

Certificate of Need Application Form

Version 03.2011

Name of Applicant	Bayada Nurses, Inc.
Title of Application	Bayada Nurses Certificate of Need Application
Date of Submission	January 9, 2012
Type of review	<input checked="" type="checkbox"/> Regular Review <input type="checkbox"/> Accelerated Review (complete Appendix A) <input type="checkbox"/> Expeditious Review (provide letter from the state agency)
Tax Status of Applicant	<input type="checkbox"/> Non-Profit <input checked="" type="checkbox"/> For-Profit

Pursuant to Chapter 15, Title 23 of The General Laws of Rhode Island, 1956, as amended, and Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R23-15- CON).

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

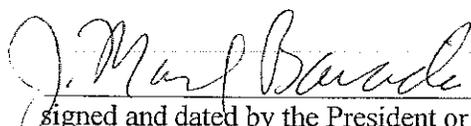
<p>Please have the appropriate individual attest to the following: <i>"I hereby certify that the information contained in this application is complete, accurate and true."</i></p> <p align="center">  12/27/2011 signed and dated by the President or Chief Executive Officer </p>
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PROJECT DESCRIPTION AND CONTACT INFORMATION

1.) Please provide below an Executive Summary of the proposal.

Bayada Nurses submits its Certificate of Need application to the Rhode Island Department of Health as part of its plans for expansion and greater offering of services. Currently Bayada Nurses maintains three office suites at the location 2 Charles Street in Providence, Rhode Island. Under the Home Nursing Care license number of HNC02278 we offer Adult Skilled Visit Care, Adult Skilled Shift Care, Adult Personal Care and Support Services, Pediatric Skilled Shift Care, and Pediatric Personal Care. It is the intention of Bayada Nurses to move the Adult Skilled Visit Care aspect of our business to a new location that has yet to be determined, the Visit Care office will maintain the current Home Nursing Care license and Medicare certification when they move to a new location. This will allow us to provide a greater focus on the private duty nursing and personal care services to our clients while expanding these services. This move necessitate a new Home Nursing Care license to be obtained for the 2 Charles Street location. The Certificate of Need application is required to have a new license in order to maintain our services at 2 Charles Street, Suite 1A in Providence. Having two locations will allow us to provide more focused and specialized care for our patients, as well as offer them enhanced services and reach more people in Rhode Island who need care.

2.)

Capital Cost	\$0	From responses to Questions 10 and 11
Operating Cost	\$1,000,600.00	For the first full year after implementation, from response to Question 18
Date of Proposal Implementation	04/2012	Month and year

3.) Please provide the following information:

Information of the applicant:

Name:	Bayada Nurses, Inc.	Telephone #:	856-778-4400
Address:	101 Executive Drive, Suite 4, Moorestown, New Jersey	Zip Code:	08057-4236

Information of the facility (if different from applicant):

Name:	Bayada Nurses, Inc.	Telephone #:	401-330-2525
Address:	2 Charles Street, Suite 1A, Providence, Rhode Island	Zip Code:	02904

Information of the Chief Executive Officer:

Name:	Joseph Mark Baiada	Telephone #:	856-231-1000
Address:	290 Chester Avenue, Moorestown, New Jersey	Zip Code:	08057-4236
E-Mail:	<u>mbaiada@bayada.com</u>	Fax #:	856-231-1955

Information for the person to contact regarding this proposal:

Name:	Cristin Toscano	Telephone #:	973-267-1754
Address:	32 Maple Avenue, 1st Floor, Morristown, New Jersey	Zip Code:	07960
E-Mail:	<u>ctoscano@bayada.com</u>	Fax #:	973-656-0003

4.) Select the category that best describes the facility named in Question 3.

Freestanding ambulatory surgical center Home Care Provider

Home Nursing Care Provider Hospital

Hospice Provider

Inpatient rehabilitation center (including drug/alcohol treatment centers)

Multi-practice physician ambulatory surgery center

Multi-practice podiatry ambulatory surgery center

Nursing facility Other (specify): _____

5.) Please select each and every category that describes this proposal.

- A. construction, development or establishment of a new healthcare facility;
- B. a capital expenditure for:
 - 1. health care equipment in excess of \$2,250,000;
 - 2. construction or renovation of a health care facility in excess of \$5,250,000;
 - 3. an acquisition by or on behalf of a health care facility or HMO by lease or donation;
 - 4. acquisition of an existing health care facility, if the services or the bed capacity of the facility will be changed;
- C. any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers);
- D. any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, which ever is greater, and for which the related capital expenditures do not exceed \$2,000,000
- E. the offering of a new health service with annualized costs in excess of \$1,500,000;
- F. predevelopment activities not part of a proposal, but which cost in excess of \$5,250,000;
- G. establishment of an additional inpatient premise of an existing inpatient health care facility;
- H. tertiary or specialty care services: full body MRI, CT, cardiac catheterization, positron emission tomography, linear accelerators, open heart surgery, organ transplantation, and neonatal intensive care services. Or, expansion of an existing tertiary or specialty care service involving capital and/or operating expenses for additional equipment or facilities;

HEALTH PLANNING AND PUBLIC NEED

6.) Please discuss the relationship of this proposal to any state health plans that may have been formulated by the state agency, including the Health Care Planning and Accountability Advisory Council, and any state plans for categorically defined programs. In your response, please identify all such priorities and how the proposal supports these priorities.

This proposal is closely related to and in the interest of Rhode Island state health plans as a great number of our patients are covered by them. Our office in Providence saw the greatest utilization of our home health services from state Medicaid recipients, accounting for 70% of our business in fiscal year 2011. We serve patients of varying medical needs who are covered state health plans such as the DEA Waiver and Katie Becket Waiver. In 2011 our office served 4 EDS Waiver patients accounting for 39 service hours, 83 EPSDT Waiver patients accounting for 165,192.25 service hours and 208 A&D waiver patients accounting for 336,558.75 service hours. We also provide PCA services as well as substitute nursing and one-on-one care for area school districts and their students. Through the implementation of Certificate of Need application we intend to continue and even grow our services to state health plans and the communities in which we reside. We feel that the State's Medicaid population, especially those covered by waiver programs, are those that require the highly skilled care and attention our professional staff can provide.

7.) On a separate sheet of paper, please discuss the proposal and present the demonstration of the public need for this proposal. Description of the public need must include at least the following elements:

A. Please identify the documented availability and accessibility problems, if any, of all existing facilities, equipments and services available in the state similar to the one proposed herein:

Name of Facility/Service Provider	List similar type of Service/Equipment	Documented Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance from Applicant (in miles)
Home Care Solutions	Home Health	Yes	Yes	1.1 Miles
Memorial Hospital Home Care	Home Health	No	Yes	4.4 Miles
Vital Care of Rhode Island	Home Health	No	Yes	4.1 Miles
VNS of Greater Rhode Island	Home Health	No	Yes	8.5 Miles
VNS of Newport & Bristol Counties	Home Health	No	Yes	26; 33; 15 Miles

B. Please discuss the extent to which the proposed service or equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment, including those identified in (A) above.

The proposed services will not result in any unnecessary duplication of existing services, including those specified in question A because the services are already in place. Our request for a new Certificate of Need is to continue to provide the quality home care services that our clients and community have come to expect and need from Bayada Nurses, Inc. Additionally out of 46 agencies providing non-skilled care surveyed by the Rhode Island Department of Health, Bayada Nurses was the only agency to provide therapists and other professional staff to patients. Among other services such as nursing, home health aides and homemakers/companions Bayada Nurses ranked within the state average of all agencies. For all parameters of patient satisfaction ranked by the Rhode Island Department of Health Bayada Nurses ranked at or above the state average for skilled and non-skilled services.

C. Please identify the cities and towns that comprise the primary and secondary service area of the facility. Identify the size of the population to be served by this proposal and (if applicable) the projected changes in the size of this population.

From our office in Providence we provide home health care services to all towns in the counties of Bristol, Kent, Newport, Providence and Washington. These counties had 2010 populations of 49,875; 166,158; 82,888; 626,667; and 126,979 respectively. On average the population of these counties decreased by 0.3% over the last ten years. The U.S. Census Bureau projects that the population of Rhode Island will grow by 7.6% of 2010 levels by 2015, and 8.8% and 9.0% from 2010 levels in 2020 and 2025 respectively.

D. Please identify the health needs of the population in (C) relative to this proposal.

21.3% of Rhode Island's population was under the age of 18 in 2010 and an additional 14.4% were over the age of 65. These two groups comprise the majority of Bayada's service population. Bayada has recognized and specializes in a smaller aspect of the Rhode Island community that requires high tech care. We feel that those children and adults who have the most difficulty providing for themselves deserve our care and attention.

E. Please identify utilization data for the past three years (if existing service) and as projected through the next three years, after implementation, for each separate area of service affected by this proposal. Please identify the units of service used.

Actual (last 3 years)	FY 2008	FY 2009	FY 2010
Hours of Operation	8,736	8,736	8,736
Utilization (#)	228,811	312,219	357,342
Throughput Possible (#)	416,000	416,000	416,000
Utilization Rate (%)	55.0%	75.1%	85.9%

Projected	FY 2011	FY 2012	FY 2013
Hours of Operation	8,736	8,736	8,736
Utilization	375,209	393,970	413,668
Throughput Possible	416,000	416,000	416,000
Utilization Rate (%)	90.2%	94.7%	99.4%

F. Please identify what portion of the need for the services proposed in this project is not currently being satisfied, and what portion of that unmet need would be satisfied by approval and implementation of this proposal.

Bayada wishes to continue to provide the highly skilled care throughout Rhode Island that other Home Health Agencies are not able to provide. We specialize in skilled nursing and high tech care that service a smaller community of patients that have a greater need. For our lines of adult care services the majority of cases we handle are for those individuals with debilitating dementia, congestive heart failure, Alzheimer's Disease and COPD. Amongst pediatric patients we provide even more highly skilled care as the majority of our cases are for patients with convulsions, extremely premature infants, cerebral palsy, and esophageal reflux. Without Bayada Nurses these patients may not be able to find competent and reliable home care and be forced to depend on emergency services or alternate living situations. Beyond the medical care that our nurses and aides provide to the patient population they also provide social support. The connection and personal relationship that our staff makes with clients is important to their well being and recovery. In 2008 the Rhode Island Department of Health stated that 20% of the adult population 18 or older did not receive adequate social support. By having the ability to expand our business with a new Certificate of Need Bayada will be able to further address and care for those that lack adequate social support.

G. Please identify and evaluate alternative proposals to satisfy the unmet need identified in (F) above, including developing a collaborative approach with existing providers of similar services.

If the Certificate of Need is not approved by the Rhode Island Department of Health, Bayada Nurses will continue to provide all services out of the current office setting. This will inhibit growth of service however as our client base has expanded enough to warrant a separate office space and staff dedicated to lines of service.

H. Please provide a justification for the instant proposal and the scope thereof as opposed to the alternative proposals identified in (G) above.

Approval of Bayada's Certificate of Need proposal will allow our business to continue to grow and patient care expand according to company plans. If we are able to secure new office space we will be able to further dedicate staff and resources to each line of service we provide. The freeing up of space will allow us to better utilize our resources and achieve greater efficiency in caring for our clients.

HEALTH DISPARITIES AND CHARITY CARE

8.) The RI Department of Health defines health disparities as inequalities in health status, disease incidence, disease prevalence, morbidity, or mortality rates between populations as impacted by access to services, quality of services, and environmental triggers. Disparately affected populations may be described by race & ethnicity, age, disability status, level of education, gender, geographic location, income, or sexual orientation.

A. Please describe all health disparities in the applicant's service area. Provide all appropriate documentation to substantiate your response including any assessments and data that describe the health disparities.

Rhode Island's population is at or below national averages in almost all areas of adverse medical conditions. Despite a relatively healthy population however health disparities still exist. Four areas are of particular concern for Bayada Nurses and would be the target of our services.

Rhode Island averaged 22.2 deaths per 100,000 population due to Alzheimer's Disease in 2007.

In 2009, 913 births of low birth weight occurred in the state, representing 8.0% of all births. The percentages varied by race and ethnicity, those who identified as non-Hispanic Black average 10.5% low birth weight births while the percentage for those identified as Hispanic stood at 7.8%. Both percentages are higher than for those who identified as White where the average was 7.4%

In 2010 7.85% of the population of Rhode Island had diabetes, this correlated with the percentage of diabetes related deaths per 100,000 population which stood at 19.2% in 2007. In the same year 24% of male deaths were related to Diabetes while 15.7% of female deaths were Diabetes related. No statistical data exists for the number of Diabetes related deaths in Rhode Island by race/ethnicity but nationally the Black population suffers from a higher prevalence of the disease than both White and Hispanic. It is safe to assume that this trend also exists in the state of Rhode Island. Diabetes deaths also vary by age group. In 2005 6.8 deaths occurred per 100 adult population. While the prevalence of the disease was lower amongst those 65-74 and 75+, the percentages of resulting deaths were 17.7% and 16.4% respectively.

Finally, the percent of adults who participated in moderate to vigorous physical activity in Rhode Island in 2009 stood at 48.3%. While this is a very broad metric, nationally the elderly do not receive enough physical activities.

All figures and information have been included with this application and are available through the US Census Bureau and statehealthfacts.org.

B. Discuss the impact of the proposal on reducing and/or eliminating health disparities in the applicant's service area.

Implementation of Bayada Nurses' Certificate of Need application will help to reduce the above noted Rhode Island health disparities in the following ways. First, our nurses are trained to provide services to the most demanding and high-tech of cases. We specialize in providing daily care to those with Alzheimer's disease. While no cure exists for this terrible disease and treatments have largely proven ineffective Bayada Nurses seeks to help these individuals live their lives with dignity.

We provide services to the entire state of Rhode Island, however our presence in Providence will help us address the State's health disparities for Diabetes. 88% of the State's African American population and 90.1% of the State's Hispanic population lives within Providence County. This means our services are more visible to these populations than the other counties in which we serve. Additionally, 55.5% of the population that is 65 or older resides in Providence County, providing the same benefit. While the majority of our services occur in the county of Providence our services and clients in all the State's counties are none-the-less important. We will continue to strive to further reach out to these communities, provide greater services and reduce health disparities that occur.

Much the same as with Diabetes, our presence in Providence will help to address the racial disparities that occur with low birth weight. The African-American population suffers from a 10.5% prevalence of low birth weight which is considerably higher than the White population. Through our services we hope to reach more of this population to have a positive effect on the disparity.

Finally, through the implementation of our Certificate of Need application we will look to continue to serve the elderly and disabled population through our Home Health Aides. These professionals help our clients with the important Activities of Daily Living (ADL). Helping our clients become more active and independent is part of our mission and doing so with compassion, excellence, and reliability is of the utmost importance.

While Bayada Nurses seeks to reduce health disparities within the state of Rhode Island our services are offered and completed without consideration or age, race, creed, disability, sexual orientation, veteran status, lifestyle, ethnicity or gender. Bayada Nurses value individual differences and demographic variables. We maintain an environment that is open and accepting of all people, regardless of their race, religion, gender, national or geographic origin, disability, sexual orientation or age.

Bayada Nurses shows sensitivity to the cultural beliefs of our clients, fellow employees, and the community. We respect the customs of all people and ensure that every effort is made to adhere to client's guidance and direction when providing care in their homes. A copy of our Client Agreement Form and Client Admission Booklet has been included to further illustrate our commitment to our clients.

9.) Please provide a copy of the applicant's charity care policies and procedures and charity care application form.

No formal application exists for those seeking charity care. Need is determined on a per client basis taking many factors into consideration including but not limited to clinical diagnosis, established need, and financial considerations. Clients can either be accepted into charity care from the onset of their care or once their relationship with Bayada Nurses has been established. Please see attached policy #0-5603 Uncompensated Care – RI for our formal policies regarding charity care.

FINANCIAL ANALYSIS

10.) A) Please itemize the capital costs of this proposal. Present all amounts in thousands (e.g., \$112,527=\$113). If the proposal is going to be implemented in phases, identify capital costs by each phase.

CAPITAL EXPENDITURES		
	Amount	Percent of Total
Survey/Studies	\$0	%
Fees/Permits	\$0	%
Architect	\$0	%
"Soft" Construction Costs	\$0	%
Site Preparation	\$0	%
Demolition	\$0	%
Renovation	\$0	%
New Construction	\$0	%
Contingency	\$0	%
"Hard" Construction Costs	\$0	%
Furnishings	\$0	%
Movable Equipment	\$0	%
Fixed Equipment	\$0	%
"Equipment" Costs	\$0	%
Capitalized Interest	\$0	%
Bond Costs/Insurance	\$0	%
Debt Services Reserve ¹	\$0	%
Accounting/Legal	\$0	%
Financing Fees	\$0	%
"Financing" Costs	\$0	%
Land	\$0	%
Other (specify)	\$0	%
"Other" Costs	\$0	%
TOTAL CAPITAL COSTS	\$0	100%

¹ Should not exceed the first full year's annual debt payment.

B.) Please provide a detailed description of how the contingency cost in (A) above was determined.

This Certificate of Need application required no capital expenditures of Bayada Nurses as it is the intention to retain our current office setting as is, no new lines of service

intend to be offered at this time, and our patient demographics are well known and previously researched.

C.) Given the above projection of the total capital expenditure of the proposal, please provide an analysis of this proposed cost. This analysis must address the following considerations:

i. The financial plan for acquiring the necessary funds for all capital and operating expenses and income associated with the full implementation of this proposal, for the period of 6 months prior to, during and for three (3) years after this proposal is fully implemented, assuming approval.

Our Bayada Nurses office in Providence, Rhode Island is completely self-sufficient financially and has been profitable for many years. We expect this trend to continue and even grow should the Certificate of Need application be approved. The Providence office also has the backing of the entire Bayada Nurses organization and all its resources should the need arise.

ii. The relationship of the cost of this proposal to the total value of your facility's physical plant, equipment and health care services for capital and operating costs. **Bayada Nurses will only have to provide capital to cover the fees for the Certificate of Need application. As such it only represents a small fraction of the equity and revenue that we have enjoyed through our physical presence in Providence as well as the services that we provide.**

iii. A forecast for inflation of the estimated total capital cost of the proposal for the time period between initial submission of the application and full implementation of the proposal, assuming approval, including an assessment of how such inflation would impact the implementation of this proposal.

Bayada Nurses does not anticipate the inflation will be a factor for the implementation of this proposal as the funding has all been sourced internally.

11.) Please indicate the financing mix for the capital cost of this proposal. **NOTE:** the Health Services Council's policy requires a minimum 20% equity investment in CON projects (33% equity minimum for equipment-related proposals).

Source	Amount	Percent	Interest Rate	Terms (Yrs.)	List source(s) of funds (and amount if multiple sources)
Equity*	\$2,000	100%			Internal revenues and funds
Debt**	\$0	0%	0%		
Lease**	\$0	0%	0%		
TOTAL	\$2,000	100%			

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged (R23-15-CON).

** If debt and/or lease financing is indicated, please complete **Appendix F**.

12.) Will a fundraising drive be conducted to help finance this approval? Yes ___ No X

13.) Has a feasibility study been conducted of fundraising potential? Yes ___ No X

- If the response to Question 13 is 'Yes', please provide a copy of the feasibility study.

14.) Will the applicant apply for state and/or federal capital funding? Yes ___ No X

- If the response to Question 14 is 'Yes', please provide the source: _____, amount: _____, and the expected date of receipt of those monies: _____.

15.) Please calculate the yearly amount of depreciation and amortization to be expensed.

Depreciation/Amortization Schedule - Straight Line Method					
	Improvements	Equipment		Amortization	Total
		Fixed	Movable		
Total Cost	\$0	\$0	\$0	\$0	\$0 *1*
(-) Salvage Value	\$0	\$0	\$0	\$0	\$0
(=) Amount Expensed	\$0	\$0	\$0	\$0	\$0
(/) Average Life (Yrs.)					
(=) Annual Depreciation	\$0	\$0	\$0	\$0	\$0 *2*

1 Must equal the total capital cost (Question 10 above) less the cost of land and less the cost of any assets to be acquired through lease financing

2 Must equal the incremental "depreciation/amortization" expense, column -5-, in Question 18 (below).

16.) For the first full operating year of the proposal (identified in Question 18 below), please identify the total number of FTEs (full time equivalents) and the associated payroll expense (including fringe benefits) required to staff this proposal. Please follow all instructions and present the payroll in thousands (e.g., \$42,575=\$43).

Personnel	Existing		Additions/(Reductions)		New Totals	
	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes
Medical Director		\$		\$		\$
Physicians		\$		\$		\$
Administrator		\$		\$		\$
RNs	25	\$227.3	1	\$114	26	\$238.7
LPNs	24	\$192.8	1	\$96	25	\$202.5

	EXISTING		ADDITIONS		NEW TOTALS	
	# FTE'S	PAYROLL W/FRINGES	# FTE'S	PAYROLL W/FRINGES	# FTE'S	PAYROLL W/FRINGES
Nursing Aides		\$		\$		\$
PTs		\$		\$		\$
OTs		\$		\$		\$
Speech Therapists		\$		\$		\$
Clerical		\$		\$		\$
Housekeeping		\$		\$		\$
Other: (HHA)	125	\$569.0	3	\$284	128	\$597.4
TOTAL	174	\$989.1	5	\$494	179	\$1,038.6

1 Must equal the incremental "payroll w/fringes" expense in column -5-, Question 18 (below).

INSTRUCTIONS:

- "FTEs" Full time equivalents, are the equivalent of one employee working full time (i.e., 2,080 hours per year)
- "Additions" are NEW hires;
- "Reductions" are staffing economies achieved through attrition, layoffs, etc. It does NOT report the reallocation of personnel to other departments.

17.) Please describe the plan for the recruitment and training of personnel.

The Office Director will oversee all recruitment efforts and test available media and copy approaches to increase qualified applicants. The Director will employ a wide scope approach to the recruitment of employees and a particular emphasis will be placed on employee referrals. Directors will also devote time each quarter to a reactivation campaign of former employees. Those that have separated from Bayada Nurses in good standing will be contacted in an attempt to rehire them.

All potential field employees must be able to provide a minimum of two positive, verifiable references and must have at least one year of related work experience. Prior to an interview candidates must complete an Employee Application, a Skills Checklist, and the Employee Integrity Insurance Coverage Application. After a successful interview each potential candidate will complete a written exam/skills review for their particular professional field. All testing must be conducted under Bayada Nurses' or designee's supervision with the prospective employees achieving the required passing score. Any missed answers must be reviewed with the test taker until 100% mastery of the information is verified.

After the written examination is successfully mastered a conditional offer of employment is made pending the satisfactory completion of the following paperwork

- Job Placement Medical Questionnaire
- I-9 Form
- W-4 Form
- Work History Investigation Forms
- RN/LPN Experience Verification Forms (as applicable)
- Agreement of Standards

- **Criminal Background Check**
- **Child Abuse Screening (only required if work with client under 18 years old is anticipated and in states where available)**

Bayada Nurses promotes and provides initial and ongoing education for employees to perform successfully in their positions and to advance their knowledge and skills. Every field employee receives a complete orientation to Bayada Nurses and to their position prior to providing care independently. This orientation includes comprehensive instruction, discussion, and the distribution of reference materials for the employee. At a minimum the Becoming a Hero: A Guide to Bayada Nurses, Staying Healthy: A Guide to Infection Control, and Honesty and Confidentiality Handouts are provided as a reference to all employees at orientation and may be accessed at any time during employment in the Personnel Manual. The in-office orientation is paid and includes:

- a) **The Bayada Way, Mission and Core Values**
- b) **Standards of Performance and review of Agreement of Standards signed by the employee**
- c) **Roles of the employee and office team members**
- d) **Job Description and Performance Evaluation Procedures**
- e) **Process for being offered case assignments**
- f) **Requirements for following the Plan of care/service and reporting changes**
- g) **Process for completing time records and clinical documentation**
- h) **Payroll procedures and pay including time spent providing client care, documentation and travel between cases**
- i) **Respect and Security of client property**
- j) **Standards of honest in work and maintaining the confidentiality of client information**
- k) **Standards of honesty billing and documentation**
- l) **Compliance Program and employee reporting procedures, including use of Compliance Hotline and reporting of safety and quality of care issues**
- m) **On Call set-up and procedures**
- n) **Client Rights and Responsibilities including Advance Directive Information**
- o) **Infection control and Bloodborne pathogen transmission and prevention of exposure including Hep B, Hep C, and TB management**
- p) **Hand Hygiene practice and Standard Precautions**

- q) **Proper identification, handling, and disposal of hazardous or infectious materials and wastes**
- r) **Use and provision of Personal Protective Equipment**
- s) **Maintaining a safe environment and basic home safety**
- t) **Proper storage, handling and access to supplies, medical gases, and drugs, when appropriate**
- u) **Information regarding personal safety issues and appropriate responses in unsafe situations**
- v) **Proper use and maintenance of equipment, as applicable to the care being provided**
- w) **Incident, adverse event and medical device reporting**
- x) **Ethics Committee**
- y) **Emergency Preparedness**
- z) **General discussion about home care, client needs, common problems, community resources, etc.**

Prior to working independently in the home, all nurses and therapy staff must complete a required minimum number of orientation hours or visits in the field with a Clinical Manager or qualified RN preceptor, or Clinical Manager or supervisory therapist, respectively. This time is used to observe performance and skills in the home, and provide guided practice and instruction as needed. Evidence of field orientation is documented.

There is a specific orientation to each case assignment which is presented before an employee begins a new case. This can be accomplished from the office when assigning the case, either over the telephone or in person, and/or on-site at the client's home by the supervising clinician at the start of service. Included in this specific orientation is review of:

- **The specific care and service needs of the client, as indicated in the care or service plan**
- **The community in which the client lives and the resources available in the area**
- **The correct use and management of any equipment required in the care of the client**
- **The correct storage, handling, and access to any drugs, medical gases or supplies needed in caring for the client**
- **The care, if any, that is being provided by other Bayada employees, for better coordination**

Every field employee must complete a minimum number of hours of in-service education each calendar year in addition to in-services completed as part of orientation/training. In-service topics are chosen to best cover the most relevant. Clinical Leader, Educators and office Directors keep abreast of the education needs throughout the company and in the individual offices, respectively. Field staff is also encouraged to present suggestions for in-service topics and education. Bayada Nurses is continuously adding to the materials in the company and individual office in-service libraries and on-line resources.

18.) Please complete the following pro-forma income statement for each unit of service. Present all dollar amounts in thousands (e.g., \$112,527=\$113). Be certain that the information is accurate and supported by other tables in this worksheet (i.e., "depreciation" from Question 15 above, "payroll" from Question 16 above). If this proposal involved more than two separate "units of service" (e.g., pt. days, CT scans, outpatient visits, etc.), insert additional units as required.

PRO-FORMA P & L STATEMENT FOR WHOLE FACILITY					
	Actual Previous Year 2010 (1)	Budgeted Current Year 2011 (2)	<-- FIRST FULL OPERATING YEAR 2012 -->		
			CON Denied (3)	CON Approved (4)	Incremental Difference *1* (5)
REVENUES:					
Net Patient Revenue	\$846.0	\$989.2	\$778.9	\$1,038.6	\$259.7
Other:	\$0	\$0	\$0	\$0	\$0
Total Revenue	\$846.0	\$989.2	\$778.9	\$1,038.6	\$259.7
EXPENSES:					
Payroll w/Fringes	\$716.4	\$827.5	\$819.5	\$868.9	\$4.94
Bad Debt	\$6.5	\$9.5	\$10.0	\$10.0	\$0
Supplies	\$5.7	\$5.7	\$4.5	\$6.0	\$1.5
Office Expenses	\$15.4	\$19.6	\$15.5	\$20.6	\$5.1
Utilities	\$10.0	\$4.6	\$4.9	\$4.9	\$0
Insurance	\$0	\$0	\$0	\$0	\$0
Interest	\$0	\$0	\$0	\$0	\$0
Depreciation/Amortization	\$3.0	\$3.8	\$4.0	\$4.0	\$0
Leasehold Expenses	\$0	\$0	\$0	\$0	\$0
Other: (specify Advertising, Support Office Expenses)	\$735.0	\$821.0	\$647.0	\$862.0	\$215.0
Total Expenses	\$830.5	\$952.8	\$923.1	\$1,000.6	\$775.0
OPERATING PROFIT:	\$155.0	\$364.0	\$-144.2	\$380.0	\$-182.2

For each service to be affected by this proposal, please identify each service and provide: the utilization, average net revenue per unit of services and the average expense per unit of service.

Service Type:	Home Health Care				
Service (#s):					
Net Revenue Per Unit *8*	\$23.67	\$26.36	\$26.31	\$26.36	\$0.05
Expense Per Unit	\$23.24	\$25.39	\$31.19	\$25.39	\$-5.80

INSTRUCTIONS: Present all dollar amounts (except unit revenue and expense) in thousands.

- *1* The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column -3-.
- *2* Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.
- *3* Payroll with fringe benefits (column -5-) equals that identified in Question 16 above.
- *4* Bad Debt is the same as that identified in column -4-.
- *5* Interest Expense equals the first full year's interest paid on debt.
- *6* Depreciation equals a full year's depreciation (Question 15 above), not the half year booked in the year of purchase.
- *7* Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service;
- *8* Net Revenue per unit (of service) is the actual average net reimbursement received from providing each unit of service; it is NOT the charge for that service.

19.) Please provide an analysis and description of the impact of the proposed new institutional health service or new health equipment, if approved, on the charges and anticipated reimbursements in any and all affected areas of the facility. Include in this analysis consideration of such impacts on individual units of service and on an aggregate basis by individual class of payer. Such description should include, at a minimum, the projected charge and reimbursement information requested above for the first full year after implementation, by payor source, and shall present alternate projections assuming (a) the proposal is not approved, and (b) the proposal is approved. If no additional (incremental) utilization is projected, please indicate this and complete this table reflecting the total utilization of the facility in the first full fiscal year.

Pending approval of the Certificate of Need proposal Bayada Nurses anticipates no deviation from the Standard Charges for Rhode Island, a schedule of which has been attached. These rates serve only as a base line for our company and are often negotiated to rates that are more favorable to our payors and clients. Considerations are also given to those individuals who are self-pay and rates are further negotiated.

Additionally Bayada Nurses also anticipates no further utilization or change in case mix pending approval of the Certificate of Need. It is our goal however to better utilize our current resources and improve efficiency in order to gradually increase the number of patients we see and their utilization rates.

Projected First Full Operating Year: FY 2012									
Payor Mix	Implemented			Not Implemented			Difference		
	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue
	#	%	\$	#	%	\$	#	%	\$
Medicare	0	0	\$0	0	0	\$0	0	0	0
RI Medicaid	235,389	69.9%	\$3,494,354.59	164,733	63.8%	\$2,446,048.21	70,656	-6.1%	\$1,048,306.38
Non-RI Medicaid	0	0	\$0	0	0	\$0	0	0	0
RiteCare	0	0	\$0	0	0	\$0	0	0	0
Blue Cross	926	0.2%	\$24,415.83	788	0.3%	\$20,753.46	138	+0.1%	\$3,662.37
Commercial	55,901	16.6%	\$1,098,239.34	53,106	20.6%	\$1,043,327.37	2,795	+4.0%	\$54,911.97
HMO's	0	0	\$0	0	0	\$0	0	0	0
Self Pay	28,099	8.3%	\$350,144.08	25,290	9.9%	\$315,129.67	2,809	+1.6%	\$35,014.41
Charity Care	3,600	1.2%	\$0	2,600	1%	\$0	1,000	-0.2	\$0
Other: Contracts (Schools, Local Agencies, Etc)	12,891	3.8%	\$262,113.91	11,344	4.4%	\$230,660.24	1,547	+0.6%	\$31,453.67
TOTAL	336,806	100%	\$5,229,267.75	257,861	100%	\$4,055,918.95	78,945	0%	\$1,173,348.80

20.) Please provide the following:

A. Please provide audited financial statements for the most recent year available.

Please refer to the audited financial statements that have been included with this proposal.

B. Please discuss the impact of approval or denial of the proposal on the future viability of the (1) applicant and (2) providers of health services to a significant proportion of the population served or proposed to be served by the applicant.

Denial of the Certificate of Need application will not threaten the viability of the Bayada Nurses' Providence office nor will it significantly affect the professional staff which we employ. Approval of the application however will strengthen the viability of the Providence office and Bayada Nurses as a whole and may lead to further employment of professional staff.

21.) Please identify the derivable operating efficiencies, if any, (i.e., economies of scale or substitution of capital for personnel) which may result in lower total or unit costs as a result of this proposal.

If the Certificate of Need is implemented, Bayada Nurses anticipates no identifiable derivable operating efficiencies to occur initially as a result. However given the opportunity

to apply greater focus and possibly expand our services at our location in Providence may result in increased efficiency that will allow us to reassess our unit costs to a lower rate.

22.) Please describe on a separate sheet of paper all energy considerations incorporated in this proposal.

As we have not had to undertake any ventures such as construction to complete this proposal we feel that we have achieved the maximum energy efficiency possible in the space in which we operate. At Bayada Nurses we take energy conservation seriously not only for the financial benefit it provides but for the social responsibility we feel we have towards the communities in which we operate.

23.) Please comment on the affordability of the proposal, specifically addressing the relative ability of the people of the state to pay for or incur the cost of the proposal, at the time, place and under the circumstances proposed. Additionally, please include in your discussion the consideration of the state's economy.

Bayada Nurses' anticipates that this proposal will be a minimal, if at all, a financial burden to the State of Rhode Island and that any costs incurred by the Department of Health in the processing of this application should be fully covered by the fees associated and included.

We feel that our continued business and prosperity in the State of Rhode Island will only benefit its economy. As a business that is fortunate enough to achieve a large and steady revenue stream we help the State's economy through our tax contribution, the large amount of professional and non-professional staff that we employ, the services that we provide to state agencies, the State population that we care for and the burden that we potentially remove from the State in doing so. We view ourselves as a positive contributor to the State's economy and will look to strengthen our contribution pending the approval of our Certificate of Need application.

QUALITY, CONTINUITY OF CARE, AND RELATIONSHIP TO THE HEALTH CARE SYSTEM

24.) A) If the applicant is an existing facility:

Please identify and describe any outstanding cited health care facility licensure or certification deficiencies, citations or accreditation problems as may have been cited by appropriate authority. Please describe when and in what manner this licensure deficiency, citation or accreditation problem will be corrected.

The Bayada Nurses' office in Providence, Rhode Island has not outstanding licensure or certification deficiencies, citations or accreditation problems. To the best of our knowledge our office and company are in good standing with the Department of Health, the State of Rhode Island, and any accrediting and regulatory bodies which oversee us.

B) If the applicant is a proposed new health care facility:

Please describe the quality assurance programs and/or activities which will relate to this proposal including both inter and intra-facility programs and/or activities and patient health outcomes analysis whether mandated by state or federal government or voluntarily assumed. In the absence of such programs and/or activities, please provide a full explanation of the reasons for such absence.

C) If this proposal involves construction or renovation:

Please describe your facility's plan for any temporary move of a facility or service necessitated by the proposed construction or renovation. Please describe your plans for ensuring, to the extent possible, continuation of services while the construction and renovation take place. Please include in this description your facility's plan for ensuring that patients will be protected from the noise, dust, etc. of construction.

25.) Please discuss the impact of the proposal on the community to be served and the people of the neighborhoods close to the health care facility who are impacted by the proposal.

26.) Please discuss the impact of the proposal on service linkages with other health care facilities/providers and on achieving continuity of patient care.

27.) Please address the following:

- A. How the applicant will ensure full and open communication with their patients' primary care providers for the purposes of coordination of care;
- B. Discuss the extent to which preventive services delivered in a primary care setting could prevent overuse of the proposed facility, medical equipment, or service and identify all such preventative services;
- C. Describe how the applicant will make investments, parallel to the proposal, to expand supportive primary care in the applicant's service area.

D. Describe how the applicant will use capitalization, collaboration and partnerships with community health centers and private primary care practices to reduce inappropriate Emergency Room use.

E. Identify unmet primary care needs in your service area, including “health professionals shortages”, if any (information available at Office of Primary Care and Rural Health at <http://www.health.ri.gov/disease/primarycare/hpsa-professionals.php>).

28.) Please discuss the relationship of the services proposed to be provided to the existing health care system of the state.

The services provided by our office in Providence are complimentary to the State health care system, Medicaid, State agencies and entities. As illustrated in the Projected First Full Operating Year table we anticipate service to State Medicaid beneficiaries to provide the majority of our utilization and revenue. Additionally we have multiple existing contracts with State Agencies and local entities such as public schools.

Select and complete the Appendixes applicable to this application:

Appendix	Check off:	Required for:
A		Accelerated review applications
B		Applications involving provision of services to inpatients
C		Nursing Home applications
D		All applications
E		Applications with healthcare equipment costs in excess of \$1,000,000 and any tertiary/specialty care equipment
F		Applications with debt or lease financing
G		All applications

Appendix A

Request for Expeditious Review

- 1.) Name of applicant: _____
- 2.) Indicate why an expeditious review of this application is being requested by marking at least one of the following with an 'X'.
 - _____ a. for emergency needs documented in writing by the state fire marshal or other lawful authority with similar jurisdiction over the relevant subject matter;
 - _____ b. for the purpose of eliminating or preventing fire and/or safety hazards certified by the state fire marshal or other lawful authority with similar jurisdiction of the relevant subject matter as adversely affecting the lives and health of patients or staff;
 - _____ c. for compliance with accreditation standards failure to comply with which will jeopardize receipt of federal or state reimbursement;
 - _____ d. for such an immediate and documented public health urgency as may be determined to exist by the Director of Health with the advice of the Health Services Council.
- 3.) For each response with an 'X' beside it in Question 2 above, furnish documentation as indicated:
 - 2.a: a written communication from the State Fire Marshal or other lawful authority with similar jurisdiction over the relevant subject matter setting forth the particular emergency needs cited and the measures required to meet the emergency;
 - 2.b: documentation from the State Fire Marshal or other lawful authority with similar jurisdiction of the relevant subject matter certifying that particular fire and/or safety hazards currently exist which adversely affect the life and health of patients or staff and outlining the measures which must be taken in order to alleviate these hazards;
 - 2.c: a written communication from the accrediting agency naming specific deficiencies and required remedies for situations failure of compliance with which will jeopardize receipt of federal or state reimbursement;
 - 2.d: a complete description and documentation of the immediate and documented public health urgency, which, in the applicant's opinion, necessitates an expeditious review.

Appendix B

Provision of Health Services to Inpatients

1. Are there similar programmatic alternatives to the provision of institutional health services as proposed herein which are superior in terms of:
 - a. Cost Yes No
 - b. Efficiency Yes No
 - c. Appropriateness Yes No
2. For each No response in Question 1, discuss your finding that there are no programmatic alternatives superior to this proposal separately for each such finding.
3. For each Yes response in Question 1, identify the superior programmatic alternative to this proposal, and explain why that superior alternative was rejected in favor of this proposal separately for each such finding..
4. In the absence of proposed institutional health services proposed herein, will patients encounter serious problems in obtaining care of the type proposed in terms of:
 - a. Availability Yes No
 - b. Accessibility Yes No
 - c. Cost Yes No
5. For each Yes response in Question 4, please justify and provide supporting evidence separately for availability, accessibility and cost.

Appendix C

Nursing Home Proposals

1. Provide the current patient census at the facility by payer source in the table below.
 Date of Census ___/___/___, Licensed bed capacity_____.

Payor	Number of Patients	Percent of Total
Medicare		%
RI Medicaid		%
Non-RI Medicaid		%
Private Pay		%
Veterans		%
Other: (specify _____)		%
TOTAL:		100%

2. Please complete the following Medicaid per diem worksheet for the facility.

Expense	COSTS		REIMBURSEMENT		MAXIMUM RATE	
	Current FY 20__	First FY 20__ Project Approved (proposed)	Current FY 20__	First FY 20__ Project Approved (proposed)	Current FY 20__	First FY 20__ Project Approved (proposed)
Pass Through Cost Center						
Fair Rental Cost Center						
Direct Labor Cost Center						
Other Operating Expenses						
TOTAL:						

3. Pursuant to Section 5.8 of the Rules and Regulations for Licensing of Nursing Facilities (R23-17-NF), please demonstrate that the applicant or proposed license holder shall have sufficient resources to operate the nursing facility at licensed capacity for thirty (30) days, evidenced by an unencumbered line of credit, a joint escrow account established with the Department, or a performance bond secured in favor of the state or a similar form of security satisfactory to the Department, if applicable.

4. Complete the following itemization of projected utilization and net patient revenue for the first full operating year.

Payors	Implemented	Not Implemented	Incremental Difference
MEDICAID			
Per Diem Revenue			
Patient Days			
Total Revenue			
MEDICARE			
Per Diem Revenue			
Patient Days			
Total Revenue			
COMMERCIAL			
Per Diem Revenue			
Patient Days			
Total Revenue			
PRIVATE PAY			
Per Diem Revenue			
Patient Days			
Total Revenue			
VETERANS			
Per Diem Revenue			
Patient Days			
Total Revenue			
Other			
Per Diem Revenue			
Patient Days			
Total Revenue			
TOTAL PATIENT REVENUE			
TOTAL PATIENT DAYS			

5. Based on the format below, please provide a summary of the applicant's administrative and operational policies and procedures to provide individualized and resident-centered care, services, and accommodations, and a sense of peace, safety, and community, and clearly identify how the proposal would advance these areas:

- a. Resident's physical environment:
 - i. Accommodations for privacy vs. congregate and common areas;
 - ii. Choice and autonomy in personal space, fixtures, furniture;
 - iii. Access to and involvement in decentralized services, such as, community kitchen(s), laundry, activities;

- iv. Access to outdoors and outdoor activities (e.g., sunrooms, patios, gardens and gardening);
- b. Resident-centered systems of care:
- i. Security systems and care delivery systems to foster autonomy, choice, and negotiated risk;
 - ii. Individualized daily/nightly scheduling (e.g., daily rhythm, going to bed, waking);
 - iii. Dining flexibility (e.g., time, access to dining style and menu choice);
 - iv. Lifestyle/activities flexibility;
- c. Workforce administration:
- i. How do staffing schedules and assignments ensure consistent delivery of resident services and foster relationship building?
 - ii. Administrative status strategies for dealing with licensed staff turn-over (e.g. Registered nurses, Licenses Practical nurses, Nursing Assistants)

Appendix D

All applications must be accompanied by responses to the questions posed herein.

1. Provide a description and schematic drawing of the contemplated construction or renovation or new use of an existing structure and complete the Change in Space Form.

This proposal does not reflect a plan for any construction, renovation, or new use of the existing space in which we currently operate.

2. Please provide a letter stating that a preliminary review by a Licensed architect indicates that the proposal is in full compliance with the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" and identify the sections of the guidelines used for review. Please include the name of the consulting architect, and their RI Registration (license) number and RI Certification of Authorization number.

This proposal does not involve any construction, renovation or change or space to the office in which we currently reside, therefore a licensed architect was not consulted prior to submission of the proposal. Evidence of facility compliance is evident is the approval and subsequent approvals of our Rhode Island Department of Health Office of Facilities Regulation license, number HNC02278, for this space.

3. Provide assurance and/or evidence of compliance with all applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

This proposal does not involve any construction, renovation or change or space to the office in which we currently reside, therefore a licensed architect was not consulted prior to submission of the proposal. Evidence of facility compliance is evident is the approval and subsequent approvals of our Rhode Island Department of Health Office of Facilities Regulation license, number HNC02278, for this space.

4. Does the construction, renovation or use of space described herein corrects any fire and life safety, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), U.S. Department of Health and Human Services (DHHS) or other code compliance problems: Yes _____ No X

- o If Yes, include specific reference to the code(s). For each code deficiency, provide a complete description of the deficiency and the corrective action being proposed, including considerations of alternatives such as seeking waivers, variances or equivalencies.

5. Describe all the alternatives to construction or renovation which were considered in planning this proposal and explain why these alternatives were rejected.

This proposal does not involve and construction or renovation.

6. Attach evidence of site control, a fee simple, or such other estate or interest in the site including necessary easements and rights of way sufficient to assure use and possession for the purpose of the construction of the project.

This proposal does not involve any construction necessitating any site control.

7. If zoning approval is required, attach evidence of application for zoning approval.

Zoning approval is not required for any aspect of this proposal.

8. If this proposal involves new construction or expansion of patient occupancy, attach evidence from the appropriate state and/or municipal authority of an approved plan for water supply and sewage disposal.

This proposal does not involve any new construction or expansion of patient occupancy that necessitates state or municipal approval for water supply and sewage disposal.

9. Provide an estimated date of contract award for this construction project, assuming approval within a 120-day cycle.

This proposal does not involve any construction.

10. Assuming this proposal is approved, provide an estimated date (month/year) that the service will be actually offered or a change in service will be implemented. If this service will be phased in, describe what will be done in each phase.

Pending approval of this proposal services will continue on unfettered.

Change in Space Form Instructions

The purpose of this form is to identify the major effects of your proposal on the amount, configuration and use of space in your facility.

Column 1

Column 1 is used to identifying discrete units of space within your facility, which will be affected by this proposal. Enter in Column 1 each discrete service (or type of bed) or department, which as a result of this proposal is:

- a.) to utilize newly constructed space
- b.) to utilize renovated or modernized space
- c.) to vacate space scheduled for demolition

In each of the Columns 3, 4, and 5, you are requested to disaggregate the construction, renovation and demolition components of this proposal by service or department. In each instance, it is essential that the total amount of space involved in new construction, renovation or demolition be totally allocated to these discrete services or departments listed in Column 1.

Column 2

For each service or department listed in Column 1, enter in this column the total amount of space assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 3

For each service or department, please fill in the amount of space which that service or department is to occupy in proposed new construction. The figures in Column 3 should sum to the total amount of space of new construction in this proposal.

Column 4

For each service or department, please fill in the amount of space, which that service or department is to occupy in space to be modernized or renovated. The figures in column 4 should sum to the total amount of space of renovation and modernization in this proposal.

Column 5

For each service or department fill in the amount of currently occupied space which is proposed to be demolished. The figures in Column 5 should sum to the total amount of space of demolition specified in this proposal.

Column 6

For each service or department entered in Column 1, enter in this column the total amount of space which will, upon completion of this project, be assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 7

Subtract from the amount of space shown in Column 6 the amount shown in Column 2. Show an increase or decrease in the amount of space.

Change in Space Form

Please identify and provide a definition for the method used for measuring the space (i.e. gross square footage, net square footage, etc.):

1. Service or Department Name	2. Current Space Amount	3. New Construction Space Amount	4. Renovation Space Amount	5. Amount of Space Currently Occupied to be Demolished	6. Proposed Space Amount	7. Change [(6)-(2)]
TOTAL:						

Appendix E

Acquisition of Health Care Equipment Valued in Excess of \$1,000,000 or Tertiary/Specialty Care Equipment

Complete separate copies of this appendix for each piece of such equipment contained in this application.

1. Identify the proposed equipment (and current if it is being replaced) and at least two similar alternative makes or models that were considered for acquisition in the following format

	Current Equipment	Proposed Equipment	Alternative 1	Alternative 2
Type of Equipment				
Name of Manufacturer				
Make and Model Number				
Capital Cost of Equipment				
Operating Cost				

2. Describe the clinical application for which the proposed equipment will be used.
3. Please identify the reasons the alternative two options were rejected in favor of the proposed equipment
4. If the proposal is to replace current existing equipment, please provide the following information:

	Current Equipment
Date of Acquisition	
Expected Salvage Value	
Remaining Useful Life	
Method of disposition	

5. Please state below the number of new full-time equivalent personnel by job category whom you will hire in order to operate the proposed equipment.

Job Category	Number of FTE's	Payroll Expense

6. Please describe below your anticipated utilization for this equipment for each of the three fiscal years following acquisition of this equipment.

Fiscal Year	20__	20__	20__
Hours of Operation			
Utilization			
Potential Throughput			
Utilization Rate (%)			

Appendix F

Financing

Applicants contemplating the incurrence of a financial obligation for full or partial funding of a certificate of need proposal must complete and submit this appendix.

1. Describe the proposed debt by completing the following:
 - a.) type of debt contemplated: _____
 - b.) term (months or years): _____
 - c.) principal amount borrowed _____
 - d.) probable interest rate _____
 - e.) points, discounts, origination fees _____
 - f.) likely security _____
 - g.) disposition of property (if a lease is revoked) _____
 - h.) prepayment penalties or call features _____
 - i.) front-end costs (e.g. underwriting spread, feasibility study, legal and printing expense, points etc.) _____
 - j.) debt service reserve fund _____
2. Compare this method of financing with at least two alternative methods including tax-exempt bond or notes. The comparison should be framed in terms of availability, interest rate, term, equity participation, front-end costs, security, prepayment provision and other relevant considerations.
3. If this proposal involves refinancing of existing debt, please indicate the original principal, the current balance, the interest rate, the years remaining on the debt and a justification for the refinancing contemplated.
4. Present evidence justifying the refinancing in Question 3. Such evidence should show quantitatively that the net present cost of refinancing is less than that of the existing debt, or it should show that this project cannot be financed without refinancing existing debt.
5. If lease financing for this proposal is contemplated, please compare the advantages and disadvantages of a lease versus the option of purchase. Please make the comparison using the following criteria: term of lease, annual lease payments, salvage value of equipment at lease termination, purchase options, value of insurance and purchase options contained in the lease, discounted cash flows under both lease and purchase arrangements, and the discount rate.
6. Present a debt service schedule for the chosen method of financing, which clearly indicates the total amount borrowed and the total amount repaid per year. Of the amount repaid per year, the total dollars applied to principal and total dollars applied to interest must be shown.
7. Please include herewith an annual analysis of your facility's cash flow for the period between approval of the application and the third year after full implementation of the project.

Appendix G

Ownership Information

All applications must be accompanied by responses to the questions posed herein.

1. List all officers, members of the board of directors, trustees, stockholders, partners and other individuals who have an equity or otherwise controlling interest in the applicant. For each individual, provide their home and business address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

Joseph Mark Baiada – President, CEO & Founder of Bayada Nurses, Inc.

100% controlling interest of Bayada Nurses, Inc.

Home Address:

741 Mill Street

Moorestown, NJ 08057

Business Address:

290 Chester Avenue

Moorestown, NJ 08057

2. For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

Joseph Mark Baida is the President and CEO of Bayada Nurses, Inc. and maintains a 100% controlling interest of the company and is its only shareholder. Please see the attached list of Bayada Nurses, Inc. locations, their license, accreditation and Medicare provider numbers.

3. If any individual listed in response to Question 1 above, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

Joseph Mark Baiada does not have any business relationship with any companies that provide financial services, professional services or any business-related merchandise that is supplied to Bayada Nurses, Inc.

4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes ___ No X .

- If response is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

5. Please provide organization chart for the applicant, identifying all "parent" entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all subsidiary entities owned by the applicant. Please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals

have in each (if applicable), and the role of each and every legal entity that will have control over the applicant.

Bayada Nurses, Inc. does not have any “parent” entity or companies that have indirect ownership or control, nor does it have any legal “sister” entities under its control. Please see the attached organization chart that applies to the governmental structure of our company and our office in Providence.

6. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 5 above (applicant and/or its principals). For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

Please refer to the list of office locations and specific information referenced in the answer to question 2 of Appendix G that are all wholly owned by Bayada Nurses’ President and CEO, Joseph Mark Baiada.

7. Have any of the facilities identified in Question 5 or 6 above had: A) federal conditions of participation out of compliance, B) decertification actions, or C) any actions towards revocation of any state license? Yes ___ No X
- If response is 'Yes', please identify the facility involved, the nature of each incident, and the resolution of each incident.
8. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 or 6 above during the last 5-years had bankruptcies and/or were placed in receiverships? Yes ___ No X
- If response is 'Yes', please identify the facility and its current status.
9. For applications involving establishment of a new entity or involving out of state entities, please provide the following documents:
- Certificate and Articles of Incorporation and By-Laws (for corporations)
 - Certificate of Partnership and Partnership Agreement (for partnerships)
 - Certificate of Organization and Operating Agreement (for limited liability corporations)



statehealthfacts.org

Your source for state health data

kff.org kaiserhealthnews.org kaiseredu.org healthreform.kff.org globalhealth.kff.org

Rhode Island: Number of Deaths Due to Alzheimer's Disease per 100,000 Population, 2007

Compare Rhode Island to:

Number of Deaths Due to Alzheimer's Disease per 100,000 Population, 2007		View 50-St
RI	22.2	US
		22.7 ¹

(show/hide notes)



statehealthfacts.org

Your source for state health data

kff.org
 kaiserhealthnews.org
 kaiseredu.org
 healthreform.kff.org
 globalhealth.kff.org

Rhode Island: Number of Births of Low Birthweight, 2009

Compare Rhode Island to:

Number of Births of Low Birthweight, 2009

	RI #	RI % of US Total	US #	% C
	913	0.3%	336,747	

View 50-St

(show/hide notes)



statehealthfacts.org

Your source for state health data

kff.org

kaiserhealthnews.org

kaiseredu.org

healthreform.kff.org

globalhealth.kff.org

Rhode Island: Births of Low Birthweight as a Percent of All Births, 2009

Compare Rhode Island to:

Births of Low Birthweight as a Percent of All Births, 2009

[View 50-St](#)

	RI %	US %
	8.0%	8.2%

[\(show/hide notes\)](#)



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globalhealth.kff.org

Rhode Island: Births of Low Birthweight as a Percent of All Births by Race/Ethnicity, 2009

Compare Rhode Island to:

Births of Low Birthweight as a Percent of All Births by Race/Ethnicity, 2009

	RI %	US %
Non-Hispanic White	7.4%	7.2%
Non-Hispanic Black	10.5%	13.6%
Hispanic	7.8%	6.9%
Total	8.0%	8.2%

[\(show/hide notes\)](#)



statehealthfacts.org
 YOUR SOURCE FOR STATE HEALTH DATA

kff.org
kaiserhealthnews.org
kaiseredu.org
healthreform.kff.org
globalhealth.kff.org

Rhode Island: Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes, 201

Compare Rhode Island to:

Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes, 2010	RI %	US %
Yes	7.8%	8.7%
Yes, Pregnancy-Related	1.3%	0.8%
No	88.6%	89.0%
No, Pre-Diabetes or Borderline Diabetes	2.3%	1.2%

[View 50-St](#)

(show/hide notes)



statehealthfacts.org

Your source for state health data

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kaiseredu.org

healthreform.kff.org

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Rhode Island: Prevalence of Diagnosed Diabetes per 100 Adult Population, 2005

Compare Rhode Island to:

Prevalence of Diagnosed Diabetes per 100 Adult Population, 2005

View 50-St

	RI #	US #
	6.8	5.5

(show/hide notes)



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Your source for state health data

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healthreform.kff.org

globalhealth.kff.org

Rhode Island: Prevalence of Diagnosed Diabetes per 100 Adult Population by Age Group, 2005

Compare Rhode Island to:

Prevalence of Diagnosed Diabetes per 100 Adult Population by Age Group, 2005

	RI #	US #
Ages 18-44	2.3	NA ¹
Ages 45-64	7.9	10.2
Ages 65-74	17.7	18.5
Ages 75+	16.4	15.6
Total	6.8	5.5

[\(show/hide notes\)](#)

[View 50-St](#)



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healthreform.kff.org

globalhealth.kff.org

Rhode Island: Number of Diabetes Deaths per 100,000 Population, 2007

Compare Rhode Island to:

Number of Diabetes Deaths per 100,000 Population, 2007

View 50-St

US

RI

22.5¹

19.2

(show/hide notes)



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kaiseredu.org

healthreform.kff.org

globalhealth.kff.org

Rhode Island: Number of Diabetes Deaths per 100,000 Population by Gender, 2007

Compare Rhode Island to:

Number of Diabetes Deaths per 100,000 Population by Gender, 2007

	RI	US
Male	24.0	26.3
Female	15.7	19.5

[\(show/hide notes\)](#)



statehealthfacts.org

Your source for state health data

kff.org

kaiserhealthnews.org

kaiseredu.org

healthreform.kff.org

globalhealth.kff.org

Rhode Island: Percents of Adults who Participated in Moderate or Vigorous Physical Activities, 2009

Compare Rhode Island to:

Percents of Adults who Participated in Moderate or Vigorous Physical Activities, 2009

View 50-St

	RI %	US %
	48.3%	50.9%

(show/hide notes)

2010 Demographic Profile

RI - Rhode Island

Population

Total Population	1,052,567
------------------	-----------

Housing Status (in housing units unless noted)

Total	463,388
Occupied	413,600
Owner-occupied	250,952
Population in owner-occupied (number of individuals)	650,674
Renter-occupied	162,648
Population in renter-occupied (number of individuals)	359,230
Vacant	49,788
Vacant: for rent	15,763
Vacant: for sale	5,171
Vacant: for seasonal/recreational/occasional use	17,077

Population by Sex/Age

Male	508,400
Female	544,167
Under 18	223,956
18 & over	828,611
20 - 24	82,167
25 - 34	126,962
35 - 49	218,160
50 - 64	211,639
65 & over	151,881

Population by Ethnicity

Hispanic or Latino	130,655
Non Hispanic or Latino	921,912

Population by Race

White	856,869
African American	60,189
Asian	30,457
American Indian and Alaska Native	6,058
Native Hawaiian and Pacific Islander	554
Other	63,653
Identified by two or more	34,787

RI - Rhode Island**Population**

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------------------	-----------

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(in housing units unless noted)

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Asian	30,457
American Indian and Alaska Native	6,058
Native Hawaiian and Pacific Islander	554
Other	63,653
Identified by two or more	34,787

2010 Demographic Profile

RI - Bristol County

Population	
Total Population	49,875
Housing Status (in housing units unless noted)	
Total	20,850
Occupied	19,150
Owner-occupied	13,511
Population in owner-occupied (number of individuals)	35,549
Renter-occupied	5,639
Population in renter-occupied (number of individuals)	11,084
Vacant	1,700
Vacant: for rent	575
Vacant: for sale	204
Vacant: for seasonal/recreational/occasional use	536

Population by Sex/Age	
Male	23,951
Female	25,924
Under 18	10,160
18 & over	39,715
20 - 24	3,926
25 - 34	4,355
35 - 49	10,091
50 - 64	10,875
65 & over	8,343

Population by Ethnicity	
Hispanic or Latino	989
Non Hispanic or Latino	48,886

Population by Race	
White	47,752
African American	398
Asian	716
American Indian and Alaska Native	80
Native Hawaiian and Pacific Islander	3
Other	185
Identified by two or more	741

2010 Demographic Profile

RI - Kent County

Population

Total Population	166,158
------------------	---------

Housing Status (in housing units unless noted)

Total	73,701
Occupied	68,645
Owner-occupied	49,046
Population in owner-occupied (number of individuals)	126,217
Renter-occupied	19,599
Population in renter-occupied (number of individuals)	38,405
Vacant	5,056
Vacant: for rent	1,833
Vacant: for sale	805
Vacant: for seasonal/recreational/occasional use	886

Population by Sex/Age

Male	79,969
Female	86,189
Under 18	34,254
18 & over	131,904
20 - 24	9,046
25 - 34	19,083
35 - 49	36,855
50 - 64	37,168
65 & over	26,069

Population by Ethnicity

Hispanic or Latino	5,309
Non Hispanic or Latino	160,849

Population by Race

White	155,219
African American	2,405
Asian	3,378
American Indian and Alaska Native	437
Native Hawaiian and Pacific Islander	39
Other	1,610
Identified by two or more	3,070

2010 Demographic Profile

RI - Newport County

Population		Population by Sex/Age	
Total Population	82,888	Male	40,409
		Female	42,479
		Under 18	16,426
		18 & over	66,462
		20 - 24	5,291
		25 - 34	8,719
		35 - 49	17,210
		50 - 64	18,725
		65 & over	14,063
Housing Status (in housing units unless noted)		Population by Ethnicity	
Total	41,796	Hispanic or Latino	3,512
Occupied	34,911	Non Hispanic or Latino	79,376
Owner-occupied	22,024		
Population in owner-occupied (number of individuals)	52,522	Population by Race	
Renter-occupied	12,887	White	74,729
Population in renter-occupied (number of individuals)	26,790	African American	2,864
Vacant	6,885	Asian	1,288
Vacant: for rent	1,409	American Indian and Alaska Native	315
Vacant: for sale	475	Native Hawaiian and Pacific Islander	63
Vacant: for seasonal/recreational/occasional use	4,164	Other	1,150
		Identified by two or more	2,479

2010 Demographic Profile

RI - Providence County

Population

Total Population	626,667
------------------	---------

Housing Status (in housing units unless noted)

Total	264,835
Occupied	241,717
Owner-occupied	130,368
Population in owner-occupied (number of individuals)	344,247
Renter-occupied	111,349
Population in renter-occupied (number of individuals)	254,635
Vacant	23,118
Vacant: for rent	10,957
Vacant: for sale	2,864
Vacant: for seasonal/recreational/occasional use	1,507

Population by Sex/Age

Male	302,382
Female	324,285
Under 18	137,625
18 & over	489,042
20 - 24	53,338
25 - 34	83,786
35 - 49	128,388
50 - 64	115,734
65 & over	84,389

Population by Ethnicity

Hispanic or Latino	117,819
Non Hispanic or Latino	508,848

Population by Race

White	460,033
African American	53,040
Asian	23,006
American Indian and Alaska Native	4,123
Native Hawaiian and Pacific Islander	420
Other	59,862
Identified by two or more	26,183

2010 Demographic Profile

RI - Washington County

Population

Total Population	126,979
------------------	---------

Housing Status (in housing units unless noted)

Total	62,206
Occupied	49,177
Owner-occupied	36,003
Population in owner-occupied (number of individuals)	92,139
Renter-occupied	13,174
Population in renter-occupied (number of individuals)	28,316
Vacant	13,029
Vacant: for rent	989
Vacant: for sale	823
Vacant: for seasonal/recreational/occasional use	9,984

Population by Sex/Age

Male	61,689
Female	65,290
Under 18	25,491
18 & over	101,488
20 - 24	10,566
25 - 34	11,019
35 - 49	25,616
50 - 64	29,137
65 & over	19,017

Population by Ethnicity

Hispanic or Latino	3,026
Non Hispanic or Latino	123,953

Population by Race

White	119,136
African American	1,482
Asian	2,069
American Indian and Alaska Native	1,103
Native Hawaiian and Pacific Islander	29
Other	846
Identified by two or more	2,314



0-5603 UNCOMPENSATED CARE - RI

This policy was adopted on Apr. 14, 2011.

Our Policy:

Bayada Nurses, in accordance with Rhode Island state regulation, provides uncompensated care annually.

Our Practice:

- 1.0 Offices providing home care services licensed in the state of Rhode Island provide uncompensated care.
 - 1.1 The statewide community standard for uncompensated care is one percent of net client revenue earned on an annual basis.
 - 1.2 Uncompensated care is cost adjusted by applying a ratio of costs to charges from the licensee's Medicare Cost Report.
 - 1.3 Licensees not filing Medicare Cost Reports submit an audited financial report or such other report as deemed acceptable to the Director of the Rhode Island Department of Health.
- 2.0 Uncompensated care is reported yearly on the license renewal application.

0-5603 - UNCOMPENSATED CARE - RI

References: **Rules and Regulations for Licensing Home Nursing Care Providers and Home Care Providers [R23-17-HNC/HC/PRO]**

Revisions:

Author(s): LINDSAY EDRIS (2011)

Manual, Section: RHODE ISLAND, POLICIES

Comments:

0-5603 - UNCOMPENSATED CARE - RI

CLIENT AGREEMENT FORM



Client Name: _____ Client #: _____

I. CONSENT TO SERVICES AND RELEASE OF INFORMATION

I have personally, or through my physician, requested home health services from BAYADA NURSES in my home. I consent to such services by the nurses and/or live-ins and/or home health aides and/or therapists and/or social workers and/or homemakers and/or companions of BAYADA NURSES as ordered by me, my family, and/or my physician. I agree that BAYADA NURSES shall be waived of all liability related to or as the result of such services, excepting acts of negligence. I understand that employees may not be CPR certified.

I hereby authorize any and all physicians, hospitals, skilled nursing facilities, and other health care facilities, programs, or agencies who possess my medical records to release to BAYADA NURSES any portions of my medical records or copies of them that BAYADA NURSES may request. I authorize BAYADA NURSES to release and disclose my medical records as required to communicate with my physician, referral sources, accrediting or certifying bodies, or as requested by insurance companies or other payment sources.

II. RECEIPT OF PRIVACY NOTICE

I have received and reviewed the BAYADA NURSES Privacy Notice. I have had an opportunity to ask questions about it. I understand and agree that BAYADA NURSES may notify the police, emergency services, electric company, and/or telephone company about circumstances related to my care for safety reasons or for emergency preparedness.

III. CLIENT'S RIGHTS AND RESPONSIBILITIES

I acknowledge that prior to signing this document, I have received and reviewed a copy of my rights and responsibilities (Section 2 of this Admissions Booklet) and a representative of BAYADA NURSES has explained them to me. I have had an opportunity to ask any additional questions, and my questions have been answered to my satisfaction.

I have been informed, verbally and in writing, of the procedure for filing complaints or concerns about the home care services I am receiving, directly to BAYADA NURSES and to applicable State, Regulatory and Accrediting organizations. I have been provided with the available hotline number(s) and days and hours these organizations can receive complaints or questions about home care agencies. I have also been advised where I may get additional information, including information about Advance Directives, if needed.

I recognize the rights of BAYADA NURSES as an employer and agree not to directly or indirectly employ any BAYADA NURSES employees for a period of 180 days following the last day any individual employee has provided services to me. If I violate this condition, I agree to immediately pay BAYADA NURSES a liquidated damages fee equal to four (4) months of the specific employee's annual gross salary or \$5,000.00, whichever is greater.

IV. ADVANCE DIRECTIVE VERIFICATION

I acknowledge that BAYADA NURSES has given me information about Advance Directives.

I have an Advance Directive (Living Will). Yes No

If Yes, I will give a copy to BAYADA NURSES. Yes No

If Yes, who else has a copy of your Advance Directive?

Name: _____ Relationship: _____

I have a health care representative or Medical Power of Attorney. Yes No

If Yes, who is your health care representative or your Medical Power of Attorney for health care decisions?

Name: _____ Phone #: _____

I understand that in the absence of an Advance Directive and a physician's order not to resuscitate, BAYADA NURSES will take all appropriate measures in an attempt to sustain life.

BAYADA
NURSES
Home Care Specialists

Admission Booklet



Heroes on the Home Front ♦ www.bayada.com

Editor's Note

This admission booklet (#0-2249) was designed specifically for general home care services. A separate admission booklet is available for Medicare certified home health care services (#0-2248). A separate admission booklet is available for pediatric home health services (#0-2550). A separate admission booklet is available in Spanish for general home care services.

A Message from Mark Baiada



J. Mark Baiada

Thank you for choosing Bayada Nurses as your home care provider. We truly appreciate the opportunity to work with you and your family.

Our mission is to help you have a safe home life with comfort, independence and dignity. We call our employees *Heroes on the Home Front* because they deliver home care with compassion, excellence, and reliability; our Bayada Nurses' core values. Not everyone can be a Bayada Nurse, but those selected are a special group who symbolize quality. Our

heroes will do everything in their power to ensure that your home care experience is as pleasant as possible.

This booklet is designed to acquaint you with some of the philosophies and policies that affect you as a Bayada Nurses client. To ensure that you fully understand everything and that your questions are answered, your nurse or therapist will review it with you. However, if you ever have any questions or need further clarification about something, feel free to contact your service office. Our staff are there to support you 24 hours a day, 7 days a week.

Nothing is more important to us than your health and welfare. Therefore, you can rest assured that we are ready to help in the fullest sense. Once again, thank you for the opportunity to serve you and your family.



J. Mark Baiada
President and Owner

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Section 1: How We Work With You

The Home Care Experience

We realize that the home care experience might often feel intrusive or disruptive to you and your family—especially when we first begin providing services. Please realize that it will take a while for our employees to “fit” properly into your home and for you to feel comfortable with them. The more hours of service that we provide, the longer this period of adjustment will probably take.

As guests in your home, we never wish to invade your privacy in any way. Our employees are also instructed to always observe your “house rules.” One of the keys to achieving these goals is honest, two-way communication. Therefore, we always encourage you to voice your concerns, suggestions, and complaints. Also know that our staff will do everything in their power to ease this period of transition and to ensure that your home care experience is a positive one.

Your Care Plan

At the beginning of our service, a nurse or therapist will assess your needs and, together with you, your family, and, if appropriate, your physician, develop a care plan to guide the staff serving you. Throughout our service, we will provide ongoing professional care management and supervision. We will also coordinate our care with all involved parties—you, your family, your physician, and your hospital.

The office staff is always ready to assist you and answer questions. Clinical Managers manage your care plan. Client Services Managers are responsible for scheduling your care, and the Director is available to answer questions.

Pain Management

If your medical condition causes you to experience pain, please tell us. We consider the management of pain an important part of your care. We will work with you, your family, and your doctor to assess and manage your pain.

Emergencies

If there is an environmental disaster or emergency (such as a severe storm or power failure), we have an emergency plan that will be implemented. When you are admitted to our care, we evaluate your situation and assign a risk priority level for services during an emergency. All reasonable efforts will be made to ensure that your home care needs are met.

Helpful Hints

Bayada Nurses is proud of the reputation we have established in the home health care field. Our employees are carefully screened, and we base our placements in your home on the qualifications of the employee.

We thought it might be helpful to share some of our rules and regulations with you. This will give you some guidance as you welcome a Bayada Nurses employee into your home.

- ◆ Our employees are not permitted to accept money or tips. They are paid weekly by Bayada Nurses. Therefore, you should never pay an employee directly. If any employee asks you for payment or money for any reason, please notify the Office immediately.
- ◆ Our employees are instructed not to do banking for their clients, so please try to make other arrangements.
- ◆ We suggest that you do not leave loose cash or valuables around your home. Our reputation supports the integrity and honesty of our employees. However, we feel that money and valuables should be kept in a safe place in order to avoid any misunderstandings.
- ◆ Our employees are not permitted to make or receive personal phone calls from your home. Likewise, they are not to have any visitors or bring anyone with them when they report to work.

- ◆ Our employees are not permitted to give out their personal telephone number or address. If it is necessary for you to reach an employee when off-duty, please call the Office.
- ◆ According to state regulations, Home Health Aides, Homemakers, and Companions are not permitted to provide any skilled nursing services (such as medication administration). Please respect the fact that our employees are instructed to carefully follow the care plan that has been left in your home. If you have a question about an employee's tasks, please contact the Office.

Payment Information

Bayada Nurses participates in many private health insurance, Workers Compensation, auto insurance, VA benefits, and managed care plans. In some states, we also participate in Medicare and Medicaid.

During admission, we will ask you about your insurance coverage and other possible sources of payment for your care. Please note that coverages, co-payments, and deductibles are determined by your insurer and are subject to change. If you have any questions, please check with your insurer. If your insurance plan or source of payment changes for any reason, please tell us immediately so that we can take the proper steps.

We will contact your insurance company or payment source to determine if you have a home health benefit and if we are authorized to provide the services requested. After we have confirmed this information with your insurance company or payment source, we will notify you about your financial responsibility for any applicable co-payments or deductibles. When possible, we will bill the insurance company or payment source directly on your behalf.

We will not bill you for co-payments or deductibles until we have billed your insurer.

After we receive their portion of the payment, we will send you a letter confirming the amount owed. Payment is expected within 14 days of receiving this letter.

If you choose to pay for our services personally, we will bill you on a weekly basis. Payment is expected within 14 days of receiving the invoice. Please send remittances to the payment address indicated on the invoice. If you wish to pay by credit card, please call the Office.

If you have any questions about your bill, please call the Office or the Bayada Nurses Finance Department at 1-800-220-0133 (toll-free).

Medicare

Some Bayada Nurses offices participate in Medicare. The federal government dictates what Medicare covers. Medicare pays for home health services if you meet the following criteria:

- ◆ You are confined to your home (home-bound).
- ◆ The care you need includes visits for skilled nursing care, physical therapy, or speech therapy on a part-time or intermittent basis.
- ◆ You are under a physician's care.

Please note that Medicare does not pay for:

- ◆ Home Health Aide services without accompanying skilled services
- ◆ Around-the-clock nursing care at home
- ◆ Drugs and medicines
- ◆ Blood transfusions
- ◆ Meals delivered to your home
- ◆ Homemaker services
- ◆ Registered dietician services.

If you have questions about Medicare, please call the Office.

Medicaid

Medicaid is a health insurance program that is administered by each state. Eligibility and coverage vary greatly from state to state. Please check with the Office if you believe that you may qualify for Medicaid.

Section 2: Rights and Responsibilities

Your Rights and Responsibilities

Bayada Nurses pledges to honor and protect your rights as a client. All Bayada Nurses clients and their formal caregivers have a right to mutual respect and dignity. Clients also have

the right to have a relationship with their home care provider that is based on honest and ethical standards of conduct. Your rights and responsibilities as a Bayada Nurses client are outlined in this section.

Your Rights Regarding Decision-Making

- ◆ To jointly participate with BAYADA NURSES in the initial planning of care (including the care to be provided and the schedule) and in any change in the care plan before the change is made.
- ◆ To be notified in writing of the care to be furnished, the type of caregivers who will provide this care, and the frequency and duration of the visits.
- ◆ To refuse services or request a change in caregivers without fear of reprisal or discrimination.
- ◆ To be informed of the consequences of refusing all or part of the planned care. If you do not follow the care plan and if this threatens to compromise BAYADA NURSES' commitment to quality care, BAYADA NURSES or your physician may need to refer you to another source of care.
- ◆ To participate in the selection of caregivers to provide the care.
- ◆ To be informed of the right to formulate an Advance Directive (also known as a Living Will) and BAYADA NURSES' policies regarding such rights; to have Advance Directives respected to the extent provided by law; and to receive service whether or not an Advance Directive has been executed.
- ◆ To be informed about the outcomes of care, including unanticipated outcomes.
- ◆ To participate in experimental treatments or research, only after voluntary and informed consent is obtained.
- ◆ To have a health care representative, appointed by you or designated in your Medical Power of Attorney, make health care decisions for you.
- ◆ To have your appointed family member or guardian exercise your rights in the event that you have been judged incompetent.

Your Rights Regarding Complaints

- ◆ To be informed of the procedure to follow to register complaints about BAYADA NURSES, the care provided, or any lack of respect for your property, including the availability, purpose, and appropriate use of hot line numbers.
- ◆ To know that appropriate action has been taken in response to your complaint.
- ◆ To voice your concerns without fear of discrimination or reprisal for having done so.

Your Rights Regarding Quality of Care

- ◆ To receive care of the highest quality without regard to race, creed, gender, age, disability, sexual orientation, veteran status, or lifestyle.
- ◆ To be admitted for care only if BAYADA NURSES has the capability to provide the care safely, at the required level of intensity, and in a timely manner, as determined by a professional assessment and BAYADA NURSES' policy.
- ◆ To be told what to do in case of an emergency.
- ◆ To have all skilled services provided in accordance with a physician's orders.
- ◆ To be assured that all services are provided under the supervision of qualified home care professionals.
- ◆ To be informed of discharge procedures, including treatment options, transfers, changes in service, when and why care will be stopped, and instructions for continuing care.
- ◆ To receive an assessment and appropriate management of pain.
- ◆ To be referred to another provider if BAYADA NURSES is unable to meet your needs or if you are dissatisfied with the care you are receiving.
- ◆ To have your property treated with respect.
- ◆ To be free of any mental, physical, sexual and verbal abuse, neglect and exploitation.

Your Rights Regarding Confidentiality

Additional information can be found in Section 3: Confidentiality Matters.

- ◆ To expect confidentiality with regard to information about your health, social, and financial circumstances and what takes place in your home.
- ◆ To expect BAYADA NURSES to release information only as required by law or authorized by you.
- ◆ To access and receive your clinical records and reports on the care provided.

Your Rights Regarding Financial Information

- ◆ To be informed, orally and in writing, of all personal liability for services and any changes in such within 15 days of when BAYADA NURSES was made aware of the change.
- ◆ To be informed of payment sources for BAYADA NURSES' services.
- ◆ To be informed of BAYADA NURSES' liability insurance upon request.
- ◆ To be informed of BAYADA NURSES' ownership and control upon admission and to be informed of any beneficial relationships that may bring profit to BAYADA NURSES when making referrals to another organization.

Your Responsibilities

- ◆ To inform BAYADA NURSES of any treatment changes prescribed by your doctor.
- ◆ To cooperate with BAYADA NURSES' staff in carrying out your care plan.
- ◆ To provide a safe environment for the delivery of care.
- ◆ To call the office if you will not be home when service is scheduled.
- ◆ To provide accurate information about all insurance coverage or payment sources.
- ◆ To inform BAYADA NURSES of any changes in insurance or payment sources.
- ◆ To inform BAYADA NURSES of any Power of Attorney involved in your care or financial matters.
- ◆ To inform BAYADA NURSES of any dissatisfaction with services.
- ◆ To provide the supplies needed for the delivery of care, as indicated in the care plan.
- ◆ To jointly supervise the caregiver with BAYADA NURSES.

Cultural Diversity and Sensitivity

Bayada Nurses value individual differences and demographic variables. We maintain an environment that is open and accepting of all people, regardless of their race, religion, gender, national or geographic origin, disability, sexual orientation, or age.

Bayada Nurses show sensitivity to the cultural beliefs of our clients, fellow employees, and the

community. We respect the customs of all people and ensure that every effort is made to adhere to clients' guidance and direction when providing care in their homes.

Bayada Nurses is committed to compliance with all applicable federal, state, and local laws, as well as any rules, regulations, or accepted practices that ensure equal treatment to all with whom we come in contact.

CLIENT AGREEMENT FORM



Client Name: _____ Client #: _____

I. CONSENT TO SERVICES AND RELEASE OF INFORMATION

I have personally, or through my physician, requested home health services from BAYADA NURSES in my home. I consent to such services by the nurses and/or live-ins and/or home health aides and/or therapists and/or social workers and/or homemakers and/or companions of BAYADA NURSES as ordered by me, my family, and/or my physician. I agree that BAYADA NURSES shall be waived of all liability related to or as the result of such services, excepting acts of negligence. I understand that employees may not be CPR certified.

I hereby authorize any and all physicians, hospitals, skilled nursing facilities, and other health care facilities, programs, or agencies who possess my medical records to release to BAYADA NURSES any portions of my medical records or copies of them that BAYADA NURSES may request. I authorize BAYADA NURSES to release and disclose my medical records as required to communicate with my physician, referral sources, accrediting or certifying bodies, or as requested by insurance companies or other payment sources.

II. RECEIPT OF PRIVACY NOTICE

I have received and reviewed the BAYADA NURSES Privacy Notice. I have had an opportunity to ask questions about it. I understand and agree that BAYADA NURSES may notify the police, emergency services, electric company, and/or telephone company about circumstances related to my care for safety reasons or for emergency preparedness.

III. CLIENT'S RIGHTS AND RESPONSIBILITIES

I acknowledge that prior to signing this document, I have received and reviewed a copy of my rights and responsibilities (Section 2 of this Admissions Booklet) and a representative of BAYADA NURSES has explained them to me. I have had an opportunity to ask any additional questions, and my questions have been answered to my satisfaction.

I have been informed, verbally and in writing, of the procedure for filing complaints or concerns about the home care services I am receiving, directly to BAYADA NURSES and to applicable State, Regulatory and Accrediting organizations. I have been provided with the available hotline number(s) and days and hours these organizations can receive complaints or questions about home care agencies. I have also been advised where I may get additional information, including information about Advance Directives, if needed.

I recognize the rights of BAYADA NURSES as an employer and agree not to directly or indirectly employ any BAYADA NURSES employees for a period of 180 days following the last day any individual employee has provided services to me. If I violate this condition, I agree to immediately pay BAYADA NURSES a liquidated damages fee equal to four (4) months of the specific employee's annual gross salary or \$5,000.00, whichever is greater.

IV. ADVANCE DIRECTIVE VERIFICATION

I acknowledge that BAYADA NURSES has given me information about Advance Directives.

I have an Advance Directive (Living Will). Yes No

If Yes, I will give a copy to BAYADA NURSES. Yes No

If Yes, who else has a copy of your Advance Directive?

Name: _____ Relationship: _____

I have a health care representative or Medical Power of Attorney. Yes No

If Yes, who is your health care representative or your Medical Power of Attorney for health care decisions?

Name: _____ Phone #: _____

I understand that in the absence of an Advance Directive and a physician's order not to resuscitate, BAYADA NURSES will take all appropriate measures in an attempt to sustain life.

CLIENT AGREEMENT FORM



Client Name: _____ Client #: _____

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I have personally, or through my physician, requested home health services from BAYADA NURSES in my home. I consent to such services by the nurses and/or live-ins and/or home health aides and/or therapists and/or social workers and/or homemakers and/or companions of BAYADA NURSES as ordered by me, my family, and/or my physician. I agree that BAYADA NURSES shall be waived of all liability related to or as the result of such services, excepting acts of negligence. I understand that employees may not be CPR certified.

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I understand that in the absence of an Advance Directive and a physician's order not to resuscitate, BAYADA NURSES will take all appropriate measures in an attempt to sustain life.

Client Name: _____ Client #: _____

V. PAYMENT FOR SERVICES RENDERED

I understand that I will be receiving the following types of services from BAYADA NURSES: RN/LPN HHA PT OT ST RD _____

I have provided BAYADA NURSES with complete and accurate information regarding my health insurance and other payment sources. Based on that information, BAYADA NURSES has determined that the following may be available to pay for my care, at the rates quoted, subject to confirmation by my health insurance company or other payment sources. I understand that I will be responsible for all co-payments, deductibles and non-covered services. If my health insurance or other third party payor coverage changes (e.g., the plan, deductible, co-payments, eligibility for coverage), I will immediately inform BAYADA NURSES and I understand that I will be financially responsible for any changes in terms or changes due to misinformation provided by the insurance company to Bayada Nurses related to co-payments, deductibles, non-covered services or eligibility for services.

- Medicare will pay in full for home care services.
- Medicaid will pay for the home care services with a co-payment from me of \$_____.
- Private Medical Insurance, Managed Care Company, or other Third Party Payor will pay BAYADA NURSES for the home care services provided, with a co-payment or deductible from me estimated to be \$_____.
- Other sources of payment: _____.
- Private Home Care Insurance will pay for home care services with a co-payment or deductible from me estimated to be \$_____.
- Private Pay: I am responsible for the total amount of the bill. Charges are: \$_____.

VI. ASSIGNMENT OF INSURANCE BENEFITS

I assign to BAYADA NURSES all benefits payable under any insurance policy for services rendered by BAYADA NURSES and specifically authorize the appropriate insurance carrier to pay such benefits directly to BAYADA NURSES. BAYADA NURSES may submit a copy of this assignment to the appropriate insurer in lieu of the original. I authorize the insurer to rely on a copy of this assignment. I understand that this assignment shall not relieve me or any of my guarantors of responsibility for payment of services rendered by BAYADA NURSES, including payments for any co-payments and deductibles that may be required by my insurance carrier, unless otherwise required by law.

VII. GUARANTEE OF PAYMENT

I agree to be responsible for the payment of all services provided to me by BAYADA NURSES, unless otherwise required by law. I further agree to pay interest on any past due balances at the rate of 1.25% per month (15% per year), and I agree to pay the reasonable costs of collection, including attorney's fees and expenses. I understand the rates and my financial obligations for these services. I understand that if payment is not received for any services for which I am financially responsible, these services will be discontinued.

All sections of this Agreement have been reviewed with me; I understand and agree to the provisions outlined above. The information that I have provided above is truthful and complete. With my signature below, I agree to be legally bound and acknowledge receipt of a copy of this Agreement.

 _____ <i>Signature of Client</i>	_____ <i>Social Security #</i>	_____ <i>Date</i>	_____ <i>Witness</i>
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_____ <i>Representative, Relationship & Reason Client Unable to Sign</i>	_____ <i>Date</i>	_____ <i>Witness</i>
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VIII. SECONDARY GUARANTOR

If the client cannot, will not or does not pay for the services provided by BAYADA NURSES, I/we guarantee to pay for them in full.

 _____ <i>Guarantor's Signature & Name (print)</i>	_____ <i>Social Security #</i>	_____ <i>Date</i>	_____ <i>Witness</i>
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Section 3: Confidentiality Matters

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Bayada Nurses respects your confidentiality. We have policies and procedures in place that protect your personal health information. In addition, federal and state governments oversee home health care to be sure that we take reasonable steps to keep anything we learn about you confidential.

Collection and Use of Personal Health Information

To provide services to you, we must collect information about you and your health care needs from you and from others (*e.g.*, hospitals, physicians, family members, other caregivers, insurance companies). We may also share information about you and your health care needs with them and the members of our health care team.

Here are some examples of how we may use your personal health information.

- ◆ To communicate with your physician about your care to obtain directions and orders for keeping your care plan up-to-date.
- ◆ To share information about your care with your insurer or health plan in order to receive authorization and payment for your care.
- ◆ For review and learning purposes within our company to help ensure that we are providing quality care.

For other disclosures not related to your treatment, payment to Bayada Nurses, or our general health care operations, we must have your signature on a specific authorization form.

For example, if you change doctors, we will need your authorization to release your records to your new doctor.

There are a few situations where we may release information about your care **without** seeking your permission. These are all clearly defined in laws and government regulations, which we must follow. For example:

- ◆ When a law enforcement official presents us with a subpoena, warrant, or court order to see your records.
- ◆ When an accrediting body asks to see your records to ensure that we are providing quality health care.
- ◆ When a government regulatory agency or oversight board asks to see your records to ensure that we are conforming to laws and regulations, including the Health Insurance Portability and Accessibility Act (HIPAA).

Your Rights

You have the right:

- ◆ **To know and see information about your care in our files and to request copies of your medical chart.** You must give us reasonable time to prepare for your visit to the Office to see the records or to make copies of your information. If you cannot see the records personally, you may designate someone to do so on your behalf. We may deny your request to see your records if your physician tells us that doing so is not in your best interest.

- ◆ To request that certain people NOT have access to your personal health information. Please provide the names to our staff. We will make our best effort to comply.
- ◆ To ask us to amend information in our files that you think is incorrect or incomplete. You may use our "Request to Amend My Personal Health Information Form" for this purpose. Under some circumstances we may deny your request. This may happen if:
 - We did not create the information.
 - The medical information is not kept by us.
 - The information is accurate and complete.
- ◆ To request an accounting of any disclosures that you did not authorize. This is a list of any releases of your medical information that is not related to treatment, payment, or Bayada Nurses' health care operations. To request an accounting of disclosures, please contact the Office.

Visual Images

Photographs, videotapes, and digital or other images may need to be recorded to document your care. Bayada Nurses retains ownership rights to these photographs, videotapes, and digital or other images. We will take reasonable steps to store them in a secure manner in order to protect your privacy. You have the right to view these images or to obtain copies.

E-Mail

Bayada Nurses may occasionally communicate information about your care via e-mail (electronic mail). Bayada Nurses uses reasonable means to protect the security and confidentiality of e-mail information that is sent and received. The following precautions are taken with e-mail that contains confidential information.

- ◆ When possible, we will remove any detailed identifying information (e.g., refer to you by first name and last initial or by our internal client number instead of by your full name).

- ◆ We will print all e-mails about your health care treatment or payment and make them part of your record.

Bayada Nurses does not use e-mail to communicate sensitive medical information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disabilities, or substance abuse. If there are other types of information you do not wish to be transmitted via e-mail, please notify us as soon as possible.

We recommend that any e-mail you or third parties send regarding your treatment by Bayada Nurses should only be sent to an e-mail address at Bayada Nurses (i.e., an address ending in bayada.com).

Bayada Nurses employees endeavor to read and respond to e-mails promptly. However, we recommend that you avoid using e-mail for emergencies or time-sensitive matters.

Changes to This Notice

If we change the privacy or confidentiality practices described in this section, we will give you a revised copy of this notice. Copies are also available in our Office and on our web site. If you would like to receive another copy of this notice, please ask your Client Services Manager or Clinical Manager.

Questions

If you feel your confidentiality rights have been violated or if you have any questions or concerns regarding possible violations of your privacy, please contact our Office or the Bayada Nurses' Privacy Officer using the methods below.

**Toll-Free Compliance Hot Line:
1-866-665-4295**

**Compliance E-Mail Address:
hotline@bayada.com**

You may also file a complaint with the Office for Civil Rights of the U.S. Department of Human Services.

Effective Date: April 14, 2003

Section 4: Making Your Wishes Known

Your Rights

You have the right to make decisions concerning your medical care. These include:

- ◆ The right to accept or refuse medical or surgical treatment
- ◆ The right to execute an Advance Directive
- ◆ The right to execute a Medical Power of Attorney or appoint a health care representative.

You are not required to have an Advance Directive to receive medical treatment.

What Is An Advance Directive?

An Advance Directive (sometimes called a Living Will) is a document that specifies the treatment you would want and would not want if you were terminally or irreversibly ill and unable to communicate those wishes yourself. You can provide written instructions regarding care that you wish to receive and instructions for withholding or withdrawing life-prolonging treatment.

What Is A Medical Power of Attorney?

A Medical Power of Attorney is a legal document that gives someone else the authority to make medical decisions for you.

Through a Medical Power of Attorney or by designating a health care representative, you can permit another person to make treatment decisions for you in the event that you are incapable of doing so.

Resources and Forms

There are many resources for Advance Directive and Medical Power of Attorney forms. They are available in many doctors' offices and hospitals, as well as your local governmental office on aging or social services. Your attorney or legal advisor may also have them. Forms and

information are also available from the Partnership for Caring—a national, nonprofit organization devoted to raising consumer awareness on end-of-life care and medical decisions. You may call them toll-free at 1-800-989-9455 or visit their web site at the following address: www.partnershipforcaring.org.

Please remember that requirements for Advance Directives and Medical Powers of Attorney vary from state to state. Therefore, you should look for information specific to your state.

Because an Advance Directive has important legal, physical, and emotional implications, you may wish to discuss it with your family, doctor(s), legal advisor, and spiritual counselor before signing. Be sure to carefully read all materials before you sign, and do not sign anything unless you fully understand the information. Ask questions if there is anything you do not understand.

Who Needs to Know?

If you have prepared an Advance Directive or Medical Power of Attorney (or have designated a health care representative), you should tell:

- ◆ Your doctor
- ◆ Bayada Nurses
- ◆ Your family
- ◆ Your health care representative or Medical Power of Attorney
- ◆ Close friends (only if they are involved in your health care).

You should also give copies of the documents to these people and tell them where the originals are kept. In addition, you should review your Advance Directive periodically and initial and date it to indicate your continuing agreement with what it contains. Properly signed and witnessed, your Advance Directive will remain in effect indefinitely unless revoked.

Bayada Nurses does not require that you have an Advance Directive, but, if you do, we

require a copy for our records so that all of our personnel will be aware of your wishes. We also suggest that you keep a copy of your Advance Directive in an easily identifiable place in your home (*e.g.*, the refrigerator, medicine cabinet, or home care record) so that emergency personnel can locate it quickly.

What If You Change Your Mind?

You may revoke or change your Advance Directive at any time by:

- ◆ A signed, dated written statement
- ◆ Destroying all copies
- ◆ Saying that you want to change it.

Always notify your doctors and your health care providers (including Bayada Nurses) if you execute a new Advance Directive or change or cancel your current Advance Directive. If you complete more than one Advance Directive, make sure that your instructions in each document are consistent with the others.

If you have additional questions after you read this, please call the Office.

In the absence of an Advance Directive and a physician's order not to resuscitate, Bayada Nurses will take all appropriate measures in an attempt to sustain life.

Section 5: Safe At Home

Being Safe In Your Home

Safety in the home is one of our primary concerns. This section provides practical tips on increasing your family's safety and health. By implementing these suggestions, you will have a safer and more comfortable home life.

Environmental Safety

- ◆ Secure loose rugs, runners, and mats to the floor with double-sided adhesive or rubber matting.
- ◆ Tack down carpet edges.
- ◆ Repair, replace, or remove torn, worn, or frayed carpeting.
- ◆ Organize cupboards so that frequently used items are on lower shelves.
- ◆ Use a sturdy step stool to reach items on high shelves.
- ◆ Store heavy items flatly on lower levels of the closet to avoid falls and injuries.
- ◆ Keep stairs, hallways, and passageways between rooms well-lit and free of clutter.
- ◆ Make sure that stairs have sturdy, well-secured handrails on both sides. If needed, install gates to protect children from falls.
- ◆ Avoid using stairs while wearing only socks or smooth-soled shoes.
- ◆ Arrange furniture to allow free movement in heavy traffic areas.
- ◆ Lock up hazardous tools and firearms. Unplug appliances and tools when not in use.
- ◆ Store cleaning fluids, polishes, bleaches, detergents, and all poisons separately and make sure they are clearly marked.
- ◆ Ensure that there is proper ventilation when cleaning agents are being used.

- ◆ Clean up spills promptly.
- ◆ Do not stockpile old newspapers and cleaning cloths.
- ◆ Control insects, rodents, and bad odors.
- ◆ Locate at least one accessible phone in the event that an accident renders a person unable to stand.
- ◆ Post emergency numbers near the phone. Numbers should include: ambulance, doctor, fire department, police, and Bayada Nurses.
- ◆ Clear entranceways of leaves, snow, and ice.

Bathroom Safety

- ◆ Install a textured surface or nonskid mats/ strips in tubs and showers to prevent falls.
- ◆ Install grab-bars to assist transfers in the tub, shower, and toilet areas.
- ◆ Check water temperature with your hand before entering the tub or shower in case the temperature needs to be lowered.
- ◆ Use a night light in the bathroom.
- ◆ Place a bell, buzzer, or appropriate noise-maker in the bathroom for emergency use.
- ◆ Ensure that door locks can be opened from the outside in case of an emergency.
- ◆ Never leave a child alone in a bathtub. A child can drown in a few inches of water.
- ◆ If possible, locate a bathroom on the first floor.

Medication Safety

- ◆ Take medication as ordered. Understand how and when to take each medication.
- ◆ Never take more or less medication than ordered by your doctor.

- ◆ Learn the actions and possible side effects for each medication you are taking. Report any side effects or new symptoms to your doctor and to Bayada Nurses.
- ◆ Store medication where children or confused adults cannot reach them.
- ◆ Discard medications your doctor no longer wants you to take.

Needle and Lancet Safety at Home

If your doctor has ordered medicines to be given by injection, it is important to handle used needles and lancets safely because they may have germs that can cause serious disease. These diseases can also infect a person who is stuck with someone else's used needle or lancet.

Handling Used Needles or Lancets

- ◆ Never hand a used needle or lancet to another person or let someone hand a used needle or lancet to you. Instead, place the needle or lancet on a flat surface for the other person to pick up.
- ◆ Never walk holding a used needle or lancet.
- ◆ Never reach into a needle disposal container.

Throwing Away Used Needles or Lancets

- ◆ Dispose of needles and lancets in an approved container.
- ◆ Pick up the needle or lancet by the non-pointed end.
- ◆ Aim the pointed end into the container and let the needle or lancet drop into the bottle.
- ◆ Close the lid to the bottle and store it in a safe place, away from children.

- ◆ Dispose of the bottle when it is three-quarters full. For proper disposal, screw the lid on tightly, tape the lid, and then throw the bottle in the trash.

Storing Needles and Lancets

- ◆ Store new needles and lancets away from water, which may cause moisture and germs to soak into the package. If the package gets wet, throw it away.
- ◆ Put new needles and lancets in a safe place, away from children and others.

Infection Control at Home

Infections can be spread by people or animals. Certain medical conditions make people more susceptible to infection. Good practices can reduce the chances of infection in your home. Tips for reducing infection include the following.

- ◆ Wash your hands before and after giving care; after coughing, sneezing, or using the toilet; and after contact with blood or body fluids (even if you wear gloves). To wash hands correctly, follow these steps.
 - Wet your hands and rinse under warm, running water.
 - Using a generous amount of soap in the palm of your hands, rub your hands together briskly—making sure to rub and scrub nail and finger areas.
 - Rinse thoroughly.
 - Dry with a paper towel or a clean towel.
 - Turn off the faucet with a paper towel.
- ◆ Cover coughs and sneezes with a tissue. Throw away tissues in a trashcan lined with plastic.
- ◆ Keep rooms as clean as possible. Pay special attention to the kitchen, bathrooms, counter tops, floors, and refrigerator.
- ◆ Make sure each family member has his/her own toothbrush, towel, and washcloth.

- ◆ Wash dishes and laundry used by an infected person in warm soapy water or in a dishwasher or washing machine.
- ◆ Use plastic bags in trashcans. Wash out the trashcan when you empty it. Double-bag an infected person's trash.
- ◆ Cook food thoroughly. Wash your hands thoroughly after handling raw meats and eggs. Clean cutting boards and work surfaces so that raw meats and eggs do not touch any other food.
- ◆ Do not share drinking glasses. Do not eat by dipping food out of a common dish.
- ◆ If you use well water, have the water tested each year. Your local health department can provide information on how to do this.
- ◆ Take precautions when caring for or playing with pets. Keep litter boxes, cages, and aquariums clean. Wash hands after contact with animals.
- ◆ Use electrical appliances safely and have them inspected periodically.
- ◆ Safely dispose of matches, cigarettes, and smoking materials in an ashtray or fire-resistant container.
- ◆ Keep your kitchen stove free of grease, plastics, or cloth materials. Do not wear loose-fitting clothes when cooking. Turn pot handles away from the front of the stove. Always use potholders.
- ◆ Do not leave cooking unattended for extended periods of time.
- ◆ **Do not use oxygen near open flames and heat.** Do not smoke or permit others to smoke while you are using oxygen. Do not use electrical devices (such as electric razors) while using oxygen. Post "No Smoking" signs.
- ◆ Develop a fire safety plan. Guidelines for doing this can be found in the next section.

Tips for Using Gloves

- ◆ Use gloves only once.
- ◆ Wear clean, non-sterile gloves when touching a person's sores or wounds; body fluids (including mucous, urine and stool); and items covered with blood or body fluids.
- ◆ Take gloves off and discard in the trash immediately after use and thoroughly **wash your hands**. This is especially important after changing a diaper or emptying a urinal or bedpan.

Eliminating Fire Hazards

- ◆ Have your furnace and water heater checked at least once a year.
- ◆ Make sure that wood stoves or portable heaters are properly installed. Have chimneys cleaned and inspected every year.
- ◆ Store flammable liquids outside (away from any heat source) and dispose of properly.

Developing a Fire Safety Plan

- ◆ Standard fire regulations recommend having one smoke detector on every level of a home.
- ◆ Develop an evacuation plan for use in case of fire. Note which family members will require assistance because of age, illness, or disability.
- ◆ **Notify the local fire company about residents who will need assistance in the event of fire.**
- ◆ Establish clear pathways to all exits. Do not block exits with furniture or boxes.
- ◆ Have a key accessible near doors locked with deadbolts.
- ◆ Have chimneys inspected annually to avoid a dangerous build-up of creosote.
- ◆ Do not leave kerosene heaters, wood stoves, and fireplaces unattended while in use. Never use a gas stove for space heating.

- ◆ Have a fire extinguisher in an easily accessible place (e.g., the kitchen).

Electrical Safety

- ◆ Do not place cords beneath furniture or rugs.
- ◆ Replace any frayed cords.
- ◆ Do not overload extension cords. Check rating labels on cords and appliances.
- ◆ Do not use multiple outlet adapters on electrical outlets.
- ◆ Cover unused outlets and teach young children not to touch plugs, cords, or outlets.
- ◆ Never replace a fuse with a penny or a higher amp fuse. Use correct-sized fuses at all times.
- ◆ Never turn on an appliance or plug one in while standing in water or when your hands are wet.
- ◆ Call a professional electrician if you suspect an electrical problem. Blown fuses or dimmed lights may indicate a wiring problem.
- ◆ Make sure the electrical system is sufficient when using medical equipment such as ventilators and oxygen concentrators. Check with a medical supplier or electrician if you are unsure.
- ◆ Use three-pronged adapters when required.
- ◆ When walking with a pump, IV pole, electrical cord, or IV tubing, carefully position the equipment between you and the outlet to avoid falls or electrical accidents.

Activity Safety

- ◆ Use walkers, canes, and wheelchairs as recommended.
- ◆ If you have lightheadedness due to low blood sugar or low blood pressure, eat soon after waking up. Keep a drink or snack at your bedside.

- ◆ Change position slowly. Dangle your legs at the side of your bed, sofa, or chair for a few minutes before standing.

- ◆ Place things you use often within easy reach.
- ◆ Avoid climbing and reaching to get to high shelves. Use a reacher or stable step stool with handrails. Do not stand on a chair to reach high shelves.

Protecting Cash and Valuables

- ◆ Store cash, checkbooks, valuable keepsakes, and jewelry in a secure location whenever visitors are present in your home.
- ◆ To protect your home from intrusion, keep your doors locked at all times. Ask visitors to identify themselves before allowing them in your home.
- ◆ Obtain receipts for merchandise purchased or bills paid.
- ◆ Never give your debit card PIN number to anyone other than a trusted family member or friend.

Reporting Safety Concerns

As a Bayada Nurses client, we encourage you and your family to take an active role in your own care. We value your feedback and want to promptly address any concerns or questions you may have about the safety and quality of care you receive. To report concerns so that they can be adequately addressed, you may contact the Clinical Manager, Director or other Bayada Nurses management directly or toll-free via the Compliance Hotline at 1-866-665-4295 or hotline@bayada.com.

The BAYADA[®] Way

Our clients come first.

Our Mission

Bayada Nurses has a special purpose - to help people to have a safe home life with comfort, independence, and dignity. Bayada Nurses provide skilled, rehabilitative, therapeutic, and personal home health care services to children, adults, and seniors nationwide. We care for our clients 24 hours a day, seven days a week.

Families coping with significant illness or disability need help and support while caring for a family member. Our goal at Bayada Nurses is to provide the highest quality home health care services available. We believe our clients and their families deserve home health care delivered with compassion, excellence, and reliability, our Bayada Nurses' core values.

Our Vision for the Future

With a strong commitment from each of us, Bayada Nurses will make it possible for millions of people worldwide to experience a better quality of life in the comfort of their own homes. We want to build and maintain a lasting legacy as the world's most compassionate and trusted team of home health care professionals.

We will accomplish our mission and achieve our vision by following our core beliefs and values.

Our Beliefs

- ◆ We believe our clients come first.
- ◆ We believe our employees are Bayada Nurses' greatest asset.
- ◆ We believe that building relationships and working together are critical to our success as a community of compassionate caregivers.
- ◆ We believe we must demonstrate honesty and integrity at all times.
- ◆ We believe in providing community service where we live and work.
- ◆ We believe it is our responsibility to maintain the organization's strong financial foundation and to support its growth.

Our Values

- ◆ **Compassion.** Our clients and their families feel supported and cared for.
- ◆ **Excellence.** We provide home health care services to our clients with the highest professional, ethical, and safety standards.
- ◆ **Reliability.** Our clients and their families can rely on us and are able to live their lives to the fullest, with a sense of well-being, dignity, and trust.


BAYADA[®]
NURSES
Home Care Specialists
Heroes on the Home Front



Clinical Measures for Home Health Agencies in Rhode Island¹ Alphabetized by Agency, July 2008 – June 2009

	Patients who get better at walking or moving around	Patients who get better at getting in and out of bed	Patients who have less pain when moving around ²	Patients whose bladder control improves	Patients who get better at bathing	Patients who get better at taking their medicines correctly (by mouth)	Patients who are short of breath less often	Patients who stay at home after an episode of home health care ends	Patients who had to be admitted to the hospital ³	Patients who need urgent, unplanned medical care ²	Patients whose wounds improved or healed after an operation ²
Assisted Daily Living, Inc	51% ♦♦	66% ♦♦♦	74% ♦♦♦	55% ♦♦	65% ♦♦	44% ♦♦	69% ♦♦♦	59% ♦	39% ♦	24% ♦♦	81% ♦♦
Bayada Nurses, Inc	51% ♦♦	63% ♦♦♦	64% ♦♦	47% ♦♦	61% ♦♦	39% ♦♦	60% ♦♦	50% ♦	44% ♦	24% ♦♦	87% ♦♦♦
Capitol Home Care Network, Inc	28% ♦	42% ♦	38% ♦	40% ♦♦	41% ♦	18% ♦	42% ♦	54% ♦	41% ♦	31% ♦	N/A
Cathleen Naughton, Inc	42% ♦♦	42% ♦	63% ♦♦	47% ♦♦	57% ♦	29% ♦	58% ♦♦	64% ♦	33% ♦	24% ♦♦	86% ♦♦
Concord Health Services, Inc	46% ♦♦	64% ♦♦♦	67% ♦♦	56% ♦♦♦	67% ♦♦	39% ♦♦	74% ♦♦♦	60% ♦	37% ♦	33% ♦	79% ♦♦
H&T Medicals, Inc	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Home & Hospice Care of RI	38% ♦♦	N/A	N/A	N/A	47% ♦	N/A	N/A	45% ♦	30% ♦♦	8% ♦♦♦	N/A
Home Care Advantage CHC, Inc	55% ♦♦♦	58% ♦♦	75% ♦♦♦	66% ♦♦	66% ♦♦	44% ♦♦	59% ♦♦	53% ♦	43% ♦	30% ♦	84% ♦♦
Interim Healthcare of RI	63% ♦♦♦	72% ♦♦♦	N/A	N/A	69% ♦♦	35% ♦♦	76% ♦♦♦	69% ♦♦	26% ♦♦	28% ♦♦	N/A
Life Care at Home of RI	51% ♦♦	64% ♦♦♦	77% ♦♦♦	64% ♦♦	68% ♦♦	49% ♦♦	76% ♦♦♦	76% ♦♦♦	20% ♦♦♦	24% ♦♦	90% ♦♦
Memorial Hospital Home Care	53% ♦♦♦	61% ♦♦♦	66% ♦♦	55% ♦♦♦	72% ♦♦	49% ♦♦	78% ♦♦♦	62% ♦	36% ♦	31% ♦	84% ♦♦♦
Roger Williams Home Care	44% ♦♦	58% ♦♦♦	67% ♦♦♦	59% ♦♦	58% ♦	42% ♦♦	68% ♦♦♦	68% ♦♦	28% ♦♦	19% ♦♦	79% ♦♦
Saranna Home Care, Inc	54% ♦♦♦	65% ♦♦♦	67% ♦♦	51% ♦♦	64% ♦♦	49% ♦♦	66% ♦♦	71% ♦♦	27% ♦♦	28% ♦	90% ♦♦
Tender Loving Care / Staff Builders Home Care Services	46% ♦♦	53% ♦♦	83% ♦♦♦	59% ♦♦♦	70% ♦♦	47% ♦♦	72% ♦♦♦	64% ♦	32% ♦	28% ♦	96% ♦♦♦
Vital Care of RI, Inc	35% ♦	60% ♦♦♦	62% ♦♦	60% ♦♦♦	60% ♦♦	36% ♦	59% ♦♦	66% ♦♦	30% ♦♦	28% ♦	75% ♦♦
VNA of Care New England	39% ♦	43% ♦	60% ♦	29% ♦	55% ♦	34% ♦	55% ♦	66% ♦♦	30% ♦♦	20% ♦♦	83% ♦♦♦
VNA of RI	57% ♦♦♦	55% ♦♦	69% ♦♦♦	67% ♦♦	71% ♦♦	55% ♦♦	68% ♦♦♦	82% ♦♦♦	16% ♦♦♦	10% ♦♦	86% ♦♦♦
VNS Home Health Services	50% ♦♦♦	60% ♦♦♦	77% ♦♦♦	54% ♦♦♦	74% ♦♦	49% ♦♦	76% ♦♦♦	69% ♦♦	28% ♦♦	26% ♦	75% ♦
VNS of Greater RI	47% ♦♦	47% ♦	65% ♦♦	57% ♦♦	66% ♦♦	58% ♦♦	75% ♦♦♦	64% ♦	32% ♦	17% ♦♦	87% ♦♦♦
VNS of Newport & Bristol Counties	45% ♦♦	54% ♦♦	62% ♦♦	48% ♦♦	63% ♦♦	45% ♦♦	69% ♦♦♦	68% ♦♦	28% ♦♦	16% ♦♦	78% ♦♦
State Average	47%	53%	67%	53%	64%	46%	63%	67%	30%	21%	82%
National Average	46%	54%	64%	47%	65%	43%	60%	67%	29%	22%	80%

¹ Diamonds are assigned based on a home health agency's rate compared to the national reference score.

² The reported score is the observed score (i.e., NOT risk-adjusted).

³ For 'Patients who had to be admitted to the hospital' and 'Patients who need urgent, unplanned medical care', lower percentages are more desirable.

♦♦♦ Agency's percentage is statistically above the national reference score (except for 'Acute Care Hospitalization' and 'Any Emergent Care Provided', where three diamonds means the agency's percentage is statistically below the national reference score)

♦♦ Agency's percentage is statistically the same as the national reference score

♦ Agency's percentage is statistically below the national reference score (except for 'Acute Care Hospitalization' and 'Any Emergent Care Provided', where one diamond means the agency's percentage is statistically above the national reference score)

N/A Too few cases to report on

The diamonds show you how agencies compare to one another

Table 1: Patient satisfaction with agencies providing skilled care paid for by Medicare (e.g., nursing and therapy)

Home Health Agency (Alphabetical)	Care of Patients	Communication between Providers and Patients	Specific Care Issues	Care from the Agency's Home Health Providers	Recommend this Agency to Friends or Family
1. Assisted Daily Living	•••	•••	•••	•••	••
2. Bayada Nurses	•••	•••	•••	•••	••
3. Capitol Home Care Network	•••	•••	•••	•••	••
4. Cathleen Naughton	•••	•••	•••	•••	••
5. Concord Home Health Services	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
6. Home Care Advantage	•••	•••	•••	•••	••
7. Interim Healthcare of RI	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
8. Life Care At Home of RI	•••	•••	•••	•••	••
9. Memorial Hospital Home Care	•••	•••	•••	•••	••
10. Roger Williams Home Care	•••	•••	•••	•••	••
11. Nursing Placement	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
12. St Jude Home Care	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
13. Tender Loving Care	•••	•••	•••	•••	••
14. Vital Care of RI	•••	•••	•••	•••	••
15. VNA of Care New England	•••	•••	•••	•••	••
16. VNA of RI	•••	•••	•••	•••	••
17. VNS Home Health Services	•••	•••	•••	•••	••
18. VNS of Greater RI	•••	•••	•••	•••	••
19. VNS of Newport & Bristol Counties	•••	•••	•••	•••	••

Some agencies were not required to submit these data:

Consistent Care, H & T Medicals, and Homefront Healthcare received a Federal exemption because they had too few Medicare patients during this time frame (October–December 2010). Independence Health Services is seeking a similar exemption.

Dependable Health Services had no patients during this time frame (October–December 2010) because the agency was new.

The diamonds show you how agencies compare to one another

Table 2: Patient satisfaction with agencies providing non-skilled care (e.g., help with dressing, bathing and light cleaning)

Home Health Agency (Alphabetical)	Arranging Home Care	Dealing with the Office	Nurses	Home Health Aides	Homemakers/ Companions	Therapists and Others	Likelihood to Recommend	Overall Quality
1. A Caring Experience	-	-	-	-	-	n/a	-	-
2. Access Healthcare	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
3. All About Homecare	♦♦♦	♦♦♦	♦♦	♦♦♦	♦♦♦	n/a	♦♦♦	♦♦♦
4. Alternative Care Medical Services	-	-	-	-	-	n/a	-	-
5. Assisted Daily Living	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
6. Bayada Nurses	♦♦	♦♦	♦♦	♦♦	♦♦	♦♦	♦♦	♦♦
7. Bayside Nursing	-	-	-	-	-	-	-	-
8. Bright Star Health Care of Kent/ Washington Counties	-	-	-	-	-	n/a	-	-
9. Brightstar Healthcare	-	-	-	-	-	n/a	-	-
10. Cathleen Naughton	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
11. Child & Family Services of Newport	♦♦	♦♦	♦♦♦	♦♦	♦♦	n/a	♦♦	♦♦
12. Community Care Nurses	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
13. Concord Home Health Services	♦♦	♦♦	-	♦♦	-	n/a	♦♦	♦♦
14. Consistent Care	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
15. Cowesett Home Care	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
16. Family Friends Health Care	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
17. Gleason Medical Services	-	-	-	-	-	-	-	-
18. H & T Medicals	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦♦	♦♦
19. Health Care Connections Nursing Services	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
20. Health Care Services	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
21. Healthtouch	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦	♦
22. Home Care Advantage	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
23. Home Care Services of RI	♦♦	♦♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
24. Home Care Solutions	♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
25. Homefront Health Care	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦
26. Hope Nursing Home Care	♦♦	♦♦	♦♦	♦♦	♦♦	n/a	♦♦	♦♦

Home Health Agency (Alphabetical)	Arranging Home Care	Dealing with the Office	Nurses	Home Health Aides	Homemakers/ Companions	Therapists and Others	Likelihood to Recommend	Overall Quality
27. Ideal Home Care Service	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	n/a	Did not survey	Did not survey
28. Independence Health Services	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
29. Jamestown Home Health	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey	Did not survey
30. Lifetime Medical Support Services	..	..	..	..	..	n/a	..	..
31. Mass Home Care of RI	..	..	-	..	-	n/a	-	..
32. Maxim Healthcare Services	-	-	-	-	-	n/a	-	-
33. Morning Star Homecare	..	..	..	..	..	n/a	..	..
34. New Care	..	-	-	-	-	n/a	-	..
35. Nursing Placement Inc	..	..	..	..	..	n/a	..	..
36. Ocean State Nursing Service	..	..	..	..	..	n/a	..	..
37. Phenix Home Care	..	..	..	..	..	n/a	..	..
38. Preferred Health Care Services	-	-	-	-	-	n/a	-	-
39. Senior Helpers	..	..	..	..	..	n/a	..	..
40. South County Quality Care	-	-	-	-	-	n/a	-	-
41. Specialty Home Care Services	..	..	..	..	..	n/a	..	..
42. St Jude Home Care	..	..	..	..	..	n/a	..	..
43. Summit Health Services	-	-	-	-	-	n/a	-	-
44. Visiting Angels	-	-	-	-	-	n/a	-	-
45. VNA Support Services	..	..	-	..	-	n/a	..	..
46. VNS of Newport & Bristol Counties	-	-	-	-	-	n/a	-	-

n/a Not applicable. Non-skilled patients do not typically receive these services.

- Data withheld because fewer than 10 patients provided feedback.

Dependable Health Services had no patients during this time frame (October-December 2010) because the agency was new.

Bayada Nurses, Inc. and Subsidiaries
Consolidated Balance Sheets
January 2, 2011 and January 3, 2010

	Fiscal 2010	Fiscal 2009
Assets		
Current assets		
Cash and cash equivalents	\$ 3,397,839	\$ 31,379,415
Available-for-sale securities at fair value	35,695,516	8,005,051
Accounts receivable, less allowance for doubtful accounts of \$4,561,861 and \$3,317,603, respectively	113,203,571	88,852,856
Prepaid expenses, including prepaid insurance	3,991,789	5,041,299
Deposits and other current assets	<u>516,601</u>	<u>228,010</u>
Total current assets	156,805,316	133,506,631
Property and equipment, net	9,320,300	10,110,033
Intangible assets, net	17,296,995	14,483,796
Prepayments of obligations under insurance programs	5,671,374	5,900,347
Notes receivable	58,550	71,987
Deferred tax asset	76,289	192,904
Investment held to maturity	2,000,000	2,000,000
Other investments	100,000	100,000
Other assets	<u>703,698</u>	<u>527,001</u>
Total assets	<u>\$ 192,032,522</u>	<u>\$ 166,892,699</u>
Liabilities and Shareholder's Equity		
Current liabilities		
Book overdrafts	\$ 5,157,900	\$ 923,901
Line of credit	6,038,992	9,000,000
Accounts payable	1,298,120	955,728
Accrued expenses	15,785,951	12,708,869
Accrued payroll liabilities	10,651,932	9,919,312
Deferred revenue	1,400,353	1,231,221
Deferred tax liability	266,385	656,211
Current portion of obligations under insurance programs	9,614,222	8,995,624
Other current liabilities	<u>2,610,482</u>	<u>1,265,366</u>
Total current liabilities	52,824,337	45,656,232
Obligations under insurance programs	<u>22,469,615</u>	<u>19,904,420</u>
Total liabilities	<u>75,293,952</u>	<u>65,560,652</u>
Shareholder's equity		
Paid-in capital	9,000	9,000
Retained earnings	115,240,942	101,466,588
Accumulated other comprehensive income (loss)	<u>1,488,628</u>	<u>(143,541)</u>
Total shareholder's equity	<u>116,738,570</u>	<u>101,332,047</u>
Total liabilities and shareholder's equity	<u>\$ 192,032,522</u>	<u>\$ 166,892,699</u>

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Bayada Nurses, Inc. and Subsidiaries
Consolidated Statements of Net Income
Fiscal Years Ended January 2, 2011 and January 3, 2010

	Fiscal 2010	Fiscal 2009
Net revenue	\$ 601,801,944	\$ 529,227,944
Cost of services	<u>378,035,329</u>	<u>334,272,806</u>
Gross profit	223,766,615	194,955,138
Selling, general and administrative expenses	204,148,645	175,563,988
Loss on disposal of software asset	<u>3,316,927</u>	<u>-</u>
Operating income	16,301,043	19,391,150
Investment income	1,044,712	1,320,394
Contribution to charitable foundation	(3,000,000)	(3,000,000)
Other expenses	<u>(705,713)</u>	<u>(70,898)</u>
Income before income taxes	13,640,042	17,640,646
Income tax (credit) expense	<u>(269,312)</u>	<u>131,714</u>
Net income	<u>\$ 13,909,354</u>	<u>\$ 17,508,932</u>

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