendments, we can assume their expected revenue gains would equal or exceed the cost of compliance. The smaller number of private pay-only nursing homes are not expected to pursue this service and so the changes to the respiratory care requirements will have no impact. Finally, DHSR will incur staff time costs of approximately $2,025 per case for application and construction review.

Background, Problem, and Description of the Rule Revisions

Background

North Carolina has three nursing homes in the state that provide ventilator beds. These homes are in Guilford, Forsyth and Alexander counties. These locations are in the central and western portions of the state. The combined bed capacity is 90 beds. In past years, two additional nursing homes located in Wake and Washington counties provided 19 more ventilator beds. These two nursing homes closed in 2012 and 2014. The Nursing Home Licensure & Certification Section has had hospital discharge planners seeking placement for residents requiring life supporting ventilator care and NC did not having any bed availability close to families in eastern North Carolina.

Historically, nursing homes have expressed an interest in providing life-supporting mechanical ventilation beds and then withdrew interest. The reasons associated with not following through with licensure included difficulty securing a contract with a pulmonologist, staffing requirements, decision to focus on existing care for residents and lack of clarity on the definition of life supporting versus non-life supporting care. As of late, we have had a new interest in licensing ventilator beds with more inquiries about the rules.

Problem

There is an identified need for more ventilator assisted care beds in nursing homes as currently, access to care for these residents is limited with there being only three Nursing Homes in the state providing residents ventilator assisted care. By adopting the requirements in the Code of Federal Regulations (CFR) in the proposed rule amendments, confusion will be eliminated between the differences in the standards between the State licensure rules and the CFR. The requirements of the CFR currently apply to all providers who participate in Medicare and/or Medicaid. Aligning the requirements in the proposed rule amendments with the federal requirements is expected to reduce regulatory barriers associated with proximity to an acute care facility and adherence to the current definition for ventilator dependence for providers and encourage more availability of ventilator assisted care service in Nursing Homes. The requirements will be more up-to-date and relevant, in addition to being backed by research.

Description of the Rule Revisions

The proposed rule amendments include technical changes to clarify definitions, and the deletion of the definition of ventilator dependence in rule 10A NCAC 13D .2001 because the definition is being redefined in Rule 10A NCAC 13D .3003 with a refer by reference to the CFR. The rules added the requirement for administration of respiratory care with a reference to the CFR. Reference to the location of a facility was deleted. The lack of statutory authority for respiratory therapists has been eliminated by including a reference to statute G.S. 90-648, regarding The North Carolina Respiratory Care Board. The requirements in Rule 10A NCAC 13D .2506 for physician services for ventilator dependent patients was repealed. The lack of statutory authority in Rule 10A NCAC 13D .2506 was addressed with new language and a reference to The American Board of Internal Medicine. The duties of the physician are the same as they were described in Rule 10A NCAC 13D .2506. The requirements for direct care nursing personnel staffing ratios have been incorporated into one rule from Rule 10A NCAC 13D .3005. There is no change in the staffing ratios.

The current definition in rule 10A NCAC 13D .2001 is "Ventilator dependence means a physiological dependency by a patient on the use of a ventilator for more than eight hours a day." This definition was effective in 1996 and had not been updated. The definition is not supported by reference or current practice.

42 CFR Part §483.25(i), Respiratory Care, was issued on 11/22/17 and became effective on 11/28/17. The regulation included intent, definitions, guidance to surveyors, sections on care policies, staffing and personnel, monitoring and documentation of respiratory services/response, modalities/respiratory therapy/care/services, coughing/deep breathing/therapeutic percussion/vibration and bronchopulmonary drainage, respiratory medication versus aerosols, generators, oxygen therapy, obstructive sleep apnea, respiratory services for mechanical ventilation with tracheostomy/tracheotomy care and care plan for mechanical ventilation/tracheostomy care. The federal

definition is **“Mechanical Ventilation”** that may be defined as a life support system designed to replace or support normal ventilatory lung function and a **“Ventilator Assisted Individual (VAI)”** requires mechanical aid for breathing to augment or replace spontaneous ventilatory efforts to achieve medical stability or maintain life.

The federal regulation also includes other relevant definitions such as ***“Noninvasive ventilation (NIV)”*** *refers to the administration of ventilatory support without using an invasive artificial airway (endotracheal tube or tracheostomy tube).* These clarifying respiratory care definitions are helpful to providers, surveyors and the public so that everyone understands the difference between treatments that are life supporting care versus other specialized respiratory treatments.

Differences in existing Nursing Home rules and the federal regulation

Topic	**NH Rule** 10A NCAC 13D .2001, .2506 & .3003	**Federal Regulation** 42 CFR Part 483.25(i), F695
Definition	Outdated 1996 8 hours/day	Up-to-date 2017 clarifying definitions, supported by research Life-supporting mechanical ventilation
Physician Services	Lacked Statutory authority	yield to state laws and scope of practice
Location of Nursing Home	30 min from acute care facility	Not mentioned
Respiratory Therapist (RT)	Lacked Statutory authority	Have sufficient numbers of trained, competent, qualified staff, consistent with State practice acts/laws;
RT frequency of assessment	RT weekly onsite assessment with progress notes	based on current professional standards of practice
Policies & Procedures	Establish ventilator and emergency P&P	Extensive, but not all inclusive, list of P&P needed to care for residents
Staffing	Direct Nursing Care 5.5 hrs./ppd	Have sufficient numbers of trained, competent, qualified staff, consistent with State practice acts/laws;
Guidance to Surveyors	None	Guidance provided such as Respiratory Services for Mechanical Ventilation with Tracheostomy/Tracheotomy Care
Examples of Deficient Practice Severity	None	Severity guidance

Impact

Nursing Homes

428 nursing home providers participate in M/M and 9 nursing home providers in the state do not participate in M/M. Any nursing home provider that chooses to provide care to patients requiring mechanical ventilation at life support settings will be impacted with costs outlined below. If M/M facilities choose to expand respiratory care services due to the rule amendments, we can assume their expected revenue gains would equal or exceed the cost of compliance. There would be no newer or higher costs to a M/M provider because those providers must comply with the CFR. Similar costs would exist for a non-M/M provider who chose to develop this new service. However, the agency does not expect private pay-only providers to pursue this service based on feedback received from stakeholders representing this group.

Costs associated with providing ventilator services:

- Services from a physician trained in pulmonary medicine $130/hour
- Services from a respiratory therapist $33.00/hour ($305,000 per year)
- DHSR Construction Plan Review Cost $500.00
- Facility architect, if needed $38.00/hour
- Costs associated with getting room/unit ventilator ready (electrical & gas)
- Cost of the ventilator and associated equipment & parts ($5000 + per unit)
- Cost of respiratory supplies ($8000/month according to one NH with an 18-bed unit)
- Liquid oxygen refills $4000/month according to one NH with an 18-bed unit)
- Inspection Fee $1000/year
- Preventative Maintenance $2600/month for each machine according to one NH with an 18-bed unit
- Costs associated with 5.5 direct care staff per patient day

Benefits to Providers

The current rules limit the use of ventilator care to life-saving situations. The proposed rules expand the definition to allow ventilator care in more settings. Providers are no longer bound by the definition of ventilator dependence meaning physiological dependence by a patient on the use of a ventilator for more than eight hours a day. Providers have the benefit of an array of respiratory definitions that clear the path for care modalities that meet a variety of patient needs. Furthermore, providers no longer need to be concerned with the proximity of the nursing home to a hospital. Together, these changes are intended to reduce regulatory barriers to providers interested in providing this service.

Patient

Currently, patients who need life-saving ventilator care can only receive it in three locations in North Carolina. The existing providers are in Greensboro, Winston Salem and Taylorsville. Families from the eastern part of North Carolina must travel two to four hours to visit their loved ones. The proposed rules eliminate a nursing home's proximity to an acute care facility and make it easier for a rural facility to provide this service.

State

We would anticipate an increase of approximately one application a year once the definition is consistent with the federal requirement. An increase of one application a year due to the proposed rule amendments would not have an immediate and significant financial impact on DHSR. DHSR's Nursing Home Section would require approximately 3 hours of time to review contracts and policies and procedures by a FCCII ($36.05 per hour) per application. DHSR's Construction Section would require approximately 16 hours of plan reviews from both an Architect and Engineer ($38.46 & $36.05 per hour, respectively) per application. Further, DHSR's Construction Section would conduct an annual 2 to 4-hour inspection at the facility ($20.19 per hour), per application. The total cost to DHSR per application is estimated at $2025.00.

Appendix: Source of the Cost Estimates

Cost Estimate	Source
physician trained in pulmonary medicine $130/hour	https://www.salary.com/research/salary/benchmark/pulmonary-physician-hourly-wages accessed 3/8/2020
Services from a respiratory therapist $33.00/hour or $305,000 per year	NH Provider with a vent unit
DHSR Construction Plan Review Cost $500.00	DHSR Construction Section Chief
Facility architect, if needed $38.00/hour	https://www.salary.com/research/salary/listing/architect-salary accessed 3/8/2020
Costs associated with getting room/unit ventilator ready (electrical & gas)	NH Provider with a vent unit
Cost of the ventilator and associated equipment & parts ($5000 + per unit)	NH Provider with a vent unit
Cost of respiratory supplies ($8000/month)	NH Provider with a vent unit
Liquid oxygen refills $4000/month	NH Provider with a vent unit
Inspection Fee $1000/year	NH Provider with a vent unit
Preventative Maintenance $2600/month	NH Provider with a vent unit
Costs associated with 5.5 direct care staff per patient day (already in the rule)	
DHSR FCC II contract, P&P & application review (salary + benefits according OSHR's compensation calculator) and assuming 2080 hours/year (40-hour work week) $53.82 x 3 hours = $161.00	DHSR Budget Office
DHSR Architect plan review/application (salary + benefits according OSHR's compensation calculator) and assuming 2080 hours/year (40-hour work week) $57.22 x 16 hours = $915.00	DHSR Budget Office
DHSR Engineer plan review/application (salary + benefits according OSHR's compensation calculator) and assuming 2080 hours/year (40-hour work week) $53.81 x 16 hours = $860.96	DHSR Budget Office
Annual 4-hour inspection at $20.19/hour/application	DHSR Construction Section
Total Cost to DHSR/application $2018.19	DHSR

10A NCAC 13D .2001 is proposed for amendment as follows:

SECTION .2000 – GENERAL INFORMATION

10A NCAC 13D .2001 DEFINITIONS

In addition to the definitions set forth in 131E-101, the ~~The~~ following definitions ~~will~~ shall apply throughout this Subchapter:

(1) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

(2) "Accident" means an unplanned event resulting in the injury or wounding, no matter how slight, of a patient or other individual.

(3) "Addition" means an extension or increase in floor area or height of a building.

(4) "Administrator" as defined in G.S. 90-276(4).

(5) "Alteration" means any construction or renovation to an existing structure other than repair, maintenance, or addition.

(6) "Brain injury long term care" means an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Brain injury long term care is provided through a medically supervised interdisciplinary process and is directed toward maintaining the individual at the optimal level of physical, cognitive, and behavioral functions.

(7) "Capacity" means the maximum number of patient or resident beds for which the facility is licensed to maintain at any given time.

(8) "Combination facility" means a combination home as defined in G.S. 131E-101.

(9) "Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons with functional limitations or chronic disabling conditions who have the potential to achieve a significant improvement in activities of daily living, including bathing, dressing, grooming, transferring, eating, and using speech, language, or other communication systems. A comprehensive, inpatient rehabilitation program utilizes a coordinated and integrated, interdisciplinary approach, directed by a physician, to assess patient needs and to provide treatment and evaluation of physical, psychosocial, and cognitive deficits.

(10) "Department" means the North Carolina Department of Health and Human Services.

(11) "Director of nursing" means a registered nurse who has authority and ~~direct~~ responsibility for all nursing services and nursing care.

(12) "Discharge" means a physical relocation of a patient to another health care setting, the discharge of a patient to his or her home, or the relocation of a patient from a nursing bed to an adult care home bed, or from an adult care home bed to a nursing bed.

(13) "Existing facility" means a facility currently licensed, a proposed facility, a proposed addition to a licensed facility, or a proposed remodeled licensed facility that will be built according to design development drawings and specifications approved by the Department for compliance with the standards established in Sections .3100, .3200, and .3400 of this Subchapter, to the effective date of this Rule.

(14) "Facility" means a nursing facility or combination facility as defined in this Rule.

(15) "Incident" means any accident, event, or occurrence that is unplanned, or unusual, and has ~~actually~~ caused harm to a patient, or has the potential for harm.

(16) "Inpatient rehabilitation facility or unit" means a free-standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) within an existing licensed health service facility approved in accordance with G.S. 131E, Article 9 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program.

(17) "Interdisciplinary" means an integrated process involving representatives from disciplines of the health care team.

(18) "Licensee" means the person, firm, partnership, association, corporation, or organization to whom a license to operate the facility has been issued. The licensee is the legal entity that is responsible for the operation of the business.

(19) "Medication error rate" means the measure of discrepancies between medication that was ordered for a patient by the health care provider and medication that is ~~actually~~ administered to the patient. The medication error rate is calculated by dividing the number of errors observed by the surveyor by the opportunities for error, multiplied times 100.

(20) "Misappropriation of property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.

(21) "Neglect" means a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

(22) "New facility" means a proposed facility, a proposed addition to an existing facility, or a proposed remodeled portion of an existing facility that will be built according to design development drawings and specifications approved by the Department for compliance with the standards established in Sections .3100, .3200, and .3400 of this Subchapter after the effective date of this Rule.

(23) "Nurse Aide" means a person who is listed on the N.C. Nurse Aide Registry and provides nursing or nursing-related services to patients in a nursing home. A nurse aide is not a licensed health professional. Nursing homes that participate in Medicare or Medicaid shall comply with 42 CFR Part 483.75(e), which is incorporated by reference, including subsequent amendments. The Code of Federal Regulations may be accessed at ~~http://www.access.gpo.gov/nara/cfr/waisidx_08/42cfr483_08.~~ *https://www.ecfr.gov.*

(24) "Nursing facility" means a nursing home as defined in G.S. 131E-101.

(25) "Patient" means any person admitted for nursing care.

(26) "Remodeling" means alterations, renovations, rehabilitation work, repairs to structural systems, and replacement of building systems at a nursing or combination facility.

(27) "Repair" means reconstruction or renewal of any part of an existing building for the purpose of its maintenance.

(28) "Resident" means any person admitted for care to an adult care home part of a combination ~~facility as defined in G.S. 131E-101.~~ facility.

(29) "Respite care" means services provided for a patient on a temporary basis, not to exceed 30 days.

(30) "Surveyor" means ~~an authorized~~ a representative of the Department who inspects nursing facilities and combination facilities to determine compliance with ~~rules~~ rules, laws, and regulations as set forth in G.S. 131E-117; Subchapters 13D and 13F of this Chapter; and 42 CFR Part 483, Requirements for States and Long Term Care Facilities.

~~(31) "Ventilator dependence" means a physiological dependency by a patient on the use of a ventilator for more than eight hours a day.~~

~~(32)~~(31) "Violation" means a failure to comply with ~~the regulations, standards, and requirements~~ rules, laws, and regulations as set forth in G.S. 131E-117 and 131D–21; Subchapters 13D and 13F of this Chapter; or 42 CFR Part 483, Requirements for States and Long Term Care Facilities, that ~~directly~~ relates to a patient's or resident's health, safety, or welfare, or ~~which~~ that creates a ~~substantial~~ risk that death, or ~~serious~~ physical harm ~~will~~ may occur.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Readopted Eff. July 1, ~~2016.~~ 2016;
Amended Eff. January 1, 2021.

10A NCAC 13D .2506 is proposed for repeal as follows:

10A NCAC 13D .2506 PHYSICIAN SERVICES FOR VENTILATOR DEPENDENT PATIENTS

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, ~~2015.~~ 2015;
Repealed Eff. January 1, 2021.

10A NCAC 13D .3003 is proposed for amendment as follows:

10A NCAC 13D .3003 VENTILATOR ~~DEPENDENCE~~ ASSISTED CARE

(a) ~~The general requirements in this Subchapter shall apply when applicable. In addition, facilities having patients requiring the use of ventilators for more than eight hours a day shall meet the following requirements:~~ For the purpose of this Rule, ventilator assisted individuals, means as defined in 42 CFR Part 483.25(i), F695, herein incorporated by reference including subsequent amendments and editions. Copies of the Code of Federal Regulations, Title 42, Public Health, Part 482-End, 2019 may be accessed free of charge online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

(b) Facilities having patients who are ventilator assisted individuals shall:

(1) ~~The facility shall be located within 30 minutes of an acute care facility.~~ administer respiratory care in accordance with 42 CFR Part 483.25(i), F695;

(2) ~~Respiratory therapy shall be provided and supervised by a respiratory therapist currently registered by the National Board for Respiratory Care.~~ administer respiratory care in accordance with the scope of practice for respiratory therapists defined in G.S. 90-648; and ~~The respiratory therapist shall:~~

~~(a) make, as a minimum, weekly on-site assessments of each patient receiving ventilator support with corresponding progress notes;~~

~~(b) be on-call 24 hours daily; and~~

~~(c) assist the pulmonologist and nursing staff in establishing ventilator policies and procedures, including emergency policies and procedures.~~

(3) ~~Direct nursing care staffing shall be in accordance with Rule .3005 of this Section.~~ provide pulmonary services from a physician who has training in pulmonary medicine according to The American Board of Internal Medicine. The physician shall be responsible for respiratory services and shall:

(A) establish with the respiratory therapist and nursing staff, ventilator policies and procedures, including emergency procedures;

(B) assess each ventilator assisted patient's status at least monthly with corresponding progress notes;

(C) respond to emergency communications 24-hours a day; and

(D) participate in individual care planning.

(c) Direct care nursing personnel staffing ratios established in Rule .2303 of this Subchapter shall not be applied to nursing services for patients who are ventilator assisted at life support settings. The minimum direct care nursing staff shall be 5.5 hours per patient day, allocated on a per shift basis as the facility chooses; however, in no event shall the direct care nursing staff fall below a registered nurse and a nurse aide I at any time during a 24-hour period.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;

Eff. January 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, ~~2015.~~ 2015;

Amended Eff. January 1, 2021.

EXHIBIT E

2020 Schedule of Fees

Scotia Village

APARTMENTS

Model	Type	Square Footage	Entrance Fee	50% Refund Entrance Fee	90% Refund Entrance Fee	Monthly Fee	Second Person
The Selkirk	Studio	400	$43,000	$64,500	$81,700	$2,382	$991
	Expanded Studio	450	$47,000	$70,500	$89,300	$2,558	$991
The Stirling	One Bedroom	650	$64,000	$96,000	$121,600	$2,708	$991
	Expanded One Bedroom	725	$79,000	$118,500	$150,100	$2,852	$991
The Shetland	Two Bedroom	975	$131,000	$196,500	$248,900	$3,154	$991

Add an additional $4,500 for apartments in Scotia Hall with a patio.

GARDEN APARTMENTS

Model	Type	Square Footage	Entrance Fee	50% Refund Entrance Fee	90% Refund Entrance Fee	Monthly Fee	Second Person
The Aberdeen	One Bedroom	712-812	$97,000	$145,500	$184,300	$2,934	$991
	Two Bedroom	1086	$153,000	$229,500	$290,700	$3,221	$991
	Two Bedroom Expanded	1260	$157,000	$235,500	$298,300	$3,523	$991

VILLAS

Model	Type	Square Footage	Entrance Fee	50% Refund Entrance Fee	90% Refund Entrance Fee	Monthly Fee	Second Person
The Cromarty	Two Bedroom	1400-1600	$203,000	$304,500	$385,700	$3,401	$991
	Three Bedroom	1675-1875	$240,000	$360,000	$456,000	$3,516	$991

SINGLE FAMILY HOMES

Model	Type	Square Footage	Entrance Fee	50% Refund Entrance Fee	90% Refund Entrance Fee	Monthly Fee	Second Person
The Inverness	Two Bedroom	1450	$262,000	$393,000	$497,800	$3,526	$991
	Three Bedroom	2000-2400	$317,000	$475,500	$602,300	$3,663	$991

These fees are effective January 1, 2020 and are in effect until future changes deemed appropriate by The Presbyterian Homes, Inc.
All floor plans are representative of the various floor plans at Scotia Village. They may differ due to changes made by previous residents.

Scotia Village

RESIDENT OF THE FUTURE PROGRAM

If you are interested in moving to Scotia Village in the next few years, you should join our Resident of the Future program. Residents of the Future have primary access to available residences and are extended an offer based on date of membership. You may join the program at any age, and we offer two programs to reflect your timetable:

PRIORITY LIST

This is the first tier of the Resident of the Future program. To join, submit a completed application with a fully-refundable $1,000 deposit plus a non-refundable $200 application fee. You will detail the type(s) of residences you desire and your preferred time frame for moving. As a Priority List member, you will have many opportunities to become better acquainted with Scotia Village and the people who live and work here.

READY LIST

This is the second tier of the Resident of the Future program. Priority List members are called in order of membership date when there is room on the Ready List. This list is for those who are ready to move to Scotia Village when we have the type of residence you want available. You will complete an in-depth application and pay a deposit equal to 10% of the Entrance Fee for the residence you choose. You may also choose to join the Ready List first if you feel you are ready to move as soon as your preferred residence type is available. Ready List applicants are called before Priority List applicants as residences become available.

* Ask about our special programs for retired military, educators, and partners in ministry.

NOTES ON FEES

ENTRANCE FEES

2% of the entrance fee accrues to Scotia Village each month less a 4% non-refundable fee. The refund decreases to zero over 48 months.

50% Refundable Plan: Traditional Entrance Fee x 1.5

2% of the Entrance Fee accrues to Scotia Village each month for 23 months less a 4% non-refundable fee, after which the refund remains at 50%.

90% Refundable Plan: Traditional Entrance Fee x 1.9

1% of the Entrance Fee accrues to Scotia Village each month for 6 months less a 4% non-refundable fee, after which the refund remains at 90%.

ON CAMPUS LEVELS OF CARE

Scotia Village provides on-site continuing care. Current Scotia Village residents living independently have prepaid an entrance fee. Therefore, Scotia Village residents have priority access to all levels of care. Occasionally, when space is available, new residents may be admitted directly from the outside community into Scotia Village, and they must pay a non-refundable entrance fee for the appropriate level of care upon admission.

	Type Of Accommodation	Entrance Fee	Monthly Fee
Assisted Living	Studio	$15,000	$4,357
	One Bedroom	$20,000	$5,841

	Type Of Accommodation	Entrance Fee	Daily Fee
Special Care	Studio	$10,000	$295
Skilled Nursing	Studio	$10,000	$289

These fees are effective January 1, 2020 and are in effect until future changes deemed appropriate by The Presbyterian Homes, Inc.

2020 Schedule of Fees

APARTMENTS

MODEL	TYPE	SQUARE FOOTAGE	STANDARD ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE (1 PERSON)	MONTHLY FEE (2 PEOPLE)
The Heritage	One Bedroom	750	$128,000	$192,000	$243,200	$3,020	$4,334
The Players I & II	Two Bedroom	1050 - 1068	$178,000	$267,000	$338,200	$3,715	$5,029
The Classic I & II	Three Bedroom	1402 - 1500	$248,000	$372,000	$471,200	$3,949	$5,263
The Legends*	Three Bedroom	1800	$325,000	$487,500	$617,500	$4,446	$5,760
The Masters*	Three Bedroom	1900	$325,000	$487,500	$617,500	$4,446	$5,760

Add an additional $5,000 for apartments with a patio or balcony. All square footage is approximate.

COTTAGES, VILLAS & TOWNHOMES

MODEL	TYPE	SQUARE FOOTAGE	STANDARD ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE (1 PERSON)	MONTHLY FEE (2 PEOPLE)
The Jones*	Two Bedroom	1100 - 1250	$211,000	$316,500	$400,900	$3,735	$5,049
The Hogan*	Three Bedroom	1500 - 1650	$278,000	$417,000	$528,200	$3,990	$5,304
The Snead	Two Bedroom	1200 - 1350	$228,000	$342,000	$433,200	$3,788	$5,102
The Nelson	Three Bedroom	1600 - 1780	$293,000	$439,500	$556,700	$4,039	$5,353
The Palmer I & II	Two Bedroom	1400 - 1605	$278,000	$417,000	$528,200	$3,886	$5,200
The Nicklaus I & II	Three Bedroom	1900 - 2097	$377,000	$565,500	$716,300	$4,087	$5,401

If the home does not have a sunroom, the entrance fee is $20,000 less than the stated price. All square footage is approximate.

** Very limited number.*

2020 Schedule of Fees

NOTES ON FEES

HOMES

The monthly service fee for townhomes, villas, and cottages includes: weekly housekeeping and interior and exterior maintenance; $250 per person per month dining allowance; extended basic cable; 14 "grace days" per calendar year in the Health Center if needed; and water, sewer, trash, and recycling services. Gas, electricity, telephone, and internet are not included. River Landing charges separately for a telephone, internet and cable service bundle.

APARTMENTS

The monthly service fee for apartments includes: weekly housekeeping and interior and exterior maintenance; $400 per person per month dining allowance; extended basic cable; 14 "grace days" per calendar year in the Health Center if needed; all utilities except telephone and internet. River Landing charges separately for a telephone, internet and cable service bundle.

ENTRANCE FEE TYPES

A portion of the monthly service and entrance fee may be deducted as a prepaid medical expense. Please consult your tax advisor.

Standard Entrance Fee Plan: The entrance fee is refundable less an amortization of 2% per month of occupancy (for 48 months) and a 4% administrative fee.

50% Refundable Plan: The entrance fee is refundable less an amortization of 2% per month of occupancy (for 23 months) and a 4% administrative fee. Refund will always be at least 50%.

90% Refundable Plan: The entrance fee is refundable less an amortization of 1% per month of occupancy (for 6 months) and a 4% administrative fee. Refund will always be at least 90%.

RESIDENT OF THE FUTURE PROGRAM

If you're interested in moving to River Landing in the next 1 - 15 years, you should join our Resident of the Future program. The earlier you become a Resident of the Future, the more options you'll have for your future. Residents of the Future have primary access to available residences and are extended based on date of membership. You may join the program at any age, and we offer two programs to reflect your timetable:

PRIORITY LIST

This is the first tier of the Resident of the Future program. To join, you submit a completed application with a fully-refundable $1,000 deposit. There is a non-refundable Application Fee of $200. You will detail the type(s) of residences you desire and your preferred time frame for moving. As a Priority List member, you will have many opportunities to become better acquainted with River Landing and the people who live and work here.

READY LIST

This is the second tier of the Resident of the Future program. Priority List members are called in order of membership date when there is room on the Ready List. This list is for those who are ready to move to River Landing when we have the type of residence you want. You may decline to move to this list without losing your position on the Priority List. You will complete an in-depth application and pay a deposit equal to 10% of the Entrance Fee for the residence you choose. We then have your doctor send medical information to our Clinic Nurse. We use the financial and medical information to determine your eligibility for admission.

These fees are effective January 1, 2020 and are in effect until future changes deemed appropriate by The Presbyterian Homes, Inc.

2020 Schedule of Fees

EXPANSION HYBRID APARTMENTS

MODEL	TYPE	SQUARE FOOTAGE	STANDARD ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE (1 PERSON)	MONTHLY FEE (2 PEOPLE)
The Berg	Two Bedroom	1522	$311,000	$466,500	$590,900	$4,014	$5,328
The Lopez	Two Bedroom	1667	$343,000	$514,500	$651,700	$4,068	$5,382
The Trevino	Two Bedroom/Den	1805	$359,000	$538,500	$682,100	$4,122	$5,436
The Ballesteros	Three Bedroom	2055	$397,000	$595,500	$754,300	$4,578	$5,892

All square footage is approximate.

EXPANSION COTTAGE HOMES

MODEL	TYPE	SQUARE FOOTAGE	STANDARD ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE (1 PERSON)	MONTHLY FEE (2 PEOPLE)
The Mickelson	Two Bedroom/ Sunroom	2024	$334,000	$501,000	$634,600	$4,088	$5,402
The Crenshaw	Three Bedroom/ Sunroom	2366	$426,000	$639,000	$809,400	$4,195	$5,509

All square footage is approximate.

2020 Schedule of Fees

NOTES ON FEES

HOMES

The monthly service fee for cottages includes: weekly housekeeping and interior and exterior maintenance; $250 per person per month dining allowance; extended basic cable; 14 "grace days" per calendar year in the Health Center if needed; and water, sewer, trash, and recycling services. Gas, electricity, telephone, and internet are not included. River Landing charges separately for a telephone, internet and cable service bundle.

HYBRID APARTMENTS

The monthly service fee for Hybrid Apartments includes: weekly housekeeping and interior and exterior maintenance; $250 per person per month dining allowance; extended basic cable; 14 "grace days" per calendar year in the Health Center if needed; all utilities except telephone and internet. River Landing charges separately for a telephone, internet and cable service bundle.

ENTRANCE FEE TYPES

A portion of the monthly service and entrance fee may be deducted as a prepaid medical expense. Please consult your tax advisor.

Standard Entrance Fee Plan: The entrance fee is refundable less an amortization of 2% per month of occupancy (for 48 months) and a 4% administrative fee.

50% Refundable Plan: The entrance fee is refundable less an amortization of 2% per month of occupancy (for 23 months) and a 4% administrative fee. Refund will always be at least 50%.

90% Refundable Plan: The entrance fee is refundable less an amortization of 1% per month of occupancy (for 6 months) and a 4% administrative fee. Refund will always be at least 90%.

RESIDENT OF THE FUTURE PROGRAM

If you're interested in moving to River Landing in the next 1 - 15 years, you should join our Resident of the Future program. The earlier you become a Resident of the Future, the more options you'll have for your future. Residents of the Future have primary access to available residences and are extended based on date of membership. You may join the program at any age, and we offer two programs to reflect your timetable:

PRIORITY LIST

This is the first tier of the Resident of the Future program. To join, you submit a completed application with a fully-refundable $1,000 deposit. There is a non-refundable Application Fee of $200. You will detail the type(s) of residences you desire and your preferred time frame for moving. As a Priority List member, you will have many opportunities to become better acquainted with River Landing and the people who live and work here.

READY LIST

This is the second tier of the Resident of the Future program. Priority List members are called in order of membership date when there is room on the Ready List. This list is for those who are ready to move to River Landing when we have the type of residence you want. You may decline to move to this list without losing your position on the Priority List. You will complete an in-depth application and pay a deposit equal to 10% of the Entrance Fee for the residence you choose. We then have your doctor send medical information to our Clinic Nurse. We use the financial and medical information to determine your eligibility for admission.

These fees are effective January 1, 2020 and are in effect until future changes deemed appropriate by The Presbyterian Homes, Inc.

Health Center at River Landing
2020 Fee Schedule for Outside Admissions

Effective January 1, 2020

The Health Center at River Landing has achieved the highest rating of 5 stars by the Centers for Medicare and Medicaid Services. We offer residents a warm and caring 24-hour nursing team, a complete activity program, on-site physical therapy and rehabilitation, transportation to medical appointments, and medication management.

Model	Entrance Fee (optional)	Discounted Monthly Fee	Regular Monthly Fee
Muirfield - Assisted Living			
Studio	$20,000	$5,028	$6,285
1 Bedroom	$25,000	$6,176	$7,720

Model	Entrance Fee (optional)	Discounted Daily Fee	Regular Daily Fee
Pebble Beach - Skilled Nursing			
Semi-Private Room	$11,500	$323	$404
Private Room	$11,500	$343	$429
Winged Foot			
Private Room	$11,500	$443	NA

Model	Entrance Fee (optional)	Discounted Monthly Fee	Regular Monthly Fee
St. Andrews - Memory Care			
Private Room	$11,500	$7,964	$9,955

NOTES:

1. Individuals can choose to pay an Entrance Fee that enables them to pay a discounted daily or monthly fee. Alternatively, they can pay the regular daily or monthly fee without paying an Entrance Fee.

2. The Monthly Service Fee includes housekeeping and maintenance services, three meals a day, cable television, personal laundry services, and all utilities except telephone and internet.

3. Prices are subject to change.

1575 John Knox Drive • Colfax, NC 27235
(888) 993-7677 • (336) 668-4900
riverlandingsr.org

2019-2020 Schedule of Fees

APARTMENTS

MODEL	TYPE	SQUARE FOOTAGE	ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE	SECOND PERSON
Beech*	Studio	526	$66,000	$99,000	$125,400	$2,512	$1,109
Thistle*	One Bedroom	785	$124,000	$186,000	$235,600	$2,942	$1,109
Thyme*	One Bedroom	979	$155,000	$232,500	$294,500	$2,942	$1,109
Twinflower	One Bedroom / Study	1,090	$165,000	$247,500	$313,500	$3,440	$1,109
Rhododendron*	Two Bedroom	1,087	$201,000	$301,500	$381,900	$3,440	$1,109
Willow*	Two Bedroom	1,138	$205,000	$307,500	$389,500	$3,440	$1,109

WEE LOCH APARTMENTS

MODEL	TYPE	SQUARE FOOTAGE	ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE	SECOND PERSON
Jasmine	Two Bedroom / Den	1,363	$292,000	$438,000	$554,800	$3,735	$1,109
Gardenia	Two Bedroom / Den	1,385	$297,000	$445,500	$564,300	$3,752	$1,109
Laurel	Two Bedroom / Den	1,447	$326,000	$489,000	$619,400	$3,967	$1,109
Azalea	Two Bedroom / Den	1,808	$363,000	$544,500	$689,700	$4,064	$1,109
Magnolia	Two Bedroom / Den	2,088	$404,000	$606,000	$767,600	$4,576	$1,109

COTTAGES

MODEL	TYPE	SQUARE FOOTAGE	ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE	SECOND PERSON
Fern Carport	Two Bedroom / Den	1,750	$285,000	$427,500	$541,500	$3,564	$1,109
Fern Garage	Two Bedroom / Den	1,750	$311,000	$466,500	$590,900	$3,564	$1,109
Heather	Two Bedroom / Den	2,000	$361,000	$541,500	$685,900	$3,947	$1,109
Juniper	Two Bedroom / Den	2,100	$394,000	$591,000	$748,600	$3,947	$1,109
Wintergreen	Three Bedroom / Den	2,290	$394,000	$591,000	$748,600	$3,947	$1,109

**Add an additional $10,000 for apartments with a patio or balcony (All square footage is approximate.).*
These fees are effective October 1, 2019 until future changes deemed appropriate by The Presbyterian Homes, Inc.

Glenaire

Traditional Entrance Fee Plan

2% of the Entrance Fee accrues to Glenaire each month less a 4% non-refundable fee. The refund decreases to zero over 48 months.

50% Refundable Plan: Traditional Entrance Fee x 1.5

2% of the Entrance Fee accrues to Glenaire each month for 23 months less a 4% non-refundable fee, after which the refund remains at 50%.

90% Refundable Plan: Traditional Entrance Fee x 1.9

1% of the Entrance Fee accrues to Glenaire each month for 6 months less a 4% non-refundable fee, after which the refund remains at 90%.

Wait List Deposit

To become a member of the Glenaire Wait List, please submit your application for residential living along with a $1,200 deposit. The deposit of $1,200 places your name on the list. Part of this amount is a $200 non-refundable administration fee. The remaining $1,000 is a refundable deposit that can be applied towards your Entrance Fee.

On Campus Levels of Care

Glenaire provides on-site continuing care with all private suites. Current Glenaire residents living independently have prepaid an Entrance Fee. Therefore, Glenaire residents have priority access to all facilities and levels of care and may move into any level of care with no additional Entrance Fee.

Occasionally, when space is available, new residents may be admitted directly from the outside community into Glenaire, and they must pay a non-refundable Entrance Fee for the appropriate level of care upon admission.

TYPE OF ACCOMMODATION	MONTHLY/DAILY FEES
Assisted Living	$6,036
Skilled Nursing (Daily)	$313

A non-refundable fee of $200 is charged for processing each admission application.

These fees are effective October 1, 2019 until future changes deemed appropriate by The Presbyterian Homes, Inc.

2020 Schedule of Fees

EXPANSION APARTMENTS

MODEL	TYPE	SQUARE FOOTAGE	ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE	SECOND PERSON
Ivy	Two Bedroom / Den	1439	$362,000	$543,000	$687,800	$3,982	$1,109
Camellia	Two Bedroom	1445	$362,000	$543,000	$687,800	$3,982	$1,109
Tupelo	Two Bedroom	1530	$403,000	$604,500	$765,700	$4,007	$1,109
Chestnut	Two Bedroom / Den	1581	$434,000	$651,000	$824,600	$4,110	$1,109
Birch	Two Bedroom / Den	1653	$449,000	$673,500	$853,100	$4,110	$1,109
Dogwood	Two Bedroom / Den	1667	$449,000	$673,500	$853,100	$4,110	$1,109
Bradford	Two Bedroom / Den	1750	$479,000	$718,500	$910,100	$4,213	$1,109
Leyland	Two Bedroom / Den	1803	$495,000	$742,500	$940,500	$4,316	$1,109
Hawthorn	Two Bedroom / Den	1832	$495,000	$742,500	$940,500	$4,316	$1,109
Sycamore	Three Bedroom	2081	$550,000	$825,000	$1,045,000	$4,572	$1,109
Cypress	Three Bedroom / Den	2769	$704,000	$1,056,000	$1,337,600	$5,240	$1,109

All square footage is approximate. Floor plans are subject to change.

Glenaire

Traditional Entrance Fee Plan

2% of the Entrance Fee accrues to Glenaire each month less a 4% non-refundable fee. The refund decreases to zero over 48 months.

50% Refundable Plan: Traditional Entrance Fee x 1.5

2% of the Entrance Fee accrues to Glenaire each month for 23 months less a 4% non-refundable fee, after which the refund remains at 50%.

90% Refundable Plan: Traditional Entrance Fee x 1.9

1% of the Entrance Fee accrues to Glenaire each month for 6 months less a 4% non-refundable fee, after which the refund remains at 90%.

Wait List Deposit

To become a member of the Glenaire Wait List, please submit your application for residential living along with a $1,200 deposit. The deposit of $1,200 places your name on the list. Part of this amount is a $200 non-refundable administration fee. The remaining $1,000 is a refundable deposit that can be applied towards your Entrance Fee.

On Campus Levels of Care

Glenaire provides on-site continuing care with all private suites. Current Glenaire residents living independently have prepaid an Entrance Fee. Therefore, Glenaire residents have priority access to all facilities and levels of care and may move into any level of care with no additional Entrance Fee.

Occasionally, when space is available, new residents may be admitted directly from the outside community into Glenaire, and they must pay a non-refundable Entrance Fee for the appropriate level of care upon admission.

TYPE OF ACCOMMODATION	MONTHLY/DAILY FEES
Assisted Living	$6,036
Skilled Nursing (Daily)	$313

A non-refundable fee of $200 is charged for processing each admission application.

These fees are effective January 1, 2020 until future changes deemed appropriate by The Presbyterian Homes, Inc.

2020 Schedule of Fees

EXPANSION APARTMENTS

MODEL	TYPE	SQUARE FOOTAGE	ENTRANCE FEE	50% REFUND ENTRANCE FEE	90% REFUND ENTRANCE FEE	MONTHLY FEE	SECOND PERSON
Ivy	Two Bedroom / Den	1439	$362,000	$543,000	$687,800	$3,982	$1,109
Camellia	Two Bedroom	1445	$362,000	$543,000	$687,800	$3,982	$1,109
Tupelo	Two Bedroom	1530	$403,000	$604,500	$765,700	$4,007	$1,109
Chestnut	Two Bedroom / Den	1581	$434,000	$651,000	$824,600	$4,110	$1,109
Birch	Two Bedroom / Den	1653	$449,000	$673,500	$853,100	$4,110	$1,109
Dogwood	Two Bedroom / Den	1667	$449,000	$673,500	$853,100	$4,110	$1,109
Bradford	Two Bedroom / Den	1750	$479,000	$718,500	$910,100	$4,213	$1,109
Leyland	Two Bedroom / Den	1803	$495,000	$742,500	$940,500	$4,316	$1,109
Hawthorn	Two Bedroom / Den	1832	$495,000	$742,500	$940,500	$4,316	$1,109
Sycamore	Three Bedroom	2081	$550,000	$825,000	$1,045,000	$4,572	$1,109
Cypress	Three Bedroom / Den	2769	$704,000	$1,056,000	$1,337,600	$5,240	$1,109

All square footage is approximate. Floor plans are subject to change.

Capital Towers Apartments

4808-4812 Six Forks Rd. Raleigh, NC 27609
Telephone: 919 787-1231
Fax: 919 881-9417

Offering Affordable Senior Housing

Basic Information	Building I (55 and older)
Rent	Efficiency - $734 including utilities - additional cost for Cable TV Efficiency- 450 square feet 1 bedroom - $849.00 including utilities- additional cost for Cable TV 1 bedroom – 570 square feet
Security Deposit	The equivalent one month's rent
Amenities	Library, Movie Room & Laundry facilities.
Transportation	Provided to and from Grocery Store only
Internet/WIFI	Residents choose their own providers.
Income Restrictions	50% Annual Maximum $32,950 (single) $37,650 (couple) 60% Annual Maximum $39,540 (single) $45,180 (couple)
Parking	Non - Reserved Parking Available
Application Fee	$11.00
Basic Information	Building II (55 and older)
Rent	Studio - $734.00 including utilities – additional cost for Cable TV Studio – 400 square feet 1 bedroom - $849.00 including utilities- additional cost for Cable TV 1 bedroom – 600 square feet
Security Deposit	The equivalent one month's rent
Amenities	Library, Movie Room & Laundry facilities.
Transportation	Provided to and from Grocery Store only
Internet/WIFI	Residents choose their own providers.
Income Restrictions	Annual Maximum $39,540 (single) Annual Maximum $45,180 (couple)
Parking	Non-Reserved Parking available
Application Fee	$11.00

- **Activities Coordinator onsite**
- **Free Van Rides to local grocery stores and specific shopping centers.**

NC MCC Bond Sale Approval Form	
Facility Name: Presbyterian Homes, Inc. - Glenaire Project	
	Time of Preliminary Approval
SERIES: 2020A (Public Fixed Rate Bonds)	
PAR Amount	$131,270,000.00
Estimated Interest Rate	5.00%
All-in True Interest Cost	5.10%
Maturity Schedule (Interest) - Date	10/01/21 - 10/01/51
Maturity Schedule (Principal) - Date	10/01/32 - 10/01/51
NOTES:	
	Time of Preliminary Approval
SERIES: 2020B (Direct Bank Loan)	
PAR Amount	$85,000,000.00
Estimated Interest Rate	4.00%
All-in True Interest Cost	4.05%
Maturity Schedule (Interest) - Date	11/01/20 - 11/01/25 (expected)
Maturity Schedule (Principal) - Date	Final Maturity 11/01/25 (expected)
Bank Holding Period (if applicable) - Date	5-Years
NOTES:	To be repaid as entrance fees are
	received on the expansion project.

FEE SCHEDULE

NEW APARTMENTS

APARTMENTS	Type	Sq. Ft.	Monthly Service Fees	*Traditional Amortizing* Entrance Fee Plan *	*50 % Refundable* Entrance Fee Plan *	*90 % Refundable* Entrance Fee Plan *
Elm	1 BR/ 1 BA	895	$3,475	$172,800	$233,300	$285,200
Mulberry	1 BR/ 1.5 BA / Den	1,008	$3,820	$198,900	$268,500	$328,200
Cherry	1 BR / 2 BA / Den	1,260	$4,610	$233,600	$315,400	$385,500
Hickory	2 BR / 2 BA	1,274	$4,670	$242,700	$327,700	$400,500
Willow	2 BR / 2 BA	1,367	$4,860	$253,400	$342,100	$418,100
Birch	2 BR / 2 BA/Den	1,382	$4,910	$256,200	$345,900	$422,700
Maple	2 BR / 2.5 BA / Den	1,492	$5,000	$268,900	$363,000	$443,700
Pine	2 BR / 2.5 BA / Den	1,504	$5,030	$271,100	$366,000	$447,300
Cedar	2 BR/ 2.5 BA / Den	1,700	$5,410	$310,200	$418,100	$511,800
Second Person			$1,226			

* All Entrance Fees are Base Line Entrance Fees. Any prior upgrades may increase the final Entrance Fee.

Monthly Service Fees, 10/01/2019 through 09/30/2020

PENNYBYRN at MARYFIELD
A Continuing Care Retirement Community

FEE SCHEDULE

APARTMENTS	Type	Sq. Ft.	2019/20 Monthly Service Fees 1 Person	2019/20 Monthly Service Fees Couple**	Traditional Amortizing Entrance Fee Plan *	50 % Refundable Entrance Fee Plan *	90 % Refundable Entrance Fee Plan *
Dogwood	1 BR/ 1 BA	770	$3,012	$4,238	$136,400	$187,200	$225,700
Redbud	1 BR/ 1 BA / Den	908	$3,333	$4,559	$168,400	$229,100	$273,900
Periwinkle	1 BR / 1 BA / Den	937	$3,505	$4,732	$173,800 - $197,100	$236,200 - $259,500	$284,800 - $308,100
Periwinkle Enhanced	1 BR / 1.5 BA / Den	987	$3,505	$4,731	$182,600 - $205,700	$239,100 - $262,300	$287,800 - $310,900
Magnolia	2 BR / 2 BA	1,055	$3,841	$5,067	$185,200 - $209,200	$245,000 - $268,200	$305,200 - $328,400
Wisteria	2 BR / 2 BA	1,178	$4,302	$5,528	$225,000	$295,700	$369,800
Camellia	2 BR / 2 BA	1,181	$4,302	$5,528	$225,000	$295,700	$369,800
Azalea	2 BR / 2 BA / Den	1,333	$4,510	$5,736	$220,700 - $244,100	291,400 - $314,800	$363,000 - $386,200
Azelea Deluxe	3 BR/2 BA/Den	1,550	$4,746	$5,972	$281,900	$349,700	$416,300
Rose	2 BR / 2 BA / Den	1,386	$4,733	$5,959	$226,700 - $249,900	$301,000 - $324,200	$374,500 - $397,800
Holly	2 BR / 2 BA / Den	1,580	$4,751	$5,977	$244,100	$322,400	$408,100
Jasmine	2 BR / 2.5 BA / Den	1,600	$5,148	$6,374	$276,600 - $299,000	$362,700 - $385,800	$451,600 - $471,500
Second Person			$1,226	$2,452			
SHAMROCK COTTAGES							
Standard	2 BR / 2 BA/Garage	1458	$4,144	$5,370	$218,700	$336,100	$418,500
Enhanced / Deluxe	2 BR / 2 BA / Den / Garage	1633 - 1710	$4,830	$6,056	$241,800	$366,700	$456,800
Second Person			$1,226				

* All Entrance Fees are Base Line Entrance Fees -any prior upgrades may increase the final Entrance Fee.
**2nd Person Monthly fee of $1,226 included.
Monthly Service Fees, 10/01/2019 through 09/30/2020.

FEE SCHEDULE

Style		Address	Accommodation Style	Sq. Ft.	2019/20 Monthly Fee 1 Person	Second Person Monthly	2019/20 Monthly Fee 2 People	2019/20 0% Ref. Traditional *	2019/20 50% Ref. Plan *	2019/20 90% Ref. Plan *	Special Features
1	D	1404 Maryfield Ct.	Apt. 4 Plex. 1 Bdr/1 Bath	584	$2,630	$1,226	$3,856	$99,500	$135,500	$186,800	
1	D	1408 Maryfield Ct.	Apt. 4 Plex. 1 Bdr/1 Bath	584	$2,630	$1,226	$3,856	$99,500	$135,500	$186,800	End Unit
					$0						
1	C	1510 Kenmare Ct.	Apt. 2 Plex. 1 Bdr/1 Bath/Carport	579	$2,285	$1,226	$3,511	$80,000	$108,900	$196,400	Storage
2	C	1402 Maryfield Ct.	Apt. 4 Plex. 1 Bdr/1 Bath	778	$2,630	$1,226	$3,856	$99,500	$135,500	$186,800	End Unit
2	C	1406 Maryfield Ct.	Apt. 4 Plex. 1 Bdr/1 Bath	778	$2,630	$1,226	$3,856	$99,500	$135,500	$186,800	
2	C	1414 Maryfield Ct.	Apt. 2 Plex. 1 Bdr/1 Bath/Carport	763	$2,630	$1,226	$3,856	$97,500	$133,000	$157,800	
2	C	1504 Kenmare Ct.	Apt. 2 Plex. 1 Bdr/1 Bath/Screen Porch	778	$2,630	$1,226	$3,856	$105,300	$143,500	$172,300	
					$0						
3	B	1600 Maryfield Ct.	***Cottage*** 1 Bdr/1.5 BA/Sun Rm/Carport	997	$2,948	$1,226	$4,174	$127,600	$173,800	$208,500	
4	B	1416 Maryfield Ct.	Apt. 2 Plex. 2 Bdr/2 Bath	1136	$3,967	$1,226	$5,193	$145,300	$198,000	$237,600	
4	B	1500 Kenmare Ct.	***Cottage*** 2 Bdr/2 Bath/Carport	1132	$3,967	$1,226	$5,193	$144,800	$197,200	$236,900	
4	B	1506 Kenmare Ct.	Apt. 2 Plex. 2 Bdr/2 Bath/Carport	1253	$3,967	$1,226	$5,193	$165,900	$226,300	$271,600	
4	B	1601 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Carport	1168	$3,967	$1,226	$5,193	$149,300	$203,700	$241,100	
4	B	1702 Maryfield Ct.	***Cottage*** 2 Bdr/1.5 Bath/Carport	1168	$3,967	$1,226	$5,193	$149,000	$203,700	$241,100	
4	B	1705 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Carport	1282	$3,967	$1,226	$5,193	TBD	TBD	TBD	
					$0						
5	A2	1712 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Scr. Porch/Garage	1816	$4,829	$1,226	$6,055	$232,300	$316,600	$388,300	A' frame
5	A2	1412 Maryfield Ct.	***Cottage*** 2 Bdr./2 Bath/Den/2 Carports	1877	$4,829	$1,226	$6,055	$240,000	$327,200	$392,600	
6	A2	1418 Maryfield Ct.	***Cottage*** 2 Bdr./2 Bath/Den	1435	$4,144	$1,226	$5,370	TBD	TBD	TBD	
6	A2	1502 Kenmare Ct.	***Cottage*** 2 Bdr/2 Bath/Den/Carport	1444	$4,144	$1,226	$5,370	$190,400	$259,600	$272,200	
5	A2	1512 Kenmare Ct.	2 Plex. 2 Bdr/1.5 Bath/Den/Sun Rm/Carport	1707	$4,829	$1,226	$6,055	$218,300	$297,600	$358,100	
6	A2	1609 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Den/Carport	1500	$4,144	$1,226	$5,370	$191,900	$261,600	$313,700	
6	A2	1701 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Den/Carport	1500	$4,144	$1,226	$5,370	$191,900	$261,600	$313,700	
7	A2	1518 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/2 Carports	1603	$4,477	$1,226	$5,703	$205,000	$279,400	$335,300	Fireplace
5	A2	1511 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Den/Lg. Storage/Carport	1700	$4,829	$1,226	$6,055	$217,300	$296,400	$355,700	
7	A2	1608 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Den/Carport	1661	$4,477	$1,226	$5,703	$223,900	$301,300	$359,000	
7	A2	1508 Kenmare Ct.	***Cottage*** 2 Bdr/2 Bath/Den/Sun Rm/Carport	1679	$4,477	$1,226	$5,703	$214,700	$292,600	$351,200	
6	A2	1605 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Den/Carport	1877	$4,829	$1,226	$6,055	$240,000	$327,200	$392,600	
					$0						
8	A1	1606 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Study/Sun Rm/Carport	1975	$5,057	$1,226	$6,283	$252,500	$344,200	$413,100	Fireplace
9	A1	1706 Maryfield Ct.	***Cottage*** 2 Bdr/2 Bath/Study/Sun Rm//2 Garages	1960	$5,135	$1,226	$6,361	TBD	TBD	TBD	Fireplace
10	A1	1400 Maryfield Ct.	***Cottage*** Custom	3850	$5,824	$1,226	$7,050	TBD	TBD	TBD	Fireplace
			Second Person Monthly Fee		$1,226						

*** All Entrance Fees are Base Line Entrance Fees -any prior upgrades may increase the final Entrance Fee.**
The Fees stated above apply to the period 10/1/2019 through 9/30/2020.

NC MCC Bond Sale Approval Form	
Facility Name: Pennybyrn Retirement Community	
	Time of Preliminary Approval
SERIES: 2020A (Public Fixed Rate Bonds)	
PAR Amount	$44,150,000.00
Estimated Interest Rate	6.00%
All-in True Interest Cost	6.18%
Maturity Schedule (Interest) - Date	4/01/21 - 10/01/50
Maturity Schedule (Principal) - Date	10/01/36 - 10/01/50
NOTES:	
	Time of Preliminary Approval
SERIES: 2020B (Direct Bank Loan)	
PAR Amount	$11,000,000.00
Estimated Interest Rate	3.50%
All-in True Interest Cost	4.26%
Maturity Schedule (Interest) - Date	10/01/20 - 10/01/25 (expected)
Maturity Schedule (Principal) - Date	Final Maturity 10/01/25 (expected)
Bank Holding Period (if applicable) - Date	5-Years
NOTES:	To be repaid as entrance fees are
	received on the expansion project.