VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

November 19, 2021

RE: COPN Request No. VA-8569
Autumn Care of Altavista, LLC
Campbell County, Virginia
Add 8 Nursing Home Beds through Transfer from within PD 11

Applicant

Autumn Care of Altavista, LLC (ACA) is a single purpose entity that began operations in 1990. While the applicant has no subsidiaries, there are numerous Virginia nursing homes affiliated with the applicant through common ownership, Forest Health and Rehab (Forest) (formerly The Carrington—ownership change effective 2021) being one. ACA's parent organization is the Autumn Corporation, a North Carolina corporation, originally established in 1977.

Presently, ACA operates 111 licensed and dually-certified nursing facility beds. Services currently provided by ACA include post-acute short-term rehabilitation, skilled nursing care, long-term nursing care, therapeutic diets, social services and recreation therapy, along with supportive services such as housekeeping, linen and laundry, maintenance, personal fund bookkeeping, and making arrangements with local transportation for medical appointments. ACA is located in Altavista, Virginia, in Planning District (PD) 11 within Health Planning Region (HPR) III. DCOPN notes that Forest is also located in PD 11, HPR III.

Background

Presently in PD 11, there are 15 facilities authorized to house licensed skilled nursing beds: 13 nursing homes, one continuing care retirement community (CCRC), and one hospital (beds licensed as nursing home beds effective November 1, 2021). Using 2019 VHI data and Division of Certificate of Public Need (DCOPN) records, DCOPN calculated that for 2019, PD 11's 1,596 licensed nursing home beds operated at a collective utilization of 84.2% (**Table 1**). DCOPN notes that there have been no additions to the PD 11 skilled nursing bed inventory subsequent to 2019; however, the 36 beds at Virginia Baptist Hospital were decertified as of January 1, 2021. Thus, the present number of nursing home facility beds in PD 11 is 1,560.

Table 1. PD 11 Nursing Home Facilities, Beds, and Occupancy: 2019

Facility	Beds	Occupancy Rate
Accordius Health at Lynchburg LLC	120	87.1%
Appomattox Health and Rehab Center	60	92.9%
Autumn Care of Altavista	111	94.0%
Bedford County Nursing Home	90	96.6%
Forest Health and Rehab Center	97	70.3%
Fairmont Crossing	120	93.3%
Guggenheimer Nursing Home	130	68.1%
Heartland Healthcare Center	118	80.4%
Heritage Hall--Brookneal	60	93.4%
Liberty Ridge Health and Rehabilitation	90	83.9%
Lynchburg Health and Rehabilitation Center	180	90.0%
Oakwood Manor (Bedford Memorial Hospital LTC)	111	86.2%
Summit Health and Rehabilitation Center	120	72.9%
Virginia Baptist Hospital LTC	0*	--
Westminster-Canterbury of Lynchburg**	105	90.4%
Woodhaven Nursing Home	48	59.7%
TOTAL/Average	**1,560[1]**	**84.2%**

Source: VHI (2019) and DCOPN records
*36 LTC beds at this facility decertified as of January 1, 2021. Accordingly, these beds are not included in the total count for inventory.
**Operates as part of a CCRC

Collective utilization of the PD 11 skilled nursing bed inventory has decreased from 91.5% in 2009 to 84.2% in 2019, representing an approximate 7.3% decrease over the ten-year period (**Table 2**). While the overall decrease in occupancy is not necessarily a large one, it has been generally consistent despite an increase in the total PD 11 population, as well as in the population of individuals aged 65 and older (**Tables 3 and 4**). DCOPN additionally notes that in its most recent Projected Notice of No Need for Target Year 2022, it calculated a PD 11 projected net bed surplus of 103 beds for the 2022 planning year.

[1] This number accounts for the decertification of the 36 nursing facility beds at Virginia Baptist Hospital.

Table 2. Historical PD 11 Utilization (2009-2019)

Year	Beds	Occupancy
2019	1,596	84.2%
2018	1,440	84.2%
2017	1,455	83.7%
2016	1,594	83.8%
2015	1,594	83.8%
2014	1,609	85.0%
2013	1,638	78.7%
2012	1,300	88.2%
2011	1,443	89.7%
2010	1,443	90.4%
2009	1,397	91.5%

Source: VHI (2009-2019) and DCOPN records

Table 3. Statewide and PD 11 Total Population Projections, 2010-2030

Locality	2010	2020	% Change	2030	% Change	2010-2030 % Change
Virginia	8,001,024	8,655,021	8.17%	9,331,666	7.8%	16.6%
Amherst	32,353	31,831	(1.6%)	31,402	(1.3%)	(2.9%)
Appomattox	14,973	15,866	6.0%	16,742	5.5%	11.8%
Bedford County	74,898	79,241	5.8%	84,604	6.8%	13.0%
Campbell	58,842	5,565	1.5%	57,325	3.0%	4.5%
Lynchburg City	75,568	82,791	9.6%	90,526	9.3%	19.8%
TOTAL PD 11	**252,634**	**265,394**	**5.1%**	**280,600**	**5.7%**	**11.1%**

Source: U.S. Census, Weldon Cooper Center Projections (August 2019) and DCOPN (interpolations)

Table 4. PD 11 Population Projections for 65+ Age Cohort, 2010-2030

Locality	2010	2020	% Change	2030	% Change	2010-2030 % Change
Amherst	5,330	6,553	22.9%	7,577	15.6%	42.2%
Appomattox	2,607	3,309	26.9%	4,112	24.3%	57.7%
Bedford County	12,484	17,775	42.4%	22,859	28.6%	83.1%
Campbell	8,685	10,922	25.8%	12,667	16.0%	45.8%
Lynchburg City	10,556	12,162	15.2%	13,565	11.5%	28.5%
TOTAL PD 11	**39,662**	**50,719**	**27.9%**	**60,780**	**19.8%**	**53.2%**

Source: U.S. Census, Weldon Cooper Center Projections (August 2019) and DCOPN (interpolations)

With regard to ACA specifically, the 111 nursing home beds operated at a collective utilization of 94% in 2019. As demonstrated in **Table 5** below, occupancy at ACA has remained between 92.5% and 94.7% since 2015, demonstrating no consistent increase or decrease. DCOPN additionally notes that the 97 nursing home beds at Forest, the facility from which the requested beds will be transferred, operated at 70.3% utilization in 2019 (**Table 1**).

Table 5. Historical ACA Utilization (2015-2019)

Year	Beds	Occupancy
2019	111	94.0%
2018	111	94.7%
2017	111	93.4%
2016	111	92.5%
2015	111	93.9%

Source: VHI (2015-2019) and DCOPN Records

Proposed Project

The applicant proposes to increase its licensed nursing facility bed capacity by eight beds through the relocation of licensed beds already existing within PD 11. The eight licensed nursing home beds proposed for relocation are currently located in Lynchburg at Forest (formerly The Carrington), approximately 20 miles from the ACA campus. The applicant states that a forbearance agreement has been reached regarding the transfer of the beds from the Forest facility, and that the costs associated with the transfer of the beds total approximately $120,000, an amount that has been included in the overall capital cost of the project. The applicant provided assurances that, if approved, the additional eight beds will be dually-certified.

In order to accommodate the expansion, the applicant proposes to convert its existing 16-bed assisted living space. The applicant states that the assisted living wing was designed and constructed to skilled nursing home standards, and accordingly complies with all applicable Life Safety Code and state licensure regulations pertaining to nursing homes. The project will not alter the existing building footprint, and involves no new construction costs other than cosmetic remodeling. Each assisted living room is currently licensed for double occupancy, and after conversion to nursing facility use, each room will be licensed for single occupancy. Thus, upon completion of the project, both ACA and Forest will have eight additional private rooms in their respective complements. Also upon completion of the project, ACA will no longer operate assisted living beds. The applicant anticipates that most, if not all, current residents of the assisted living wing will become eligible for long-term nursing home services by having a physician perform a needs assessment, including clinical needs, and will remain in the current wing as long-term care patients in dually-certified nursing home beds. Should any resident choose to remain living in an assisted living level of care, the applicant states that it will provide assistance to secure such arrangements in the nearby community.

The total projected capital cost of the proposed project is $178,843 (**Table 6**), the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with this project. The applicant stats that with regard to the Forest facility, only minor operational costs will be incurred as a result of the proposed transfer, all of which will be attributed to cosmetic remodeling.

Table 6. ACA Capital Costs

Value of Existing Space to be Converted	$10,843
Direct Construction Costs	$40,000
Equipment Not Included in Construction Contract	$8,000
Consultant Fees	$120,000
TOTAL Capital Costs	**$178,843**

Source: COPN Request No. VA-8569

The applicant anticipates the proposed project to become operational in early 2022, within three months of Certificate of Public Need (COPN) issuance. If approved, schedule allowances may need to be made in order to accommodate the applicant's response to the ongoing COVID-19 pandemic. As already discussed, DCOPN calculated a net surplus of 103 skilled nursing beds in PD 11 for the 2022 planning year, however notes that approval of the proposed project would ultimately have a neutral impact on the PD 11 skilled nursing bed inventory.

Project Definition

Section 32.1-102.1:3 of the Code of Virginia defines a project, in part, as the "relocation of beds from an existing medical care facility described in subsection A to another existing medical care facility described in subsection A…" or "An increase in the total number of beds…in an existing medical care facility described in subsection A." Medical care facilities are defined, in part, as "Any facility licensed as a nursing home, as defined in § 32.1-123."

Required Considerations -- § 32.1-102.3, of the Code of Virginia

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable.

1. **The extent to which the proposed project will provide or increase access to health care services for people in the area to be served and the effects that the proposed project will have on access to health care services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to health care;**

ACA is located in the Town of Altavista, which is approximately 20 miles away from the City of Lynchburg via US Highway 29. The facility maintains access to public transportation via the Altavista Community Transit System.

Regarding socioeconomic barriers to access to services, the applicant has provided assurances that it currently offers, and will continue to offer, access to all of its dually-certified nursing facility beds according to patients' health care needs and without regard to source of payment. **Table 7** below indicates that in 2019, approximately 70.4% of ACA's skilled nursing home utilization was attributed to Medicaid services, with that percentage reportedly rising marginally to 71.8% in 2020. The applicant projects that by the end of the second year of operation after completion of the proposed project, approximately 69.6% of skilled nursing home utilization will be attributed to Medicaid/financially underserved, long-term care services. In accordance with

section 32.1-102.2.A.7 of the Code of Virginia, imposition of a charity condition pursuant to subsection B of § 32.1-102.4 would not be appropriate for the proposed project.

Table 7. ACA Projected Payer Source Utilization

Source of Payment	Actual Patient Days				Projected Patient Days			
	2019	%	2020	%	Year 1	%	Year 2	%
Medicare	4,137	10.9%	3,834	10.4%	4,777	11.8%	4,867	12.0%
Medicaid	26,813	70.4%	26,479	71.8%	28,242	69.7%	28,273	69.6%
Self-Pay	5,145	13.5%	3,941	10.7%	4,870	12.0%	4,870	12.0%
Other	1,986	5.2%	2,626	7.1%	2,626	6.5%	2,626	6.5%
TOTAL	**38,081**	--	**36,880**	--	**40,515**	--	**40,636**	--
Percent Occupancy	93.99%	--	90.78%	--	93.28%	--	93.56%	--

Source: COPN Request No. VA-8569

As demonstrated above in **Table 3**, the most recent Weldon-Cooper data projects a total PD 11 population of 280,600 persons by 2030. This represents an approximate 11.1% increase in total population from 2010 to 2030. Comparatively, Weldon-Cooper projects the population of Virginia as a whole to increase by 16.6% for the same period. With regard to Campbell County specifically, the county in which the proposed project is located, Weldon-Cooper projects a total population increase of only 4.5% from 2010-2030. With regard to the 65 and older age cohort, Weldon-Cooper projects an increase of approximately 53.2% among PD 11's collective 65 and older age cohort from 2010 to 2030, while an increase of approximately 45.8% is expected among this cohort in Campbell County (**Table 4**). This is important, as this age group uses medical care resources, including skilled nursing beds, at a rate much higher than the rest of the population.

DCOPN did not identify any other unique geographic, socioeconomic, cultural, transportation, or other barriers to care in the planning district.

2. The extent to which the project will meet the needs of people in the area to be served, as demonstrated by each of the following:

(i) The level of community support for the proposed project as demonstrated by people, businesses, and governmental leaders representing the area to be served;

The applicant provided numerous letters of support for the proposed project from healthcare providers associated with ACA. Collectively, these letters addressed the following:

1. The proposed expansion would bring numerous changes to what ACA can offer community residents. Private rooms provide privacy and increase comfort while also reducing the risk of transmitting infectious diseases. The additional private resident rooms will provide the community with a state-of-the-art option when making the important decision of where to receive skilled nursing care.

2. The conversion of the existing assisted living space to a skilled nursing unit will provide ACA with the ability to serve the increasing requests of patients to have private rooms and bathrooms during their skilled or rehab stay.

DCOPN is unaware of any opposition to the proposed project. Additionally, DCOPN did not receive any request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public to hold a public hearing on the proposed project and accordingly, one was not held.

(i) The availability of reasonable alternatives to the proposed project that would meet the needs of the people in the area to be served in a less costly, more efficient, or more effective manner;

As already discussed, VHI data demonstrates that in 2019, PD 11 skilled nursing beds operated well beneath maximum capacity (**Table 1**), indicating that there is ample underutilized inventory within the planning district to provide adequate skilled nursing care to residents of PD 11 for the foreseeable future. Additionally, DCOPN again notes that in its most recently published Projected Notice of No Need for Target Year 2022, it calculated a projected net surplus of 103 skilled nursing beds for the 2022 planning horizon. However, DCOPN nonetheless maintains that approval of the proposed project is more favorable than maintaining the status quo and that accordingly, a better alternative to the proposed project does not exist.

First, DCOPN again notes that in 2019, the 111 existing skilled nursing beds at ACA operated at 94.0% utilization (**Table 1**). Approval of the proposed project would help to decompress the ACA complement, while simultaneously improving utilization at Forest, a facility that operated at only 70.3% utilization in 2019.[2] Next, DCOPN reiterates that the proposed project will have a neutral impact on the total PD 11 inventory, and accordingly will not add to an existing surplus. Furthermore, DCOPN contends that by increasing the number of available private rooms both at ACA and at Forest, the project incorporates elements of culture change design that have been sweeping the long-term care industry over the past decade and will result in added privacy for residents of PD 11.[3] Finally, the addition of private rooms will enhance ACA's ability, as well as that of Forest, to serve residents with infectious disease by adding additional space for quarantine, should such space be necessary. For these reasons, DCOPN contends that approval of the proposed project is more favorable than maintaining the status quo.

(ii) Any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6;

Currently, there is no organization in HPR III designated by the Virginia Department of Health to serve as the Health Planning Agency for PD 11. Therefore, this consideration is not applicable to the review of the proposed project.

[2] DCOPN notes that should 2019 actual patient days at Forest remain unchanged, resulting utilization with eight fewer beds would be approximately 76.6%.

[3] Shield, Renée R, et al. "Would You Do That in Your Home?" Making Nursing Homes Home-like in Culture Change Implementation." *Journal of Housing for the Elderly*, U.S. National Library of Medicine, 2 Dec. 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC5363857/.

(iii) Any costs and benefits of the proposed project;

As illustrated in **Table 6**, the total projected capital cost of the proposed project is $178,843, the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with this project. DCOPN concludes that the costs for the proposed project are low when compared to previously approved projects similar in clinical scope.[4]

The applicant cited the following benefits of the proposed project:

1. The current existing supply of beds in PD 11 will become better distributed to meet current and future demand.

2. The capital costs per bed of $22,355 are low compared to other recent Commissioner approved bed relocation projects.

3. Additional staffing requirements for the proposed eight bed addition are incremental and involve the hiring of few additional direct care staff.

4. Importantly, the project will not add beds to the existing nursing home inventory in PD 11 and instead will more effectively utilize capacity which is currently underutilized.

5. There will be more single occupant private nursing home beds available in PD 11 to meet patient choice (eight private rooms each at ACA as well as at Forest Health and Rehab), which will offer more privacy, comfort and improved infection control environments for patients, staff, and visitors.

(iv) The financial accessibility of the proposed project to people in the area to be served, including indigent people; and

To reiterate, the applicant has provided assurances that all skilled nursing beds at ACA will continue to be dually-certified and that it will continue to offer access to all beds according to patients' health care needs and without regard to payment source. As previously discussed, should the Commissioner approve the proposed project, a charity card condition would not be appropriate.

(v) At the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a proposed project;

ACA's Nursing Home Compare Ratings

The current overall rating as well as ratings for three component-rating categories (health inspection, staffing, and quality measures) for ACA can be found at Nursing Home Compare

[4] COPN No. VA-04080 authorized the relocation of 10 skilled nursing beds and had a capital cost of $12,308,000; COPN No. VA-04746 authorized the relocation of 25 skilled nursing beds and had a capital cost of $3,431,518; COPN No. VA-04582 authorized the addition of 10 skilled nursing beds and had a capital cost of $500,000.

(medicare.gov) and are illustrated in **Table 8** below. The ratings are based on a five-star system, with an awarded five stars being the best rating possible.

Table 8. ACA Nursing Home Compare Ratings

Overall Rating	Health Inspection	Staffing	Quality Measures
5 Stars	4 Stars	2 Stars	5 Stars

Source: Nursing Home Compare (medicare.gov)
Key: 1 Star—much below average
2 stars—below average
3 stars—average
4 stars—above average
5 stars—much above average

Executive Order 52 and the COVID-19 Pandemic

On March 12, 2020, Governor Ralph Northam declared a state of emergency throughout Virginia in response to the COVID-19 pandemic. Subsequent to this declared state of emergency, on March 20, 2020, Governor Northam signed Executive Order 52 (EO 52) providing that notwithstanding the provisions of Article 1.1 of Chapter 4 of Title 32.1 of the Code of Virginia, the State Health Commissioner, at his discretion, may authorize any general hospital or nursing home to increase licensed bed capacity as determined necessary by the Commissioner to respond to increased demand for beds resulting from COVID-19. Such beds authorized by the Commissioner under EO 52 would, not withstanding Virginia Code § 32.1-132, constitute licensed beds that do not require further approval or the issuance of a new license. DCOPN notes that ACA did not request to temporarily add additional capacity pursuant to EO 52 in order to respond to the COVID-19 pandemic. However, the applicant provided information regarding the number of COVID-19 cases and deaths at both ACA and Forest up to October 20, 2021 (**Table 9**). As already discussed, the applicant asserts, and DCOPN agrees, that the addition of private rooms within each facility will enable the applicant to better care for patients with infectious diseases in the future.

Table 9. ACA and Forest COVID-19 Data

	ACA	Forest*
Covid Cases-Current	1	0
Cases YTD (10/29/2021)	62	0
Deaths YTD (10/29/2021)	3	0

Source: COPN Request No. VA-8569
*Began operations under new ownership (Forest) on June 1, 2021

State Health Services Plan Task Force

Section 32.1-102:1 of the Code of Virginia calls for the State Health Services Plan Task Force to develop, by November 1, 2022, recommendations for a comprehensive State Health Services Plan (SHSP). In the interim, DCOPN will consider the consistency of the proposed project with the predecessor of the SHSP, the State Medical Facilities Plan (SMFP).

3. The extent to which the application is consistent with the State Medical Facilities Plan;

Part VII of the SMFP provides the criteria and standards for nursing facilities. They are as follows:

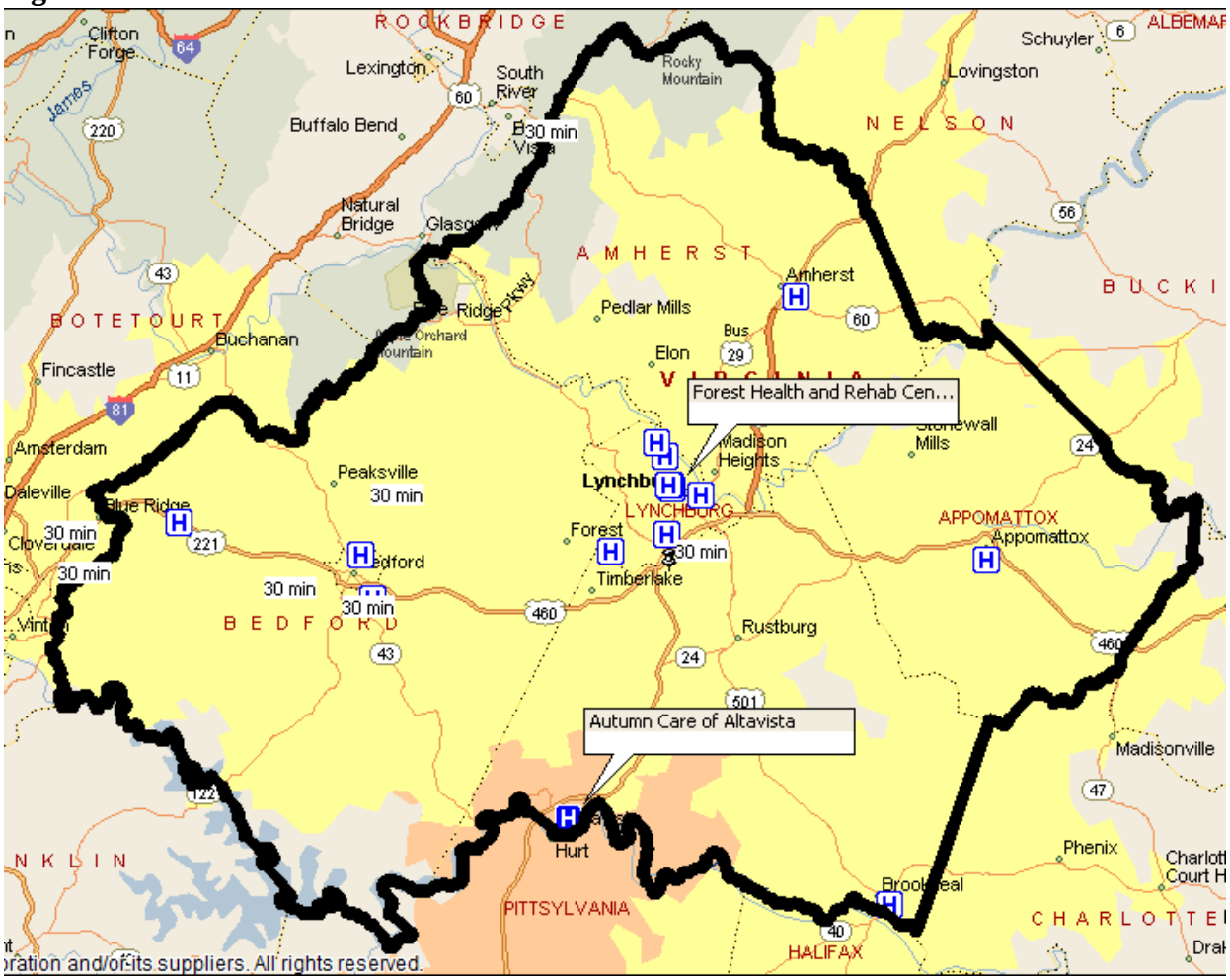
Part VII
Nursing Facilities

12VAC5-230-600. Travel Time.

A. Nursing facility beds should be accessible within 30 minutes driving time one way under normal conditions of 95% of the population in a health planning district using mapping software as determined by the commissioner.

The heavy black line in **Figure 1** identifies the boundary of PD 11. The solid blue "H" sign marks the location of the proposed project. The solid white "H" signs mark the locations of all other providers of skilled nursing care in PD 11. The yellow shaded area illustrates the area of PD 11 and the surrounding area that is currently within a 30-minute drive of existing skilled nursing care services. The pink shaded area illustrates the area of PD 11 that is served by ACA, but not within a 30-minute drive of other existing providers. Given the amount and location of shaded area, it is reasonable to conclude that at least 95% of the PD 11 population is with 30-minutes drive time, one way, under normal driving conditions, of existing skilled nursing services. Furthermore, because the applicant currently provides this service, DCOPN concludes that the proposed project would not improve geographical access for residents of PD 11 in any meaningful way.

Figure 1.



B. Nursing facilities should be accessible by public transportation when such systems exist in an area.

As previously discussed, the ACA facility maintains access to public transportation via the Altavista Community Transit System.

C. Preference may be given to proposals that improve geographic access and reduce travel time to nursing facilities within a health planning district.

The proposed project is not competing with another project. Accordingly, this standard is not applicable.

12VAC5-230-610. Need for New Service.

A. A health planning district should be considered to have a need for additional nursing facility beds when:

1. **The bed need forecast exceeds the current inventory of existing and authorized beds for the health planning district; and**
2. **The median annual occupancy of all existing and authorized Medicaid-certified nursing facility beds in the health planning district was at least 93%, and the average annual occupancy of all existing and authorized Medicaid-certified nursing facility beds in the health planning district was at least 90%, excluding the bed inventory and utilization of the Virginia Veterans Care Centers.**

EXCEPTION: When there are facilities that have been in operation less than one year in the health planning district, their occupancy can be excluded from the calculation of average occupancy.

B. No health planning district should be considered in need of additional beds if there are unconstructed beds designated as Medicaid certified. This presumption of "no need" for additional beds extends for three years from the issuance date of the certificate.

C. The bed need forecast will be computed as follows:

PDBN = (UR64 x PP64) + (UR69 x PP69) + (UR74 x PP74) + (UR79 x PP79) + (UR84 x PP84) + (UR85 x PP85)

Where:

PDBN = Planning district bed need.

UR64 = The nursing home bed use rate of the population aged 0 to 64 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP64 = The population aged 0 to 64 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR69 = The nursing home bed use rate of the population aged 65 to 69 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP69 = The population aged 65 to 69 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR74 = The nursing home bed use rate of the population aged 70 to 74 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP74 = The population aged 70 to 74 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR79 = The nursing home bed use rate of the population aged 75 to 79 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP79 = The population aged 75 to 79 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR84 = The nursing home bed use rate of the population aged 80 to 84 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP84 = The population aged 80 to 84 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR85+ = The nursing home bed use rate of the population aged 85 and older in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP85+ = The population aged 85 and older projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

Health planning district bed need forecasts will be rounded as follows:

Health Planning District Bed Need	Rounded Bed Need
1-29	0
30-44	30
45-84	60
85-104	90
105-134	120
135-164	150
165-194	180
195-224	210
225+	240

EXCEPTION: When a health planning district has:

1. **Two or more nursing facilities;**
2. **Had a median annual occupancy rate of 93% of all existing and authorized Medicaid-certified nursing facility beds and an annual average occupancy rate of at least 90% of all existing and authorized Medicaid-certified nursing facility beds for each of the most recent two years for which bed utilization has been reported to VHI; and**
3. **Has a forecasted bed need of 15 to 29 beds, then the bed need for this health planning district will be rounded to 30.**

D. No new freestanding nursing facilities of less than 90 beds should be authorized. However, consideration may be given to a new freestanding facility with fewer than 90 nursing facility beds when the applicant can demonstrate that such a facility is justified based on a locality's preference for such smaller facility and there is a documented poor distribution of nursing facility beds within the health planning district.

E. When evaluating the capital cost of a project, consideration may be given to projects that use the current methodology as determined by the Department of Medical Assistance Services.

F. Preference may be given to projects that replace outdated and functionally obsolete facilities with modern facilities that result in the more cost-efficient resident services in a more aesthetically pleasing and comfortable environment.

The applicant does not wish to establish a new service, but rather, to expand an existing service through the transfer of licensed skilled nursing home beds from within the planning district. Accordingly, this provision is not applicable to the proposed project. However, in the interest of completeness, DCOPN will address this standard.

As previously discussed, in its most recent Projected Notice of No Need for Target Year 2022, DCOPN calculated a large surplus of skilled nursing beds for the 2022 planning horizon. However, DCOPN nonetheless contends that approval of the proposed project is more advantageous than maintaining the status quo and therefore, warrants approval despite the calculated surplus. First, the project ultimately will have a neutral impact on the existing PD 11 skilled nursing bed inventory. Secondly, approval of the proposed project would assist in the decompression of ACA's complement, while simultaneously aiding in the improvement of Forest's underutilized complement. Finally, approval of the proposed project would result in eight additional private rooms at each ACA and Forest, contributing to improved patient privacy as well as improved methods for infectious disease control should the need arise in the future.

12VAC5-230-620. Expansion of Services.
Proposals to increase an existing nursing facility's bed capacity should not be approved unless the facility has operated for at least two years and the average annual occupancy of the facility's existing beds was at least 90% in the relevant reporting period as reported to VHI.

Note: Exceptions will be considered for facilities that operated at less than 90% average annual occupancy in the most recent year for which bed utilization has been reported when the facility offers short stay services causing an average annual occupancy lower than 90% for the facility.

As previously discussed, 2019 VHI data indicates that ACA's existing 111 beds operated at a collective utilization of 94% in 2019 (**Table 1**). Furthermore, historical VHI data demonstrates that the applicant's existing complement has operated at least 92.5% occupancy consistently since 2015 (**Table 5**). Accordingly, DCOPN concludes that the applicant has satisfied this standard.

12VAC5-230-630. Continuing Care Retirement Communities.
Proposals for the development of new nursing facilities or the expansion of existing facilities by continuing care retirement communities (CCRC) will be considered when:

1. **The facility is registered with the State Corporate Commission as a continuing care provider pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia;**
2. **The number of nursing facility beds requested in the initial application does not exceed the lesser of 20% of the continuing care retirement community's total number of beds that are not nursing home beds or 60 beds;**
3. **The number of new nursing facility beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed 20% of its total number of beds that are not nursing facility beds; and**
4. **The continuing care retirement community has established a qualified resident assistance policy.**

The applicant is not part of a CCRC and as such, this provision of the SMFP is not applicable to the proposed project.

12VAC5-230-640. Staffing.
Nursing facilities should be under the direction or supervision of a licensed nursing home administrator and staffed by licensed and certified nursing personnel qualified as required by law.

The applicant has provided assurances that the facility is currently, and will continue to be, under the direction and supervision of a licensed Nursing Home Administrator, and will be staffed by licensed and certified nursing personnel as required by law.

Eight Required Considerations Continued

4. The extent to which the proposed project fosters institutional competition that benefits the area to be served while improving access to essential health care services for all people in the area to be served;

To reiterate, there are currently 15 COPN authorized skilled nursing care facilities, operating 1,560 beds, in PD 11. Most of these facilities are operated by different owners and operators. DCOPN contends that the proposed project is not likely to foster additional institutional competition benefitting PD 11, as ample competition already exists among current providers. Additionally, DCOPN again notes that the proposed project is not intended to foster institutional competition, but rather is intended to decompress the over utilized complement at ACA. DCOPN further maintains that, because the number of beds requested by the applicant is small, and because the project has a neutral impact upon the existing PD 11 inventory, any negative impact on existing facilities is not likely to be destabilizing or even substantial. DCOPN additionally notes that no letters of opposition were received with regard to this project.

5. The relationship of the proposed project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

As demonstrated in **Table 2**, utilization rates of nursing facilities in PD 11 have been steadily declining for the past decade. Furthermore, DCOPN has calculated a large surplus of skilled nursing beds for the 2022 planning horizon. However, for reasons discussed throughout this report, DCOPN maintains that approval of the proposed project is a better alternative than maintaining the status quo. To reiterate, the proposed project would ultimately have a neutral impact on the existing PD 11 inventory, would alleviate the over utilization of the ACA complement while simultaneously improving utilization at Forest, and would add a total of 16 private skilled nursing beds to PD 11. Furthermore, DCOPN notes that the approval of the project would result in the geographical redistribution of beds in PD 11 from the urban center of Lynchburg to the rural surrounding area, partially correcting a current maldistribution of beds in PD 11. DCOPN further reiterates that any potential negative impact approval of the proposed project may have on existing providers is not likely to be significant.

6. The feasibility of the project, the financial benefits of the project to the applicant, the cost of construction, the availability if financial and human resources, and the cost of capital;

The Pro Forma Income statement (**Table 10**) provided by the applicant anticipates a net profit of $1,351,778 in year one and $1,389,422 in year two, illustrating that the proposed project would be financially feasible both in the immediate and the long-term. As already discussed, DCOPN contends that the projected capital costs for the proposed project are quite low when compared to previously authorized projects similar in clinical scope. The applicant will fund the project entirely using accumulated reserves. Accordingly, there are no financing costs associated with this project.

Table 10. ACA Pro Forma Income Statement

	2022	2023
Total Gross Patient Care Services Revenue	$12,176,673	$12,242,819
Deductions from Revenue	($2,595,221)	($2,608,739)
Net Patient Care Services Revenue	**$9,581,452**	**$9,634,080**
Other (Non-Patient Care) Revenue	$4,974	$4,988
TOTAL—Net Revenue	**$9,586,426**	**$9,639,069**
Direct Patient Care Expenses	$4,244,020	$4,259,020
Indirect Patient Care Expenses	$2,897,116	$2,897,116
Capital-Related Expenses	$1,093,511	$1,093,511
TOTAL Expenses	**$8,234,647**	**$8,249,647**
Per Diem Expenses	$203.25	$203.01
Net Income (before income taxes)	**$1,351,778**	**$1,389,422**

Source: COPN Request No. VA-8569

With regard to staffing, the applicant intends to retain all assisted living facility staff and anticipates the need to hire an additional two full-time employees in order to staff the proposed project. The applicant states that ACA competes very effectively within the market to hire staff as positions turn over from time to time, and that no appreciable changes are expected as a result of the proposed project. DCOPN notes that the applicant is an established provider of skilled nursing considers with a robust employee recruitment and retention plan. DOCPN does not anticipate that the applicant will have difficulty filling the needed positions or that, due to the small number of employees needed, doing so will have a significantly negative impact on neighboring facilities.

7. The extent to which the proposed project provides improvements or innovations in the financing and delivery of health care services, as demonstrated by (i) the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services; (ii) the potential for the provision of health care services on an outpatient basis; (iii) any cooperative efforts to meet regional health care needs; and (iv) at the discretion of the Commissioner, any other factors as may be appropriate;

DCOPN again notes that the proposed project would increase the number of private rooms both at ACA and at Forest, implementing designs of culture change that have swept the long-term care industry in recent years. Furthermore, the addition of private rooms at both ACA and Forest will aid the applicant in appropriately responding to any future instances of infection control or quarantine, should the need so arise. The applicant does not provide, nor has it proposed to provide, improvements or innovations in the financing and delivery of health services as demonstrated by cooperative efforts to meet regional health care needs. DCOPN did not identify any other factors, not addressed elsewhere in this staff analysis report, to bring to the Commissioner's attention regarding the determination of a public need for the proposed project.

8. In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, (i) the unique research, training, and clinical mission of the teaching hospital or medical school and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care services for citizens of the Commonwealth, including indigent or underserved populations.

Not applicable. The applicant is not, nor is it affiliated with, a teaching hospital associated with a public institution of higher education or a medical school in the area to be served.

DCOPN Staff Findings and Conclusions

The applicant proposes to relocate eight dually-certified skilled nursing beds from Forest, also located in PD 11, to ACA. Approval of the proposed project would have a neutral impact on the existing PD 11 inventory; however, approval of the project would result in the addition of eight private rooms at both ACA and Forest. The project involves the conversion and renovation of space in ACA's assisted living facility. Upon completion of the proposed project, ACA will cease operation of the assisted living facility.

The total projected capital cost of the proposed project is $178,843, the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with this project. DCOPN concludes that this cost low when compared to previously authorized projects similar in clinical scope. The applicant projects patient service to begin within three months of COPN issuance.

Based on the Pro Forma profit and loss statement provided by the applicant, the addition of the eight skilled nursing beds would add to the facility's overall profitability. The applicant projects a net income of $1,351,778 in the first year of operation and $1,389,422 in year two, indicating that the proposed project is economically feasible both in the immediate and in the long-term. Should the Commissioner approve the proposed project, DCOPN concludes that a charity care condition would not be appropriate.

Should the proposed project be approved, the applicant anticipates the need to hire an additional two FTE personnel to staff the proposed expansion. DCOPN does not anticipate that the applicant will have difficulty securing the needed staff, or that doing so will have a significant negative impact on existing facilities.

While DCOPN has calculated a large surplus of skilled nursing beds for the 2022 planning horizon, DCOPN nonetheless contends that approval of the proposed project is warranted. First, approval of the proposed project would alleviate the over utilized inventory at ACA while simultaneously improving utilization of the Forest complement. Secondly, approval of the project would result in an additional 16 private rooms within PD 11, without adding to the existing surplus. Accordingly, DCOPN maintains that approval of the proposed project is far more advantageous than maintaining the status quo.

DCOPN Staff Recommendation

The Division of Certificate of Public Need recommends **approval** of Autumn Care of Altavista, LLC's request to add eight nursing home beds through transfer from within PD 11 for the following reasons:

1. The proposed project is generally consistent with the applicable criteria and standards of the State Medical Facilities Plan and the Eight Required Considerations of the Code of Virginia.

2. The proposed project is more favorable than maintaining the status quo.

3. The capital costs are reasonable.

4. The proposed project appears economically viable both in the immediate and in the long-term.

5. Approval of the proposed project is not likely to have a significant negative impact on the staffing and utilization of existing PD 11 facilities.