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CN22-18

Certificate of Need Application
Hospice Agency

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer Wenatchee Hospice Holdings LLC By: Matt Ham, COO Stride Health Care LLC, its Manager Email Address matt@advhh.com	Date 12/29/2021 Telephone Number (480) 710-7323
Legal Name of Applicant Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee Address of Applicant 285 Technology Center Way, Suite 108 Wenatchee, WA 98801	Provide a brief project description ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $0
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee intends to operate a Medicare Certified and Medicaid eligible Hospice service to residents located in Chelan County.	

Wenatchee Hospice LLC, dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

Proposing to Operate a Medicare Certified and Medicaid Eligible Hospice Agency in Chelan County

December 2021

Table of Contents

Introduction……5
Applicant Description……6
Project Description……7
Certificate of Need Review Criteria……11
A. Need……11
B. Financial Feasibility……22
C. Structure and Process (Quality) of Care……28
D. Cost Containment……35

Tables

Table 1 – Project Implementation Timeline……8
Table 2 – Advanced Hospice Agency Services……9
Table 3 – Not Applicable……11
Table 4 – Advanced Hospice Utilization Projection……11
Table 5 – State Methodology Calculation……12
Table 6 – Projected Need based on State Methodology……13
Table 7 – County Utilization Factor……14
Table 8 – Adjusted Unmet Need based on Utilization Factor……15
Table 9 - Estimated Capital Expenditure……25
Table 10 – Payer Mix Breakdown……27
Table 11 – FTE's……28
Table 12 – FTE Assumptions……29
Table 13 – Alternative Analysis……36-37

Appendix

Appendix 1 - Organizational Structure
Appendix 2 - Applicant Information
Appendix 3 - List of Owned Entities
Appendix 4 - Letter of Intent
Appendix 5 - Department of Health 2021-2022 Hospice Numeric Need Methodology
Appendix 6- Admissions Policy
Appendix 7 - Charity Care Policy
Appendix 8 - Patient Rights and Responsibilities Policy
Appendix 9 - Non Discrimination Policy
Appendix 10 – Hiring / Orientation Policies
Appendix 11 – QAPI Policy
Appendix 12 - Projections and Pro Forma
Appendix 13 – Operating Agreements
Appendix 14 – Medical Director Agreement
Appendix 15 – Lease Agreement
Appendix 16 – Letter of Financial Commitment
Appendix 17 – Financial Status Information
Appendix 18 - Closing the Gap in Hospice Utilization for Minority Medicare Population Study
Appendix 19 - Medicare Cost in Matched Hospice and Non-Hospice Cohorts Study

Exhibits

Exhibit 1 – Hospice Utilization in Chelan County
Exhibit 2 – Hospice Utilization, Chelan County vs State
Exhibit 3 - Speed of Admission Washington Hospice Programs
Exhibit 4 - Chelan County Hospice Speed of Admission for Hospital Discharges 2016-2020
Exhibit 5 - Dual-Eligible Hospice Utilization Rates in Washington State Counties
Exhibit 6 – Chelan County Dual-Eligible Hospice Admissions per 1,000 Deaths 2018-2020
Exhibit 7 – Visit Hours per Patient Day, Washington Hospice Program
Exhibit 8 – Visit Hours per Patient Day, Chelan County Hospice 2016-2020
Exhibit 9 – Chelan County Hospice Utilization by Race

Introduction

Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee requests certificate of need approval for a Medicare Certified and Medicaid eligible hospice agency to serve patients in Chelan County. Hospice utilization in Chelan County has been decreasing over the last three years. Dual eligible hospice utilization in Chelan County is nearly 11% below national utilization levels. Clinician time spent with patients on hospice in Chelan County is below national averages. In addition, the speed in which patients are admitted to hospice in Chelan County ranks among the lowest in the state – meaning that patients in Chelan County are admitted to hospice services less quickly after electing hospice than those in other counties. In fact, only 31% of admissions in Chelan County are admitted on the day of discharge from the hospital as compared to 80% nationally. Slower speed to hospice admission will most significantly affect those who use hospice services for 7 days or less. These facts indicate the need for additional hospice services to keep up with growing demand in the community.

Almost 29% of the population in Chelan County is Hispanic. However, beyond basic translation services, there is no hospice cultural programming or outreach for the Hispanic population of Chelan County. Per claims data, there is almost no hospice utilization among the Hispanic population in Chelan County. Need exists for cultural outreach and programming to ensure access to hospice services to the Hispanic community of Chelan County. Increased utilization of hospice services leads to lesser symptoms, improved quality of life, and decreased overall healthcare spending.

Only one Hospice provider exists in Chelan County with a population of nearly 80,000. In a market indicating challenges in meeting the hospice needs of the community, a second provider would not only add choice to the market, but also help improve the availability of services to many additional population cohorts within the community.

Advanced Hospice[1] will establish cultural programming and outreach through this project to overcome the barriers to access for the Hispanic community in Chelan County. This project will also help improve the above mentioned metrics indicating additional services are needed in the county. Advanced Hospice will be able to partner with Wenatchee Home Health, LLC dba Advanced Home Health Northwest of Wenatchee which already provides home health services throughout Chelan County. Because of this already established footprint in the county, this project would most quickly improve access to hospice services in the county while minimizing cost through applying existing resources, both administrative and clinical. This project will help improve access to care, and will do so in a cost effective manner. This application will outline how Advanced Hospice will meet the intent of WAC 246-310-290(12) in providing access to the underserved Hispanic population of Chelan County.

[1] For simplicity and to shorten the application, "Advanced Hospice" will be used throughout this application in place of Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee.

I. Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

1. **Provide the legal name(s) and address(es)of the applicant(s).**
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-310-010(6).

   Wenatchee Hospice LLC, dba Advanced Hospice Northwest of Wenatchee is the applicant.
   285 Technology Center Way Suite 108
   Wenatchee WA, 98801

   It is wholly owned by Wenatchee Hospice Holdings, LLC which is a subsidiary of Stride Health Care, LLC. See Appendix 1 for Organizational Structure

2. **Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the Unified Business Identifier (UBI).**

   Wenatchee Hospice LLC is a Washington LLC with UBI 604 840 149.
   See Appendix 2 – Applicant Information

3. **Provide the name, title, address, telephone number, and email address of the contact person for this application.**

   Matthew Ham, COO
   285 Technology Center Way, Suite 108
   Wenatchee, WA 98801
   (480) 710-7323
   matt@advhh.com

4. **Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).**

   Not Applicable

5. **Provide an organizational chart that clearly identifies the business structure of the applicant(s).**

   See Appendix 1 – Organizational Structure

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:**
    - **Facility and Agency Name(s)**
    - **Facility and Agency Location(s)**
    - **Facility and Agency License Number(s)**
    - **Facility and Agency CMS Certification Number(s)**
    - **Facility and Agency Accreditation Status**
    - **If acquired in the last three full calendar years, list the corresponding month and year the sale became final**
    - **Type of facility or agency (home health, hospice, other)**

    See Appendix 3 – List of Owned Entities

II. Project Description

1. **Provide the name and address of the existing agency, if applicable.**

    Not Applicable.

2. **If an existing Medicare and Medicaid certified hospice agency, explain if/how this proposed project will be operated in conjunction with the existing agency.**

    Not Applicable.

3. **Provide the name and address of the proposed agency. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.**

    Wenatchee Hospice LLC, dba Advanced Hospice Northwest of Wenatchee
    285 Technology Center Way, Suite 108
    Wenatchee WA 98801

4. **Provide a detailed description of the proposed project.**

    Advanced Hospice will be a state licensed and Medicare and Medicaid certified hospice agency serving the county of Chelan. This project will provide a new hospice agency in the county and will offer choice to the residents of Chelan County when deciding to utilize hospice services.

    This project will be led by an administrator with two decades of hospice experience and will be comprised of a compassionate team of local health care providers focused on patient and family needs and experience. This will include physicians, nurses, social work, chaplain, volunteer services, therapy, DME,

medical supplies, pharmacy services and bereavement support for family and friends of the patients. Services will include all necessary hospice services and supplies. Personalized plans of care will be developed based on each patients needs and wants in order to best meet their palliation needs and to best manage their terminal illness with dignity and respect.

Advanced Hospice will support patients throughout the community and wherever they may live and will place special emphasis on outreach throughout the county. A main reason for low hospice utilization is caused by a lack of awareness of hospice benefits and services. Outreach and education will be a significant focus of this project by Advanced Hospice and will be tailored to the particular unmet needs in the community with special emphasis on cultural programming and education for the Hispanic community.

Advanced Hospice will work in partnership with the local healthcare community to best meet the needs of the county residents. Although Advanced Hospice is a new agency, Wenatchee Home Health, LLC dba Advanced Home Health Northwest of Wenatchee is an existing member of the healthcare community in Chelan County. Advanced Home Health's[2] owner is also a wholly owned subsidiary of Stride Health Care, LLC. Advanced Hospice will be able to benefit from the relationships already established by Advanced Home Health to quickly integrate into the healthcare community.

5. **Confirm that this agency will be available and accessible to the entire geography of the county proposed to be served.**

   This agency will be available and accessible to the entire geography of Chelan County. Advanced Home Health already has a footprint throughout the county and is familiar with the geography and Advanced Hospice will be able to serve the entire county.

6. **With the understanding that the review of a Certificate of Need application typically takes at least six to nine months, provide an estimated timeline for project implementation, below:**

Table 1 – Project Implementation Timeline

Event	Anticipated Month/Year
CN Approval	September 2022
Design Complete (if applicable)	N/A
Construction Commenced* (if applicable)	N/A
Construction Completed* (if applicable)	N/A
Agency Prepared for Survey	October 2022
Agency Providing Medicare and Medicaid hospice services in the proposed county.	Jan 2023

[2] "Advanced Home Health" will be used throughout this application in place of Wenatchee Home Health, LLC dba Advanced Home Health Northwest of Wenatchee.

*** If no construction is required, commencement of the project is project completion, commencement of the project is defined in WAC 246-310-010(13) and project completion is defined in WAC 246-310-010(47).**

7. **Identify the hospice services to be provided by this agency by checking all applicable boxes below. For hospice agencies, at least two of the services identified below must be provided.**

Table 2 – Advanced Hospice Agency Services

X Skilled Nursing	□ Durable Medical Equipment
X Home Health Aide	□ IV Services
X Physical Therapy	□ Nutritional Counseling
X Occupational Therapy	X Bereavement Counseling
□ Speech Therapy	X Symptom and Pain Management
□ Respiratory Therapy	□ Pharmacy Services
X Medical Social Services	X Respite Care
X Palliative Care	X Spiritual Counseling
□ Other (please describe)	

8. **If this application proposes expanding an existing hospice agency, provide the county(ies) already served by the applicant and identify whether Medicare and Medicaid services are provided in the existing county(ies).**

   This application is not proposing expanding an existing hospice agency.

9. **If this application proposes expanding the service area of an existing hospice agency, clarify if the proposed services identified above are consistent with the existing services provided by the agency in other planning areas.**

   This application is not proposing expanding an existing hospice agency.

10. **Provide a general description of the types of patients to be served by the agency at project completion (age range, diagnoses, special populations, etc).**

    Advanced Hospice will work to meet the needs of the community of Chelan County and will serve patients of all ages and diagnoses for which staff are competent as outlined in its agency plan. All patients will be served regardless of race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, or national origin.

    Patients will have terminal conditions with a life expectancy of 6 months or less. The main causes of death in Chelan County are comprised of cardiovascular disease, cancer, Alzheimer's disease, chronic lower respiratory disease, diabetes

and chronic liver disease[3]. Most services will be provided in patients homes while some will be provided in Skilled Nursing Facilities, Group Homes, Assisted Living, and Independent Living facilities. Needs vary by the individual and this agency will work to meet the individual needs of each patient and their family while providing competent and compassionate care.

Chelan County has a rapidly growing elderly population with 18.42% ages 65 and above which is higher than the state average of 14.53.[4] and the largest percent increase in the numbers of deaths of any county in WA when trending the last 3 years[5]. The majority of patients will be elderly.

Chelan County is comprised of 28.55%[6] Hispanic population. This population in particular will be a significant focus for this project as will be outlined in the following section of this application, along with other identified population cohorts.

11. Provide a copy of the letter of intent that was already submitted according to WAC 246-310-080 and WAC 246-310-290(3).

See Appendix 4 – Letter of Intent

12. Confirm that the agency will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing agency, provide the existing agency's license number and Medicare and Medicaid numbers.

This agency will be licensed and certified by Medicare and Medicaid but it is not expanding on an existing agency.

IHS.FS. - Not applicable

Medicare #: - Not Applicable

Medicaid #: - Not Applicable

[3] Washington State Department of Health, Community Health Assessment Tool, 2013-2017
[4] Washington State Department of Health, Community Health Assessment Tool, 2013-2017
[5] Washington State Vital Statistics Death Data for Years 2018-2020
[6] Washington State Department of Health, Community Health Assessment Tool, 2013-2017

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

1. **For existing agencies, using the table below, provide the hospice agency's historical utilization broken down by county for the last three full calendar years. Add additional tables as needed.**

   This is not applicable as this agency is not expanding upon an existing agency.

Table 3 – Not Applicable

COUNTY	Identify Year	Identify Year	Identify Year
Total number of admissions	N/A	N/A	N/A
Total number of patient days	N/A	N/A	N/A
Average daily census	N/A	N/A	N/A

2. **Provide the projected utilization for the proposed agency for the first three full years of operation. For existing agencies, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.**

   Table 4 shows projected utilization for the Advanced Hospice for the first three years of operation. This is not an existing agency so there is no historical data. Assumptions are explained below.

Table 4 – Advanced Hospice Utilization Projection

ADVANCED HOSPICE UTILIZATION PROJECTION	2023	2024	2025
Total number of admissions	85	165	183
Total number of patient days	5,263	10,220	11,383
Projected average daily census	14.3	27.8	31

Assumptions used to make these projections:

Assumption 1:
Advanced Hospice plans to be ready to start its first year of operation in 2023. State methodology calculated unmet need from 2021-2023. See appendix 5 for Department of Health 2021-2022 Hospice Numeric Need Methodology. In order to calculate unmet need in years 2024 and 2025, and to maintain consistency, Advanced Hospice used the same calculations from the Department of Health 2021-2022 Hospice Numeric Need Methodology, but expanded its application into 2024 and 2025 using population data provided in the state methodology to determine the projected average daily census for these years. Steps 1-3 remained consistent. Step 4 applied the same calculated use rate to the state provided population projections for 2024 and 2025. Steps 5-7 remained consistent. This calculation yielded the following results:

Table 5 – State Methodology Calculation

	0-64	65+
Step 1: Calculate the Two Statewide Hospice Use Rates:	25.67%	60.15%
Step 2: Calculate the 3 Yr Death Rate by Age Cohort:	164	661
Step 3: Calculate Projected # of Patients	42	398
Step 4: Calculate Use Rate from Projected Patients	0.000677	0.025044

	2021	2022	2023	2024	2025
Population					
0-64	62512	62562	62611	62611[7]	62710
65+	17052	17695	18339	18982	19626
Expected Admissions					
0-64	42	42	42	42	42
65+	427	443	459	475	492
Total both Cohorts	469	486	502	518	534
Step 5: Subtract the Actual Capacity of 428.69 from the Total Both Cohorts	41	57	73	89	105
Step 6: Multiply the unmet Admissions determined in step 5 by the state ALOS of 62.12	2525	3560	4531	5534	6538
Step 7: Divide the Daily Census by the number of days in the year to get Unmet ADC	7	10	12	15	18

[7] Data taken from 2021-2022 Hospice Numeric Need Methodology 0-64 Population Projection showed no increase from 2023 to 2024 which could be a transcription error but would be negligible and is a more conservative calculation, therefore this application utilized this number for calculation.

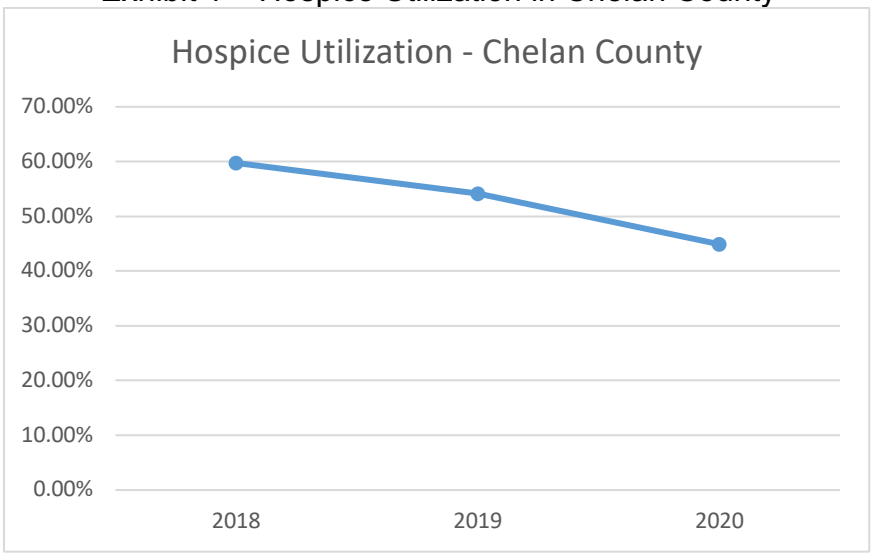
The highlighted data is condensed and presented in Table 6 to assist in presenting the following assumptions.

Table 6 – Projected Need Based on State Methodology

Year	2023	2024	2025
Projected Need Based on State Methodology	12	15	18

Assumption 2:
Calculations from the Data provided in the Department of Health 2021-2022 Hospice Numeric Need Methodology showed a significant drop in combined utilization rate in Chelan County[8].

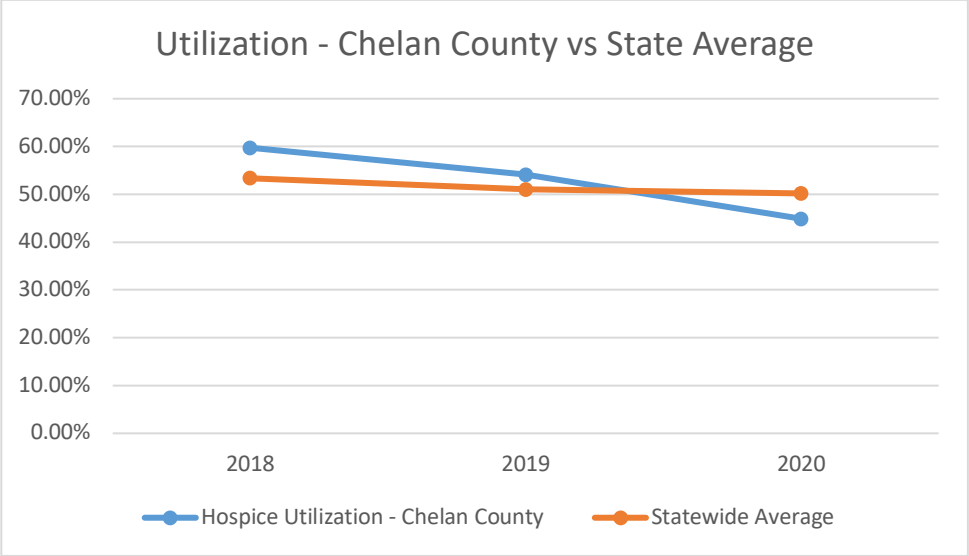
Exhibit 1 – Hospice Utilization in Chelan County



The combined rate for Chelan County dropped from 59.74% in 2018 to 44.90% in 2020. The statewide average utilization during the same time dropped from 53.36% to 50.19%. This is a drop in utilization of 15% in Chelan County as compared to 3% statewide.

[8] Combined utilization was calculated using the same formula from WAC 246-310-290(8)(a) Step 1 but dividing the total number of deaths for both age cohorts by the unduplicated admissions from both age cohorts.

Exhibit 2 – Hospice Utilization, Chelan County vs. State



Because of this decreasing trend in utilization, an assessment of the impact of this trend was conducted and represented in Table 7. The decreased actual utilization rate of Chelan County for 2020 was compared to the Statewide average utilization rates. Expected admissions were calculated as per State Methodology using the statewide average. This was compared to Chelan County Actual Admissions and the Difference was noted. Based on this assessment, after combining the difference of each age cohort, an additional 77 patients should have needed services. This number of additional patients was multiplied by the Average Length of Stay as per State Methodology, showing need for patient days of 4,763. This was then divided by 365 as per State Need Methodology and determined an additional unmet need of 13 ADC.

Table 7 – County Utilization Factor

	WA State Avg Use Rate	Chelan 2020 Actual Deaths	Expected Admissions	Chelan 2020 Actual Admissions	Difference
0-64	25.67%	224	58	32	26
65+	60.15%	785	472	421	51
				Total	77
				Patient Days	4763
				Additional Unmet Need	13

This additional unmet need was added to the projected unmet ADC for years 2023, 2024, and 2025 as outlined in Table 8.

Table 8 – Adjusted Unmet Need based on Utilization Factor

Year	2023	2024	2025
Projected Need Based on State Methodology	12	15	18
Adjusted unmet ADC based on Low Utilization	25	28	31

Advanced Hospice is confident these numbers more appropriately reflect the Hospice need in Chelan County versus available capacity and will discuss this further in questions 3, 4, and 6 of this section. Applying this additional numeric unmet need to future expected need demonstrates a need in the third year of operation for Advanced Hospice of 31 ADC. In addition, as financial projections indicate, this will be a financially viable project and will allow for the underserved Hispanic population in Chelan county to gain access to hospice services as discussed below.

3. Identify any factors in the planning area that could restrict patient access to hospice services.

In a 2019 study among residents of Chelan County, 25% of those surveyed expressed access to healthcare was a significant factor that could help improve quality of life.[9] The following factors could restrict patient access to hospice specific services in Chelan County:

1. Lack of Hispanic programming and outreach. Of the total population in Chelan County, 28.55% is Hispanic as compared to 12.38% of the state's population.[10] In addition, 10% of the population of Chelan County is linguistically isolated. This is much higher than WA averages of 7.6% and US averages of 8.5%.[11] This number is important because it is made up of individuals who speak a language other than English at home and who do not speak English well. The inability to speak English well can create barriers such as healthcare access, provider communication and overall health literacy.[12] Racial and ethnic minorities utilize hospice less than that of the White population. A recent study

[9] North Central Washington Community Health Needs Assessment 2019 – Appendix B, Community Voice Survey
[10] Washington State Department of Health, Community Health Assessment Tool, 2013-2017
[11] U.S. Census Bureau, American Community Survey, 2009-2013 and 2013-2017
[12] North Central Washington Community Health Needs Assessment 2019

validated this even when controlling for other socioeconomic factors such as income, area population, education, and age.[13] In Chelan County, this is also the case as there have been no claims submitted for hospice services for Hispanic beneficiaries.[14] The current hospice provider does not offer any Spanish Language or cultural programming beyond basic translation services to reach this population. According to the most recent Washington State Department of Health Community Health Assessment, the state's population is becoming more racially and ethnically diverse. One implication identified by the state is an increased demand for linguistically and culturally appropriate health services. Specifically it reads, "To be effective, service providers and organizations need to be reflective of the communities they serve. They also need to partner with communities to develop interventions, materials and services that are accessible and culturally appropriate."[15] Lack of Hispanic cultural programming and outreach in Chelan County restricts access to care among this population.

2. Lack of choice is a factor in access for patients. When dealing with something as challenging as death and dying, choice is extremely important for individuals to feel they have options and some control over their healthcare decisions. A negative experience, an employer/employee relationship, or many other considerations with the only provider of a particular healthcare service in a community can leave someone feeling they only have a choice of either care with the existing provider, or no care at all. This is a difficult indicator to measure but its impacts must be considered in a county of this size with only one provider. The state need methodology is most effective in assessing the needs of a larger community with multiple providers. One provider in a county this size should be considered as a significant factor in access to hospice services throughout the county.

3. Speed of admissions for Chelan county is also a factor that can affect access to Hospice services for a number of populations. Speed of admissions is significantly lower in Chelan County than state averages. Only 31% of admits to Chelan County Hospice services are admitted on the day of discharge from the hospital. Nationally, 80% of hospice patients are admitted on the day of discharge from the hospital.[16] This indicator speaks to the availability of the provider in meeting the community needs. Some simply are not able to access care timely. This has a most significant impact on patients who are on hospice for 7 days or less but can also have an impact on other patients accessing hospice services. Another hospice provider would give access to hospice

[13] See Appendix 18 - Hughes MC, Vernon E. Closing the Gap in Hospice Utilization for the Minority Medicare Population. Gerontol Geriatr Med. 2019;5:2333721419855667. Published 2019 Jun 27. doi:10.1177/2333721419855667

[14] See Exhibit 9 - Berg Data Solutions. It should be noted that demographic groups with less than 11 patients are suppressed in this data per CMS requirements.

[15] Washington State Department of Health, Community Health Assessment Tool, 2013-2017 pg. 6

[16] Berg Data Solutions. See Exhibit 3 – Speed of Admission Washington Hospice Programs and Exhibit 4 – Chelan County Hospice Speed of Admission for Hospital Discharges 2016-2020.

services to those population groups that are limited due to choice or speed of admissions. At least three additional population cohorts will be impacted by choice and speed of admissions as outlined in the next 3 points.

a. Dual eligible hospice utilization data for Chelan County indicates much lower utilization than state and national averages. Dual eligible patients in Chelan County are admitted at a rate of 367 per 1000 Medicare Deaths where the national average is 474 admissions per 1000 Medicare Deaths.[17] Choice and speed of admissions are significant barriers for this population.

b. Skilled Nursing Facilities care for residents who require extensive assistance with Activities of Daily Living (ADL's) and are some of the most compromised residents in the county. Access to hospice services is an opportunity nationally and for residents of nursing facilities within Chelan county. When choice is limited or speed to admit to hospice is slow, this population cohort can be significantly impacted. In addition, limited awareness and understanding of services and their benefits can also be a barrier to hospice use in this setting.

c. Advanced Home Health refers Approximately 10% of Home Health patients for Hospice. Hospice referrals have at times taken over a week for admission due to capacity. Choice and speed of admissions are barriers to access of Hospice services.

4. Households that have no motor vehicle have a definite barrier to accessing healthcare. Chelan county reports 7% of households with no motor vehicle[18]. Although hospice services are most often provided in the home, those with no motor vehicles are less likely to access even basic physician services, and are therefore less likely to even be aware of or have access to available home based services.

5. The native population of Chelan County has expressed the need for additional services. Lack of cultural programming and outreach in Chelan County restricts access to care among this population on the Colville Reservation.

6. With almost 5,000 Veterans in Chelan County, this population deserving special attention to ensure needs are met.

[17] Berg Data Solutions. See Exhibit 5 – Dual-Eligible Hospice Utilization Rates in Washington State Counties and Exhibit 6 – Chelan County Dual-Eligible Hospice Admissions per 1,000 Deaths 2018-2020
[18] U.S. Census Bureau, American Community Survey, 2009-2013 and 2013-2017

4. **Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.**

   Advanced Hospice believes this project to be necessary to meet the community needs for access to hospice care. Although the current hospice provider is well respected and is well connected into the healthcare delivery system for the county, the following indicators point to the challenges of keeping up with the changing demand in the community.

   1. County Hospice utilization has declined steadily over the past 3 years putting the county below the state average for utilization. See Exhibits 1 and 2.
   2. The lack of Hispanic cultural programming and outreach in the county where 28.55% of the population is Hispanic. There have been no claims for Hispanic hospice patients in Chelan County. See Exhibit 9
   3. Dual Eligible utilization in Chelan County is nearly 11% less than the national average. See Exhibits 5 and 6.
   4. Choice and speed of access are very real concerns in Chelan County. Only one provider of Hospice services operates in the county so there is no choice. Only 31% of hospital discharges to hospice are admitted on the day of discharge as compared to 80% annually. See Exhibits 3 and 4.
   5. Chelan County hospice data indicates average time spent with each hospice patient per day is .41 hours where national average is .52. This can be indicative of staffing challenges which can limit access to hospice services. See Exhibits 7 and 8.

   These indicators help in explaining how this project will focus on the underserved populations and unmet needs in the community. This project will improve access to those underserved without unnecessary duplication of services.

5. **Confirm the proposed agency will be available and accessible to the entire planning area.**

   This agency will be available and accessible to the entire geography of Chelan County. Advanced Home Health already has a footprint throughout the county and is familiar with the geography and Advanced Hospice will be able to serve the entire county.

6. **Identify how this project will be available and accessible to under-served groups.**

   As discussed in 3 above, there are some barriers that exist for some being able to access hospice services. This project will be available and accessible to under-served groups in the following ways:

1. Through development of a Spanish language outreach and education program along with cultural programming for staff and volunteers. This will including written materials in Spanish along with staff and volunteers available to help promote and educate the Hispanic community regarding hospice services. One of the key recommendations to decreasing the gap between white and ethnic minorities hospice utilization is through outreach and education.[19] Through a culturally competent program, Advanced will enhance understanding and utilization of Hospice services among the Hispanic Population and provide care to this population utilizing staff and volunteers that have been trained and are able to provide culturally competent care.

   Advanced Hospice will work with the Hispanic Business Council and Chamber of Commerce as well as Columbia Valley Community Health clinics to identify opportunities for outreach and education. Just over 49% of Columbia Valley Community Health Clinics patient population is Hispanic.[20] This project will engage resources and support from the Hispanic community in order to promote the program to help ensure maximum exposure to the targeted audience.

   Patient services will also be provided by staff who are culturally trained and where possible, speak Spanish, or, work in coordination with the volunteer programming to ensure availability of community support and cultural awareness. Resources will be allocated given the patient and family needs and desires. The volunteer program will play a key role in filling in gaps with non-bilingual staff or in assisting in culturally sensitive care discussions surrounding delivery of care. Training will be carried out on the cultural programing with all staff of the agency and will be a competency item for each team member. See Appendix 10 for a sample competency and orientation checklist. Materials are being developed and will be available prior to project completion. Training will be upfront and ongoing for staff and volunteers in order to ensure programming goes beyond just language translation, to cultural programming that meets needs of both patients and their families. Focus will be on all aspects of caring for individuals while respecting cultural needs and expectations. It will not simply be a translation into Spanish but a wholistic program to ensure understanding and meeting of cultural needs within the hospice framework. The outreach coordinator and volunteer coordinator will also be bilingual.

   Benefits of serving this population are many including improved access to care, more appropriate cultural programming, improved understanding of objectives and benefits of hospice services, and decreased overall healthcare costs

[19] See Appendix 18 - Hughes MC, Vernon E. Closing the Gap in Hospice Utilization for the Minority Medicare Population. Gerontol Geriatr Med. 2019;5:2333721419855667. Published 2019 Jun 27. doi:10.1177/2333721419855667

[20] Data.HRSA.gov. Health Center Program Uniform Data System (UDS) Data Overview – Columbia Valley Community Health, Wenatchee, Washington.

across the healthcare continuum. Nationally, Medicare spends close to 20% more on the last year of life for Hispanic People than White people due to underutilization of Hospice.[21]

2. The dual eligible population in Chelan County will be a focus for outreach and education. Dual eligible needs are dependent on their unique circumstances. Advanced Hospice will work with health plans and providers to identify and work to overcome their barriers to accessing hospice care. This will overlap into skilled nursing facilities, Hispanic programming and other areas.

3. Advanced Hospice will work with the 3 local skilled nursing facility providers, namely, Regency Wenatchee Rehabilitation and Nursing Center, Cashmere Care Center, and Colonial Vista Post-acute & Rehab Center to offer outreach regarding involvement of Hospice in meeting this specific populations needs. Because of the patient being in a residential care facility, assumptions are often made that all needs are being met by clinicians in the SNF, however, Advanced Hospice will work to provide outreach to local SNFs on the benefits of hospice as they relate to both the patient and their families. This population can benefit from appropriate and timely hospice intervention and will also include some of the dual eligible population as many dual eligible patients reside in skilled nursing facilities.

4. Advanced Hospice will improve overall accessibility through additional staff and resources in the county to help reach additional households with no motor vehicles. Having a second provider will not only allow choice in the community, but will also allow for additional access for all patients in Chelan County and will increase opportunities for outreach and education to those with no motor vehicles. Community outreach and volunteer support will help in better reaching and assisting this population in obtaining awareness and access to available resources. In essence there will be a wider net cast over the county. The existing home health footprint can also be used to enhance community outreach and education in this area. Columbia Valley Community Health clinics provide care to low income families in Chelan County. Advanced Hospice will work to partner with Columbia Valley Community Health clinics to identify opportunities for outreach and education.

5. Advanced Hospice will work to develop and provide cultural programing to the native population on the Colville Reservation through partnerships being developed with tribal leaders and medical delivery services.

6. Advanced Hospice will meet with the veterans advisory board and focus education and outreach efforts to include veteran community of Chelan County.

[21] See Appendix 18 - Hughes MC, Vernon E. Closing the Gap in Hospice Utilization for the Minority Medicare Population. Gerontol Geriatr Med. 2019;5:2333721419855667. Published 2019 Jun 27. doi:10.1177/2333721419855667

7. **Provide a copy of the following policies:**
   - **Admissions policy**
   - **Charity care or financial assistance policy**
   - **Patient Rights and Responsibilities policy**
   - **Non-discrimination policy**

   Suggested additional policies include any others believed to be directly related to patient access (death with dignity, end of life, advanced care planning)

   See Appendix 6 for Admissions Policy
   See Appendix 7 for Charity Care Policy
   See Appendix 8 for Patient Rights and Responsibilities Policy
   See Appendix 9 for Non-Discrimination Policy
   See Appendix 10 for Hiring / Orientation Policies
   See Appendix 11 for QAPI Policy

8. **If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:**
   - **All applicable review criteria and standards with the exception of numeric need have been met;**
   - **The applicant commits to serving Medicare and Medicaid patients; and**
   - **A specific population is underserved; or**
   - **The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.**

     Note: The department has sole discretion to grant or deny application(s) submitted under this subsection.

   Although the state methodology does not show a numeric need, this application and supporting documentation will show applicability under WAC 246-310-290(12) in that:
   1. All applicable review criteria and standards with the exception of numeric need will been met;
   2. Advanced Hospice does commit to serve Medicare and Medicaid patients; and
   3. There is a specific population that is underserved. See questions 3, 4, and 6 above along with all the supporting documentation referenced therein. In particular, the Hispanic population comprises 28.55% of the total population of Chelan County. Medicare billing data shows no Hispanic Hospice utilization in Chelan County and Dual Eligible data also shows underutilization as compared to national averages. This population is not accessing hospice services and is by definition underserved. There is no cultural programming to ensure this population has access to hospice services. Hispanic cultural programming

combined with outreach to both the Hispanic population as well as the additional identified underserved populations will be the focus of this project.

B. Financial Feasibility (WAC 246-310-220)

Financial feasibility of a hospice project is based on the criteria in WAC 246-310-220.

1. **Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
   - **Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
   - **Pro Forma revenue and expense projections for at least the first three full calendar years of operation using at a minimum the following Revenue and Expense categories identified at the end of this question. Include all assumptions.**
   - **Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.**
   - **For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.**

Revenue	Expenses
Medicare, including Managed Care	Advertising
Medicaid, including Managed Care	Allocated Costs
Private Pay	B & O Taxes
Other, [TriCare, Veterans, LNI, etc.] detail what is included	Depreciation and Amortization
Non-operating revenue	Dues and Subscriptions
	Education and Training

	Employee Benefits
	Equipment Rental
	Information Technology/Computers
Deductions from Revenue:	**Insurance**
(Charity)	**Interest**
(Provision for Bad Debt)	**Legal and Professional**
(Contractual Allowances)	**Licenses and Fees**
	Medical Supplies
	Payroll Taxes
	Postage
	Purchased Services (utilities, other)
	Rental/Lease
	Repairs and Maintenance
	Salaries and Wages (DNS, RN, OT, clerical, etc.)
	Supplies
	Telephone
	Travel (patient care, other)
	Other, detail what is included

Documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met are found in Appendix 12 - Projections and Pro Forma

2. **Provide the following agreements/contracts:**
   - **Management agreement.**
   - **Operating agreement**
   - **Medical director agreement**
   - **Joint Venture agreement**

   Note, all agreements above must be valid through at least the first three full years following completion or have a clause with automatic renewals. <u>Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.</u>

See Appendix 13 for Operating Agreement.
See Appendix 14 for Medical Director Agreement

3. **Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site.**

   If this is an existing hospice agency and the proposed services would be provided from an existing main or branch office, provide a copy of the deed or lease agreement for the site. If a lease agreement is provided, the agreement must extend through at least the third full year following the completion of the project. Provide any amendments, addendums, or substitute agreements to be created as a result of this project to demonstrate site control.

   If this is a new hospice agency at a new site, documentation of site control includes one of the following:

   a. **An executed purchase agreement or deed for the site.**
   b. **A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**
   c. **An executed lease agreement for at least three years with options to renew for not less than a total of two years.**
   d. **A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**

   See Appendix 15 for documentation of site control.

4. **Complete the following table with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed in the table, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.**

Table 9 – Estimated Capital Expenditure

Item	Cost
a. Land Purchase	$ 0
b. Utilities to Lot Line	$ 0
c. Land Improvements	$ 0
d. Building Purchase	$ 0
e. Residual Value of Replaced Facility	$ 0
f. Building Construction	$ 0
g. Fixed Equipment (not already included in the construction contract)	$ 0
h. Movable Equipment	$ 0
i. Architect and Engineering Fees	$ 0
j. Consulting Fees	$ 0
k. Site Preparation	$ 0
l. Supervision and Inspection of Site	$ 0
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	N/A
1. Land	$ 0
2. Building	$ 0
3. Equipment	$ 0
4. Other	$ 0
n. Washington Sales Tax	$ 0
Total Estimated Capital Expenditure	**$ 0**

5. **Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.**

   This is not applicable as there will be no initial capital costs.

6. **Identify the amount of start-up costs expected to be needed for this project. Include any assumptions that went into determining the start-up costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service. If no start-up costs are expected, explain why.**

Start-up costs will be minimal as office space and computer/electronic equipment is available in the current Home Health space. In addition, key staffing positions (i.e. administrator, social worker, etc.,) will be shared from Home Health initially to keep costs at a minimum.

Start-up costs for this project are estimated at $35,000. This will include salaries for staff and cost for development of supplies and materials related to cultural programming.

$7,500 is expected for development of materials and supplies
$27,500 is expected for salaries related to programming development, staff training, competencies and outreach

7. **Identify the entity responsible for the estimated start-up costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.**

   Wenatchee Hospice Holdings LLC through Stride Health Care LLC, its manager, will be responsible for startup costs. See Appendix 16.

8. **Explain how the project would or would not impact costs and charges for healthcare services in the planning area.**

   This project will not negatively impact costs or charges in Chelan County. It would allow for choice and for services to be more readily available to underserved populations and will allow for more effective use of existing healthcare and management personnel. Hospice care is also shown to reduce end of life costs and this project will increase access to Hospice services for additional individuals, ultimately decreasing overall health care costs.

9. **Explain how the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for health services in the planning area.**

   Because Advanced Hospice will have a connection to Advanced Home Health, both startup costs and some fixed expenses will be kept to a minimum. There will be no negative impact on the costs and charges for health services in Chelan County due to this project. Improved efficiencies will be promoted through this project in that some staff and ancillary expenses will be able to be shared across the two entities allowing for cost containment.

10. **Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."**

Table 10 – Payer Mix Breakdown

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	89%	88%
Medicaid	7%	7%
Commercial	4%	5%
Self Pay	0	0
Total	100%	100%

11. If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.

Not applicable as this project is not adding an additional county for an existing agency.

12. Provide a listing of equipment proposed for this project. The list should include estimated costs for the equipment. If no equipment is required, explain.

There is no equipment needed for this project as office and computer/telephone equipment is owned and will be shared through Advanced Home Health's current office.

13. Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.

Wenatchee Hospice Holdings LLC through Stride Health Care LLC, its manager, will finance the project. See Appendix 16.

14. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

Not applicable.

15. Provide the most recent audited financial statements for:

- **The applicant, and**
- **Any parent entity responsible for financing the project.**

No audited financials are available. See Appendix 17 for CPA Financial Status Information.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

1. **Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.**

Table 11 – FTE's

Clinical Staff	Year 1	Year 2	Year 3
Clinical Director*	0.50	0.50	0.50
RN Case Manager	1.40	2.80	3.10
CNA	1.40	2.80	3.10
QAPI Nurse*	0.50	0.50	0.50
Social Worker	0.46	0.92	1.02
Spiritual Care Coordinator	0.46	0.92	1.02
Total	**4.72**	**8.45**	**9.25**
Administrative Staff	**Year 1**	**Year 2**	**Year 3**
Administrator*	0.50	0.50	0.50
Outreach Coordinator	1.00	1.00	1.00
Volunteer Coordinator	1.00	1.00	1.00
Intake Coordinator / Clinical Support	1.00	1.00	1.00
Office Manager*	0.50	0.50	0.50
Total	**4.00**	**4.00**	**4.00**
Total FTE's	**8.72**	**12.45**	**13.25**

*Staff with the asterisks will be shared with Home Health

2. **If this application proposes the expansion of an existing agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.**

   Not Applicable.

3. **Provide the assumptions used to project the number and types of FTEs identified for this project.**

Table 12 – FTE Assumptions

Category	Wenatchee Hospice FTE Assumptions
Skilled Nursing (RN & LPN)	1:10
Physical Therapist	Contract only
Occupational Therapist	Contract only
Medical Social Worker	1:30
Speech Therapist	Contract only
Home Health / Hospice Aide	1:10
Chaplain	1:30

The number and types of FTE's is based off of data taken from other agencies offering Hospice services in Washington and other states. Special emphasis for this project was placed on the outreach coordinator and volunteer coordinator positions given the focus of the Hispanic community and the need for programming and outreach.

4. **Provide a detailed explanation of why the staffing for the agency is adequate for the number of patients and visits projected.**

   Advanced Hospice is confident in the adequacy of planned staffing levels and verified through a review and comparison to a number of other entities that are currently in operation as well as a comparison to approved certificate of need applications in the 2018, 2019, and 2020 application cycles.

5. **Provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.**

   Dr. Jonathan S Kim will be the contracted Medical Director. His Washington License number is MD60204584

6. **If the medical director is/will be an employee rather than under contract, provide the medical director's job description.**

   Medical Director will be contract, however the job duties can be seen in Appendix 14

7. **Identify key staff by name and professional license number, if known. If not yet known, provide a timeline for staff recruitment and hiring (nurse manager, clinical director, etc.)**

   Joel Stephens will be the administrator and there is no professional license for this position. Maria Jay will be the Clinical Director. Her professional license number is RN00122257.

8. **For existing agencies, provide names and professional license numbers for current credentialed staff.**

   Not Applicable.

9. **Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.**

   Staff recruitment and retention is key in order for any health care organization to meet its objectives. Advanced Hospice is a local provider who will work to not only recruit talented and competent staff for its needs, but as a member of the state and national Home Care Association, will continue to do all it can to promote state and national campaigns as well in order to recruit compassionate individuals to the healthcare industry.

   Advanced Home Health has had a presence in the community for years and as such, is familiar with the challenges and opportunities of recruiting talent both locally in Chelan County as well as outside of the county and state. Advanced Home Health has been able to recruit talent to meet its objectives in providing home health services in Chelan County. They offer competitive wages and benefits. Many of its current staff have interest and availability to also provide hospice services. This will help improve access in the county by allowing additional workforce to be available to meet hospice needs in the community.

Recruitment efforts will continue in the same manner for Advanced Hospice as has worked for Advanced Home Health, in order to meet staffing needs.

Advanced Hospice will carry forward the same fundamental operating focus embraced by Advanced Home Health. This starts with the belief that culture is the most important factor in recruitment and retention. An advantage of being a smaller local provider is the direct involvement in the community allowing decisions to be made locally that are best for the community. Culture for the organization is not based on a larger corporate goals, but rather developed by the team providing care in Chelan County. The culture is a sum of the actions of each employee each day and the operational focus is to keep those actions centered on respect, competency, meeting people where they are, and working to fulfil the personal mission of making a difference in the lives of those served. This focus drives all actions and decisions in the organization.

All phases of recruitment and onboarding lead to effective retention and as such, great emphasis is placed on the orientation and onboarding process. In order to succeed, the organization works to ensure the right people are brought onboard and then onboarded for success. In order to consistently ensure this process is followed, Advanced Hospice has policies and procedures addressing selection and hiring of personnel as well as orientation. See Appendix 10.

The most effective recruitment has been through word of mouth referrals from existing staff. Referral bonuses are offered internally as positions become available. Advanced Hospice also has access to typical recruiting platforms such as Indeed, Glassdoor, Linked In, etc. and will use those as needed to fill immediate and ongoing needs. Advanced Hospice also has access to national recruiters and additional resources available to garner potential interest in open positions.

10. Identify your intended hours of operation and explain how patients will have access to services outside the intended hours of operation.

Hours of operation will be Monday through Friday 8 am to 5 pm. Patients will have access to services outside of intended hours of operation through an on call program overseen by the clinical director and medical director. Information will be given to patients upon admission to hospice services.

11. For <u>existing</u> agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the hospice agency.

This is not applicable.

12. For existing agencies, provide a listing of ancillary and support service vendors already in place.

This is not applicable.

13. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

This is not applicable.

14. For new agencies, provide a listing of ancillary and support services that will be established.

Advanced Home Health provides ancillary and support services including Occupational Therapy and Physical Therapy. Advanced Hospice will be able to meet the needs of the project through contract for many services already established with Advanced Home Health and will be able to quickly establish contractors including:

Wellsky – EMR
Forcura – Document Management and HIPAA compliant communication platform for clinicians
Medbridge – Learning and resource platform for clinicians
Pharmacy Vendor – Enclara Pharmacia, Local pharmacies as needed
Medline – Supply Vendor
DME Vendor – Bellevue Healthcare Central Washington
Fazzi - Customer Satisfaction

15. For existing agencies, provide a listing of healthcare facilities with which the hospice agency has documented working relationships.

This is not applicable.

16. Clarify whether any of the existing working relationships would change as a result of this project.

This is not applicable.

17. For a new agency, provide the names of healthcare facilities with which the hospice agency anticipates it would establish working relationships.

Hospitals: Central Washington Hospital, Wenatchee Valley Medical Center, Lake Chelan Community Hospital.

Skilled Nursing Facilities: Colonial Vista Post-acute & Rehab Center, Regency Wenatchee Rehabilitation & Nursing Center, and Cashmere Care Center.

Assisted Living Facilities: Prestige Senior Living at Colonial Vista, Blossom Valley Assisted Living, Highgate at Wenatchee, Avamere Wenatchee, Riverwest Assisted Living, Mountain Meadows Senior Living Campus, Western Saddlerock, and Heritage Heights.

Clinics: Columbia Valley Community Health Clinics, Indian Health Services, and Wenatchee VA Clinic

18. **Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)**
    a. **A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or**
    b. **A revocation of a license to operate a health care facility; or**
    c. **A revocation of a license to practice a health profession; or**
    d. **Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.**

No individual, facility or practitioner associated with this application has had a history of actions a-d above.

19. **Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230**

This proposed project will promote continuity in the provision of health care services and diminish fragmentation of services in a few ways.

First, by not significantly changing the landscape of providers in the community. Currently, there are two providers of home health care in Chelan County. Central Washington Hospital Home Health and Advanced Home Health. There is only one provider of Hospice services – Central Washington Hospital Hospice. Central Washington Hospital Hospice is part of Confluence Health and is well known and respected for their services across all levels of care from physicians to hospitals and home health and hospice. They are an important and influential provider of health care in the community. Advanced Hospice will work to enhance and expand the already existing community outreach and education provided by Central Washington Hospital Hospice by focusing specifically on outreach and education to the Hispanic population as there is a need for culturally competent hospice service delivery to this underserved population.

This service will improve continuity and decrease fragmentation in the community. This project will not detract from, but will add to what is being done.

Second, Advanced Home Health already has relationships in place within the health care community and Advanced Hospice will work to build on these relationships and partner with Skilled Nursing and Assisted Living Facilities in particular to identify needs among the patients who are most at risk and in need of hospice services. This will be in addition to what is already being done for the patients in the Skilled Nursing and Assisted Living Facilities. This project will work through outreach to help ensure hospice services that are needed by patients are identified and accessed in order to help decrease overall healthcare costs and provide timely and appropriate palliative, comfort and supportive services to the patients and their families. This will add value and improve continuity in the delivery of healthcare in this market. It will not create unwarranted fragmentation.

Lastly, some fragmentation currently exists when patients from Advanced Home Health need hospice services. They currently have to change providers to receive hospice services. This happens in nearly 10% of those patients on home health services. This project would allow choice for all residents of Chelan County but in particular for those already familiar with the staff, culture, and services of Advanced Home Health to transition to hospice services in a less fragmented way.

To reiterate, having an additional provider of Hospice that already has a footprint in Home Health throughout the county will also allow for additional outreach and therefore improved utilization of hospice services for both providers as additional populations would be able to receive outreach, education, and access to hospice services. This increased utilization will bring the county closer to state and national levels of utilization. This increased utilization will ultimately lead to improved patient and family outcomes and satisfaction when dealing with death and dying. It will also lead to improved efficiency in use of the healthcare system as well as decreased overall healthcare costs.[22]

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

Advanced Home Health has been serving the community of Chelan County for years and has already established appropriate relationships in the existing health care system. This proposed project will allow for a seamless transition into the existing health care system. Advanced Hospice will be able to build upon and

[22] See Appendix 19 - Pyenson B, Connor S, Fitch K, Kinzbrunner B. Medicare cost in matched hospice and non-hospice cohorts. J Pain Symptom Manage. 2004 Sep;28(3):200-10. doi: 10.1016/j.jpainsymman.2004.05.003. PMID: 15336332.

expand the already existing appropriate relationships with health care partners in the community. Advanced Hospice will be able to utilize existing resources in an effective and efficient manner to add needed hospice services in the county without creating a burden to the existing healthcare system. Through utilizing existing admin and clinical staff from home health, It will lead to a more effective use of resources to allow for additional staff and resources to help meet community needs.

21. **The department will complete a quality of care analysis using publicly available information from CMS. If any facilities or agencies owned or operated by the applicant reflect a pattern of condition-level findings, provide applicable plans of correction identifying the facility's current compliance status.**

    No pattern of condition-level findings are reflected by the applicant.

22. **If information provided in response to the question above shows a history of condition-level findings, provide clear, cogent and convincing evidence that the applicant can and will operate the proposed project in a manner that ensures safe and adequate care, and conforms to applicable federal and state requirements.**

    Not applicable.

D. Cost Containment (WAC 246-310-240)

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. **Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.**

   Alternatives considered prior to submission include:

   A. Do nothing or postpone the project

B. Purchase an existing hospice
C. Apply for CN and move forward with the project

Please see discussion in Table 13 Below.

2. Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

Table 13 - Alternative Analysis

	A. Do Nothing	B. Purchase Existing Hospice	C. Apply for Certificate of Need and move project forward
Patient Access to Healthcare Services	This option would continue with the status quo in the community which has shown a 3 year trend of decreased utilization. The identified underserved populations would continue to be underserved.	This is not an option as there is not an available Hospice for sale. It would likely not allow for significant improvements in access to care in the immediate. It would take more time as time and energy would be focused on a transition.	This option will allow for an efficient use of an already existing network to allow for quick set up and improved access to care for the identified underserved populations.
Capital Cost	This option would include no capital cost.	Depending on purchase price, this could have significant implications on immediate ability to expand and meet underserved population needs.	This project will be co-located with Advanced Home Health, therefore eliminating capital costs, and minimizing startup costs. In addition, the speed to project completion and improved access would be quickest.
Legal Restrictions	There would be no real advantages.	A lengthy and costly process to evaluate purchase would be a disadvantage. There would be no real advantages.	Advanced Home Health staff that have interest and availability would be able to provide care to underserved population which improves access and quality of care and

			continuity. It does take time for CN approval which is a disadvantage.
Staffing Impacts	It would have no real impact on staffing in community.	It would have no real impact on staffing in community.	It will have an advantage of sharing key staff and allowing more clinicians to meet community hospice needs. It will also create new jobs in the community.
Quality of Care	There would be no change to quality of Care in Chelan County.	It would have no real impact on quality of care in Chelan County.	This will allow for improved access to care by underserved Hispanic population.
Cost/Operation Efficiency	There would be no real cost/operational efficiency change.	This option could potentially have a negative impact based on purchase price with no real improvement.	This option allows for a cost-effective method to leverage existing resources in an efficient way to meet the identified underserved populations. Administrative, Lease, equipment and other fixed and variable costs could be minimized by sharing them between Home Health and Hospice. Start up and operational costs would be minimized as compared to other options.
Analysis and Rationale	This option does not improve access to identified underserved populations.	This option is not realistic in that a hospice is not for sale. It would also not likely improve access to underserved populations or	This option would improve access to identified underserved populations in a very cost effective and timely manner while improving continuity and minimizing any impact to the existing community healthcare services.

3. **If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):**
   - **The costs, scope, and methods of construction and energy conservation are reasonable; and**

- **The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.**

The proposed project will have no construction and will not have an impact on costs and charges to the public of providing health services by other persons.

4. **Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.**

This project will promote cost effectiveness and will meet the criteria of WAC 246-310-240. This project will share or spread already existing fixed and variable costs between Advanced Home Health and Advanced Hospice, decreasing overall costs. Entry into the market will come with minimal expense. The time needed to connect and integrate into the existing healthcare network will be almost nonexistent as relationships already exist between current providers and Advanced Home Health. In addition, time to setup and initiate services will be minimal as there will not be significant hiring efforts needed to begin offering services. Many key staff are already in place to begin Hispanic cultural program development and outreach and ultimately to start providing care. Only chaplain services, outreach coordinator and volunteer coordinator will need to be identified and hired in order to begin services. This project will lead most quickly and cost effectively to serving the identified underserved Hispanic population. All other options would have increased capital and startup costs as well as time to form connections in the healthcare system.

This project will also promote quality assurance from its inception as Advanced Home Health has been able to implement and learn from new QAPI programming. This process has involved all staff and involves systematic review of key performance metrics to assess and improve quality outcomes. A framework and structure to build upon is already in place and will require minimal efforts. See Appendix 11 for QAPI Policy. The project will allow for seamless integration into the community and to continue to work to partner with other providers in improving continuity and access to quality care.

Hospice Agency Superiority

In the event that two or more applications meet all applicable review criteria and there is not enough need projected for more than one approval, the department uses the criteria in WAC 246-310-290(11) to determine the superior proposal.

Multiple Applications in One Year

In the event you are preparing more than one application for different planning areas under the same parent company – regardless of how the proposed agencies will be operated – the department will require additional financial information to assess conformance with WAC 246-310-220. The type of financial information required from the department will depend on how you propose to operate the proposed projects. Related to this, answer the following questions:

1. **Is the applicant (defined under WAC 246-310-010(6)) submitting any other hospice applications under either of this year's concurrent review cycles? This could include the same parent corporation or group of individuals submitting under separate LLCs under their common ownership.**

   If the answer to this question is no, there is no need to complete further questions under this section.

   Not applicable, applicant is not submitting any other hospice applications under either of this year's concurrent review cycles.

2. **If the answer to the previous question is yes, clarify:**
   - **Are these applications being submitted under separate companies owned by the same applicant(s); or**
   - **Are these applications being submitted under a single company/applicant?**
   - **Will they be operated under some other structure? Describe in detail.**

   Not applicable

3. **Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of this project in the first three full calendar years of operation. Provide pro forma balance sheets for the applicant, assuming approval of this project showing the first three full calendar years of operation. In addition, provide a pro forma balance sheet for the applicant assuming approval of all proposed projects in this year's review cycles showing the first three full calendar years of operation.**

   Not applicable

4. **In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements may be required.**
    - **If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.**
    - **If your applications propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.**

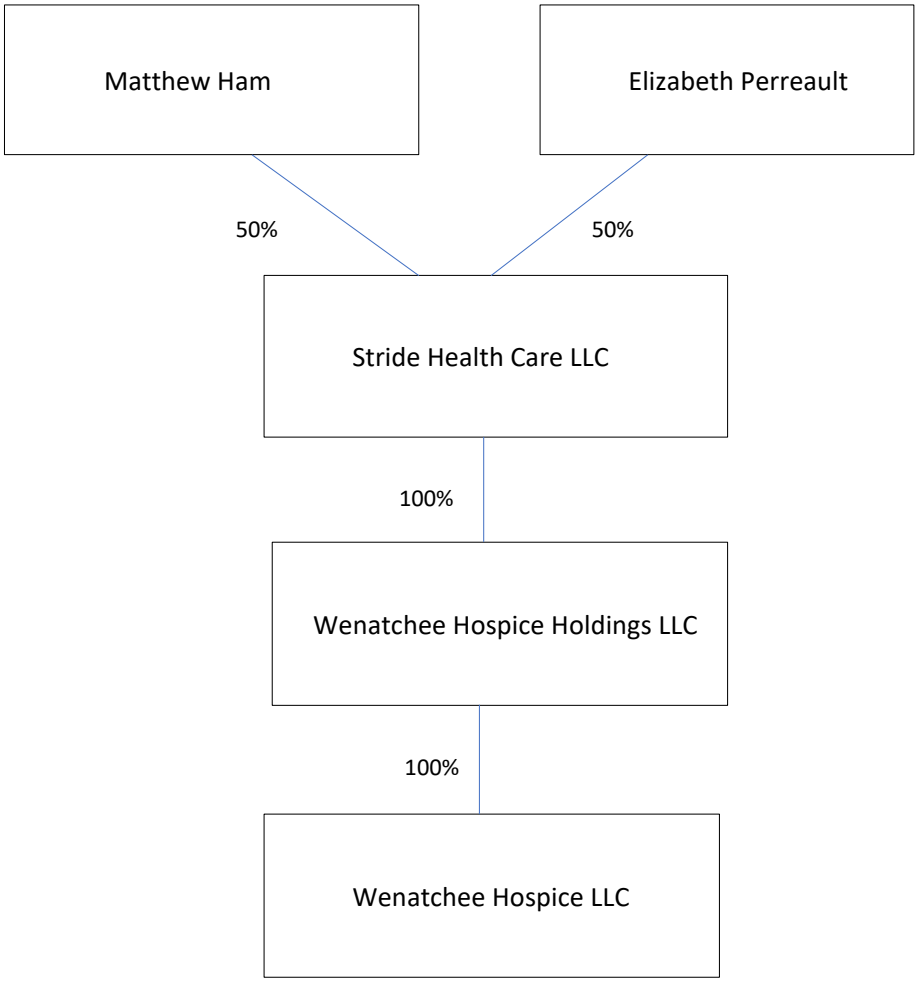
Not applicable

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 1

Organizational Structure



Disclosure of Ownership

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 2

Applicant Information

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, STEVE R. HOBBS, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

WENATCHEE HOSPICE LLC

A **WA LIMITED LIABILITY COMPANY**, effective on the date indicated below.

Effective Date: 12/01/2021
UBI Number: 604 840 149

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Steve R. Hobbs, Secretary of State

Date Issued: 12/01/2021

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 3

List of Owned Entities

List of Owned Entities	
Agency Name	Wenatchee Home Health LLC dba Advanced Home Health Northwest of Wenatchee
Agency Location	285 Technology Center Way Suite 107, Wenatchee, WA 98801
Agency License Number	IHS.FS.60796898
Agency CMS Certification Number	50-7713
Agency Accreditation Status	Not Accredited
Type of Agency	Home Health

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 4

Letter of Intent

WENATCHEE HOSPICE, LLC

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 9:16 pm, Nov 29, 2021

Via email to FSLCON@doh.wa.gov

November 29, 2021

Eric Hernandez, Program Manager
Washington State Department of Health
Health Facilities and Certificate of Need
111 Israel Rd., SE
Tumwater, WA 98501

LOI21-11WHCh

Dear Mr. Hernandez,

This letter of intent is submitted on behalf of Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee who, in accordance with WAC 246-310-080, intends to operate a Medicare certified and Medicaid eligible Hospice agency to serve residents of Chelan County.

1. Description of proposed service: Wenatchee Hospice Holdings LLC, through Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee requests approval for a certificate of need to operate a Hospice Agency in Chelan County.

2. Estimated cost of the project: There will be no capital costs for this proposed project.

3. Identification of the service area: Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee will provide services in Chelan County.

Please let me know if you have any questions or need additional information. My direct line is 480-710-7323, email is matt@advhh.com, and address below.

Respectfully,
Wenatchee Hospice Holdings LLC

By: Matt Ham, COO
Stride Health Care LLC, its Manager

285 TECHNOLOGY CENTER WAY STE 108 WENATCHEE, WA 98801 (509)-663-9585

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 5

Washington State Department of Health 2021-2022 Hospice Numeric Need Methodology

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(a) Step 1:

Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.

WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Hospice admissions ages 0-64	
Year	Admissions
2018	4,114
2019	3,699
2020	3,679
	average: 3,831

Deaths ages 0-64	
Year	Deaths
2018	14,055
2019	14,047
2020	16,663
	average: 14,922

Use Rates	
0-64	25.67%
65+	60.15%

Hospice admissions ages 65+	
Year	Admissions
2018	26,207
2019	26,017
2020	27,956
	average: 26,727

Deaths ages 65+	
Year	Deaths
2018	42,773
2019	44,159
2020	46,367
	average: 44,433

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(b) Step 2:
Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

0-64				
County	2018	2019	2020	2018-2020 Average Deaths
Adams	28	35	20	**28**
Asotin	52	54	56	**54**
Benton	331	346	555	**411**
Chelan	130	137	224	**164**
Clallam	191	186	195	**191**
Clark	874	887	1,043	**935**
Columbia	6	7	7	**7**
Cowlitz	300	294	314	**303**
Douglas	51	63	42	**52**
Ferry	28	20	19	**22**
Franklin	145	123	100	**123**
Garfield	5	5	5	**5**
Grant	195	197	186	**193**
Grays Harbor	227	251	209	**229**
Island	135	167	110	**137**
Jefferson	64	72	68	**68**
King	3,264	3,275	4,456	**3,665**
Kitsap	515	557	454	**509**
Kittitas	68	90	78	**79**
Klickitat	58	46	42	**49**
Lewis	227	210	205	**214**
Lincoln	25	25	15	**22**
Mason	158	167	143	**156**
Okanogan	103	119	88	**103**
Pacific	64	66	55	**62**
Pend Oreille	43	31	41	**38**
Pierce	1,964	1,911	2,364	**2,080**
San Juan	19	20	18	**19**
Skagit	231	229	269	**243**
Skamania	27	19	26	**24**
Snohomish	1,533	1,533	1,587	**1,551**
Spokane	1,177	1,143	1,634	**1,318**
Stevens	113	112	86	**104**
Thurston	554	525	628	**569**
Wahkiakum	13	11	10	**11**
Walla Walla	110	118	150	**126**
Whatcom	360	394	457	**404**
Whitman	66	47	51	**55**
Yakima	601	555	653	**603**

65+				
County	2018	2019	2020	2018-2020 Average Deaths
Adams	72	93	59	**75**
Asotin	214	222	186	**207**
Benton	1,125	1,154	1,522	**1,267**
Chelan	573	626	785	**661**
Clallam	871	955	777	**868**
Clark	2,767	2,987	3,205	**2,986**
Columbia	43	52	43	**46**
Cowlitz	840	951	968	**920**
Douglas	255	270	160	**228**
Ferry	55	64	58	**59**
Franklin	278	313	263	**285**
Garfield	30	21	11	**21**
Grant	524	508	455	**496**
Grays Harbor	647	659	558	**621**
Island	675	642	505	**607**
Jefferson	336	338	273	**316**
King	9,917	10,213	11,186	**10,439**
Kitsap	1,713	1,811	1,714	**1,746**
Kittitas	239	266	241	**249**
Klickitat	158	160	113	**144**
Lewis	730	722	653	**702**
Lincoln	94	89	75	**86**
Mason	526	548	408	**494**
Okanogan	332	358	277	**322**
Pacific	279	265	177	**240**
Pend Oreille	130	125	101	**119**
Pierce	4,926	5,002	5,608	**5,179**
San Juan	114	127	94	**112**
Skagit	1,001	1,018	1,068	**1,029**
Skamania	56	87	47	**63**
Snohomish	4,055	4,081	4,278	**4,138**
Spokane	3,556	3,545	4,322	**3,808**
Stevens	373	345	248	**322**
Thurston	1,823	1,908	2,007	**1,913**
Wahkiakum	33	53	18	**35**
Walla Walla	445	450	522	**472**
Whatcom	1,252	1,461	1,481	**1,398**
Whitman	199	219	226	**215**
Yakima	1,517	1,451	1,675	**1,548**

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(c) Step 3.
Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

0-64		
County	2018-2020 Average Deaths	Projected Patients: 25.67% of Deaths
Adams	28	7
Asotin	54	14
Benton	411	105
Chelan	164	42
Clallam	191	49
Clark	935	240
Columbia	7	2
Cowlitz	303	78
Douglas	52	13
Ferry	22	6
Franklin	123	31
Garfield	5	1
Grant	193	49
Grays Harbor	229	59
Island	137	35
Jefferson	68	17
King	3,665	941
Kitsap	509	131
Kittitas	79	20
Klickitat	49	12
Lewis	214	55
Lincoln	22	6
Mason	156	40
Okanogan	103	27
Pacific	62	16
Pend Oreille	38	10
Pierce	2,080	534
San Juan	19	5
Skagit	243	62
Skamania	24	6
Snohomish	1,551	398
Spokane	1,318	338
Stevens	104	27
Thurston	569	146
Wahkiakum	11	3
Walla Walla	126	32
Whatcom	404	104
Whitman	55	14
Yakima	603	155

65+		
County	2018-2020 Average Deaths	Projected Patients: 60.15% of Deaths
Adams	75	45
Asotin	207	125
Benton	1,267	762
Chelan	661	398
Clallam	868	522
Clark	2,986	1,796
Columbia	46	28
Cowlitz	920	553
Douglas	228	137
Ferry	59	35
Franklin	285	171
Garfield	21	12
Grant	496	298
Grays Harbor	621	374
Island	607	365
Jefferson	316	190
King	10,439	6,279
Kitsap	1,746	1,050
Kittitas	249	150
Klickitat	144	86
Lewis	702	422
Lincoln	86	52
Mason	494	297
Okanogan	322	194
Pacific	240	145
Pend Oreille	119	71
Pierce	5,179	3,115
San Juan	112	67
Skagit	1,029	619
Skamania	63	38
Snohomish	4,138	2,489
Spokane	3,808	2,290
Stevens	322	194
Thurston	1,913	1,150
Wahkiakum	35	21
Walla Walla	472	284
Whatcom	1,398	841
Whitman	215	129
Yakima	1,548	931

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate

	0-64							
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	7	18,160	18,456	18,622	18,787	7	7	7
Asotin	14	16,715	16,596	16,540	16,485	14	14	14
Benton	105	167,984	171,026	172,638	174,249	107	108	109
Chelan	42	62,227	62,512	62,562	62,611	42	42	42
Clallam	49	52,494	52,233	52,027	51,821	49	49	48
Clark	240	411,278	421,901	426,529	431,158	246	249	252
Columbia	2	2,822	2,745	2,710	2,675	2	2	2
Cowlitz	78	85,817	85,843	85,769	85,695	78	78	78
Douglas	13	35,130	35,803	36,080	36,356	14	14	14
Ferry	6	5,628	5,541	5,506	5,470	6	6	6
Franklin	31	88,012	92,443	94,784	97,124	33	34	35
Garfield	1	1,581	1,541	1,522	1,502	1	1	1
Grant	49	86,033	88,240	89,322	90,403	51	51	52
Grays Harbor	59	57,387	56,679	56,401	56,122	58	58	57
Island	35	63,114	63,280	63,296	63,312	35	35	35
Jefferson	17	20,705	20,636	20,550	20,463	17	17	17
King	941	1,885,115	1,918,470	1,930,192	1,941,913	958	963	969
Kitsap	131	218,538	220,614	221,192	221,771	132	132	133
Kittitas	20	38,453	39,286	39,556	39,827	21	21	21
Klickitat	12	15,702	15,439	15,304	15,168	12	12	12
Lewis	55	62,700	63,164	63,327	63,491	55	55	56
Lincoln	6	7,864	7,751	7,698	7,644	5	5	5
Mason	40	50,632	51,397	51,672	51,946	41	41	41
Okanogan	27	32,364	32,087	31,991	31,896	26	26	26
Pacific	16	14,545	14,322	14,242	14,161	16	16	15
Pend Oreille	10	9,859	9,769	9,727	9,684	10	10	10
Pierce	534	756,339	769,918	774,696	779,475	543	547	550
San Juan	5	10,863	10,730	10,707	10,684	5	5	5
Skagit	62	100,807	101,887	102,236	102,586	63	63	63
Skamania	6	9,248	9,223	9,205	9,186	6	6	6
Snohomish	398	705,787	721,527	726,273	731,019	407	410	412
Spokane	338	423,256	426,740	428,033	429,326	341	342	343
Stevens	27	34,109	33,917	33,841	33,766	26	26	26
Thurston	146	238,190	243,867	246,235	248,602	150	151	152
Wahkiakum	3	2,498	2,405	2,368	2,332	3	3	3
Walla Walla	32	50,763	51,028	51,075	51,121	33	33	33
Whatcom	104	185,418	189,267	190,722	192,178	106	107	107
Whitman	14	43,222	43,315	43,322	43,330	14	14	14
Yakima	155	222,774	225,822	227,147	228,473	157	158	159

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

65+								
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	45	2,227	2,383	2,424	2,466	48	49	50
Asotin	125	5,812	6,175	6,344	6,514	132	136	140
Benton	762	30,986	33,373	34,597	35,820	821	851	881
Chelan	398	15,876	17,052	17,695	18,339	427	443	460
Clallam	522	21,800	22,901	23,535	24,168	548	563	579
Clark	1,796	78,605	85,686	89,247	92,807	1,958	2,039	2,121
Columbia	28	1,236	1,287	1,304	1,322	29	29	30
Cowlitz	553	22,148	23,719	24,470	25,220	592	611	630
Douglas	137	7,976	8,666	8,974	9,283	149	155	160
Ferry	35	2,168	2,289	2,337	2,386	37	38	39
Franklin	171	9,188	10,083	10,557	11,030	188	197	206
Garfield	12	645	669	680	692	13	13	13
Grant	298	14,861	16,071	16,665	17,258	322	334	346
Grays Harbor	374	16,123	17,133	17,612	18,092	397	408	419
Island	365	20,239	21,412	22,047	22,682	386	398	409
Jefferson	190	11,588	12,323	12,722	13,121	202	208	215
King	6,279	310,572	337,771	350,881	363,992	6,829	7,094	7,359
Kitsap	1,050	53,833	58,185	60,492	62,800	1,135	1,180	1,225
Kittitas	150	7,647	8,266	8,589	8,911	162	168	174
Klickitat	86	5,829	6,268	6,448	6,627	93	96	98
Lewis	422	16,808	17,697	18,175	18,652	444	456	468
Lincoln	52	2,891	3,039	3,119	3,200	54	56	57
Mason	297	15,905	17,167	17,836	18,504	321	333	346
Okanogan	194	10,475	11,210	11,519	11,827	207	213	219
Pacific	145	6,747	7,035	7,159	7,284	151	153	156
Pend Oreille	71	3,925	4,239	4,371	4,504	77	80	82
Pierce	3,115	130,688	142,422	148,729	155,037	3,395	3,545	3,695
San Juan	67	5,768	6,174	6,357	6,541	72	74	76
Skagit	619	27,881	30,314	31,460	32,607	673	698	724
Skamania	38	2,670	2,923	3,048	3,172	42	43	45
Snohomish	2,489	119,333	131,978	138,737	145,495	2,753	2,894	3,035
Spokane	2,290	87,852	94,670	97,979	101,288	2,468	2,554	2,641
Stevens	194	11,360	12,214	12,591	12,969	208	215	221
Thurston	1,150	50,757	54,900	56,967	59,035	1,244	1,291	1,338
Wahkiakum	21	1,503	1,580	1,595	1,611	22	22	22
Walla Walla	284	11,006	11,350	11,632	11,915	293	300	308
Whatcom	841	40,902	44,217	45,794	47,372	909	941	974
Whitman	129	5,526	6,008	6,201	6,395	140	145	149
Yakima	931	37,530	39,475	40,559	41,643	979	1,006	1,033

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(e) Step 5:
Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2021 potential volume	2022 potential volume	2023 potential volume	Current Supply of Hospice Providers	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*
Adams	55	56	57	**51.33**	4	5	6
Asotin	146	150	153	**105.00**	41	45	48
Benton	928	959	990	**1,016.67**	(88)	(57)	(26)
Chelan	469	486	502	**428.67**	41	57	73
Clallam	597	612	627	**392.80**	204	219	234
Clark	2,204	2,288	2,372	**2,584.47**	(380)	(296)	(212)
Columbia	30	31	31	**35.00**	(5)	(4)	(4)
Cowlitz	670	689	708	**788.00**	(118)	(99)	(80)
Douglas	163	168	174	**160.67**	2	8	13
Ferry	43	44	45	**32.00**	11	12	13
Franklin	221	231	240	**201.67**	19	29	39
Garfield	14	14	15	**6.00**	8	8	9
Grant	373	386	398	**292.33**	81	93	106
Grays Harbor	455	466	477	**295.57**	160	170	181
Island	422	433	445	**399.67**	22	34	45
Jefferson	219	226	232	**198.00**	21	28	34
King	7,786	8,057	8,328	**7,693.60**	93	364	635
Kitsap	1,267	1,312	1,358	**1,223.57**	43	89	134
Kittitas	182	189	195	**168.00**	14	21	27
Klickitat	105	108	110	**217.80**	(113)	(110)	(107)
Lewis	500	512	524	**445.33**	54	67	79
Lincoln	60	61	63	**29.00**	31	32	34
Mason	361	374	387	**304.57**	57	70	82
Okanogan	234	239	245	**188.33**	45	51	57
Pacific	166	169	171	**93.00**	73	76	78
Pend Oreille	87	89	92	**65.33**	22	24	26
Pierce	3,938	4,092	4,246	**3,527.67**	410	564	718
San Juan	77	79	81	**87.00**	(10)	(8)	(6)
Skagit	736	762	787	**729.00**	7	33	58
Skamania	48	50	51	**32.00**	16	18	19
Snohomish	3,160	3,303	3,447	**3,371.20**	(211)	(68)	76
Spokane	2,809	2,897	2,984	**2,720.50**	89	176	263
Stevens	235	241	247	**148.67**	86	92	99
Thurston	1,394	1,442	1,491	**1,496.73**	(103)	(54)	(6)
Wahkiakum	25	25	25	**9.33**	15	16	16
Walla Walla	326	333	340	**272.33**	53	60	68
Whatcom	1,015	1,048	1,081	**1,094.57**	(80)	(46)	(13)
Whitman	154	159	163	**158.17**	(4)	1	5
Yakima	1,136	1,164	1,192	**1,261.00**	(125)	(97)	(69)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(f) Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	**2021 Unmet Need Admissions***	**2022 Unmet Need Admissions***	**2023 Unmet Need Admissions***	**Statewide ALOS**	**2021 Unmet Need Patient Days***	**2022 Unmet Need Patient Days***	**2023 Unmet Need Patient Days***
Adams	4	5	6	**62.12**	244	300	356
Asotin	41	45	48	**62.12**	2,563	2,786	3,009
Benton	(88)	(57)	(26)	**62.12**	(5,497)	(3,565)	(1,633)
Chelan	41	57	73	**62.12**	2,535	3,539	4,542
Clallam	204	219	234	**62.12**	12,682	13,613	14,543
Clark	(380)	(296)	(212)	**62.12**	(23,619)	(18,396)	(13,174)
Columbia	(5)	(4)	(4)	**62.12**	(281)	(258)	(235)
Cowlitz	(118)	(99)	(80)	**62.12**	(7,320)	(6,160)	(5,000)
Douglas	2	8	13	**62.12**	134	470	807
Ferry	11	12	13	**62.12**	691	737	784
Franklin	19	29	39	**62.12**	1,201	1,801	2,401
Garfield	8	8	9	**62.12**	506	518	531
Grant	81	93	106	**62.12**	5,021	5,799	6,578
Grays Harbor	160	170	181	**62.12**	9,916	10,589	11,261
Island	22	34	45	**62.12**	1,377	2,090	2,802
Jefferson	21	28	34	**62.12**	1,324	1,726	2,127
King	93	364	635	**62.12**	5,759	22,588	39,417
Kitsap	43	89	134	**62.12**	2,696	5,513	8,331
Kittitas	14	21	27	**62.12**	889	1,290	1,691
Klickitat	(113)	(110)	(107)	**62.12**	(6,994)	(6,835)	(6,676)
Lewis	54	67	79	**62.12**	3,378	4,132	4,886
Lincoln	31	32	34	**62.12**	1,917	2,004	2,091
Mason	57	70	82	**62.12**	3,529	4,319	5,108
Okanogan	45	51	57	**62.12**	2,823	3,173	3,523
Pacific	73	76	78	**62.12**	4,554	4,714	4,875
Pend Oreille	22	24	26	**62.12**	1,337	1,483	1,630
Pierce	410	564	718	**62.12**	25,499	35,048	44,597
San Juan	(10)	(8)	(6)	**62.12**	(639)	(507)	(375)
Skagit	7	33	58	**62.12**	435	2,029	3,623
Skamania	16	18	19	**62.12**	984	1,094	1,204
Snohomish	(211)	(68)	76	**62.12**	(13,131)	(4,207)	4,717
Spokane	89	176	263	**62.12**	5,511	10,934	16,357
Stevens	86	92	99	**62.12**	5,345	5,741	6,136
Thurston	(103)	(54)	(6)	**62.12**	(6,387)	(3,385)	(384)
Wahkiakum	15	16	16	**62.12**	956	967	977
Walla Walla	53	60	68	**62.12**	3,304	3,758	4,213
Whatcom	(80)	(46)	(13)	**62.12**	(4,953)	(2,888)	(823)
Whitman	(4)	1	5	**62.12**	(231)	50	330
Yakima	(125)	(97)	(69)	**62.12**	(7,760)	(6,032)	(4,305)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources: CPS MDCR Hospice 3 Report
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(g) Step 7:
Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

				Step 7 (Patient Days / 365) = Unmet ADC		
County	**2021 Unmet Need Patient Days***	**2022 Unmet Need Patient Days***	**2023 Unmet Need Patient Days***	**2021 Unmet Need ADC***	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***
Adams	244	300	356	1	1	1
Asotin	2,563	2,786	3,009	7	8	8
Benton	(5,497)	(3,565)	(1,633)	(15)	(10)	(4)
Chelan	2,535	3,539	4,542	7	10	12
Clallam	12,682	13,613	14,543	35	37	40
Clark	(23,619)	(18,396)	(13,174)	(65)	(50)	(36)
Columbia	(281)	(258)	(235)	(1)	(1)	(1)
Cowlitz	(7,320)	(6,160)	(5,000)	(20)	(17)	(14)
Douglas	134	470	807	0	1	2
Ferry	691	737	784	2	2	2
Franklin	1,201	1,801	2,401	3	5	7
Garfield	506	518	531	1	1	1
Grant	5,021	5,799	6,578	14	16	18
Grays Harbor	9,916	10,589	11,261	27	29	31
Island	1,377	2,090	2,802	4	6	8
Jefferson	1,324	1,726	2,127	4	5	6
King	5,759	22,588	39,417	16	62	108
Kitsap	2,696	5,513	8,331	7	15	23
Kittitas	889	1,290	1,691	2	4	5
Klickitat	(6,994)	(6,835)	(6,676)	(19)	(19)	(18)
Lewis	3,378	4,132	4,886	9	11	13
Lincoln	1,917	2,004	2,091	5	5	6
Mason	3,529	4,319	5,108	10	12	14
Okanogan	2,823	3,173	3,523	8	9	10
Pacific	4,554	4,714	4,875	12	13	13
Pend Oreille	1,337	1,483	1,630	4	4	4
Pierce	25,499	35,048	44,597	70	96	122
San Juan	(639)	(507)	(375)	(2)	(1)	(1)
Skagit	435	2,029	3,623	1	6	10
Skamania	984	1,094	1,204	3	3	3
Snohomish	(13,131)	(4,207)	4,717	(36)	(12)	13
Spokane	5,511	10,934	16,357	15	30	45
Stevens	5,345	5,741	6,136	15	16	17
Thurston	(6,387)	(3,385)	(384)	(17)	(9)	(1)
Wahkiakum	956	967	977	3	3	3
Walla Walla	3,304	3,758	4,213	9	10	12
Whatcom	(4,953)	(2,888)	(823)	(14)	(8)	(2)
Whitman	(231)	50	330	(1)	0	1
Yakima	(7,760)	(6,032)	(4,305)	(21)	(17)	(12)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted October 1, 2021

WAC246-310-290(8)(h) Step 8:
Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

	Step 7 (Patient Days / 365) = Unmet ADC			Step 8 - Numeric Need	
County	**2021 Unmet Need ADC***	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***	**Numeric Need?**	**Number of New Agencies Needed?****
Adams	1	1	1	FALSE	FALSE
Asotin	7	8	8	FALSE	FALSE
Benton	(15)	(10)	(4)	FALSE	FALSE
Chelan	7	10	12	FALSE	FALSE
Clallam	35	37	40	*TRUE*	*1*
Clark	(65)	(50)	(36)	FALSE	FALSE
Columbia	(1)	(1)	(1)	FALSE	FALSE
Cowlitz	(20)	(17)	(14)	FALSE	FALSE
Douglas	0	1	2	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	3	5	7	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	14	16	18	FALSE	FALSE
Grays Harbor	27	29	31	FALSE	FALSE
Island	4	6	8	FALSE	FALSE
Jefferson	4	5	6	FALSE	FALSE
King	16	62	108	*TRUE*	*3*
Kitsap	7	15	23	FALSE	FALSE
Kittitas	2	4	5	FALSE	FALSE
Klickitat	(19)	(19)	(18)	FALSE	FALSE
Lewis	9	11	13	FALSE	FALSE
Lincoln	5	5	6	FALSE	FALSE
Mason	10	12	14	FALSE	FALSE
Okanogan	8	9	10	FALSE	FALSE
Pacific	12	13	13	FALSE	FALSE
Pend Oreille	4	4	4	FALSE	FALSE
Pierce	70	96	122	*TRUE*	*3*
San Juan	(2)	(1)	(1)	FALSE	FALSE
Skagit	1	6	10	FALSE	FALSE
Skamania	3	3	3	FALSE	FALSE
Snohomish	(36)	(12)	13	FALSE	FALSE
Spokane	15	30	45	*TRUE*	*1*
Stevens	15	16	17	FALSE	FALSE
Thurston	(17)	(9)	(1)	FALSE	FALSE
Wahkiakum	3	3	3	FALSE	FALSE
Walla Walla	9	10	12	FALSE	FALSE
Whatcom	(14)	(8)	(2)	FALSE	FALSE
Whitman	(1)	0	1	FALSE	FALSE
Yakima	(21)	(17)	(12)	FALSE	FALSE

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**The numeric need methodology projects need for whole hospice agencies only - not partial hospice agencies. Therefore, the results are rounded down to the nearest whole number.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

Washington State Department of Health

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	2018	2019	2020
Adams	6	8	4
Asotin	6	9	24
Benton	118	103	132
Chelan	34	28	32
Clallam	16	23	24
Clark	336	287	297
Columbia	1	3	3
Cowlitz	107	121	94
Douglas	10	19	17
Ferry	6	5	3
Franklin	30	26	34
Garfield	1	1	3
Grant	41	45	40
Grays Harbor	35	41	27
Island	38	43	54
Jefferson	21	26	17
King	1009	765	889
Kitsap	180	173	96
Kittitas	15	16	12
Klickitat	10	12	12
Lewis	56	50	47
Lincoln	7	3	5
Mason	14	34	43
Okanogan	21	27	31
Pacific	13	15	12
Pend Oreille	8	4	17
Pierce	543	556	425
San Juan	6	6	8
Skagit	48	77	70
Skamania	2	1	3
Snohomish	422	342	361
Spokane	400	329	362
Stevens	30	20	21
Thurston	114	115	129
Wahkiakum	2	0	3
Walla Walla	24	41	41
Whatcom	117	138	80
Whitman	19	12	12
Yakima	248	175	195

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	2018	2019	2020
Adams	34	54	48
Asotin	121	71	84
Benton	887	837	973
Chelan	386	385	421
Clallam	187	234	283
Clark	2124	2060	2238
Columbia	23	25	50
Cowlitz	600	735	707
Douglas	136	130	170
Ferry	29	25	28
Franklin	155	166	194
Garfield	2	4	7
Grant	261	236	254
Grays Harbor	180	212	186
Island	348	341	375
Jefferson	155	181	194
King	6359	6315	7131
Kitsap	1021	1074	921
Kittitas	135	169	157
Klickitat	81	90	87
Lewis	420	362	401
Lincoln	29	22	21
Mason	161	193	263
Okanogan	148	171	167
Pacific	72	98	69
Pend Oreille	53	65	49
Pierce	3175	3170	2714
San Juan	79	73	89
Skagit	680	705	607
Skamania	20	33	37
Snohomish	2636	2214	2636
Spokane	2247.5	2175	2648
Stevens	121	126	128
Thurston	936	947	1070
Wahkiakum	5	7	11
Walla Walla	227	242	242
Whatcom	770	995	978
Whitman	226.5	77	128
Yakima	977	998	1190

Total Admissions by County - Not Adjusted for New

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	257	307	**255.67**
Clark	2460	2347	2535	**2447.33**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	213	**227.00**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7080	8020	**7489.33**
Kitsap	1201	1247	1017	**1155.00**
Kittitas	150	185	169	**168.00**
Klickitat	91	102	99	**97.33**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	306	**236.00**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3139	**3527.67**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	2556	2997	**2870.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1050	1062	1199	**1103.67**
Wahkiakun	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1058	**1026.00**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

Total Admissions by County - Adjusted for New
Adjusted Cells Highlighted in YELLOW

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	462.7	512.7	**392.80**
Clark	2460	2552.7	2740.7	**2584.47**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	418.7	**295.57**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7400.4	8312.4	**7693.60**
Kitsap	1201	1247	1222.7	**1223.57**
Kittitas	150	185	169	**168.00**
Klickitat	272.7	281.7	99	**217.80**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	511.7	**304.57**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3139	**3527.67**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	3378.8	3676.8	**3371.20**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1255.7	1449.4	1785.1	**1496.73**
Wahkiakun	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1263.7	**1094.57**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/62.12 ALOS = 205.7 default admissions
205.7 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Recent approvals showing default volumes:
Olympic Medical Center - Clallam County. Approved in September 2019. Default volumes for 2019-2020
Providence Hospice - Clark County. Approved in 2019. Default volumes in 2019-2020
The Pennant Group - Grays Harbor County. Approved August 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Heart of Hospice - Klickitat County. Approved in August 2017. Operational since August 2017. Default volumes in 2018-2019.
Envision Hospice - Kitsap County. Approved in 2020. Default volumes for 2020
Wesley Homes Hospice - King County. Approved in 2015, operational since 2017. 2018 volumes exceed "default" - no adjustment for 2018. Adjustments in 2019.
Envision Hospice - King County. Approved in 2019. Default volumes for 2019-2020
Continuum Care of King - King County. CN issued March 2020. Default volumes for 2020
The Pennant Group - Mason County. Approved September 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Continuum Care of Snohomish - Snohomish County. Approved in July 2019. Default volumes in 2019-2020
Heart of Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Envision Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Glacier Peak Healthcare - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Envision Hospice - Thurston County. Approved in September 2018. Default volumes in 2018-2020.
Symbol Healthcare - Thurston County. Approved in November 2019. Default volumes for 2019-2020
Bristol Hospice - Thurston County. Approved March 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
EmpRes Healthcare Group - Whatcom County. Approved in 2020. Default volumes for 2020

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Survey Responses

Note: Kindred Hospice in Whitman and Spokane Counties did not respond to the department's survey for 2018 data. As a result, the average of 2016 and 2017 data was used as a proxy for 2018.

Agency Name	License Number	County	Year	0-64	65+
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2018	40	254
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2018	6	28
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2018	6	34
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2018	1	11
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2018	4	44
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2018	16	186
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2018	24	273
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2018	35	280
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2018	41	8
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2018	10	133
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2018	34	386
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2018	2	5
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2018	54	383
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2018	87	524
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2018	1	2
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2018	6	121
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2018	1	9
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2018	79	690
Evergreen Health Home Care Services	IHS.FS.00000278	King	2018	348	1989
Franciscan Hospice	IHS.FS.00000287	Kitsap	2018	141	693
Franciscan Hospice	IHS.FS.00000287	King	2018	102	921
Franciscan Hospice	IHS.FS.00000287	Pierce	2018	331	2110
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2018	0	3
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2018	1	7
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2018	21	148
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2018	37	180
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2018	13	71
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2018	35	180
Heart of Hospice	IHS.FS.00000185	Skamania	2018	none repo	10
Heart of Hospice	IHS.FS.00000185	Klickitat	2018	1	23
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2018	6	137
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2018	24	219
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2018	20	235
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2018	1	1
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2018	20	76
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2018	243	1305
Horizon Hospice	IHS.FS.00000332	Spokane	2018	31	389
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2018	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2018	1	1
Hospice of Spokane	IHS.FS.00000337	Ferry	2018	6	29
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2018	8	53
Hospice of Spokane	IHS.FS.00000337	Stevens	2018	30	121
Hospice of Spokane	IHS.FS.00000337	Spokane	2018	346	1593
Hospice of Spokane	IHS.FS.00000337	Whitman	2018	none repo	none repor
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2018	6	60
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2018	2	67
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2018	6	79
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2018	48	680
IRREGULAR-COMMUNITY HOME HEALTH & HOSPICE	IHS.FS.00000262	Pacific	2018	0	1
IRREGULAR-MULTICARE	IHS.FS.60639376	Clallam	2018	0	1
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2018	20	144
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2018	39	436
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2018	none repo	none repor
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2018	none repo	none repor
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2018	14	94
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2018	14	96
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2018	35	198
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2018	25	416
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2018	19	226.5
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2018	23	265.5
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2018	15	135
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2018	5	40
Kline Galland Community Based Services	IHS.FS.60103742	King	2018	29	368
Memorial Home Care Services	IHS.FS.00000376	Yakima	2018	183	750
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2018	32	158

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Survey Responses

Agency Name	License Number	County	Year	0-64	65+
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2018	25	232
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2018	177	867
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2018	1	9
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2018	4	18
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2018	11	44
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2018	316	1772
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2018	none repo	none repor
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2018	11	13
Providence Hospice of Seattle	IHS.FS.00000336	King	2018	407	1959
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2018	10	117
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2018	21	140
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2018	90	663
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2018	30	155
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2018	112	750
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2018	1	23
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2018	24	227
Wesley Homes	IHS.FS.60276500	King	2018	29	368
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2018	117	770
Alpha Home Health	IHS.FS.61032013	Snohomish	2019	0	0
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2019	9	71
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2019	1	4
Central Washington Homecare Services	IHS.FS.00000250	Chelan	2019	28	385
Central Washington Homecare Services	IHS.FS.00000250	Douglas	2019	19	125
Chaplaincy Health Care 2018	IHS.FS.00000456	Benton	2019	96	700
Chaplaincy Health Care 2018	IHS.FS.00000456	Franklin	2019	26	164
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2019	98	636
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2019	0	7
Community Home Health/Hospice	IHS.FS.00000262	Clark	2019	60	453
Continuum Care of King LLC	IHS.FS.61058934	King	2019	0	0
Continuum Care of Snohomish LLC	IHS.FS.61010090	Snohomish	2019	0	0
Envision Hospice of Washington	IHS.FS.60952486	Thurston	2019	2	22
EvergreenHealth	IHS.FS.00000278	King	2019	225	2025
EvergreenHealth	IHS.FS.00000278	Snohomish	2019	53	471
EvergreenHealth	IHS.FS.00000278	Island	2019	1	11
Franciscan Hospice	IHS.FS.00000287	King	2019	92	921
Franciscan Hospice	IHS.FS.00000287	Kitsap	2019	118	757
Franciscan Hospice	IHS.FS.00000287	Pierce	2019	364	2236
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2019	27	171
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2019	0	5
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2019	4	8
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2019	41	212
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2019	15	98
Heartlinks	IHS.FS.00000369	Benton	2019	7	137
Heartlinks	IHS.FS.00000369	Yakima	2019	21	180
Heartlinks	IHS.FS.00000369	Franklin	2019	0	2
Horizon Hospice	IHS.FS.00000332	Spokane	2019	30	393
Hospice of Jefferson County, Jefferson Healthcare	IHI.FS.00000349	Jefferson	2019	26	172
Hospice of Spokane	IHS.FS.00000337	Spokane	2019	289	1692
Hospice of Spokane	IHS.FS.00000337	Stevens	2019	20	126
Hospice of Spokane	IHS.FS.00000337	Ferry	2019	5	25
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2019	4	65
Hospice of the Northwest	IHS.FS.00000437	Island	2019	14	56
Hospice of the Northwest	IHS.FS.00000437	San Juan	2019	6	73
Hospice of the Northwest	IHS.FS.00000437	Skagit	2019	77	705
Hospice of the Northwest	IHS.FS.00000437	Snohomish	2019	5	58
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Skamania	2019	0	17
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Klickitat	2019	2	24
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Clark	2019	0	3
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Snohomish	2019	0	0
Kaiser Continuing Care Services Hospice	IHS.FS.00000353	Clark	2019	43	387
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	King	2019	37	489
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Kitsap	2019	18	123
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Pierce	2019	25	176
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Snohomish	2019	7	62
Kindred Hospice	IHS.FS.60308060	Spokane	2019	10	90
Kindred Hospice	IHS.FS.60308060	Whitman	2019	12	77
Kindred Hospice	IHS.FS.60330209	King	2019	6	217
Kittitas Valley Healthcare Home Health and Hospice	IHS.FS.00000320	Kittitas	2019	16	169

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Survey Responses

Agency Name	License Number	County	Year	0-64	65+
Klickitat Valley Hospice	IHS.FS.00000361	Klickitat	2019	1	44
Kline Galland Community Based Services	IHS.FS.60103742	King	2019	35	345
Memorial Home Care Services	IHS.FS.00000376	Yakima	2019	148	730
MultiCare Hospice	IHS.FS.60639376	King	2019	27	149
MultiCare Hospice	IHS.FS.60639376	Pierce	2019	167	758
MultiCare Hospice	IHS.FS.60639376	Kitsap	2019	37	194
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2019	23	234
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2019	0	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2019	17	244
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2019	6	45
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2019	22	240
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2019	0	0
PeaceHealth Hospice	IHS.FS.60331226	Clark	2019	184	1217
PeaceHealth Hospice	IHS.FS.60331226	Cowlitz	2019	23	99
PeaceHealth Hospice	IHS.FS.60331226	Skamania	2019	0	1
PeaceHealth Whatcom	IHS.FS.00000471	Whatcom	2019	138	995
Providence Hospice	IHS.FS.60201476	Klickitat	2019	9	22
Providence Hospice	IHS.FS.60201476	Skamania	2019	1	15
Providence Hospice	IHS.FS.60201476	Clark	2019	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2019	272	1613
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2019	1	29
Providence Hospice of Seattle	IHS.FS.00000336	King	2019	338	2083
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2019	5	10
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2019	91	685
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2019	28	148
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2019	33	118
Puget Sound Hopsice	IHS.FS.61032138	Thurston	2019	0	0
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2019	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2019	3	25
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2019	8	54
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2019	41	228
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2019	3	22
Wesley Homes	IHS.FS.60276500	King	2019	5	86
WhidbeyHealth Home Health, Hospice	IHS.FS.00000323	Island	2019	27	245
Yakima HMA Home Health, LLC	IHS.FS.60097245	Yakima	2019	6	88
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0

DOH 260-028 October 2021

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Survey Responses

Agency Name	License Number	County	Year	0-64	65+
Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	0	0
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
Preliminary Death Data Updated October 12, 2021

	0-64			65+		
County	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
ADAMS	28	35	20	72	93	59
ASOTIN	52	54	56	214	222	186
BENTON	331	346	555	1,125	1154	1522
CHELAN	130	137	224	573	626	785
CLALLAM	191	186	195	871	955	777
CLARK	874	887	1043	2,767	2987	3205
COLUMBIA	6	7	7	43	52	43
COWLITZ	300	294	314	840	951	968
DOUGLAS	51	63	42	255	270	160
FERRY	28	20	19	55	64	58
FRANKLIN	145	123	100	278	313	263
GARFIELD	5	5	5	30	21	11
GRANT	195	197	186	524	508	455
GRAYS HARBOR	227	251	209	647	659	558
ISLAND	135	167	110	675	642	505
JEFFERSON	64	72	68	336	338	273
KING	3,264	3,275	4456	9,917	10213	11186
KITSAP	515	557	454	1,713	1811	1714
KITTITAS	68	90	78	239	266	241
KLICKITAT	58	46	42	158	160	113
LEWIS	227	210	205	730	722	653
LINCOLN	25	25	15	94	89	75
MASON	158	167	143	526	548	408
OKANOGAN	103	119	88	332	358	277
PACIFIC	64	66	55	279	265	177
PEND OREILLE	43	31	41	130	125	101
PIERCE	1,964	1,911	2364	4,926	5002	5608
SAN JUAN	19	20	18	114	127	94
SKAGIT	231	229	269	1,001	1018	1068
SKAMANIA	27	19	26	56	87	47
SNOHOMISH	1,533	1,533	1587	4,055	4081	4278
SPOKANE	1,177	1,143	1634	3,556	3545	4322
STEVENS	113	112	86	373	345	248
THURSTON	554	525	628	1,823	1908	2007
WAHKIAKUM	13	11	10	33	53	18
WALLA WALLA	110	118	150	445	450	522
WHATCOM	360	394	457	1,252	1461	1481
WHITMAN	66	47	51	199	219	226
YAKIMA	601	555	653	1,517	1451	1675

Sources:
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2021-2022 Hospice Numeric Need Methodology
0-64 Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,291	18,456	18,622	18,787	18,953	19,118	18,160
Asotin	16,969	16,906	16,842	16,779	16,715	16,652	16,596	16,540	16,485	16,429	16,373	16,715
Benton	162,262	163,693	165,123	166,554	167,984	169,415	171,026	172,638	174,249	175,861	177,472	167,984
Chelan	61,284	61,520	61,755	61,991	62,227	62,463	62,512	62,562	62,611	62,661	62,710	62,227
Clallam	52,716	52,661	52,605	52,550	52,494	52,439	52,233	52,027	51,821	51,615	51,409	52,494
Clark	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414	411,278
Columbia	2,988	2,947	2,905	2,863	2,822	2,780	2,745	2,710	2,675	2,640	2,605	2,822
Cowlitz	85,417	85,517	85,617	85,717	85,817	85,917	85,843	85,769	85,695	85,621	85,547	85,817
Douglas	33,540	33,938	34,335	34,732	35,130	35,527	35,803	36,080	36,356	36,633	36,909	35,130
Ferry	5,834	5,782	5,731	5,680	5,628	5,577	5,541	5,506	5,470	5,435	5,399	5,628
Franklin	79,651	81,742	83,832	85,922	88,012	90,102	92,443	94,784	97,124	99,465	101,806	88,012
Garfield	1,665	1,644	1,623	1,602	1,581	1,560	1,541	1,522	1,502	1,483	1,464	1,581
Grant	81,535	82,660	83,784	84,909	86,033	87,158	88,240	89,322	90,403	91,485	92,567	86,033
Grays Harb	59,105	58,675	58,246	57,817	57,387	56,958	56,679	56,401	56,122	55,844	55,565	57,387
Island	62,514	62,664	62,814	62,964	63,114	63,264	63,280	63,296	63,312	63,328	63,344	63,114
Jefferson	20,636	20,653	20,670	20,688	20,705	20,722	20,636	20,550	20,463	20,377	20,291	20,705
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	1,965,356	1,885,115
Kitsap	212,548	214,045	215,543	217,040	218,538	220,035	220,614	221,192	221,771	222,349	222,928	218,538
Kittitas	36,206	36,768	37,330	37,892	38,453	39,015	39,286	39,556	39,827	40,097	40,368	38,453
Klickitat	16,208	16,082	15,955	15,828	15,702	15,575	15,439	15,304	15,168	15,033	14,897	15,702
Lewis	61,494	61,796	62,097	62,398	62,700	63,001	63,164	63,327	63,491	63,654	63,817	62,700
Lincoln	8,101	8,042	7,982	7,923	7,864	7,805	7,751	7,698	7,644	7,591	7,537	7,864
Mason	48,672	49,162	49,652	50,142	50,632	51,122	51,397	51,672	51,946	52,221	52,496	50,632
Okanogan	33,087	32,906	32,726	32,545	32,364	32,183	32,087	31,991	31,896	31,800	31,704	32,364
Pacific	15,115	14,972	14,830	14,688	14,545	14,403	14,322	14,242	14,161	14,081	14,000	14,545
Pend Oreill	10,045	9,998	9,952	9,905	9,859	9,812	9,769	9,727	9,684	9,642	9,599	9,859
Pierce	721,137	729,937	738,738	747,538	756,339	765,139	769,918	774,696	779,475	784,253	789,032	756,339
San Juan	11,305	11,194	11,084	10,974	10,863	10,753	10,730	10,707	10,684	10,661	10,638	10,863
Skagit	97,885	98,616	99,346	100,076	100,807	101,537	101,887	102,236	102,586	102,935	103,285	100,807
Skamania	9,272	9,266	9,260	9,254	9,248	9,242	9,223	9,205	9,186	9,168	9,149	9,248
Snohomish	661,812	672,806	683,800	694,793	705,787	716,781	721,527	726,273	731,019	735,765	740,511	705,787
Spokane	414,493	416,684	418,875	421,066	423,256	425,447	426,740	428,033	429,326	430,619	431,912	423,256
Stevens	34,576	34,459	34,343	34,226	34,109	33,992	33,917	33,841	33,766	33,690	33,615	34,109
Thurston	224,951	228,261	231,571	234,880	238,190	241,500	243,867	246,235	248,602	250,970	253,337	238,190
Wahkiakun	2,726	2,669	2,612	2,555	2,498	2,441	2,405	2,368	2,332	2,295	2,259	2,498
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,981	51,028	51,075	51,121	51,168	51,215	50,763
Whatcom	175,840	178,234	180,629	183,023	185,418	187,812	189,267	190,722	192,178	193,633	195,088	185,418
Whitman	42,880	42,965	43,051	43,137	43,222	43,308	43,315	43,322	43,330	43,337	43,344	43,222
Yakima	215,882	217,605	219,328	221,051	222,774	224,497	225,822	227,147	228,473	229,798	231,123	222,774

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

DOH 260-028 October 2021

Department of Health
2020-2021 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,341	2,383	2,424	2,466	2,507	2,549	2,227
Asotin	5,041	5,233	5,426	5,619	5,812	6,005	6,175	6,344	6,514	6,683	6,853	5,812
Benton	26,328	27,492	28,657	29,821	30,986	32,150	33,373	34,597	35,820	37,044	38,267	30,986
Chelan	13,746	14,279	14,811	15,343	15,876	16,408	17,052	17,695	18,339	18,982	19,626	15,876
Clallam	19,934	20,401	20,867	21,334	21,800	22,267	22,901	23,535	24,168	24,802	25,436	21,800
Clark	64,524	68,044	71,564	75,085	78,605	82,125	85,686	89,247	92,807	96,368	99,929	78,605
Columbia	1,102	1,135	1,169	1,202	1,236	1,269	1,287	1,304	1,322	1,339	1,357	1,236
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,969	23,719	24,470	25,220	25,971	26,721	22,148
Douglas	6,450	6,831	7,213	7,595	7,976	8,358	8,666	8,974	9,283	9,591	9,899	7,976
Ferry	1,876	1,949	2,022	2,095	2,168	2,241	2,289	2,337	2,386	2,434	2,482	2,168
Franklin	7,499	7,921	8,343	8,765	9,188	9,610	10,083	10,557	11,030	11,504	11,977	9,188
Garfield	595	607	620	633	645	658	669	680	692	703	714	645
Grant	12,395	13,011	13,628	14,244	14,861	15,477	16,071	16,665	17,258	17,852	18,446	14,861
Grays Harb	14,005	14,535	15,064	15,594	16,123	16,653	17,133	17,612	18,092	18,571	19,051	16,123
Island	18,086	18,625	19,163	19,701	20,239	20,777	21,412	22,047	22,682	23,317	23,952	20,239
Jefferson	10,244	10,580	10,916	11,252	11,588	11,924	12,323	12,722	13,121	13,520	13,919	11,588
King	254,219	268,307	282,395	296,484	310,572	324,660	337,771	350,881	363,992	377,102	390,213	310,572
Kitsap	45,652	47,697	49,743	51,788	53,833	55,878	58,185	60,492	62,800	65,107	67,414	53,833
Kittitas	6,464	6,760	7,055	7,351	7,647	7,943	8,266	8,589	8,911	9,234	9,557	7,647
Klickitat	4,792	5,051	5,310	5,570	5,829	6,088	6,268	6,448	6,627	6,807	6,987	5,829
Lewis	15,166	15,576	15,987	16,398	16,808	17,219	17,697	18,175	18,652	19,130	19,608	16,808
Lincoln	2,619	2,687	2,755	2,823	2,891	2,959	3,039	3,119	3,200	3,280	3,360	2,891
Mason	13,528	14,123	14,717	15,311	15,905	16,499	17,167	17,836	18,504	19,173	19,841	15,905
Okanogan	8,773	9,198	9,624	10,050	10,475	10,901	11,210	11,519	11,827	12,136	12,445	10,475
Pacific	6,095	6,258	6,421	6,584	6,747	6,910	7,035	7,159	7,284	7,408	7,533	6,747
Pend Oreill	3,195	3,378	3,560	3,742	3,925	4,107	4,239	4,371	4,504	4,636	4,768	3,925
Pierce	108,983	114,409	119,836	125,262	130,688	136,114	142,422	148,729	155,037	161,344	167,652	130,688
San Juan	4,876	5,099	5,322	5,545	5,768	5,991	6,174	6,357	6,541	6,724	6,907	5,768
Skagit	22,735	24,021	25,308	26,595	27,881	29,168	30,314	31,460	32,607	33,753	34,899	27,881
Skamania	2,158	2,286	2,414	2,542	2,670	2,798	2,923	3,048	3,172	3,297	3,422	2,670
Snohomish	95,788	101,674	107,560	113,447	119,333	125,219	131,978	138,737	145,495	152,254	159,013	119,333
Spokane	73,817	77,325	80,834	84,343	87,852	91,361	94,670	97,979	101,288	104,597	107,906	87,852
Stevens	9,454	9,930	10,407	10,884	11,360	11,837	12,214	12,591	12,969	13,346	13,723	11,360
Thurston	42,459	44,534	46,608	48,683	50,757	52,832	54,900	56,967	59,035	61,102	63,170	50,757
Wahkiakur	1,254	1,316	1,379	1,441	1,503	1,565	1,580	1,595	1,611	1,626	1,641	1,503
Walla Wall	10,757	10,819	10,881	10,944	11,006	11,068	11,350	11,632	11,915	12,197	12,479	11,006
Whatcom	33,950	35,688	37,426	39,164	40,902	42,640	44,217	45,794	47,372	48,949	50,526	40,902
Whitman	4,370	4,659	4,948	5,237	5,526	5,815	6,008	6,201	6,395	6,588	6,781	5,526
Yakima	34,088	34,949	35,809	36,670	37,530	38,391	39,475	40,559	41,643	42,727	43,811	37,530

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

DOH 260-028 October 2021

APPENDIX 6

Admissions Policy

ADMISSION CRITERIA AND PROCESS
Policy No. 4-021.1

PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

Advanced Hospice Northwest of Wenatchee will admit any patient with a life-limiting illness that meets the admission criteria.

Patients will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence. (See "Scope of Services" Policy No. 1-024.)

While patients are accepted for services based on their hospice care needs, the patient's ability to pay for such services, whether through state or federal assistance programs, private insurance, or personal assets is a factor that will be considered.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary's Local Coverage Determinations (LCDs).

Advanced Hospice Northwest of Wenatchee reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Advanced Hospice Northwest of Wenatchee cannot meet his/her needs.

Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

Admission Criteria

1. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.

2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.

3. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and hospice Medical Director, utilizing standard clinical prognosis criteria developed by LCD.

4. The patient must desire hospice services, and be aware of the diagnosis and prognosis.

5. The focus of care desired must be palliative versus curative.

6. The patient and family/caregiver desire hospice care, agree to participate in the plan of care, and sign the consent form for hospice care.

7. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.

8. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.

9. The patient must reside within the geographical area that the Advanced Hospice Northwest of Wenatchee services.

10. Eligibility for participation will not be based on the patient's race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

11. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.

12. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

PROCEDURE

1. The organization will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.

2. The Clinical Supervisor will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source, or based on the information regarding the patient's condition or as ordered by the physician (or other authorized independent practitioner).

3. Assignment of appropriate hospice personnel to conduct the initial assessments of patient's eligibility for admission will be based on:

   A. Patient's geographical location

   B. Complexity of patient's hospice care needs/level of care required

   C. Hospice personnel's education and experience

   D. Hospice personnel's special training and/or competence to meet patient's needs

   E. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay.

   A. Such notification and approval will be documented.

   B. If approval is not obtained for the delay, the patient will be referred to another hospice for services.

5. A hospice registered nurse will make an initial contact prior to the patient's hospital discharge, if possible or appropriate. The initial home visit will be made within the time frame requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner). The purpose of the initial visit will be to:

   A. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.

   B. Provide a written copy and explain (verbally) the patient's rights and responsibilities and grievance procedure. (See "Patient Bill of Rights" Policy No. 2-002.)

   C. Provide the patient with a copy of Advanced Hospice Northwest of Wenatchee notice of privacy practices.

   D. Assess the family/caregiver's ability to provide care.

   E. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.

   F. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.

G. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

H. Provide services as needed and ordered by physician (or other authorized independent practitioner), and incorporate additional needs into the hospice plan of care.

I. Give patient information about durable power of attorney for health care, if the patient has not already done so.

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Source of payment

7. If eligibility criteria is met the patient and family/caregiver will be provided with a hospice brochure and various educational materials providing sufficient information on:

   A. Nature and goals of care and/or service

   B. Hours during which care or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)

   C. Access to care after hours

   D. Costs/charges to the patient, if any, for care, treatment or services

   E. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement

   F. Safety information

   G. Infection control information

   H. Emergency preparedness plans

   I. Available community resources

   J. Complaint/grievance process

K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

8. The hospice registered nurse will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

9. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

10. The patient or his/her representative will sign the required forms indicating election of hospice care and receipt of patient rights and privacy information.

11. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.

12. The hospice registered nurse will assist the family in understanding changes in the patient's status related to the progression of an end-stage disease.

13. The hospice registered nurse will educate the family in techniques for providing care.

14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.

15. The hospice registered nurse will complete an initial assessment during this visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment" Policy No. 4-041.)

16. The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the plan of care, prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No. 4-042.)

18. The time frames will apply for weekends and holidays, as well as weekday admissions.

19. A clinical record will be initiated for each patient admitted for hospice services.

20. If a patient does not meet the admission criteria or cannot be cared for by Advanced Hospice Northwest of Wenatchee, the Clinical Supervisor should be notified and appropriate referrals to other sources of care made on behalf of the patient.

21. The following individuals should be notified of non-admits:

    A. Patient

    B. Physician

    C. Referral source (if not physician)

22. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc.

23. In instances where patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Executive Director/Administrator in consultation with the Medical Director, upon request of the referring party and/or the patient.

24. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Executive Director/Administrator will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal organization's recommendation. The patient and family/caregiver, as appropriate, and physician will be involved in deliberations about the denial of care or conflict about care decisions.

25. A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 7

Charity Care Policy

CHARITY CARE
Policy No. 3-007.1

PURPOSE

To identify the criteria to be applied when accepting patients for charity care regardless of race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, or national origin.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria.

Advanced Hospice Northwest of Wenatchee will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The organization will consistently apply the charity care policy.

PROCEDURE

1. When it is identified that the patient has no source for payment of services and requires medically necessary care/service, the patient will be requested to provide personal financial information upon which the determination of charity care will be made.

2. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.

3. The Executive Director/Administrator, with the appropriate program director, will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care.

4. All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.

5. When financial declarations reveal the patient is able to make partial payment for services, the Executive Director/Administrator, with the appropriate program director, will determine the sliding-fee schedule to be implemented based upon current Federal Poverty Level Guidelines.

6. The sliding-fee schedule will be presented to the patient for agreement and signature.

7. After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.

8. When the organization is unable to admit the patient or to continue charity care, every effort will be made to refer the patient for appropriate care/service with an alternate provider.

9. The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

10. Eligibility for charity care under this policy is contingent upon the patient's cooperation with the application process, including submission of necessary information to effectively make a charity care determination.

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 8

Patient Rights and Responsibilities Policy

PATIENT BILL OF RIGHTS
Policy No. 2-002.1

PURPOSE

To encourage awareness of patient rights, to provide guidelines to assist patients making decisions regarding care, and to support active participation in care planning.

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights as described. The rights contained within this policy include the basic rights of the patient. Additional rights may be required by program specific standards and will be found in program specific policy.

A patient may designate someone to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

To assist with fully understanding patient rights, all policies will be available to organization personnel, the patient, and his/her representatives as well as other organizations and the interested public.

PROCEDURE

1. The Patient Bill of Rights statement defines the right of the patient to:

    A. Exercise and understand his or her rights and responsibilities as a patient of Advanced Hospice Northwest of Wenatchee and not to be subject to discrimination or reprisal for exercising these rights.

    B. Receive effective pain and symptom management for conditions related to the terminal illness(es) and choose a health care provider (including an attending physician).

    C. Have his or her property and person treated with respect, consideration and recognition of patient dignity and individuality.

    D. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the organization and must not be subjected to discrimination or reprisal for doing so.

    E. Receive an investigation by the organization of complaints made by the patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for the patient's property by anyone furnishing services on behalf of the organization; the existence of the complaint and the resolution of the complaint must be documented.

F. Be informed in advance of service about the care to be furnished, the organization's scope of services and services under the Medicare Hospice Benefit and any limitations on these services.

G. Be advised in advance of the right to participate in planning the care or service and in planning changes in the care and service.

H. Confidentiality of the patient and clinical records maintained by the organization and the policies and procedures regarding disclosure.

I. Be free from mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of an unknown source, and misappropriation of patient property.

J. Refuse care or treatment after the consequences of refusing care or treatment are fully presented.

K. Receive care/service without discrimination in accordance with physician orders.

L. Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service and as changes occur, including fees for services/products provided, direct pay responsibilities, and notification of insurance coverage.

M. Receive in writing, prior to the start of care, the telephone numbers for the ACHC Hotline, including hours of operation, and the purpose of the hotlines to receive complaints or questions about the organization.

N. Be informed of patient rights under state law to formulate Advance Directives.

O. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.

P. Be able to identify visiting personnel through proper identification.

Q. Be informed of disciplines furnishing care and the frequency of visits.

R. Recommend changes in policies and procedures, personnel or care/service.

S. Be informed of any financial benefits when referred to a hospice.

T. Be informed of anticipated outcomes of care and any barriers in outcome achievement.

U. Be informed of the patient's responsibilities.

2. Upon admission, the admitting clinician/technician will provide each patient or his/her representative with a written copy of the Patient Bill of Rights.

3. The Patient Bill of Rights will be explained (verbally/orally) and distributed to the patient prior to the initiation of organization services. This explanation will be in a language and manner he/she can reasonably be expected to understand.

4. The patient will be requested to sign the Patient Bill of Rights form. The original form will be kept in the patient's clinical record. A copy will be maintained by the patient. The patient's refusal to sign will be documented in the clinical record, including the reason for refusal.

5. The admitting clinician will document that the patient has received a copy of the Patient Bill of Rights.

   A. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made.

   B. In the event a communication barrier exists, if possible, special devices or interpreters will be made available.

   C. Written information will be provided to patients in the predominant languages of the population served.

6. When the patient's representative signs the Patient Bill of Rights form, an explanation of that relationship must be documented and kept on file in the clinical record.

7. The family or guardian may exercise the patient's rights when a patient is incompetent or a minor.

8. All organization personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually. (See "Patient Privacy Rights" Policy No. 2-012.)

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Certificate of Need Application

APPENDIX 9

Non Discrimination Policy

NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS

Policy No. 2-037.1

PURPOSE

To prevent organization personnel from discriminating against other personnel, patients, or other organizations on the basis of race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, or national origin.

POLICY

In accordance with Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Advanced Hospice Northwest of Wenatchee will, directly or through contractual or other arrangement, admit and treat all persons without regard to race, color, or place of national origin in its provision of services and benefits, including assignments or transfers within facilities.

In accordance with Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulations, Advanced Hospice Northwest of Wenatchee will not, directly or through contractual or other arrangements, discriminate on the basis of disability (mental or physical) in admissions, access, treatment or employment.

In accordance with the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Advanced Hospice Northwest of Wenatchee will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

In accordance with Title II of the Americans with Disabilities Act of 1990, Advanced Hospice Northwest of Wenatchee will not, on the basis of disability, exclude or deny a qualified individual with a disability from participation in, or benefits of, the services, programs or activities of the organization.

In accordance with other regulations the organization will not discriminate in admissions, access, treatment, or employment on the basis of gender, sexual orientation, religion, or communicable disease.

PROCEDURE

1. The Section 504/ADA Compliance Coordinator and Section 1557 Civil Rights Coordinator (can be same person) designated to coordinate the efforts of Advanced Hospice Northwest of Wenatchee to comply with the regulations will be the Executive Director/Administrator. Contact the Executive Director/Administrator at (509) 663-9585.

2. Advanced Hospice Northwest of Wenatchee will identify an organization or person in their service area who can interpret or translate for persons with limited English proficiency and who can disseminate information to and communicate with sensory impaired persons. These contacts will be listed and kept in the policy manual. (See "Facilitating Communication" Policy No. 2-038.)

3. A copy of this policy will be posted in the reception area of Advanced Hospice Northwest of Wenatchee, given to each organization staff member, and sent to each referral source.

4. A nondiscrimination statement (See #5) will be posted in a conspicuous place, such as the reception area of the organization and will be printed on brochures, other printed public materials and in a conspicuous location on the organization's web site accessible from the home page, in English and at least the top 15 non-English languages spoken in the state.

5. The nondiscrimination statement will read: *"Advanced Hospice Northwest of Wenatchee complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Advanced Hospice Northwest of Wenatchee does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Advanced Hospice Northwest of Wenatchee provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written materials in other formats (e.g. large print, audio, accessible electronic formats). Advanced Hospice Northwest of Wenatchee provides free language services to people whose primary language is not English such as qualified interpreters and information written in other languages. If you need these services, contact the Section 504/ADA Coordinator/Section 1557 Civil Rights Coordinator at* (509) 663-9585. *If you believe that Advanced Hospice Northwest of Wenatchee has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with Joel Stephens the Executive Director/Administrator at 285 Technology Center Way Suite 108, Wenatchee WA 98801 by phone at* (509) 663-9585 by fax at *(509) 663-2925 or email at Joel@advhh.com You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joel Stephens is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Compliant Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 2020; 1-800-368-1019, 800-537-7697(TDD)"*

6. Any person who believes she or he has been subjected to discrimination or who believes he or she has witnessed discrimination, in contradiction of the policy stated above, may file a grievance under this procedure. It is against the law for Advanced Hospice Northwest of Wenatchee to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

7. Grievances must be submitted to the Section 504/ADA Compliance Coordinator/ Section 1557 Civil Rights Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

8. A complaint may be filed in writing, or verbally, containing the name and address of the person filing it ("the grievant"). The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought by the grievant.

9. The Section 504 Coordinator/Section 1557 Civil Rights Coordinator (or her/his representative) will conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint.

10. The Section 504/ADA Compliance Coordinator/ Section 1557 Civil Rights Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

11. The grievant may appeal the decision of the Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator by filing an appeal in writing to Advanced Hospice Northwest of Wenatchee within 15 days of receiving the Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator's decision.

12. Advanced Hospice Northwest of Wenatchee will issue a written decision in response to the appeal no later than 30 days after its filing.

13. The Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator will maintain the files and records of Advanced Hospice Northwest of Wenatchee relating to such grievances.

14. The availability and use of this grievance procedure does not preclude a person from filing a complaint of discrimination on the basis of handicap with the regional office for Civil Rights of the U.S. Department of Health and Human Services.

15. All organization personnel will be informed of this process during their orientation process.

16. Advanced Hospice Northwest of Wenatchee will make appropriate arrangements to assure that persons with disabilities can participate in or make use of this grievance process on the same basis as the nondisabled. Such arrangements may include, but will not be limited to, the providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for providing such arrangements.

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 10

Selection/Hiring of Personnel Policy

Orientation Policy

Personnel Orientation Checklist

SELECTION/HIRING OF PERSONNEL
Policy No. 1-006.1

PURPOSE

To specify the criteria for selection of personnel to meet the care/service needs of patients.

POLICY

The organization will use a consistent, nondiscriminatory process for the selection of all personnel. The most qualified individuals will be employed without regard to race, color, religion, age, gender, sexual orientation, marital status, disability (mental or physical), communicable disease, or place of national origin as required by state and federal law.

The organization will provide promotion and advancement opportunities in a nondiscriminatory fashion.

PROCEDURE

Selection and Screening

1. A notice of position opening will be posted in-house and published in local newspapers and/or other instruments appropriate for recruiting personnel.

2. Prospective personnel will be screened by phone or in person to assure that the candidate meets the job requirements and qualifications, such as:

    A. Valid state license or certification, as applicable

    B. At least one (1) year of experience and/or as defined in the job description

Hiring

1. An individual seeking employment will complete an application, including information and verification about education, work experience, job history, and references, and have a personal interview. A criminal background check and national sex offender check, if not part of criminal background check, will be obtained for positions as required by law and regulations.

    A. The following factors will be considered for those applicants with a criminal history in determining whether to hire the external candidate: the nature of the crime and its relationship to the position, the time since the conviction, the number (if more than one) of convictions and whether hiring the applicant would pose an unreasonable risk to business.

        1. If it is determined that the organization will hire applicants with a criminal history, then additional individual supervision may be necessary.

2. Applicants for non-supervisory positions will be interviewed by the Executive Director, Clinical Director, Department Supervisor, or designee. Applicants for supervisory positions will be interviewed by the Executive Director/Administrator. The Executive Director/Administrator will confirm the applicants understanding of all care and services appropriate to the job the individual is applying for.

3. The interviewer will utilize a standardized interviewer's report form as well as the job description during the interview process.

4. Two (2) references, either telephone and/or written, will be obtained prior to an offer of employment.

5. Education will be verified, as appropriate, through viewing and copying the certificate, diploma or transcripts, or by institution contact.

6. Professional licensure/certification will be confirmed through viewing or copying the actual license and/or certificate. In addition, current licensure will be verified through the internet sites of official licensing bodies when they are available.

7. Other information obtained during the application process will include, but not be limited to, social security number and driver's license, as applicable to job position and appropriate level of automobile insurance coverage as required by the state.

8. Upon completion of the selection process, a candidate meeting all the organization requirements will be offered a position within the organization.

9. A current physical and TB test/chest X-Ray must be received prior to the first day of employment.

10. All new personnel (clinical and non-clinical) must attend an orientation program prior to assuming job responsibilities. (See "Orientation" Policy No. 1-022.)

11. Depending on the personnel classification, a specific orientation program will be conducted which addresses job responsibilities and a further review of organization policies.

12. All new personnel will be on a probationary status for 90 days from the date of hire unless otherwise specified.

13. New employee not on the Office of Inspector General (OIG) exclusion list.

14. New hires will complete the appropriate documentation forms such as withholding, Form I-9, etc.

15. Verification of the above will be documented.

Promotion

1. When possible, supervisory and management positions will be filled by internal candidates.

2. All supervisory and management position openings will be posted internally for at least two (2) weeks.

3. Interested personnel can apply for promotion verbally or in writing.

4. All interested applicants will be interviewed for the promotion.

5. In the event there is not a qualified internal applicant, the position will be filled with an outside applicant following the organization's policy.

ORIENTATION
Policy No. 1-022.1

PURPOSE

To provide guidelines for the orientation process.

POLICY

All personnel will be required to attend an orientation program upon employment and at the time of reassignment. The goal of orientation will be to inform and instruct new personnel regarding Advanced Hospice Northwest of Wenatchee's mission, policies and procedures, benefits (if applicable), the performance appraisal process, competency testing, as well as individual responsibilities and relationships to other personnel. Staff must know the importance of their role in furthering our Culture.

All personnel will demonstrate knowledge and proficiency in skills appropriate to their assigned responsibilities during the orientation period.

All clinical personnel prior to being assigned to care must present documentation of current CPR certification. CPR certification must be renewed per American Heart Association guidelines. Online CPR certification is acceptable with in-person verification of competency.

(See "Competency Based Orientation" Policy No. 3-002.)

PROCEDURE

1. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided:

   A. General company orientation including the organization's culture, mission/philosophy, policy and procedures, environmental safety program, etc.

   B. Review of organizational chart and lines of authority and responsibility

   C. Hours of work

   D. Job related responsibilities (job description), including orientation to equipment, if applicable

   E. Care and services provided by the organization; diseases and medication conditions common to hospice

   F. Baseline skills assessments as applicable to job classification

   G. Infection prevention and control within the organization and the home care setting

   H. Performance standards

   I. Confidentiality of organization and patient information/HIPAA regulations

J. Documentation requirements (record keeping and requirements)

K. OSHA compliance

L. Handling of hazardous medications and other materials

M. Medical Device Reporting/Incident Reporting

N. Equal Employment Opportunity Act

O. Ethical issue identification and resolution including conflict of interest, professional boundaries, etc.

P. Sexual Harassment Act

Q. Compensation and benefits information (salary/wages, benefits, etc.)

R. Unemployment and workers' compensation

S. Malpractice coverage, as applicable

T. Collective bargaining information, as applicable

U. Drug testing

V. Drug diversion

W. Family/State Medical Leave Act

X. Cultural Diversity and communication barriers

Y. Hispanic programing resources and expectations including volunteer program

Z. Client/Patient Rights including Advance Directives

AA. Standards of Conduct and Ethical Issues

BB. QAPI and activities

CC. Concept of death, dying, hospice philosophy, bereavement, caregiver as unit of service, etc.

DD. Pain and symptom management

EE. Emotional support of staff and client/patient (stress management)

FF. Compliance Plan and employee compliance responsibilities

GG. Emergency Management Plan for the organization and the employee's family emergency response plan

HH. Handling of patient complaints/grievances

II. If applicable, converging of charges for care/services

2. During the orientation process, the organization will provide comprehensive training drug diversion. (See "Comprehensive Controlled Substances Diversion Prevention Program" Addendum 1-022.B)

3. The orientation process, for all personnel will consist of both didactic and field supervision. Observation visits will be made by an appropriate supervisor to assess the skills demonstrated by new or reassigned personnel as well as reinforce the information presented during classroom time.

4. The orientation process for contract personnel will consist of the following:

   A. For contract personnel, the contracted organization will have one (1) member of the organization that has been oriented to Advanced Hospice Northwest of Wenatchee policies, procedures, and information presented during orientation. That individual will be responsible for orienting other contract personnel from that organization to Advanced Hospice Northwest of Wenatchee.

   B. For personnel the organization individually contracts with, a preceptor will be assigned during the orientation process.

5. During the orientation process, the supervisor will be responsible for evaluating the knowledge and skills of the personnel being oriented. Any areas of concern will be brought to the immediate attention of the new personnel. Appropriate guidance/monitoring will be provided or additional training recommended, if needed.

6. Assigned personnel will orient newly assigned personnel or volunteers to their responsibilities and to the patient needs when changes in patient assignment occur. The following will be included as appropriate:

   A. Patient needs including physical, psychosocial, and environmental aspects of care and service

   B. Personnel responsibilities

   C. Specific care and services to be provided

7. Orientation of new and reassigned personnel may include verbal or written instructions. Orientation may be provided in the patient's home.

8. Orientation of current employees assigned to new job classifications will include.

   A. Lines of authority and responsibility

   B. Hours of work

   C. Job responsibilities

D. Skills assessment as applicable to the specific job classification

E. Documentation responsibilities

9. A Personnel Orientation Checklist (See "Personnel Orientation Checklist" Addendum 1-022.A.) will be completed for all new personnel. New personnel will sign and date when their orientation has been completed.

10. The supervisor will sign and date the checklist when new personnel have completed all the required activities.

11. The probationary period will be 90 days, during which time the orientation process may be extended if the supervisor, or employee feels it is warranted.

PERSONNEL ORIENTATION CHECKLIST

Name: _____ Date:_____

CHECKLIST	DATE COMPLETED	ORIENTATION BY WHOM	PERSONNEL INITIALS
1. Tour of office/Introduction of organization personnel			
2. Introduction to work stations			
3. Completion of all employment forms			
4. Personnel file A. Application B. Sign job description (copy to personnel) C. Professional license, certification, registration, CPR documentation, as appropriate D. Driver's license, as appropriate E. Proof of auto insurance, as appropriate F. Physical exam, drug test, as appropriate G. TB Screening, as appropriate H. Hep B vaccination, as appropriate I. Standard precautions orientation J. Criminal background check/National Sex Offender Registry check K. OIG Exclusion List check verification			
5. Name and Photo Identification			
6. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided: A. General orientation to organization, including culture, philosophy, mission, and purpose, policies and procedures, environmental safety program B. Review of organizational chart and lines of authority and responsibility C. Hours of work D. Job related responsibilities E. Care and services provided by the organization F. Baseline skills assessments as applicable to job classification G. Infection prevention and control within the organization and home care setting H. Performance standards I. Confidentiality of organization and patient information/HIPAA J. Documentation requirements (Record keeping and reporting) K. OSHA compliance L. Medical Device Reporting M. Equal Employment Opportunity Act N. Ethical issue identification, resolution and boundaries/Standards of Conduct O. Sexual Harassment Act P. Compensation and benefits Q. Unemployment and workers compensation R. Malpractice coverage, as applicable S. Collective bargaining information, as applicable T. Drug testing			

CHECKLIST	DATE COMPLETED	ORIENTATION BY WHOM	PERSONNEL INITIALS
U. Family/State Medical Leave Act V. Cultural Diversity/Communication barriers W. Hispanic Programing Resources and Expectations Including Volunteer Program X. Patient/Client Rights and Handling of patient complaints Y. Concepts of death, dying and bereavement Z. Pain and symptom management AA. Emotional support of staff and patient (Stress management) BB. Advance Directives CC. Conflict of Interest DD. QAPI Plan EE. Incident/Variance Reporting FF. Compliance Program/Employee Responsibilities GG. Emergency Management Plan HH. Intro to hospice/hospice philosophy, unit of service, emotional support, psychosocial and spiritual issues II. Diseases/Conditions common to hospice JJ. Job specific: medical equipment, special populations			
7. Orientation to job description and job responsibilities (list or cross-reference)			
8. Skills/Competency Assessment (list or cross-reference)			
9. Culture and Company History and Objectives			
10. Culture and the Part You Now Play in Maintaining and Improving Culture			

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 11

QAPI Policy

IMPROVING ORGANIZATIONAL PERFORMANCE

Policy No. 5-001.1

PURPOSE

To establish palliative outcomes and end-of-life support services as the primary focus of the organization's performance improvement activities.

POLICY

Senior management will have the responsibility: to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve and maintain quality of care and service.

Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications.

All personnel will be active participants in the organization's quality assessment and performance improvement (QAPI) activities.

The Governing Body is responsible for ensuring that the QAPI program is defined, implemented and maintained, and is evaluated annually.

PROCEDURE

1. Senior management will:

    A. Participate in educational activities to increase their level of understanding and ability to implement quality assessment and performance improvement activities. The educational activities may include seminars, consultations, periodicals, and review of available information from other organizations (benchmarking).

    B. Adopt a structured framework for QAPI. The problem solving approach will stress the interrelationship of quality services provided, management activities, and sound business practices as applicable to the organization's (See "Sample QAPI Plan" Addendum 5-001.A.):

        1. Mission/philosophy
        2. Culture
        3. Strategic objectives
        4. Resources

5. Operational components/responsibilities (financial, clinical/service, and personnel)
6. Practice Standards
7. Activities related to patient care and patient safety focusing on high risk, high volume and problem prone areas; affect palliative outcomes and quality of care
8. Clinical/service skills and competencies of personnel
9. Quality indicators
10. Data collection and analysis
11. Frequency of activities

C. Identify and set specific outcomes for measurable improvement and acceptable limits for findings. (See "Prioritization of Important Processes" Addendum 5-001.B.)

1. At least one important aspect related to patient care must be monitored, one being pain brought under control within forty-eight (48) hours of admission
2. At least three (3) structural indicators must be monitored to assess the characteristics and capacity to deliver quality care. Examples:
   a. Providing care in accordance with patient and family goals
   b. Care coordination
   c. Patient safety
   d. Effective and timely symptom management
3. At least one important administrative/operational function
4. Patient satisfaction surveys will be monitored (See "Family/Caregiver Experience of Care Survey" Policy No. 5-010.)

D. Identify and participate in benchmarking activities that utilize:

1. Internal standards:
   a. Measuring current performance against past performance
   b. Measuring against internally established goals
2. Processes and protocols
3. Practice or service guidelines

4. Industry research or best practices (e.g. NHPCO, CMS)

E. Allocate resources for QAPI activities by:

1. Assigning organization personnel to participate in QAPI activities
2. Providing adequate time for organization personnel to participate in QAPI teams and activities
3. Creating and maintaining information systems and data management processes to support the collecting, managing and analyzing of data to improve performance
4. Utilizing appropriate statistical techniques to analyze and display data
    a. Statistical methodologies to consider include:
        1. Run charts that display summary comparison data
        2. Scatter diagrams
        3. Control charts that display variation and trends over time
        4. Histograms
        5. Pareto charts
        6. Cause and effect or fishbone diagrams
        7. Process flowcharts

F. Assure that each performance improvement activity contains the following elements:

1. Description of the indicator(s)/activities to be conducted
2. Frequency of activities
3. Designation of responsible party
4. Method(s) of data collection
5. Acceptable limits for findings
6. Who will receive the report
7. Follow-up plans if findings fail to meet acceptable limits including plan(s) of correction

2. Provide organization personnel training in the approaches and methods of assessment and improvement.

3. All other organization personnel will:

   A. Be involved in QAPI teams and activities.

   B. Promote communication and coordination of QAPI activities as well as contribute to those activities.

   C. Forward relevant information regarding QAPI activities to senior management and to the QAPI Coordinator.

   D. Take action on recommendations generated through performance improvement activities as outlined in the organization's written QAPI plan.

4. Trends identified through quality assessment and performance improvement measurement and analysis will be reported to the Governing Body on a quarterly basis.

5. Results of QAPI activities will be communicated with all staff via intranet, newsletters, email, etc.

6. Mandatory reporting to CMS will be completed within designated timeframes utilizing CMS reporting guidelines.

Sample Quality Assessment and Performance Improvement (QAPI) Plan

MISSION

All QAPI activities must support and be aligned with the mission of the organization.

The mission of The Hospice is to provide comprehensive coordinated care to individuals with life-limiting illnesses and to their families and to support them in the process of death and bereavement.

To carry out this mission, The Hospice provides:

- A holistic program for the dying patient and family, caring for the physical, psychological and spiritual concerns
- Relief of pain and other symptoms of illness on a 24 hour-a-day basis
- Bereavement services for individuals, families, and groups after the death of a loved one
- Education to families, caregivers, and the community at large in the areas of death and dying, grief and hospice care

PURPOSE

The purpose of The Hospice QAPI Plan is to provide a strategy for the systematic organization-wide implementation of quality assessment and performance improvement activities. This will ensure that the organization is providing appropriate, high-value, effective and efficient services in accordance with its mission and current standards of practice. Through QAPI activities, the organization provides a mechanism for identification and prioritization of opportunities for problem identification and improvement in care and operations.

OBJECTIVES

- To show measurable improvement in indicators that demonstrate an improvement in palliative outcomes and end-of-life support systems
- To measure, analyze and track quality indicators, including adverse events, to enable the assessment of processes of care, hospice services and operations
- To collect data to monitor the effectiveness and safety of services and quality of care as well as to identify opportunities for improvement
- To conduct Performance Improvement Projects aimed at performance improvement and to track performance to ensure that it is sustained
- To document QAPI activities including reasons for Performance Improvement Projects and progress achieved on these projects

METHODOLOGY

The QAPI Plan is operated through a committee structure. The QAPI Coordinator ensures that leadership priorities for improvement are evaluated. In addition, the QAPI Coordinator examines results from ongoing quality control activities to identify trends that will need follow-up action by the QAPI Committee.

The methodology selected to support and facilitate improvement activities is based on the Plan-Do-Study-Act (P-D-S-A) model. When an action for improvement is identified, an individual or project team may be designated to pilot the recommended action. A timeframe is established for implementing and evaluating the piloted action's outcome. The effectiveness of any action will be assessed through a process that measures whether the performance expectations outlined in the action plan have been met. This may require additional data collection and analysis. Statistical analysis will be used in assessing performance outcomes.

ASSIGNMENT OF RESPONSIBILITY

Resources will be made available to employees to assist them in gaining a basic understanding of QAPI principles. Inservices will be held periodically to reinforce the knowledge base. Each employee is responsible for the quality of care and services provided. The following summary of responsibilities provides a framework for the process of quality assessment and performance improvement.

The Governing Body is ultimately responsible for the QAPI Plan and for ensuring:

- That the QAPI Plan is ongoing, implemented and maintained
- That implemented QAPI activities address the appropriate priorities for the improved quality of care and patient safety
- Clear expectations for patient safety are met
- That all QAPI actions/changes are evaluated for effectiveness
- That mandatory reporting to CMS is completed within designated timeframes

RESPONSIBILITIES OF QAPI COORDINATOR

The QAPI Coordinator chairs the QAPI Committee and is responsible for coordinating and facilitating all quality improvement activities. This includes, but is not limited to:

- Ensuring the collection of accurate and reliable data
- Participating in cross-organizational activities to assess and improve overall organizational quality and performance
- Assisting in the implementation of corrective actions as appropriate
- Evaluating the effectiveness of planned and implemented actions
- Encouraging staff participation in improvement activities by mentoring; advancing education by acting as a resource to all staff
- Aggregating, trending and analyzing data using appropriate statistical techniques
- Reporting significant findings to appropriate managers, staff and governing bodies
- Reporting of structural measures and patient-level data items to CMS within designated timeframes

RESPONSIBILITIES OF QAPI COMMITTEE

The QAPI Committee is responsible for evaluating and prioritizing QAPI activities based on the aggregation of analysis of data collected. The QAPI Committee has the authority to issue recommendations for action or further study. Under the direction of the QAPI Coordinator, the committee issues a quarterly report summarizing QAPI activities and results of actions taken. The report is submitted to the Governing Body and appropriate managers and staff.

QAPI Committee members are appointed for staggered one-year terms that are renewable for a second term. The committee includes representatives from the following areas:

- Administration
- Clinical management
- Business office/billing
- Medical records
- Pharmacy
- Nursing
- Medical director or designee
- Spiritual care services
- Bereavement services
- Volunteer services
- Support services
- Contracted services
- Medical social services

Department managers and supervisors are responsible for providing leadership to ensure the communication and coordination of QAPI activities. Managers are responsible for initiating immediate corrective action if problems identified threaten the safety of patients or staff. Additionally, they are responsible for participating in the QAPI Committee when assigned and identifying opportunities for improvement through their daily interactions.

Clinical and office personnel are responsible for participating in identifying opportunities for improvement through their daily contact with patients, physicians and other employees. Staff may be requested to participate in the QAPI Committee or specific team activities such as data collection, analysis, action planning and implementation of new or improved processes as needed.

EVALUATION OF THE QAPI PLAN

A formal evaluation of all QAPI activities will occur annually. A written report will be completed by the QAPI Coordinator. After review by the directors of each department, the report will be presented to the Governing Body. The report will include a summary of all activities included as part of the QAPI Plan. The Governing Body will measure the effectiveness of the QAPI Plan based on the established objectives. The Governing Body will provide input into the identification and prioritization of future improvement activities.

CONFIDENTIALITY

The QAPI Coordinator maintains all QAPI-related records in a secure storage area. To protect individual identity, numbers/codes are assigned to employees and clinical records for data collection and reporting purposes. The master code list is maintained in a secured file. Completed unusual occurrence/incident reports are maintained by the administration. Any requests for results of or data from the QAPI Plan will be forwarded to the designated administrator, who will respond only according to the organization's policy and procedure.

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THE QAPI PLAN – DISCUSSION

This QAPI Plan is effective because the QAPI efforts are grounded in the mission of the organization. The approach is a multi-disciplinary and collaborative one, and specific areas of responsibility are outlined.

This QAPI Plan is founded on basic QAPI principles. It demonstrates that everyone in the organization is involved. It is not the job of one or two individuals. In order to accomplish this, the leaders provide education, resources in QAPI principles, and time to participate in QAPI activities.

The improvement methodology is identified to ensure a systematic approach to improvement efforts. There is a provision in the QAPI Plan to evaluate the effectiveness of the QAPI activities.

This QAPI Plan demonstrates leadership involvement throughout the process. The Plan allows the flexibility needed if new problems or opportunities take priority.

ROUTINE MEASUREMENT OF INDICATORS

SAMPLE SCHEDULE

This table presents a sample schedule of routine monitoring activities that incorporate NHPCO's Components of Quality Care. Instead, your hospice may choose other indicators such as the National Hospice and Palliative Care Organization's outcome measurements of self-determined life closure, comfortable dying, safety and effective grieving.

Indicator/Outcome	Sources of Data	Frequency of Measurement	Sample Size	Accountability
Patient and Family Centered Care				
Family willingness to refer	FEHC*	Quarterly	100%	QAPI Coordinator†
Caregiver confidence	FEHC	Quarterly	100%	QAPI Coordinator
Patient treated with respect	FEHC	Quarterly	100%	QAPI Coordinator
Bereavement POC meets family needs	Bereavement records	Quarterly	10% (min. of 10 records)	QAPI Coordinator
Ethical Behavior and Consumer Rights				
Employees oriented to Ethics policy	Employee files	Annually	100%	HR Coordinator†
Eligibility of patients	Admission & recert documentation	Quarterly	10% (min. of 10 records)	QAPI Coordinator
Clinical Excellence and Safety				
Pain assessment and management	Chart audit, ESAS**	Quarterly	10% patients with pain (min. of 10 records)	QAPI Coordinator
Management of dyspnea	Chart audit, ESAS	Quarterly	10% patients with dyspnea (min. of 10 records)	QAPI Coordinator
Management of nausea	Chart audit, ESAS	Quarterly	10% patients with nausea (min. of 10 records)	QAPI Coordinator
Management of anxiety	Chart audit, ESAS	Quarterly	10% patients with anxiety (min. of 10 records)	QAPI Coordinator
Management of depression	Chart audit, ESAS	Quarterly	10% patients with depression (min. of 10 records)	QAPI Coordinator
Management of wounds	Chart audit, ESAS	Quarterly	10% patients with wounds (min. of 10 records)	QAPI Coordinator
Feeling of well-being	Chart audit, ESAS	Quarterly	10% (min. of 10 records)	QAPI Coordinator
Appropriate use of GIP	Chart audit	Twice a year	100%	QAPI Coordinator
Respite available for caregiver need	Chart audit	Twice a year	100%	QAPI Coordinator
Continuous care appropriately used	Chart audit	Twice a year	100%	QAPI Coordinator
Hospice aide supervision every 2 weeks	Chart audit	Quarterly	10% patients with HHA care (min. of 10 records)	QAPI Coordinator
Evaluation of contracted services	Chart audit, FEHC	Annually	100%	QAPI Coordinator
Evaluation of adverse events	Incident log, chart audits	For each event	100%	Executive Director,† QAPI Coordinator

Indicator/Outcome	Sources of Data	Frequency of Measurement	Sample Size	Accountability
Inclusion and Access				
Annual inservice on cultural aspect of hospice care	Personnel files	Annually	100%	QAPI Coordinator
Organizational Excellence				
Governing body achieves functions specified in policy	Governing body minutes	Annually	100%	Executive Director
Workforce Excellence				
Staff competency evaluated yearly	Personnel files	Annually	100%	HR Coordinator
Required number of inservices	Personnel files	Annually	100%	HR Coordinator
All employees complete hospice-specific orientation	Personnel files	Annually	100%	HR Coordinator
Standards of Practice				
NHPCO Nursing Standards and/or National Consensus Standards for Palliative Care met	Chart audit	Quarterly	10% (min. of 10 records)	QAPI Coordinator
NHPCO Social Work Standards and/or National Consensus Standards for Palliative Care met	Chart audit	Quarterly	10% (min. of 10 records)	QAPI Coordinator
Compliance with Laws and Regulations				
Survey readiness: mock survey	Chart audits, administrative records	Annually	10% (min. of 10 records)	QAPI Coordinator, Executive Director
Stewardship and Accountability				
Met budget and financial goals set by Governing Body	Financial records	Annually	100%	Executive Director
Performance Measurement				
Staff inservices provided on QAPI	Inservice notebook	Annually	100%	QAPI Coordinator
QAPI Plan carried out as directed by Governing Body	QAPI documentation	Annually	100%	Executive Director, QAPI Coordinator

* *FEHC – Family Evaluation of Hospice Care (NHPCO)*
** *ESAS – Edmonton Symptom Assessment Scale*
† *Organization's title or job function may vary*

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 12

Projections and Pro Forma

ADVANCED HOSPICE UTILIZATION PROJECTION	2023	2024	2025
Total number of admissions	85	165	183
Total number of patient days	5,263	10,220	11,383
Projected average daily census	14.3	27.8	31

Advanced Hospice
3 Year Projected Income Statement

	2023	2024	2025
Census			
Medicare	12.6	24.5	27.3
Medicaid	1.0	1.9	2.2
Commercial	0.7	1.4	1.5
Census	**14.3**	**27.8**	**31.0**
Medicare			
Routine 1 - 60	866,885	1,683,187	1,874,687
Routine 61 +	22,898	44,465	49,524
Respite	23,604	46,928	52,267
GIP	23,946	46,500	51,790
Continuous	-	-	-
Medicare Total	937,333	1,821,079	2,028,268
Medicaid			
Routine 1 - 60	67,637	131,342	146,285
Routine 61 +	1,709	3,729	3,729
Respite	3,673	7,347	11,020
GIP	-	-	-
Continuous	-	-	-
Medicaid Total	73,020	142,418	161,034

Commercial			
Routine 1 - 60	43,709	84,940	93,434
Routine 61 +	1,119	1,678	3,356
Respite	2,479	4,959	4,959
GIP	-	-	-
Continuous	-	-	-
Commercial Total	47,307	91,577	101,749
Charity Total	21,153	41,101	45,821
Gross Revenue	**1,078,813**	**2,096,176**	**2,336,872**
Contractual Adjustment	(21,153)	(41,101)	(45,821)
Bad Debt	(10,577)	(20,551)	(22,911)
Net Revenue	**1,047,083**	**2,034,523**	**2,268,141**
Operating Expenses			
Clinical Labor Expense			
Clinical Director	52,418	52,418	52,418
RN Case Manager	151,580	294,348	327,836
CNA	80,001	155,350	173,025
QAPI Nurse	40,886	40,886	40,886
Social Worker	34,711	67,404	75,073
Spiritual Care Coordinator	27,769	53,923	60,058
Payroll Taxes	74,574	107,810	115,606
Workers Compensation	6,155	8,898	9,541
Direct Wages	468,093	781,036	854,443
Ancillary Expense			
Ambulance/Transportation	1,810	3,514	3,914
Medical Director	35,833	69,582	77,499
Equipment Rental / DME	23,177	45,007	50,128
GIP	16,211	31,479	35,060
Inpatient Respite	10,282	20,441	22,766
Contract Rehabilitation	2,500	5,000	6,000
Medical Supplies	10,000	19,419	21,628
Pharmacy / Lab / Xray	37,751	73,307	81,647
Total Ancillary Expense	137,563	267,749	298,643
Total Direct Care Expenses	**605,657**	**1,048,785**	**1,153,085**

Overhead Expenses			
Administration Labor			
Administrator	57,964	57,964	57,964
Volunteer Coordinator	50,321	50,321	50,321
Office Manager	31,451	31,451	31,451
Outreach Coordinator	56,611	56,611	56,611
Intake Coordinator / Clinical Support	37,741	37,741	37,741
Total Administration Labor	234,087	234,087	234,087
Administration Other Expenses			
Employee Benefits	23,358	45,359	50,519
Mileage	25,238	49,009	54,584
Advertising	14,400	14,400	14,400
Liability Insurance	7,800	7,800	7,800
Licenses and Fees	6,000	6,000	6,000
Software	24,000	24,000	24,000
Payroll Services	6,000	6,000	6,000
Management Fees	120,000	120,000	120,000
B & O Taxes	18,509	35,964	40,093
Dues & Education	12,000	12,000	12,000
Legal & Professional	1,200	1,200	1,200
Office Supplies and Postage	3,300	5,400	6,000
Telephone/Internet	9,825	13,848	14,597
Repairs and Maintenance	1,200	1,200	1,200
Recruitment	5,000	5,000	5,000
Allocated Costs	-	-	-
Total Administration Other Expenses	277,830	347,179	363,394
Total Administration Expenses	**511,918**	**581,267**	**597,481**
Non Operating Expenses			
Depreciation and Amortization	-	-	-
Interest	-	-	-
Lease Expense (Incl Utilities)	6,000	6,000	6,000
Total Non Operating Expenses	6,000	6,000	6,000
Total Expenses	**1,123,574**	**1,636,052**	**1,756,567**
Profit (Loss)	**(76,491)**	**398,471**	**511,574**

Advanced Hospice
Balance Sheet

	2023	2024	2025
Assets			
Cash	$ 92,802	$ 495,170	$ 1,008,607
Accounts Receivable	$ 76,916	$ 92,379	$ 95,460
Total Assets	**$ 169,718**	**$ 587,549**	**$ 1,104,068**
Liabilities			
Accounts Payable	$ (96,649)	$ (111,179)	$ (115,158)
Accrued Wages	$ (35,012)	$ (39,286)	$ (40,141)
Accrued Payroll Taxes	$ (4,548)	$ (5,103)	$ (5,214)
Total Liabilities	**$ (136,209)**	**$ (155,569)**	**$ (160,513)**
Equity			
Equity / (Net Income)	$ 76,491	$ (321,980)	$ (833,555)
Contribution	$ (110,000)	$ (110,000)	$ (110,000)
Total Equity	**$ (33,509)**	**$ (431,980)**	**$ (943,555)**

Advanced Hospice Rates

Level of Service	Medicare	Medicaid	Commercial	Average
Routine Home Care 0-60	$ 196.62	$ 196.62	$ 176.96	$ 195.61
Routine Home Care 61+	$ 155.38	$ 155.38	$ 139.84	$ 155.38
Respite	$ 459.16	$ 459.16	$ 413.24	$ 459.16
GIP	$ 1,034.02	$ 1,034.02	$ 930.62	$ 1,034.02
Continuous	$ 58.62	$ 58.62	$ 52.76	$ 58.62

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 13

Operating Agreements

OPERATING AGREEMENT
OF
WENATCHEE HOSPICE LLC

THIS OPERATING AGREEMENT is entered into and shall be effective as of the Effective Date, by and among the Company, the initial Manager, and the party identified on Exhibit A of this Agreement as Initial Member.

ARTICLE I
DEFINITIONS

The following terms used in this Agreement shall have the following meanings (unless otherwise expressly provided herein);

1.1 "**Act**" shall mean the Washington Limited Liability Company Act.

1.2 "**Additional Contribution**" shall mean any Contribution made pursuant to Section 6.2.

1.3 "**Additional Member**" shall mean a Member, other than an Initial Member, who has acquired a Membership Interest from the Company.

1.4 "**Agreement**" shall mean this Operating Agreement as originally executed and as amended or restated from time to time.

1.5 "**Articles**" shall mean the Certificate of Formation of the Company as filed with the Washington Secretary of State as the same may be amended or restated from time to time.

1.6 "**Bankruptcy**" shall mean, with respect to any Person, bankruptcy as defined in RCW 25.15.131.

1.7 "**Business Day**" shall mean any day other than Saturday, Sunday or any legal holiday observed in Washington.

1.8 "**Capital Account**" shall mean the account maintained with respect to a Member determined in accordance with Section 6.4.

1.9 "**Capital Interest**" shall mean a Person's positive Capital Account as it may be adjusted from time to time.

1.10 "**Cessation**" shall mean any action which causes a Person to cease to be Member as described in Article 11 hereof.

1.11 "**Code**" shall mean the Internal Revenue Code of 1986 or corresponding provisions of subsequent superseding federal revenue laws as amended.

1.12 "**Company**" shall refer to Wenatchee Hospice LLC

1.13 "**Company Property**" shall mean any Property owned by the Company.

1.14 "**Confidential Information**" means information or material proprietary to the Company or proprietary to others and entrusted to the Company, whether written or oral, tangible or intangible, which a Member obtains knowledge of through or as a result of the Member activities on behalf of the Company. Confidential Information may include, without limitation, data, know-how, trade secrets, designs, plans, drawings, specifications, reports, customer and supplier lists, pricing information, marketing techniques and materials, and manufacturing techniques and processes, whether related to the Company's past, present or future business activities, research or development, or products.

1.15 "**Contribution**" shall mean, with respect to any Member, the amount of money and the initial value of any Property (other than money) or the fair market value of services contributed or to be contributed to the Company with respect to the interest in the Company held by such Person.

1.16 "**Default Interest Rate**" shall mean the lesser of any maximum legal rate or the then current prime rate quoted by United States National Bank of Washington, N.A. plus 3 percent.

1.17 "**Dissolution Event**" shall mean the events identified in Section 12.2.

1.18 "**Economic Rights**" shall mean, with respect to any Membership Interest, a Person's share of the profits, losses, capital and distributions of Company Property pursuant to the Act, the Articles and this Agreement but shall not include any Management Rights.

1.19 "**Effective Date**" shall mean the date the Articles are filed.

1.20 "**Entity**" shall mean any general partnership, limited partnership, limited liability company, corporation, joint venture, trust, business trust, cooperative or association or any foreign trust or foreign business organization.

1.21 "**Family**" shall mean a Member's spouse, natural or adoptive lineal ancestors or descendants, and trusts in which any of them have a significant beneficial interest.

1.22 "**Fiscal Year**" shall mean the Company's fiscal year, which shall be determined pursuant to Code Section 706.

1.23 "**Incapacity**" shall mean any pathology resulting in mental or physical impairment such that the affected person is unable to perform any cognitive or physical task required to competently provide the services of the company or complete duties required under this Agreement and such mental or physical impairment is not expected to change over time.

1.24 "**Initial Contribution**" shall mean the initial Contribution made pursuant to Section 6.1.

1.25 "**Initial Member**" shall mean those Persons identified on Exhibit A attached hereto and made a part hereof by this reference who have executed the Agreement.

1.26 "**Management Right**" shall mean the right of a Member to participate in the management of the Company, including the rights to information and to consent or approve actions of the Member.

1.27 "**Manager**" shall mean a Person designated or selected to manage the affairs of Company under Article 4 hereof.

1.28 "**Member**" shall mean each of the parties who executes a counterpart of this Agreement as an Initial Member and each of the parties who may hereafter become Additional or Substitute Member.

1.29 "**Membership Interest**" shall mean a Member's entire interest in the Company including such Member's Economic Rights and Management Rights.

1.30 "**Permitted Transfer**" shall mean a Transfer of a Person's interest in the Company in accordance with Section 10.2.

1.31 "**Person**" shall mean any individual or Entity, and the heirs, executors administrators, legal representatives, successors, and assigns of such "Person" where the context so permits.

1.32 "**Property**" shall mean any property, real or personal tangible or intangible, including money and any legal or equitable interest in such property, but excluding services and promises to perform services in the future.

1.33 "**Regulations**" shall mean proposed temporary and final regulations promulgated under the Code in effect as of the date of filing the Articles and the corresponding sections of any regulations subsequently issued that amend or supersede such regulations.

1.34 "**Substitute Member**" shall mean a Person who would otherwise be a Transferee but who has been admitted to all of the rights of Membership (including Management Rights) as to the portion of a Member's Membership Interest being Transferred; provided however, it shall not include an existing Member who increases the Member's interest by acquiring an interest in the Company from another Person.

1.35 "**Transferee**" shall mean the owner of Economic Rights who is not a Member and as such has no Management Rights.

1.36 "**Transfer**" shall mean, as a noun, any voluntary or involuntary transfer, sale, or other disposition and, as a verb, voluntarily or involuntarily to transfer, sell, or otherwise dispose of.

ARTICLE 2
ORGANIZATION OF COMPANY

2.1 Organization. Matthew Ham, as organizer, by causing the limited agent to execute and file the Certificate of Formation, has created the Company in accordance with and pursuant to the Act. Consistent with the Act and the Articles, the Initial Member hereby provides for the regulation and management of the affairs of the Company.

2.2 Nature of Business. The Company may engage in any lawful business permitted by the Act or the laws of any jurisdiction in which the Company may do business. The Company shall have the authority to do all things necessary or convenient to accomplish its purpose and operate its business.

2.3 Defects as to Formalities. A failure to observe any formalities or requirements of this Agreement, the Articles or the Act shall not be grounds for imposing personal liability on the Member or Manager for liabilities of the Company.

2.4 No Partnership Intended for Nontax Purposes. The Member has formed the Company under the Act, and expressly does not intend hereby to form a partnership under either the Washington Uniform Partnership Act or the Washington Uniform Limited Partnership Act with any other third party or to form a corporation under the Washington Business Corporation Act.

2.5 Rights of Creditors and Third Parties. This Agreement is entered into among the Company and the Initial Member for the exclusive benefit of the Company, its Member, and its successors and assigns. The Agreement is expressly not intended for the benefit of any creditor of the Company or any other Person. Except and only to the extent provided by applicable statute, no such creditor or third party shall have any rights under the Agreement or any agreement between the Company and any Member with respect to any Contribution or otherwise.

2.6 Title to Property. All Company Property shall be owned by the Company as an entity and no Member shall have any ownership interest in such Property in the Member's individual name or right, and each Member's interest in the Company shall be personal property for all purposes. Except as otherwise provided in this Agreement, the Company shall hold all Company Property in the name of the Company and not in the name or names of any Member or Member.

2.7 Payments of Individual Obligations. The Company's credit and assets shall be used solely for the benefit of the Company, and no asset of the Company shall be transferred or encumbered for or in payment of any individual obligation of any Member unless otherwise provided for herein.

ARTICLE 3
Member

3.1 Authority to Act. No Member shall have the power or authority to bind the Company unless the Member is a Manager or the Member has been authorized by the Manager to act as an agent of the Company in accordance with this Agreement. However, if the sole Member shall become insolvent, or otherwise cease to exist the Member's designated agent may act as the Manager with full power set forth herein.

3.2 Limitation of Liability. Each Member's liability shall be limited as set forth in this Agreement, the Act and other applicable law. A Member will not be personally liable, merely as a Member, for any debts or losses of the Company beyond the Member's respective Contributions and any obligation of the Member under Section 6.1 to make Contributions, except as otherwise provided by law.

3.3 Indemnification. The Company shall indemnify the Member for all costs, losses, liabilities, and damages paid or accrued by such Member, and advance expenses incurred by the Member, in connection with the business of the Company, to the fullest extent provided or allowed by the laws of Washington except that this provision shall not eliminate or limit a Member's liability for:

(a) Any breach of a Member's duty of loyalty to the Company as described in this Agreement;

(b) Acts or omissions not in good faith which involve intentional misconduct or a knowing violation of law;

(c) Any unlawful distribution under the Act; or

(d) Any transaction from which the Member derives an improper personal benefit.

3.4 Member Management Rights. The Member shall be entitled to vote on or consent to any matter submitted to a vote or consent of the Member.

(a) In addition to any other actions which, by virtue of the Act, the Articles or this Agreement require a certain consent of the Member or the Manager, the following actions require the consent of the Member:

(1) Approving any transaction involving an actual or potential conflict of interest between a Member or a Manager and the Company;

(2) Admitting an Additional Member;

(3) Amending or restating this Agreement;

(4) Changing the nature of the business of the Company;

(5) Incurring a Company debt other than in the ordinary course of business; or

(6) Taking or approving any action or transaction which is reserved to the Member by the Act, the Articles or this Agreement without any express statement of the extent the Member's action is required.

(7) Amending or restating the Articles;

(8) Make and alter this Agreement not inconsistent with the Articles or the laws of Washington for managing the Company's business and regulating its affairs;

(9) Approving any action to sell, lease, exchange, mortgage, pledge or other transfer or disposition of all or substantially all of the Company Property, other than in the ordinary course of business;

(10) Merging the Company with another Entity; or

(11) Dissolving the Company pursuant to Section 12.2(c).

3.5 Actions of Member.

(a) Special Meetings. Special meetings of the Member, for any purpose or purposes, unless otherwise prescribed by statute, may be called by any Manager or by any Member.

(b) Place of Meetings. The Member may designate any place, either within or outside of Washington, as the location for any meeting of the Member. If no designation is made, or if a special meeting be otherwise called, the place of meeting shall be the principal executive office of the Company in Washington.

(c) Meeting. If the Member shall meet at any time and place, either within or outside of Washington, and consent to the holding of a meeting at such time and place, such meeting shall be valid without call or notice, and at such meeting lawful action may be taken.

(d) Record Date. For the purpose of determining the Member for any purpose, the date on which the Member consents to the meeting shall be the record date for such determination of the Company's Membership.

(e) Manner of Acting. Reserved

(f) Action by Member Without a Meeting. Action required or permitted to be taken at a meeting may be taken without a meeting if the action is evidenced by one or more written consents describing the action taken, signed by the Member and are sufficient to have approved the actions or resolutions at issue had a duly called meeting been held for inclusion in the minutes or for filing with the Company records. Action taken under this Section is effective when the Member has signed the consent, unless the consent specifies a different effective date. The record date for determining Member entitled to take action without a meeting shall be the date the Member signs a written consent.

(g) Waiver of Notice. Reserved

(h) Telephonic Meetings. Reserved

3.6 Books, Records, Reports and Information. Reserved.

ARTICLE 4
Manager

4.1 General.

(a) Initial Manager. The Initial Manager of the Company is Wenatchee Hospice Holdings LLC.

(b) Qualifications. The Manager must be a Member or the designated agent of the Member. In the event of the dissolution of the manager, Matt Ham shall serve as Manager with all the powers stated herein.

(c) Term. Each Manager shall hold office until the Manager resigns, dies, or is removed or replaced.

(d) Election. Except as otherwise provided herein, Manager shall be elected by the Member.

(e) Resignation. Any Manager may resign at any time by giving written notice to the Member. The resignation of any Manager shall take effect upon receipt of notice thereof or at such later time as shall be specified in such notice; and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. The resignation of a Manager who is also a Member shall not affect the Manager's rights as a Member and shall not constitute a withdrawal as a Member.

4.2 Authority of the Manager. Subject to the limitations and restrictions set forth in the Act, the Articles and this Agreement (including, without limitation, those set forth in this Article 4), the Manager shall have the sole and exclusive right to manage the business of the Company and shall have all of the rights and powers which may be possessed by the Manager under the Act and the Articles including and without limitation, the right and power, on behalf and in the name of the Company, to:

(a) Institute, prosecute, and complain and defend in all courts;

(b) Purchase, take, receive, lease or otherwise acquire, own, hold, improve, use and otherwise deal in or with real or personal property or any interest in real or personal property;

(c) Sell, convey, mortgage, pledge, create a security interest in, lease, exchange, transfer and otherwise dispose of all or any part of the Company Property;

(d) Purchase, take, receive, subscribe for or otherwise acquire, own, hold, vote, use, employ, sell, mortgage, lend, pledge, otherwise dispose of and otherwise use or deal in or with other interests in or obligations of any other Entity;

(e) Make contracts or guarantees, incur liabilities, borrow money, issue Company notes or other obligations that may be convertible into other securities of the Company, or include the option to purchase other securities of the Company, or secure any of the Company's obligations by mortgage or pledge of any of the Company Property, franchises or income;

(f) Lend money, invest or reinvest Company funds or receive and hold real or personal property as security for repayment of funds so loaned, invested or reinvested, including, without limitation, the loans to Manager, Member, employees and agents;

(g) Be a promoter, incorporator, general partner, limited partner, member, associate or manager of any partnership, joint venture, trust or other Entity;

(h) Conduct the Company's business, locate its offices and exercise the powers granted by the Act and the Articles within or without Washington.

(i) Elect or appoint Manager, employees or agents of the Company, define their duties, fix their compensation and lend them money and credit;

(j) Pay pensions and establish pension plans, profit sharing plans and other benefit or incentive plans for any and all of its current or former Manager, Member, employees and agents;

(k) Make donations for the public welfare or for charitable, scientific or educational purposes;

(l) Transact any lawful business that will aid governmental policy;

(m) Indemnify a Member or Manager or any other person as and to the extent not inconsistent with the provisions of the Act or the Articles;

(n) Cease the Company's activities and dissolve.

(o) So long as the Company has only a single Member, who is also the Manager, the Manager shall have the authority to place a nonmember, nonmanager as an authorized signer of any Company bank accounts.

4.3 Restrictions on Authority of Manager. In addition to any other consent requirements contained in the Act, the Articles or this Agreement, each Manager shall not have the authority to, and covenants and agrees that it shall not, do any of the following acts without the consent of the Member:

(a) Determining the amount and kind of property available for and the timing of distributions;

(b) Admitting an Additional Member;

(c) Accepting a Substitute Member;

(d) Expelling a Member; or

(e) Taking or approving any action or transaction which is reserved to the Manager by the Act, the Articles or this Agreement without any express statement of the extent of Manager action required.

4.4 Duties and Obligations of Manager. In addition to such other duties and obligations as Manager may have, the Manager shall be responsible for the following:

(a) The Manager shall cause the Company to conduct its business and operations separate and apart from that of any Manager, including, without limitation,

(1) segregating Company Property and not allowing Company Property to be commingled with the funds or other assets of, held by, or registered in the name of, any Manager or the Member;

(2) maintaining books and financial records of the Company separate from the books and financial records of any Manager, and observing all Company procedures and formalities, including, without limitation, maintaining minutes of Company meetings and acting on behalf of the Company only pursuant to due authorization of the Member;

(3) causing the Company to pay its liabilities from Company Property, and

(4) causing the Company to conduct its dealings with third parties in its own name and as a separate and independent entity.

(b) The Manager shall take all actions which may be necessary or appropriate

(1) for the continuation of the Company's valid existence as a limited liability company under the laws of Washington and of each other jurisdiction in which such existence is necessary to protect the limited liability of the Member or to enable the Company to conduct the business in which it is engaged and

(2) for the accomplishment of the Company's purposes, including the acquisition, development, maintenance, preservation, and operation of Company Property in accordance with the provisions of this Agreement and applicable laws and regulations.

(c) The Manager shall be under a fiduciary duty to perform the duties of Manager in good faith, in a manner they reasonably believe to be in the best interests of the Company and its Member, and with such care as an ordinarily prudent person in a like position would use under similar circumstances. In discharging these duties, a Manager shall be fully protected in relying in good faith upon the records required to be maintained under this Agreement and upon such information, opinions, reports or statements by any other Manager, Member, or agent, or by any other person, as to matters the Manager reasonably believes are within such other person's professional or expert competence and who has been selected with reasonable care by or on behalf of the Company, including information, opinions, reports or statements as to the value and amount of the assets, liabilities, profits and losses of the Company or any other facts pertinent to the existence and amount of assets from which distributions to the Member might properly be paid.

4.5 Right to Rely on Manager.

(a) Any Person dealing with the Company may rely (without duty of further inquiry) upon a certificate signed by any Manager as to:

(1) The identity of any Manager or any Member;

(2) The existence or nonexistence of any fact or facts which constitute a condition precedent to acts by a Manager or which are in any other manner germane to the affairs of the Company;

(3) The Persons who are authorized to execute and deliver any instrument or document of the Company; or

(4) Any act or failure to act by the Company or any other matter whatsoever involving the Company or any Member.

(b) The signature of any Manager shall be necessary and sufficient to convey title to any Company Property or to execute any promissory notes, trust deeds, mortgages, or other instruments of hypothecation, and the Member agrees that a copy of this Agreement may be shown to the appropriate parties in order to confirm the same, and further agree that the signature of any Manager shall be sufficient to execute any "statement of company" or other documents necessary to effectuate this or any other provision of this Agreement. The Member does hereby appoint the Manager as their attorney-in-fact for the execution of any or all of the documents described in this Section 4.5(b).

4.6 Liability and Indemnity of the Manager. A Manager is not personally liable for any debt, obligation or liability of the Company merely by reason of being a Manager and is not liable to the Company or its Member for monetary damages for conduct as a Manager. A Manager who performs the duties as Manager in accordance with this Agreement shall not have any liability by reason of being or having been a Manager. The Company shall indemnify the Manager and make advances for expenses to the maximum extent permitted under the Act. However, this provision shall not eliminate or limit a Manager's liability for:

(a) Any breach of a Manager's duty of loyalty to the Company or its Member as described in this Agreement;

(b) Acts or omissions not in good faith which involve intentional misconduct or a knowing violation of law;

(c) Any unlawful distribution under the Act; or

(d) Any transaction from which the Manager derives an improper personal benefit.

ARTICLE 5
CONFLICTS OF INTEREST AND CONFIDENTIAL INFORMATION

5.1 Duty of Loyalty. Each Member and Manager shall be entitled to enter into transactions that may be considered to be competitive with, or a business opportunity that may be beneficial to, the Company, so long as the same was not a business opportunity for the Company. This is expressly understood that some of the Member and Manager may enter into transactions that are similar to the transactions into which the Company may enter and the Company and each Member waives the right or claim to participate therein. Notwithstanding the foregoing, Member and Manager shall account to the Company and hold, as trustee for it, any property, profit, or benefit derived by the Member or Manager, without the consent of the Member, in the formation, conduct and winding up of the Company business or from a use or appropriation by the Member or Manager of Company Property, including information developed exclusively for the Company and opportunities expressly offered to the Company.

5.2 Other Self Interest. A Member or Manager does not violate a duty or obligation to the Company merely because the conduct furthers the interest of the Member or Manager, so long as there is no use of any Company trade secrets and the Company suffers no harm. A Member or Manager may lend money to and transact other business with the Company. The rights and obligations of a Member or Manager who lends money to or transacts business with the Company are the same as those of a person

who is not a Member or Manager, subject to other applicable law. No transaction with the Company shall be voidable solely because a Member or Manager has a direct or indirect interest in the transaction if the transaction is approved or ratified as provided for herein.

5.3 Confidential Information. The Member and Manager recognize and acknowledge that each will, at times, have access to, be provided with and, in some cases, will prepare and create Confidential Information and trade secrets as that term is used in the Revised Code of Washington. A Member or Manager shall not, either while a Member or Manager, or subsequent to Cessation, use or disclose any Confidential Information or trade secrets, either personally or for the use of others, other than in connection with the Member's or Manager's activities on behalf of the Company. Nor shall a Member or Manager disclose any Confidential Information or trade secrets to any Person who is not a Member, not employed by the Company or not authorized by the Company to receive such Confidential Information or trade secrets, without the prior written consent of the Company. Each Member or Manager shall use reasonable and prudent care to safeguard and protect and prevent the unauthorized use and disclosure of Confidential Information and trade secrets. The obligations contained in this Section shall survive for as long as the Company in its sole judgment considers subject information to be Confidential Information.

ARTICLE 6
CAPITAL CONTRIBUTIONS

6.1 Initial Contributions. The Member shall contribute the consideration described for that Member on Exhibit A at the time and on the terms specified on Exhibit A. The value of the Contributions, other than cash, shall be as set forth on Exhibit A. No interest shall accrue on any Contribution and no Member shall have the right to withdraw or be repaid any Contribution except as provided in this Agreement. Any Additional Member shall make the Contribution described in the Member's Admission Agreement. The value of the Additional Member's Contribution and the time for making such contribution shall be set forth in the Admission Agreement.

6.2 Additional Contributions. If the Member determines that capital in addition to the Initial Contribution is necessary to enable the Company to conduct business then the Member is entitled to contribute additional capital in any amount as a contribution or loan as appropriate in the Member's business judgment.

6.3 Enforcement of Commitments. Reserved.

6.4 Loans. Any Member may make loans to the Company to cover the Company's cash requirements. Any such loans will bear interest at a reasonable rate to be set by the Manager.

6.5 Maintenance of Capital Accounts. An individual Capital Account shall be maintained with respect to each Membership Interest. Each Capital Account shall be (i) credited with all Contributions made on account of such Membership Interest and the Membership Interest's distributive share of all profits (including any income exempt from federal income tax); and (ii) charged with the amount of all distributions made on account of such Membership Interest and the Membership Interest's distributive share of losses. Capital Accounts shall be maintained in accordance with federal income tax accounting principles as set forth in Regulations Section 1.704-1(b)(2)(iv) or any successor provision.

ARTICLE 7
ALLOCATIONS

Profits and Losses. All items of income, gain, profits, deductions, and losses shall be allocated 100% to the sole Member. In the event that the Company shall change its tax election to qualify as a Subchapter S corporation under Treasury regulations, then the allocations of profit and loss must follow Member ownership.

ARTICLE 8
DISTRIBUTIONS

8.1 General. Notwithstanding anything contained in this Agreement or the Articles to the contrary, no distribution shall be made in violation of RCW 25.15.236. If any such wrongful distribution is made, the provisions of RCW 25.15.236 shall determine each Person's liability and the remedy, if any, therefor.

8.2 Distributions. Except as otherwise provided in this Agreement, the amount, if any, to be distributed shall be determined by the Manager.

8.3 Division Among Member and Manager. Unless expressly required otherwise, all distributions to the Member or to Transferees shall be in proportion to their share of profits under Article 7.

8.4 Liquidating Distributions. In the event the Company is dissolved and the business and affairs are wound up, distributions shall be made pursuant to Section 12.4.

8.5 Amounts Withheld. All amounts withheld, pursuant to the Code or any provision of any state or local tax law with respect to any payment, distribution or allocation to the Member, shall be treated as amounts distributed to the Member pursuant to this Article 8 for all purposes under this Agreement. The Manager are authorized to withhold from distributions, or with respect to allocations, and to pay over to any federal, state or local government any amounts required to be so withheld pursuant to the Code or any provisions of any other federal, state or local law and shall allocate any such amounts to the Member with respect to which such amounts were withheld.

ARTICLE 9
ADDITIONAL MEMBER

9.1 Admission. Persons may be added as an Additional Member upon terms and conditions approved by the Member. Upon admission of a second member, this Agreement shall be revised to address the relative rights and obligations of the Members and the change of status for income tax purposes. Any additional member must agree to be bound by the terms of any amended operating agreement before this Agreement shall be superseded and without effect.

9.2 Accounting. No Additional Member shall be entitled to any retroactive allocation of losses, income or expense deductions incurred by the Company. The Manager may at the time an Additional Member is admitted, close the Company books (as though the Company's Fiscal Year had ended) or make pro rata allocations of loss, income and expense deductions to an Additional Member for that portion of the Company's Fiscal Year in which such Member was admitted in accordance with the provisions of Code Section 706(d) and the Regulations promulgated thereunder.

ARTICLE 10
TRANSFERS OF INTERESTS

10.1 Restriction on Transfers. Except as otherwise permitted by this Agreement, and only if the Company consists of more than one member, no Member or Transferee shall Transfer all or any portion of such Person's interests in the Company. In the event that any Member or Transferee pledges or otherwise encumbers any of such Person's interests in the Company as security for the payment of a debt, any such pledge or hypothecation shall not constitute a Transfer but shall only be made

(a) pursuant to a pledge or hypothecation agreement that requires the pledgee or secured party to be bound by all of the terms and conditions of this Article 10 and

(b) upon the consent of the Member. A Transfer of an ownership interest in a Member or Transferee that is an Entity shall not constitute a Transfer of such Entity's interests in the Company.

10.2 Permitted Transfers. Subject to the conditions and restrictions set forth in Sections 10.3 and 10.6 hereof, and so long as the Company has only one Member, a Member or Transferee may at any time Transfer all or any portion of such Person's interests in the Company to

(a) any other Member;

(b) any member of the transferee's Family;

(c) the transferee's executor, administrator, trustee, or personal representative to whom such interests are Transferred at death or involuntarily by operation of law; or

(d) Insolvency of the Single Member.

10.3 Conditions to Permitted Transfers. A transfer shall not be treated as a Permitted Transfer under Section 10.2 hereof unless and until the following conditions are satisfied:

(a) Except in the case of a Transfer of a Person's interests in the Company at death or involuntarily by operation of law, the transferor and Transferee shall execute and deliver to the Company such documents and instruments of conveyance as may be necessary or appropriate in the opinion of counsel to the Company to effect such Transfer and to confirm the agreement of the Transferee to be bound by the provisions of this Article 10. In the case of a Transfer of a Person's interests in the Company at death or involuntarily by operation of law, the Transfer shall be confirmed by presentation to the Company of legal evidence of such Transfer, in form and substance satisfactory to counsel to the Company. In all cases, the Company shall be reimbursed by the transferor and/or Transferee for all costs and expenses that it reasonably incurs in connection with such Transfer.

(b) Except in the case of a Transfer at death or involuntarily by operation of law, the transferor shall furnish to the Company an opinion of counsel, which counsel and opinion shall be satisfactory to the Company, that the Transfer will not cause the Company to terminate for federal income tax purposes or under the Act and that such Transfer will not cause the application of the rules of Code Sections 174(g)(1)(B) and 174(h) (generally referred to as the "tax exempt entity leasing rules") or similar rules to apply to the Company, Company Property, or the Manager and Member.

(c) The transferor and Transferee shall furnish the Company with the Transferee's taxpayer identification number, sufficient information to determine the Transferee's initial tax basis in the Person's interests in the Company Transferred, and any other information reasonably necessary to permit the Company to file all required federal and state tax returns and other legally required information statements or returns. Without limiting the generality of the foregoing, the Company shall not be required to make any distribution otherwise provided for in this Agreement with respect to any Transfer until it has received such information.

(d) Except in the case of a Transfer of a Person's interests in the Company at death or involuntarily by operation of law, either

(1) such a Person's interests in the Company shall be registered under the Securities Act of 1933, as amended, and any applicable state securities laws, or

(2) the transferor shall provide an opinion of counsel, which opinion and counsel shall be satisfactory to the Company, to the effect that such Transfer is exempt from all applicable registration requirements and that such Transfer will not violate any applicable laws regulating the Transfer of securities.

(e) Except in the case of a Transfer of a Person's interests in the Company at death or involuntarily by operation of law, the transferor shall provide an opinion of counsel, which opinion and counsel shall be reasonably satisfactory to the other Member, to the effect that such Transfer will not

cause the Company to be deemed to be an "investment company" under the Investment Company Act of 1940.

10.4 Prohibited Transfers. Any purported Transfer of a Person's interests in the Company that is not a Permitted Transfer shall be null and void and of no force or effect whatsoever; provided that, if the Company is required to recognize a Transfer that is not a Permitted Transfer (or if the Company, in its sole discretion, elects to recognize a Transfer that is not a Permitted Transfer), the interest transferred shall be strictly limited to the transferor's Economic Rights with respect to the transferred interests, with distributions first applied (without limiting any other legal or equitable rights of the Company) to satisfy any debts, obligations, or liabilities for damages that the transferor or Transferee may have to the Company.

In the case of a Transfer or attempted Transfer of a Person's interests in the Company that is not a Permitted Transfer, the parties engaging or attempting to engage in such Transfer shall be liable to indemnify and hold harmless the Company from all costs, liability, and damage that any of such indemnified Persons may incur (including, without limitation, incremental tax liability and lawyers' fees and expenses) as a result of such Transfer or attempted Transfer and efforts to enforce the indemnity granted hereby.

10.5 Rights and Obligations Arising out of Transfers.

(a) A Transfer (including a Permitted Transfer) of a Person's interest in the Company to a Person who is not a Member does not itself dissolve the Company or entitle the Transferee to become a Member or exercise any Management Rights. A Person who is not a Member who acquires a Person's interests in the Company but who is not admitted as a Substitute Member pursuant to Section 10.6 hereof shall be entitled only to the Economic Rights with respect to such interests, and shall have no right to any information or accounting of the affairs of the Company, and shall not be entitled to inspect the books or records of the Company.

(b) A Transfer (including a Permitted Transfer) of a Member's interest in the Company to a Person who is not a Member shall not cause the Member to cease to be a Member in connection with the assigned interest or cease to have the power to exercise the Management Rights associated with the assigned interest unless and until the Transferee or the Transferee's successor or assign becomes a Substitute Member, and Transferee has no liability as a Member solely as a result of the assignment. A Person who assigns an interest in the Company is not released from any liability to the Company solely as a result of the assignment of such Economic Rights.

(c) An assignment of an interest in the Company by a Member (the "Assigning Member') to any other Member (the "Acquiring Member') shall cause the Acquiring Member's Membership Interest to increase to the extent of such assigned interest (including both Economic Rights and Management Rights) and the Assigning Member's Membership Interest to decrease to the extent of the such assigned interest. If a Member acquires an interest in the Company from a Transferee, the Member shall acquire both the Economic Rights with respect to such interest and the Management Rights with respect to such interest, and the Management Rights of the Member from whom the Transferee's interest was obtained shall decrease accordingly. If all of an Assigning Member's interests in the Company are assigned to one or more Acquiring Member, such assignment shall constitute a Cessation of the Assigning Member subject to Article 11 hereof and a Dissolution Event subject to Article 12 hereof. The Assigning Member shall not be released from liabilities to the Company, including without limitation Contribution obligations, but notwithstanding this the Acquiring Member shall be liable for any obligation to make Contributions with respect to the interest in the Company that the Acquiring Member so acquires.

(d) In the event a court of competent jurisdiction charges a Membership Interest with the payment of an unsatisfied amount of a judgment with interest, to the extent so charged the judgment creditor shall be treated as an Transferee.

10.6 Acceptance of Transferee as Substitute Member.

(a) Subject to the other provisions of this Article 10, a Transferee may be admitted to the Company as a Substitute Member, with all of the Management Rights of a Member, to the extent Transferred, only upon satisfaction of all of the conditions set forth below in this Section 10.6.

(1) The Manager's consent to such admission which consent may be given or withheld in the sole and absolute discretion of the Manager.

(2) The Transferee shall become a party to this Agreement as a Member by executing such documents and instruments as the Manager may reasonably request as may be necessary or appropriate to confirm such Transferee as a Member in the Company and such Transferee's agreement to be bound by the terms and conditions hereof.

(3) The Transferee shall pay or reimburse the Company for all reasonable legal, filing, and publication costs that the Company incurs in connection with the admission of the Transferee as a Member with respect to the Transferred interests.

(4) The Transferee shall provide the Company with evidence satisfactory to counsel for the Company that such Transferee has made each of the representations and undertaken each of the warranties contained in the documents and instruments referred to in Section 10.6(a)(2) above.

(5) If the Transferee is not an individual of legal majority, the Transferee shall provide the Company with evidence satisfactory to counsel for the Company of the authority of the Transferee to become a Member and to be bound by the terms and conditions of this Agreement.

(b) A Transferee who becomes a Substitute Member has, to the extent of the interests assigned, the rights and powers and is subject to the restrictions and liabilities of a Member under the Act, the Articles and this Agreement, and, to the extent of the interests assigned, is also liable for any obligations of the transferor to make Contributions, but is not obligated for liabilities reasonably unknown to the Transferee at the time the Transferee becomes a Member.

(c) Neither the Member nor any subsequent transferor is released from any liability to the Company by virtue of such Transfer or admission, even if the Transferee becomes a Substitute Member and even if the Member whose Membership Interest is being transferred ceases to be a Member by virtue of such act, but the Member ceases to be a Member when one or more Transferees become Substitute Member with respect to the Member's entire Membership Interest.

10.7 Distributions and Allocations re Transfers. If any Person's interest in the Company is Transferred during any Fiscal Year in compliance with the provisions of this Article 10, profits, losses, each item thereof, and all other items attributable to such interest for such Fiscal Year shall be divided and allocated between the transferor and the Transferee by taking into account their varying interests during such Fiscal Year in accordance with Code Section 706(d), using any conventions permitted by law and selected by the Manager. All distributions on or before the date of such Transfer shall be made to the transferor, and all distributions thereafter shall be made to the Transferee. Solely for purposes of making such allocations and distributions, the Company shall recognize such Transfer not later than the end of the calendar month during which it is given notice of such Transfer, provided that, if the Company is given notice of a Transfer at least ten Business Days prior to the Transfer the Company shall recognize such Transfer as the date of such Transfer, and provided further that, if the Company does not receive a notice stating the date such interest was Transferred and such other information as the Manager may reasonably require within 30 days after the end of the Fiscal Year during which the

Transfer occurs, then all such items shall be allocated, and all distributions shall be made, to the Person who, according to the books and records of the Company, was the owner of the interest on the last day of the Fiscal Year during which the Transfer occurs. Neither the Company nor any Manager shall incur any liability for making allocations and distributions in accordance with the provisions of this Section 10.7, whether or not any Manager or the Company has knowledge of any Transfer of ownership of any interest.

10.8 Assignment to Creditors. Should the Member have a creditor with a judgment that issues assignment of the membership interest to the creditor, the creditor will only obtain an assignment of the membership interest. The creditor will not receive actual Membership in the LLC. The creditor does not have any membership rights or possess the ability to be involved in the management of the LLC. Equally, the creditor does not have the right to dissolve the LLC. The creditor is only granted rights to the distributions of the Member's interests, not the rights of membership. The creditor must release the Member's interests back to member upon payment of the judgment in accordance with the appropriate Court.

ARTICLE 11
CESSATION OF A MEMBER

This Article is Reserved.

ARTICLE 12
DISSOLUTION AND WINDING UP

12.1 Covenant Not to Cause Dissolution. Except as otherwise permitted by this Agreement, each of the Member and the Manager hereby covenant and agree not to take any voluntary action that would cause the Company to dissolve and notwithstanding any provision of the Act, the Company shall not dissolve prior to the occurrence of a Dissolution Event.

12.2 Dissolution Events. The Company shall dissolve and commence winding up and liquidating upon the first to occur of any of the following Dissolution Events:

(a) The expiration of the term specified in the Articles of Organization;

(b) The sale of all or substantially all of the Property;

(c) The vote of the Member to dissolve, wind up, and liquidate the Company;

(d) The happening of any other event that makes it unlawful, impossible, or impractical to carry on the business of the Company; or

(e) The withdrawal of a Manager as a Member or any other event that causes a Manager, who is a Member, to cease to be a Member; provided that any such Cessation event shall not constitute a Dissolution Event if the Company is continued pursuant to Section 12.3. Any event which causes a Member to cease to be a Member, other than the Bankruptcy of the Member or the admission of a Substitute Member with respect to such Member, shall constitute a Dissolution Event unless the Company is continued pursuant to Section 12.3.

Notwithstanding anything in RCW 25.15.265 to the contrary and except for the events which may cause judicial and administrative dissolution under ORS 25.15.265(5) and (6), the foregoing events are the exclusive events which may cause the Company to dissolve.

12.3 Continuation. Upon the occurrence of any Cessation Event, the Company shall not be dissolved or required to be wound up if, within 120 days after such event, the Member agrees to continue the business of the Company. Upon any such election to continue the business, the Member shall be bound thereby and shall be deemed to have consented thereto. Unless such an election is made within the 120-day period, the Company shall wind up its affairs in accordance with Section 12.4 hereof. If such an

election is made within the 120 day period, the Company shall continue until the occurrence of another Dissolution Event as provided in Section 12.2; provided that the right to continue the business of the Company shall not exist and may not be exercised unless the Company has received an opinion of counsel, in a form and content satisfactory to the Company, that the Company would not cease to be treated as a partnership for federal income tax purposes upon the exercise of such right to continue.

12.4 Winding Up. Upon the occurrence of a Dissolution Event and unless the election to continue the business of the Company is made pursuant to Section 12.3, the Company shall continue solely for the purposes of winding up its affairs in an orderly manner, liquidating its assets, and satisfying the claims of its creditors and Member, and the Member shall not take any action that is inconsistent with, or not necessary to or appropriate for, the winding up of the Company's business and affairs. To the extent not inconsistent with the foregoing, all obligations in this Agreement shall continue in full force and effect until such time as the Company Property has been distributed pursuant to this Section 12.4. The Manager shall be responsible for overseeing the winding up and dissolution of the Company, shall take full account of the Company's liabilities and Property, shall cause the Company Property to be liquidated as promptly as is consistent with obtaining the fair value thereof, and shall cause the proceeds therefrom, to the extent sufficient therefor, to be applied and distributed in the following order:

(a) First, to the payment and discharge of all of the Company's debts and liabilities to creditors other than Member;

(b) Second, to the payment and discharge of all of the Company's debts and liabilities to Member;

(c) Third, the balance, if any, to the Member in accordance with their share of the profits, after giving effect to all distributions and allocations for all periods.

12.5 Rights of Member. Except as otherwise provided in this Agreement,

(a) each Member shall look solely to the assets of the Company for the return of Contributions and shall have no right or power to demand or receive property other than cash from the Company, and

(b) no Member shall have priority over any other Member as to the return of Contributions, distributions, or allocations.

12.6 Notice of Dissolution. In the event a Dissolution Event occurs or an event occurs that would, but for provisions of Section 12.3, result in a dissolution of the Company, the Manager shall, within 30 days thereafter, provide written notice thereof to each of the Member and to all other parties with whom the Company regularly conducts business (as determined in the discretion of the Manager) and shall publish notice thereof in a newspaper of general circulation in each place in which the Company regularly conducts business (as determined in the discretion of the Manager).

ARTICLE 13
TAXES

13.1 Elections. The Manager may make any tax elections for the Company allowed under the Code or the tax laws of any state or other jurisdiction having taxing jurisdiction over the Company, including but without limitation, elections

(a) to adjust the basis of Company Property pursuant to Code Sections 754, 734(b), and 743(b), or comparable provisions of state or local law, in connection with transfers of interests in the Company and Company distributions if the Company has elected to be taxed as a partnership;

(b) with the consent of the Member, to extend the statute of limitations for assessment of tax deficiencies against Member with respect to adjustments to the Company's federal, state, or local tax returns; and

(c) to the extent provided to cause the Company to opt-out of the Centralized Audit Regime ("CAR") as described in Code Sections 6221 through 6241 by timely filing Form 1065 (or its equivalent) as amended and Schedule B-2 (Form 1065) (or its equivalent) as amended; and

(d) to be treated as an association taxable as a corporation for federal and state income tax purposes in accordance with Regulations Sections 301.7701-3 and the Members shall cooperate in the election to treat the Company as an S Corporation by filing an S Election on behalf of the Company pursuant to Code section 1362(a), which election shall be effective as of the date the election to be treated as an association taxable as a corporation is made

13.2 Taxes of Taxing Jurisdictions. To the extent that the laws of any taxing jurisdiction require, each Member requested to do so by the Manager will submit an agreement indicating that the Member will make timely income tax payments to the taxing jurisdiction and that the Member accepts personal jurisdiction of the taxing jurisdiction with regard to the collection of income taxes attributable to the Member's income, and interest and penalties assessed on such income. If the Member fails to provide such agreement, the Company may withhold and pay over to such taxing jurisdiction the amount of tax, penalty and interest determined under the laws of the taxing jurisdiction with respect to such income. Any such payments with respect to the income of a Member shall be treated as a distribution for purposes of Article 8. The Manager may, where permitted by the rules of any taxing jurisdiction, file a composite, combined or aggregate tax return reflecting the income of the Company and pay the tax, interest and penalties of some or all of the Member on such income to the taxing jurisdiction, in which case the Company shall inform the Member of the amount of such tax interest and penalties so paid.

ARTICLE 14
BOOKS, RECORDS AND ACCOUNTINGS

14.1 Books and Records. At the expense of the Company, the Manager shall maintain records and accounts of all operations and expenditures of the Company. At a minimum the Company shall keep at its principal place of business the following records:

(a) A current list of the full name and last known business, residence, or mailing address of each Member and Manager, both past and present;

(b) A copy of the Articles and all amendments thereto, together with executed copies of any powers of attorney pursuant to which any amendment has been executed;

(c) Copies of the Company's federal, state, and local income tax returns and reports, if any, for the three most recent years;

(d) Copies of the Company's currently effective written operating agreement and all amendments thereto, copies of any writings permitted or required under the Act and copies of any financial statements of the Company for the three most recent years;

(e) Minutes of every meeting of the Member or Manager and any written consents obtained from Member or Manager for actions taken without a meeting; and

(f) A statement prepared and certified as accurate by a Manager which describes the amount of cash and a description and statement of the agreed value of other Property or consideration contributed by each Member and which each Member has agreed to contribute in the future, the times at which or events on the occurrence of which any Additional Contributions agreed to be made by each Member is to be made, and if agreed upon, the time at which or the events on the occurrence of which the Company is dissolved and its affairs wound up.

14.2 Reports. The Manager shall provide reports at least annually to the Member at such time and in such manner as the Manager may determine reasonable. In addition, if the Company indemnifies or

advances expenses to a Manager in connection with a proceeding by or in the right of the Company, the Company shall report the indemnification or advance in writing to the Member.

ARTICLE 15
AMENDMENT

Generally. This Agreement may be amended, restated or modified from time to time only by a written instrument adopted by the Member. No Member or Manager shall have any vested rights in this Agreement which may not be modified through an amendment to this Agreement.

ARTICLE 16
MISCELLANEOUS

16.1 Application of Washington Law. This Agreement, and the application of interpretation hereof, shall be governed exclusively by its terms and by the laws of Washington, and specifically the Act.

16.2 Construction. Whenever the singular number is used in this Agreement and when required by the context, the same shall include the plural and vice versa, and the masculine gender shall include the feminine and neuter genders and vice versa.

16.3 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

16.4 Execution of Additional Instruments. Each Member hereby agrees to execute such other and further statements of interest and holdings, designations, powers of attorney and other instruments necessary to comply with any laws, rules or regulations.

16.5 Headings. The headings in this Agreement are inserted for convenience only and are in no way intended to describe, interpret, define, or limit the scope, extent or intent of this Agreement or any provision hereof.

16.6 Heirs, Successors and Assigns. Each and all of the covenants, terms, provisions and agreements herein contained shall be binding upon and inure to the benefit of the parties hereto and, to the extent permitted by this Agreement, their respective heirs, legal representatives, successors and assigns. If this is a Single Member LLC and the Single Member becomes incapacitated or deceased, the spouse or domestic partner of the Single Member shall have full power and authority to act for the Company as if he or she were the Member.

16.7 Notices. Any notice, demand, or communication required or permitted to be given by any provision of this Agreement shall be deemed to have been sufficiently given or served for all purposes if delivered personally to the party or to an executive officer of the party to whom the same is directed or, if sent by registered or certified mail, postage and charges prepaid, addressed to the Member's and/or Company's address, as appropriate, which is set forth in this Agreement. Except as otherwise provided herein, any such notice shall be deemed to be given three Business Days after the date on which the same was deposited in a regularly maintained receptacle for the deposit of United States mail, addressed and sent as aforesaid.

16.8 Rights and Remedies Cumulative. The rights and remedies provided by this Agreement are cumulative and the use of any one right or remedy by any party shall not preclude or waive the right to use any or all other remedies. Said rights and remedies are given in addition to any other rights the parties may have by law, statute, ordinance or otherwise.

16.9 Severability. If any provision of this Agreement or the application thereof to any person or circumstance shall be invalid, illegal or unenforceable to any extent, the remainder of this Agreement and the application thereof shall not be affected and shall be enforceable to the fullest extent permitted by law.

16.10 Waivers. The failure of any party to seek redress for violation of or to insist upon the strict performance of any covenant or condition of this Agreement shall not prevent a subsequent act, which would have originally constituted a violation, from having the effect of an original violation.

16.11 Attorney Fees. In the event legal action is instituted to enforce or determine the parties' rights in connection with the Company or duties arising out of the terms of this Agreement or the parties' relationship or a suit or action permitted herein is brought, the prevailing party shall recover from the losing party reasonable attorney fees incurred in such proceeding. The determination of who is the prevailing party and the amount of reasonable attorney fees to be paid to the prevailing party shall be decided by the court or courts, including any appellate court, in which such matter is tried, heard, or decided.

16.12 Entire Agreement. This Agreement and any other document to be furnished pursuant to the provisions hereof embody the entire agreement and understanding of the parties hereto as to the subject matter contained herein. There are no restrictions, promises, representations, warranties, covenants, or undertakings other than those expressly set forth or referred to in such documents. This Agreement and such documents supersede all prior agreements and understandings among the parties with respect to the subject matter hereof.

NOTICE: EACH MEMBER HEREBY CERTIFIES THAT HE OR SHE HAS RECEIVED A COPY OF THIS OPERATING AGREEMENT AND FORMATION DOCUMENT OF WENATCHEE HOSPICE LLC, AN WASHINGTON LIMITED LIABILITY COMPANY. EACH MEMBER REALIZES THAT AN INVESTMENT IN THIS COMPANY IS SPECULATIVE AND INVOLVES SUBSTANTIAL RISK. EACH MEMBER IS AWARE AND CONSENTS TO THE FACT THAT THE INTERESTS IN THE COMPANY HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933 OR ANY SECURITIES ACT OF THE STATE OF WASHINGTON. EACH MEMBER AGREES TO BE BOUND BY ALL OF THE TERMS AND CONDITIONS OF THIS AGREEMENT AND THE FORMATION CERTIFICATE OR ARTICLES.

Dated: 12/22/2021

COMPANY
WENATCHEE HOSPICE LLC

DocuSigned by:
Matthew Ham
3B260F8FF84B474...

By: Wenatchee Hospice Holdings LLC
Its: Manager
By: Matthew Ham, Chief Operating Officer

MEMBER
WENATCHEE HOSPICE HOLDINGS LLC

DocuSigned by:
Matthew Ham
3B260F8FF84B474...

By: Matthew Ham
Its: Chief Operating Officer

EXHIBIT A
MEMBER CONTRIBUTION

NAME AND ADDRESS	CONTRIBUTION	MEMBERSHIP INTEREST
Wenatchee Hospice Holdings LLC 285 Technology Center Way, Ste 108 Wenatchee, WA 98801-8120	$1000	100%

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 14

Medical Director Agreement

PROFESSIONAL SERVICES AGREEMENT MEDICAL DIRECTOR

This Agreement is made this _____ day of _____, _____, (effective as of the date Advanced Hospice Northwest of Wenatchee is licensed as a state certified hospice agency), by and between Advanced Hospice Northwest of Wenatchee ("ORGANIZATION") and Jonathan Kim, a physician ("MEDICAL DIRECTOR").

1. PURPOSE

Advanced Hospice Northwest of Wenatchee desires to engage a qualified physician to act as Medical Director for their hospice care program. MEDICAL DIRECTOR is a physician qualified by virtue of training and experience in the practice of medicine or osteopathy, is licensed as a doctor of medicine or osteopathy in the State of Washington, meets the requirements for membership on the medical staff of Advanced Hospice Northwest of Wenatchee and is Board Certified in a related specialty.

2. OBLIGATIONS OF MEDICAL DIRECTOR

2.1 Status and Membership. MEDICAL DIRECTOR will remain in full compliance with all of the following conditions continuously during the entire term of this Agreement. Failure of MEDICAL DIRECTOR to satisfy any or all of the following conditions will constitute grounds for automatic termination of this Agreement as set forth in Section 5.

(a) MEDICAL DIRECTOR will be licensed as a doctor of medicine or osteopathy in the State of Washington without restriction or subject to any disciplinary or corrective action and is Board Certified in a related specialty; and

(b) MEDICAL DIRECTOR will abide by the policies and procedures of Advanced Hospice Northwest of Wenatchee; and in direct compliance with all state, federal, local and ACHC rules, regulations, and standards.

2.2 Duties and Responsibilities of MEDICAL DIRECTOR.

(a) MEDICAL DIRECTOR is responsible for the submission to Advanced Hospice Northwest of Wenatchee of documentation of services provided as appropriate.

(b) MEDICAL DIRECTOR will be a participating member of the hospice interdisciplinary group of the ORGANIZATION and participate in the annual evaluation.

(c) MEDICAL DIRECTOR will advise and/or assist in the resolution of concerns/conflicts involving physicians utilizing the services of Advanced Hospice Northwest of Wenatchee.

(d) MEDICAL DIRECTOR (hospice physician) will perform face-to-face encounters as necessary.

(e) MEDICAL DIRECTOR will review and sign initial hospice certifications of terminal illness, and recertifications as indicated.

(f) MEDICAL DIRECTOR agrees to perform the duties set forth in Exhibit A.

2.3 Responsibilities of Advanced Hospice Northwest of Wenatchee. To provide skilled services to patients admitted by Advanced Hospice Northwest of Wenatchee according to its policies on acceptance of patients for service, state rules and regulations, local laws, Federal Conditions of Participation and ACHC standards.

The Administrator/Executive Director of hospice will provide MEDICAL DIRECTOR with an orientation to the hospice program. Additional informational materials will be provided, as needed, throughout the term of the agreement. Verbal reports on the status of the ORGANIZATION will be provided at least quarterly at the Professional Advisory Committee meetings. The Administrator/Executive Director of hospice will be accessible to the MEDICAL DIRECTOR and will facilitate coordination and continuity of services to patients.

Advanced Hospice Northwest of Wenatchee retains all responsibility and authority for the patient admission process; patient assessment; the development, review and revision of the plan of care; the coordination, supervision and evaluation of the patient care provided; the scheduling of visits or hours; and discharge planning.

Advanced Hospice Northwest of Wenatchee will ensure the quality and utilization of services in accordance with its quality management program. The Administrator/Executive Director of hospice is responsible for the monitoring and control of services provided.

Advanced Hospice Northwest of Wenatchee will provide MEDICAL DIRECTOR with any changes to these rules, regulations and standards and allow MEDICAL DIRECTOR at least 30 days to meet these changes.

2.4 Compliance with Standards. MEDICAL DIRECTOR will perform all services and duties under this Agreement in strict accordance with all laws, rules, regulations, ordinances, and judicial and administrative interpretations thereof, of the United States, the State of Washington, the County of Chelan, the City of Wenatchee, and all political subdivisions, agencies, and instrumentality's of any of them, as well as with the bylaws, rules, regulations, guidelines, policies, and procedures of Advanced Hospice Northwest of Wenatchee, as all of the foregoing may from time to time be in effect. Particularly, and not by way of limitation, MEDICAL DIRECTOR will comply with the Washington State Medical Practice Act or Osteopathic Practice Act and all rules and regulations of the Washington State Board of Medical Examiners or State Board of Osteopathic Physicians and will do everything necessary to maintain in effect his license as a doctor of medicine or osteopathy within the State of Washington.

2.5 Insurance. The MEDICAL DIRECTOR will at all times throughout the term of this Agreement maintain professional liability insurance in an amount no less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

The MEDICAL DIRECTOR will deliver to Advanced Hospice Northwest of Wenatchee at least annually in advance a certificate of insurance evidencing the required coverage, both during the term of this Agreement and thereafter.

Organization shall obtain and maintain in full force and effect, its own general and professional liability insurance in amounts not less than $1,000,000 per occurrence and $3,000,000, in the aggregate, either through a commercial carrier or through an adequate self-insurance program, covering its operations of the Organization. Organization represents and warrants that such insurance is in effect on the date of execution of this Agreement and shall remain in effect during the term of this agreement.

2.6 Time. MEDICAL DIRECTOR will devote such time and attention as is necessary to fulfill his or her duties and responsibilities. MEDICAL DIRECTOR will be available from 8:00 – 4:30, Monday – Friday, for on-call consultation, assistance and decisions regarding patient care. MEDICAL DIRECTOR will be responsible for arranging for coverage when he is unavailable; however, prior approval of any physician providing coverage for MEDICAL DIRECTOR must be obtained from the Administrator/Executive Director of Advanced Hospice Northwest of Wenatchee

2.7 Disclosure of Information. MEDICAL DIRECTOR recognizes and acknowledges that he will have access to certain confidential information of the ORGANIZATION and that such information constitutes valuable, special and unique property of the ORGANIZATION. MEDICAL DIRECTOR will not, during or after the term of this Agreement, without the consent of the ORGANIZATION disclose any such confidential information to any other person, firm, corporation, association, or other entity for any reason or purpose whatsoever except as may be ordered by a court or governmental agency or as may otherwise be required by law. In the event of a breach or a threatened breach by MEDICAL DIRECTOR of the provisions of this paragraph, the ORGANIZATION will be entitled to an injunction restraining MEDICAL DIRECTOR from disclosing in whole or in part any confidential information. Nothing herein will be construed as prohibiting the ORGANIZATION from pursuing any other remedies available to it for such breach or threatened breach, including the recovery of damages from MEDICAL DIRECTOR.

2.8 Financial Obligation. MEDICAL DIRECTOR will incur no financial obligation on behalf of the ORGANIZATION or for which the ORGANIZATION will be responsible without prior approval of the Administrator/Executive Director.

2.9 Billing. The MEDICAL DIRECTOR will not charge patients for services rendered as MEDICAL DIRECTOR of the ORGANIZATION. The professional fees charged to patients will be for professional services rendered to individual patients only. Such fees will be separate from ORGANIZATION fees to the patient for ORGANIZATION services, including services performed by any physician as MEDICAL DIRECTOR.

2.10 Services. MEDICAL DIRECTOR will perform all obligations of MEDICAL DIRECTOR under this Agreement at the ORGANIZATION's principal place of business, Advanced Hospice Northwest of Wenatchee's street address. All communications to ORGANIZATION will be directed to the Administrator/Executive Director at such address and the ORGANIZATION's Administrator/Executive Director will have full authority to communicate to MEDICAL DIRECTOR on behalf of ORGANIZATION.

3. OBLIGATIONS OF ORGANIZATION

3.1 Compensation. For all services provided by MEDICAL DIRECTOR pursuant to this Agreement, ORGANIZATION will pay MEDICAL DIRECTOR $200.00 per hour for consultation time payable following the month of service, commencing on the effective date of this agreement. MEDICAL DIRECTOR shall submit an invoice outlining services rendered and the time expended to provide said services.

4. INDEPENDENT CONTRACTOR

In the performance of all services pursuant to this Agreement, MEDICAL DIRECTOR is at all times acting as an independent contractor engaged in the profession and practice of medicine or osteopathy. MEDICAL DIRECTOR will employ his own means and methods and exercise his own professional judgment in the performance of such services, and ORGANIZATION will have no right of control or direction with respect to such means, methods, or judgments, or with respect to the details of such services. The only concern of ORGANIZATION under this Agreement or otherwise is that, irrespective of the means selected, such services will be provided in a competent, efficient, and satisfactory manner. It is expressly agreed that MEDICAL DIRECTOR will not for any purpose be deemed to be an employee, agent, partner, joint venture, ostensible or apparent agent, servant, or borrowed servant of ORGANIZATION. MEDICAL DIRECTOR, and all physicians and other individuals providing services pursuant to this Agreement, will not have any claim against ORGANIZATION for vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits, or employee benefits of any kind.

5. DURATION AND TERMINATION

5.1 Term. This Agreement will commence on the date the ORGANIZATION is licensed as a state certified hospice agency and will continue in effect for a term of one (1) calendar year from the effective date with automatic one-year renewals unless terminated sooner as hereinafter set forth.

5.2 Termination. Either party at any time may terminate the Agreement, with or without cause, by giving written notice of such termination to the other party at least 60 days prior to the date on which the termination is to be effective, such date to be specified in the notice. Notwithstanding the above, if MEDICAL DIRECTOR fails to comply with any or all of the requirements set forth in Section 2, of this Agreement at any time during this Agreement, ORGANIZATION will be entitled to terminate this Agreement effective immediately.

5.3 Modification or Renewal. The payment provisions of this Agreement may not be altered or modified during any 12-month term. Moreover, following termination without cause, the parties will not enter into the same or a similar contract with each other unless the new contract does not have the effect of altering or modifying the previous Agreement's payment provisions within a 12-month period. The intent of this provision is to prohibit the parties from terminating this Agreement without cause and then entering into a new contract in order to alter or modify the payment provisions within a period of less than one (1) year.

6. MISCELLANEOUS

6.1 Governing Law. This Agreement will be subject to and governed by the laws of the State of Washington.

6.2 Remedies. All rights, powers and remedies granted to either party by any particular term of this Agreement are in addition to, and not in limitation of, any rights, powers or remedies which it has under any other term of this Agreement, at common law, in equity, by statute, or otherwise. All such rights, powers and remedies may be exercised separately or concurrently, in such order and as often as may be deemed expedient by either party. No delay or omission by either party to exercise any right, power or remedy will impair such right, power or remedy or be construed to be a waiver of or an acquiescence to any breach or default. A waiver by either party of any breach or default hereunder will not constitute a waiver of any subsequent breach or default.

6.3 Amendment. No amendment or variation of the terms of this Agreement will be valid unless in writing and signed by both parties in the manner provided in Section 6.11 of this Agreement.

6.4 Assignment. Neither this Agreement nor any rights, powers or duties hereunder may be assigned by either party without the express written consent of the other party, and any such unauthorized assignment will be void. If any such unauthorized assignment is attempted by either party, the other party will have the power, at its election, to terminate this Agreement effective immediately. Further, MEDICAL DIRECTOR may not subcontract or otherwise arrange for another individual or entity to perform his duties under this Agreement, with the exception of the limited coverage provisions set out in Section 2.5, of this Agreement.

6.5 Captions. The captions for each Paragraph of this Agreement are included for convenience of reference only and are not to be considered a part hereof, and will not be deemed to modify, restrict or enlarge any of the terms of provisions of this Agreement.

6.6 Notice. Any notice required or permitted to be given under this Agreement will be sufficient if in writing and hand delivered or sent by certified or registered mail, return receipt requested, addressed as follows:

Advanced Hospice Northwest of Wenatchee

_____
Administrator/Executive Director
285 Technology Center Way
Wenatchee, WA 98801

Medical Director

_____,
M.D.
Street Address
City, State Zip

or to any other address as may be given by either party to the other by notice in writing pursuant to the provisions of this Section.

6.7 Severability. In the event that any provision of the Agreement is held to be unenforceable for any reason, the unenforceability of that provision will not affect the remainder of this Agreement, which will remain in full force and effect in accordance with its terms.

6.8 Fraud and Abuse. The parties enter into this Agreement with the intent of conducting their relationship in full compliance with applicable state, local, and federal law including the Medicare/Medicaid Anti-fraud and Abuse Amendments. Notwithstanding any unanticipated effect of any of the provisions herein, neither party will intentionally conduct itself under the terms of this Agreement in a manner to constitute a violation of the Medicare and Medicaid fraud and abuse provisions. Further, if legislation is passed, the effect of which would be to hinder ORGANIZATION's ability to obtain reimbursement from Medicare/Medicaid due to the existence of this Agreement, or if this Agreement becomes illegal under any subsequent law or regulation, then this Agreement will terminate immediately.

6.9 Access to Books and Records of Subcontractor. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the MEDICAL DIRECTOR will make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection will be available up to four (4) years after

the rendering of such services. If the MEDICAL DIRECTOR carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a 12-month period with a related individual or ORGANIZATION, the MEDICAL DIRECTOR agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Public Law 96-+99, Sec. 952 (Sec. 1861(v)(1) of the Social Security Act) and the regulations promulgated thereunder. No attorney-client, accountant-client or other legal privilege will be deemed to have been waived by the ORGANIZATION or the MEDICAL DIRECTOR by virtue of this Agreement.

6.10 Policy. *Nothing contained in this Agreement will require MEDICAL DIRECTOR or any physician to admit or refer any patients to Advanced Hospice Northwest of Wenatchee as a precondition to receiving the benefits set forth herein except insofar as the Advanced Hospice Northwest of Wenatchee's bylaws may now or in the future establish minimum requirements for eligibility for active staff privileges.*

6.11 Entire Agreement. This Agreement constitutes the entire Agreement between the parties with respect to the subject matter hereof, and supersedes any and all other agreements, understandings, negotiations, or representations, oral or written, between them.

6.12 Execution in Counterparts. This Agreement and any amendments hereto will be executed in multiple counterparts by MEDICAL DIRECTOR and by the Administrator/Executive Director of Advanced Hospice Northwest of Wenatchee for and on behalf of ORGANIZATION. Each counterpart will be deemed an original but all counterparts together will constitute one and the same instrument.

6.13 Authorization for Agreement. The execution and performance of this Agreement by ORGANIZATION and MEDICAL DIRECTOR have been duly authorized by all necessary laws, resolutions, and corporate action, and this Agreement constitutes the valid and enforceable obligations of MEDICAL DIRECTOR and ORGANIZATION in accordance with its terms.

In WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and year first above written.

_____	_____
Medical Director Signature	Agency Signature
Name: _____	Name: _____
Date: _____	Date: _____

Exhibit A

Medical Director Responsibilities

The hospice Medical Director will have overall responsibility for the medical component of the hospice program.

The hospice Medical Director will provide oversight of physician services by complementing attending physician care, acting as a medical resource to the interdisciplinary group, assuring continuity of hospice medical services, and assuring appropriate measures to control patient symptoms. The Medical director will serve as a hospice champion – promoting and representing the program to physicians, physician groups, discharge planners, other referral sources, community health organizations, and potential donors, as appropriate.

The responsibilities of the Medical Director will include, but not be limited to the following:

1. Devoting his/her best ability to the proper management of the program

2. Providing overall medical direction to the program

3. Assuring that the established policies, bylaws, rules, and regulations of the organization are followed in the program

4. Adhering to requirements, terms, and conditions required by Medicare Conditions of Participation, accrediting body, and federal and state statutes governing the provision of services

5. Establishing and continually reviewing policies and procedures related to patient care, medical education, and emergency procedures

6. Developing and continually reviewing, in cooperation with the CEO/Executive Director/Administrator and/or Chief Clinical Officer/Clinical Director, criteria to monitor the quality of the education programs provided to physicians, personnel, and volunteers

7. Evaluating quality assessment performance improvement (QAPI) plans and monitoring to identify medical education needs in cooperation with the CEO/Executive Director/Administrator and/or Chief Clinical Officer/Clinical Director. Participates in QAPI teams and activities, as needed

8. Proposing organizational programs to address the needs identified (with the assistance and input of consultants of the specialties where medical education needs were identified)

9. Working with the CEO/Executive Director/Administrator and/or CCO/Clinical Director, after implementation of the programs, to determine the impact of said programs on the quality of care

10. Serving as a hospice champion in the community

11. Acting as a liaison to community physicians by providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care

12. Acting as medical liaison with other physicians at Advanced Hospice Northwest of Wenatchee

13. Providing training regarding the medical aspects of caring for terminally ill patients to physicians, personnel, and volunteers

14. Reviewing patients' medical eligibility for hospice services, in accordance with hospice program policies and procedures, and establishing the plan of care in conjunctions with attending physician and interdisciplinary group prior to providing care written certification of terminal illness

15. Providing written certification of the terminal illness for all subsequent benefit periods

16. Perform face-to-face encounters within thirty (30) days of the third and subsequent hospice benefit certification periods and attest to the encounter. (NP may complete the encounter and report findings to the hospice physician.)

17. Consulting with attending physicians regarding pain and symptoms management for hospice patients

18. Managing oversight of the patient's medications and treatments

19. Acting as medical resource to the hospice interdisciplinary group

20. Attending interdisciplinary group meetings and working in a team approach with the group

21. In conjunction with the attending physician and interdisciplinary group, reviewing and updating the plan of care at least every 15 days, or more frequently as needed.

22. Documenting care provided in the patient's clinical record, providing evidence of progression of the end-stage disease process

23. Acting as primary physician for patients whose referring/attending physicians desire to relinquish that care and/or if the referring/attending physicians are not available for further contact

24. Maintaining current knowledge of the latest research and trends in hospice care and pain/symptom management

25. Reviewing and developing protocols for treatment, and proposing the most current options for interventions

26. Develop and implement procedures and protocols in regard to OSHA standards, including the handling of hazardous medications.

27. Demonstrating knowledge in communications, and counseling patients and family/caregivers dealing with end-of-life issues

28. Participating in resolution of interpersonal conflict and issues of clinical and ethical concern

29. Ensuring that competent physician services are routinely available on a 24-hour basis to meet the general medical needs of the hospice patient to the extent the needs are not met by the attending physician

30. Assisting with evaluation of protocols and procedures with respect to quality and cost outcome

December 28, 2021

To Whom it may concern:

This document is to express the commitment to execute the above professional services agreement for Medical Director between Advanced Hospice Northwest of Wenatchee and Jonathan Kim following Certificate of Need approval by the Washington State Department of Health for Advanced Hospice Northwest of Wenatchee.

Medical Director Signature

Name: Jonathan Kim

Date: 12/28/21

Agency Signature

Name: Matt Hayes

Date: 12/28/21

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 15

Lease Agreement

December 29, 2021

To Whom it may concern:

This document is to express the commitment to execute the sublease agreement below between Sublessor (Wenatchee Home Health, LLC dba Advanced Home Health Northwest of Wenatchee) and Sublessee (Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee) following Certificate of Need approval by the Washington State Department of Health for Wenatchee Hospice, LLC.

Wenatchee Home Health, LLC

By Joel Stephens, Administrator

Date: 12/29/2021

Wenatchee Hospice, LLC

by Wenatchee Hospice Holdings, LLC
by Matt Ham, COO Stride Health Care LLC, its Manager

Date: 12/29/2021

SUBLEASE AGREEMENT

This SUBLEASE AGREEMENT (hereinafter referred to as this "Agreement"), dated _____ ___, 20___ (the "Effective Date"), by and between Wenatchee Home Health, LLC dba Advanced Home Health Northwest Of Wenatchee whose address is 285 Technology Center Way Ste 107, Wenatchee, Washington 98801 (hereinafter referred to as the "Sublessor") and Wenatchee Hospice LLC dba Advanced Hospice Northwest Of Wenatchee (hereinafter referred to as the "Sublessee"). A copy of the original lease (the "Lease") is attached to this Agreement and is incorporated herein. The Sublessee agrees to comply with all the terms and conditions of the Lease.

1. PREMISES

WHEREAS, the Landlord is the owner or manager of the real property located at the Confluence Technology Center (the "CTC"). Address of 285 Technology Center Way, Wenatchee WA 98801 (hereinafter referred to as the "Premises"); and

WHEREAS, the Sublessor has the consent of the Landlord and wishes to sublease Office 108 of the above-mentioned Premises to the Sublessee upon the terms and conditions contained in this Agreement; and

WHEREAS, the Sublessee wishes to sublease Office 108 of the above- mentioned Premises from Sublessor upon the terms and conditions contained herein;

NOW, THEREFORE, in consideration of all of the mutual promises and covenants set forth herein, the Sublessor, Sublessor and Sublessee agree as follows:

2. TERM

2.1 The term of this Agreement shall commence on the date of the receipt of Sublessee's receipt of a Certificate of Need from the State of Washington ("Commencement Date") and shall continue for a period of one year ("Initial Term") with the option of 3 additional 1 year terms.

3. MONTHLY LEASE AMOUNT

3.1 The Sublessee shall pay to the Sublessor a monthly rental amount of $500.00 on the First day of each month for the duration of the lease term. Upon the signing of this Agreement, the Sublessee shall pay to the Sublessor the first month's rent.

3.2 All future monthly payments shall be hand delivered or mailed to the Sublessor at the address set forth in the preamble or to such other person or place as the Sublessor may designate in writing.

3.3 The monthly rental amount shall be negotiated by the parties prior to the beginning of any renewal term but will remain unchanged for the first 3 years from effective date.

4. USE OF LEASED PREMISES

4.1 The Leased Premises shall be used by Sublessee for general office purposes, and for no other purpose unless agreed to in advance by Sublessor. Further, the Sublessee agrees that:

4.2 Sublessee shall not allow the use of the Leased Premises in a manner which would increase Sublessor's insurance premiums unless Sublessee agrees to reimburse Sublessor for such increase, or for any illegal purpose.

4.3 Sublessee shall comply with all laws and shall observe all applicable rules and regulations related to the use of the Leased Premises, including (a) the Building Operating Policies and Procedures for the Confluence Technology Center, and any amendments thereto; a copy of which has been received and reviewed by Sublessee and which Building Operating Policies and Procedures is incorporated herein by this reference, (b) present and future rules and regulations of the Sublessor regarding the use of Leased space in the CTC, and (c) the present and future rules and regulations of the Confluence Technology Center including security access limitations and security badging requirements required by the CTC, acting by and through the CTC Manager. Landlord shall not be responsible to Sublessee for the non-performance by any other Tenant or occupant of the Confluence Technology Center of the Building Operating Policies and Procedures or any rules and regulations adopted by the CTC. Sublessee understands and agrees that Landlord may amend the Building Operating Policies and Procedures, and that such amendments shall be binding upon Sublessee.

5. ALTERATIONS AND IMPROVEMENTS.

5.1 Sublesseeshallmakenochanges,improvementsoralterations,totheLeased Premises without the Sublessor's prior written consent, which Sublessor is not required to give.

6. REPAIR AND MAINTENANCE.

6.1 Unless otherwise agreed, Sublessee shall, at its own expense, maintain the Leased Premises in the condition that existed at the commencement of this Lease. Such maintenance (including repairs and replacements necessary to maintain the Leased Premises as set forth herein) shall be made promptly as and when necessary. All repairs and replacements shall be approved in advance by Sublessor and must be of quality and class at least equal to the original work as reasonably determined by Sublessor.

6.2 In the event Sublessee fails to maintain the Leased Premises as required above, the Sublessor may, but shall not be required to, conduct such work and make such repairs and replacements for the Sublessee's account, and the expense thereof shall constitute and be collectible as additional rent.

6.3 Sublessor shall not be obligated to repair or replace any fixtures or equipment installed by Sublessee and Sublessor shall not be obligated to make any repair or replacement occasioned by any act or omission of Sublessee, its employees, agents, invitees or licensees.

7. RIGHT OF ENTRY.

7 . 1 Landlord may enter the Leased Premises at all times for emergencies, and at reasonable times during or after business hours, for the purpose of inspecting, cleaning, repairing, altering, improving or exhibiting the Leased Premises, but nothing in this Lease shall be construed as imposing any obligation on the Landlord to perform any repair or improvement to the Leased Premises.

8. DAMAGE OR DESTRUCTION.

8.1 All damage or injury done to the Leased Premises of the Leased Premises by Sublessee or by any persons who may be in or upon the Leased Premises or in or upon the Leased Premises at the invitation of Sublessee shall be paid for by Sublessee.

8.2 If the Property is destroyed or damaged by fire or any other casualty (except as set forth in Section 11.1) to the extent the cost of repairing the damage to the Property or Leased Premises exceeds $10,000, either Sublessor or Tenant may terminate this Lease by notice in writing to the other within thirty (30) days after the destruction or damage, unless Sublessor agrees in writing within 30 days after the destruction to pay the cost of repair, in which case the Lease shall not terminate. In the meantime, the monthly rent shall be abated in the same proportion as the untenantable portion of the Leased Premises bears to the whole of the Leased Premises.

8.3 Notwithstanding the foregoing, Sublessor shall have no obligation to repair, reconstruct, or restore the Leased Premises.

8.4 Sublessor's liability shall be limited to its contractual obligation in this Lease.

9. INDEMNITY.

9.1 The Sublessee shall indemnify the Sublessor from and against any and all claims, demands, cause of actions, suits or judgments (including fees, costs and expenses [including attorney fees] incurred in connection therewith and in enforcing the indemnity) for deaths or injuries to persons or for loss of or damage to property arising out of or in connection with the condition, use or occupancy of the Leased Premises or any improvements thereon; or by Sublessee’s non-observance or non- performance of any law, ordinance or regulation applicable to the Leased Premises; or incurred in obtaining possession of the Leased Premises after a default by the Sublessee, or after the Sublessee 's default in surrendering possession upon expiration or earlier termination of the term of the Lease, or enforcing any of the Sublessee 's covenants in this Lease. This includes, without limitation, any liability or injury to the person or property of Sublessee, its agents, officers, employees, or invitees. **The Sublessee specifically waives any immunity provided by Washington's Industrial Insurance Act. This indemnification covers claims by Sublessee's own employees.**

9.2 In the event of any such claims made or suits filed, Sublessor shall give Sublessee prompt written notice thereof and Sublessee shall have the right to defend or settle the same to the extent of its interests thereunder.

9.3 Sublessee, as a material part of the consideration to be rendered to Sublessor, waives all claims against Sublessor for damages to goods, wares, merchandise and loss of business in, upon or about the Leased Premises and for injury to Sublessee, its agents, employees, invitees or their persons in or about the Leased Premises from any cause arising at any time; except for Sublessor's negligence or wrongful conduct.

10. INSURANCE.

10.1 Sublessee shall be solely responsible for insuring its own personal property.

10.2 From and after the commencement date of the term of this Lease, Sublessee shall

provide general commercial liability insurance at its sole cost and expense, against claim for bodily injury and property damage under a policy of general liability insurance, with limits of $500,000.00 single limit or its equivalent for bodily injury, and $500,000.00 for property damage for matters occurring at the Leased Premises or the CTC as a result of Sublessee's occupancy or use. Such policy shall name Landlord and Sublessee as insureds. Before taking possession of the Leased Premises, the Sublessee shall furnish the Sublessor with a certificate evidencing the aforesaid insurance coverage.

10.3 The aforementioned minimum limits of policies shall in no event limit the liability of Tenant hereunder. No policy of Sublessee 's insurance shall be cancelable or subject to reduction of coverage or other modification except after thirty (30) days prior written notice to Sublessor by the insurer. Sublessee shall, at least thirty (30) days prior to the expiration of the policies, furnish Sublessor with renewals or binders.

10.4 The insurance shall be issued by carriers acceptable to the Sublessor, and Sublessor's approval shall not be unreasonably withheld.

10.5 Sublessee agrees that if Sublessee does not take out and maintain such insurance, Sublessor may (but shall not be required to) procure such insurance on Sublessee 's behalf and charge Sublessee the premiums together with a twenty-five percent (25%) handling charge, payable upon demand.

11. RELEASE.

11.1 In addition to, and not by way of limitation of, the Sublessee 's obligation to indemnify Sublessor, Sublessee waives its right of recovery against the Sublessor for any loss insured by fire, extended coverage, and other property insurance policies existing for the benefit of the Leased Premises. The Sublessee shall obtain any special endorsements, if required, by its insurer to evidence compliance with the waiver.

11.2 Each insurance policy obtained by the Sublessee shall provide that the insurance company waives all rights of recovery by way of subrogation against the Sublessor in connection with any damage covered by the policy. The Sublessor shall not be liable to the Sublessee for any damage caused by fire or any other risk insured against under any property insurance policy carried under the terms of this Lease.

12. ASSIGNMENT AND SUBLETTING.

12.1 The Sublessee may not assign, transfer, mortgage, pledge, hypothecate or encumber this Lease or any interest therein, and may not sublet the Leased Premises or any part thereof.

12.2 An assignment or sublet includes the following: (1) any action which causes a change in control of the Sublessee corporation at any time during the Term; (2) if all or substantially all of the assets of Sublessee shall be sold, assigned or transferred with or without a specific assignment of the Lease; or (3) if Sublessee shall merge or consolidate with any firm or corporation.

12.3 Sublessor, at its option, may, by giving fifteen (15) days' prior written notice to Sublessee after discovery of the action, declare such change to be an assignment or subletting in violation of this Lease, subject to the remedies provided for in event of breach of this Lease.

1 3 . QUIET ENJOYMENT.

1 3 . 1 Sublessor covenants that Sublessee, upon performance of all Sublessee 's obligations under this Lease, shall lawfully and quietly hold, occupy and enjoy the Leased Premises during the term of this Lease without disturbance by the Sublessor or from any person claiming through the Sublessor, except as expressly set forth in this Lease.

14. SIGNS.

14.1 All signs must comply with sign ordinances, be placed in accordance with the required permits and the Condominium Declaration, and require the advance written approval of the CTC Manager, which approval the CTC Manager is not required to give.

14.2 The Sublessor may demand the removal of any signs which do not receive its prior written approval. Sublessee 's failure to comply with Sublessor's demand to remove within forty- eight (48) hours of such demand shall constitute a breach of this paragraph and shall entitle Sublessor to cause the sign to be removed and the building repaired at the Sublessee 's sole expense.

14.3 At the termination of this Lease, Sublessee shall remove all signs placed by it upon the Leased Premises, and shall repair any damage caused by such removal.

15. VACATING UPON TERMINATION.

15.1 Sublessee covenants and agrees that upon the expiration of the Lease or renewal term, or upon the termination of the Lease for any cause, Sublessee shall at once peacefully surrender and deliver the whole of the above-described Leased Premises together with all improvements thereon to the Sublessor, or Sublessor's agents or assigns unless Sublessee shall have expressly acquired the right to remain through another written extension of this Lease. Sublessee shall make all reasonable and necessary repairs to return the Lease Premises to the same or better condition as at the initial time of occupancy.

16. PRESENCE AND USE OF HAZARDOUS SUBSTANCES.

1 6 . 1 Sublessee shall not, without Sublessor 's prior written consent, keep on or around the Leased Premises, for use, disposal, treatment, generation, storage or sale, any substances designated as, or containing designated as hazardous, dangerous, toxic or harmful (collectively referred to as "Hazardous Substances"), and/or which are subject to regulation by any federal, state or local law, regulation, statute or ordinance.

16.2 With respect to any Hazardous Substance, Sublessee shall:

16.3 Comply promptly, timely, and completely with all governmental requirements for reporting, keeping and submitting manifests, and obtaining and keeping current identification numbers;

16.4 Submit to Sublessor true and correct copies of all reports, manifests and identification numbers at the same time as they are required to be submitted to the appropriate governmental authorities;

16.5 Within five (5) days of Sublessor 's request, submit written reports to Sublessor regarding Sublessee's use, storage, treatment, transportation, generation, disposal or sale of Hazardous Substances and provide evidence satisfactory to Sublessor of Sublessee 's compliance with the applicable governmental regulation;

16.6 Allow Landlord or Landlord's agents or representatives to come on the Leased Premises at all times, after reasonable notice, to check Sublessee 's compliance with all applicable governmental regulations regarding Hazardous Substances;

16.7 Comply with minimum levels, standards or other performance standards or requirements which may be set forth or established for certain Hazardous Substances (if minimum standards or levels are applicable to Hazardous Substances present on the Leased Premises, these levels or standards shall be established by an on-site inspection by the appropriate governmental authorities and shall be set forth in an addendum to this Lease);

16.8 Comply with all governmental rules, regulations and requirements regarding the proper and lawful use, sale, transportation, generation, treatment and disposal of Hazardous Substances; and

16.9 Landlord shall have the right, at reasonable times and upon reasonable notice to Sublessee, to inspect the Leased Premises to monitor Sublessee 's compliance with this section. Landlord shall pay and be responsible for the costs of its own inspection. Notwithstanding the foregoing, if an inspection reveals the use or presence of Hazardous Substances requiring clean-up or other action, then Sublessee shall pay, as part of the clean-up cost incorporated in Paragraph 16.10 below, Landlord's actual costs, including reasonable attorney's fees and costs, incurred in making or providing for such inspection and any follow-up inspections.

16.10 Sublessee shall be fully and completely liable to Landlord for any and all clean-up costs and any and all charges, fees, penalties (civil and criminal) imposed by any governmental authority with respect to Sublessee 's use, disposal, transportation, generation and/or sale of Hazardous Substances, in or about the Leased Premises.

16.11 Sublessee shall indemnify, defend and hold Sublessor and Landlord harmless from any and all costs, fees, penalties and charges assessed against or imposed upon Landlord including Landlord's reasonable attorneys' fees and costs as a result of Sublessee 's use, disposal, transportation, generation and/or sale of Hazardous Substances.

16.11 Upon Sublessee's default under this article, in addition to the rights and remedies set forth elsewhere in this Lease, Sublessor shall be entitled to the following rights and remedies.

16.12 At Sublessor's option, to terminate this Lease immediately; and

16.13 To recover any and all damage associated with the default, including, but not limited to clean-up costs and charges, civil and criminal penalties and fees, loss of business and sales by Sublessor and any and all damages and claims asserted by third parties together with reasonable attorneys' fees and costs.

17. LICENSES AND PERMITS.

17.1 Sublessee,atitssoleexpense,shallobtainalllicensesorpermitswhichmay be required for conducting its business within the terms of this Lease.

18. DEFAULT AND RE-ENTRY.

18.1 If Sublessee defaults in any rent payment due under the terms of this Lease, and

such default is not cured within three (3) calendar days after written notice from Sublessor or if the default is other than the payment of rent and the default is not cured within fifteen (15) calendar days after written notice from Sublessor, Sublessor may terminate this Lease and re-enter the Leased Premises.

18.2 Each of the following events is a default by Sublessor and a breach of this Lease:

18.2.1 Any failure by Sublessee to make any payment required to be made by Sublessor on or before the time the payment is due.

18.2.2 The abandonment or vacation of the Leased Premises by the Sublessee.

18.2.3 A failure by Sublessee to observe and perform any provision of this Lease or any other lease or agreement between Sublessee or any subsidiaries of Sublessee and Sublessor which is to be observed or performed by the Sublessee or any subsidiary of Sublessee.

18.2.4 The appointment of a receiver to take possession of all or substantially all the assets of the Sublessee.

18.2.5 A general assignment by Sublessee for the benefit of creditors.

18.2.6 Any action taken or suffered by Sublessee under any insolvency or bankruptcy act. If Sublessee becomes insolvent, bankrupt, or if a receiver, assignee, or other liquidating officer is appointed for the Sublessee 's business, Sublessor may cancel this Lease, subject to Section 365 of Bankruptcy Code, 11 U.S.C. 365.

18.2.7 A default under this Lease may, at Sublessor's discretion, be declared to be a default under any other lease or agreement between Sublessee and Sublessor, or between any subsidiary of Sublessee and Sublessor.

19. NON-WAIVER OF COVENANTS.

1 9 . 1 The Sublessor's failure to insist upon the strict performance of any provision of this Lease shall not be construed as depriving the Sublessor of the right to insist on strict performance of such provision in the future. The subsequent acceptance of rent, whether full or partial payment, by the Sublessor shall not be deemed a waiver of any preceding breach by the Sublessee of any term, covenant, or condition of this Lease, other than the failure of the Sublessee to pay the particular part of the rent accepted, regardless of the Sublessor 's knowledge of the preceding breach at the time of the acceptance of that part of the rent.

20 AS-IS. NO WARRANTY.

26.1 TENANT ACKNOWLEDGES IT IS FAMILIAR WITH THE LEASED PREMISES AND THE CTC, HAS INVESTIGATED SAME, AND HAS BEEN PROVIDED WITH ADDITIONAL OPPORTUNITIES TO INVESTIGATE THE LEASED PREMISES AND THE CTC PRIOR TO SIGNING THIS LEASE. SUBLESSEE ACKNOWLEDGES AND AGREES THAT IT IS RELYING SOLELY ON ITS INSPECTION AND INVESTIGATION OF

THE LEASED PREMISES AND THE CTC, AND ACCEPTS THE LEASED PREMISES "AS IS, WHERE IS" IN ITS PRESENT CONDITION WITH NO WARRANTIES OF ANY KIND, EXPRESS OR IMPLIED, EITHER ORAL OR WRITTEN, MADE BY SUBLESSOR OR ANY EMPLOYEE, AGENT OR REPRESENTATIVE OF SUBLESSOR WITH RESPECT TO THE PHYSICAL CONDITION OF THE LEASED PREMISES. SUBLESSEE SHALL HAVE DETERMINED TO ITS SATISFACTION PRIOR TO SIGNING THIS LEASE, THAT THE LEASED PREMISES CAN BE USED FOR THE PURPOSES SUBLESSEE INTENDS. SUBLESSEE ACKNOWLEDGES AND AGREES THAT NEITHER SUBLESSOR NOR SUBLESSOR'S AGENTS OR EMPLOYEES HAVE MADE, AND DO NOT MAKE, ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, WITH RESPECT TO THE SUITABILITY FOR COMMERCIAL OR BUSINESS PURPOSES, MERCHANTABILITY, POTENTIAL USE OF THE LEASED PREMISES, OR FITNESS FOR A PARTICULAR PURPOSE OF THE LEASED PREMISES, ALL OF WHICH WARRANTIES SUBLESSOR HEREBY EXPRESSLY DISCLAIMS.

21. COST AND ATTORNEYS' FEES.

2 1 . 1 In the event it is necessary for either party to utilize the services of an attorney to enforce any of the terms of this agreement, such enforcing party shall be entitled to compensation for its reasonable attorneys' fees and costs. In the event of litigation regarding any of the terms of this agreement, the substantially prevailing party shall be entitled, in addition to other relief, to such reasonable attorneys' fees and costs as determined by the court.

22. CAPTIONS AND CONSTRUCTION.

2 2 . 1 The titles to sections of the Lease are not a part of this Lease and shall have no effect upon the construction and interpretation of any part of the Lease.

23. TIME.

23.1 TIME IS OF THE ESSENCE IN THIS LEASE.

24. BINDING ON HEIRS, SUCCESSORS AND ASSIGNS.

2 4 . 1 All the covenants, agreement terms and conditions contained in this Lease shall apply to and be binding upon Sublessor and Sublessee and their respective heirs, executors, administrators, successors and assigns, except as may be provided to the contrary in other sections of this Lease.

25. SAVINGS CLAUSE. Nothing in this Lease shall be construed so as to require the commission of any act contrary to law, and wherever there is any conflict between any provisions of this Lease and any statute, law, public regulation or ordinance, the latter shall prevail, but in such event, the provisions of this Lease affected shall be curtailed and limited only to the extent necessary to bring it within legal requirements.

26. INCORPORATION. This agreement represents the entire agreement of the parties. Unless set forth herein in writing, neither party shall be bound by any statements or representations made, and each agrees that there are no such statements or representations being relied upon in making this Lease. No alterations, changes, or amendments to this Lease will be binding upon either party unless

such party has executed a written statement acknowledging such alteration, change or amendment.

27. GOVERNING LAW. This Lease shall be governed by the laws of the State of Washington and venue for any action arising from this Lease shall be in Chelan County, Washington.

28. REMEDIES CUMULATIVE. The specified remedies to which the Sublessor and Sublessee may resort under the terms of this Lease are cumulative and are not intended to be exclusive of any other remedies or means of redress to which the Sublessor and Sublessee may be lawfully entitled in case of any breach or threatened breach by Sublessee or Sublessor, as the case may be, of any provision of this Lease. In addition to the other remedies provided in this Lease, Sublessor and Sublessee shall be entitled to the restraint by injunction of the violation, or attempted or threatened violation, of any of the covenants, conditions, or provisions of this Lease. The Sublessor 's or Sublessee 's selection of one or more remedies shall not constitute an election of remedies to the exclusion of any other remedies.

29. STATUS OF TENANT. If applicable, each individual executing this Lease on behalf of Sublessee, if Sublessee is a corporation or limited liability company, represents and warrants that he/she is duly authorized to execute and deliver this Lease on behalf of said corporation or limited liability company in accordance with a duly adopted resolution of the Board of Directors or the Members, as the case may be, and that this Lease is binding upon said corporation or the limited liability company in accordance with its terms.

IN WITNESS WHEREOF, the parties hereby execute this Agreement:

(Sublessor Signature)	(Dated)
Wenatchee Home Health, LLC dba Advanced Home Health	
Northwest of Wenatchee	

(Sublessee Signature)	(Dated)
Wenatchee Hospice LLC dba Advanced Hospice Northwest	
of Wenatchee	

ADDENDUM NO. 1 TO LEASE AGREEMENT 2020
("Addendum No. 1")

This Addendum No. 1 is entered into this date by and between the CHELAN DOUGLAS REGIONAL PORT AUTHORITY, a Washington municipal corporation, hereafter referred to as "Landlord," and ADVANCED HOME HEALTH, a Washington Corporation, hereafter referred to as "Tenant," sometimes collectively referred to as the "Parties" or individually a "Party."

RECITALS

A. The Parties entered into a Lease Agreement commencing September 1, 2020 (the "Lease"), whereby Tenant leased from Landlord a portion of the building commonly known as the Confluence Technology Center (the "CTC") consisting of five (5) offices in the northeast side of Unit 102 of the CTC (the "Leased Premises"), all as more fully described and depicted in the Lease.

B. The current Advanced Home Health lease is due to expire August 31, 2022, with the option of two additional one-year terms.
The Parties desire to add three (3) additional one-year option to renew at the end of the current renewal terms.

C. The Tenant, Advanced Home Health, will designate one of their 5 offices for Wenatchee Hospice, LLC. Advanced Home Health will continue to be the responsible party for the timely payments of rent per Section 3.1 of the Lease.

Now therefore, in light of the foregoing Recitals, which are incorporated herein by this reference, and the mutual terms and conditions set forth herein, the Parties agree as follows:

AGREEMENT

1. **RATIFICATION OF LEASE.** Except as modified herein, the Lease is hereby ratified by the Parties and shall remain in full force and effect.

IN WITNESS WHEREOF, the undersigned set their hands and state that they are authorized to execute this Addendum No. 1.

LANDLORD	TENANT
Chelan Douglas Regional Port Authority	Advanced Home Health
By: _____	By: _____
JAMES KUNTZ, CEO	JOEL STEVENS, Administrator
Date: 12-14-2021	Date: 12/14/2021

LEASE AGREEMENT
2020

THIS LEASE AGREEMENT ("Lease") is entered into this date, between CHELAN DOUGLAS REGIONAL PORT AUTHORITY, a Washington municipal corporation ("Landlord"), and Advanced Home Health - Wenatchee, an Washington Corporation ("Tenant"), sometimes collectively referred to as the "Parties" or individually as a "Party."

1. **PREMISES.**

1.1 Landlord hereby leases to Tenant, and Tenant leases from Landlord, upon the terms and conditions included in this Lease, located in the building commonly known as the Confluence Technology Center (the "CTC"). The portion of the CTC being leased by the Tenant are 5 offices, unfurnished, located in Unit 102 of the CTC (the "Leased Premises") indicated on attached **Exhibit "A"** which is incorporated herein by this reference.

1.2 The Tenant shall share a common access corridor to the Leased Premises, as depicted in **Exhibit "A"** with other tenants and owners of the CTC. Tenant shall have use of the common restrooms located on the first floor of the CTC.

1.3 Landlord shall have the right to relocate the Tenant to a comparable space within the CTC upon thirty (30) days advance written notice to the Tenant.

2. **TERM OF LEASE.** This Lease shall be on a Two Year Lease commencing on the 1st day of September, 2020, with an option to renew.

2.1 Tenant shall have the option to renew this Lease for two (2) additional one-year terms (each a "Renewal Term"), considering the Tenant has been in full compliance of the Lease terms. Each Renewal Term will commence immediately upon expiration of the preceding Lease term, unless Landlord is notified in writing no less than thirty (30) days prior to the expiration of the then-current Lease term. A Renewal Term shall be on the same terms and conditions applicable to the original Lease term, except for Base Rent which shall be adjusted as follows:

3. **RENT.**

3.1 During the initial term of the lease, Tenant shall pay Landlord monthly rent ("Base Rent") in the amount of Two thousand four hundred fifteen and 84/100 Dollars ($2,415.84) per month payable in lawful money of the United States. Rent shall be paid in advance on the first day of each month of the Lease term and any renewal thereof.

3.2 Effective September 1, 2021 and on an annual basis thereafter, for the remainder of the Term, the Base Rent shall be adjusted in accordance with the Consumer Price Index to the amount determined as hereafter set out.

3.2.1 The Base Rent shall be adjusted to an amount equal to the product obtained by multiplying the Base Rent set forth in Section 3.1 by a fraction, the denominator of which is the data for August 2020 from the "Consumer Price Indexes Pacific Cities and U.S. City Average" for "All Items Indexes" for "All Urban Consumers (1982-84 = 100, unless otherwise noted)", published by the Bureau of Labor Statistics of the United States Department of Labor, as

adjusted for the "West-B/C" area ("CPI_U), and the numerator of which is the CPI-U for August 2021: provided however, that in the event the period designated above shall not be listed in the Index, the closest period, or month if reporting data is monthly, preceding December will be used; and provided that rent shall not decrease as a result of a calculation set forth in this paragraph.

3.2.2 The monthly rent commencing September 1, 2021, shall be calculated as follows:

CPI-U for August 2021 for West-B/C				
_____	**X**	**$2415.84**	=	**Monthly rent beginning September 1, 2021**
CPI-U for August 2020 for West-B/C				

3.2.3 If the US Department of Labor, Bureau of Labor Statistics, shall discontinue publication of the Consumer Price Index, then other index generally recognized as authoritative shall be substituted by agreement, and if the Parties should not agree, such substituted index shall be selected by the then presiding Judge of Chelan County Superior Court upon the application of either party.

3.3 In addition to Base Rent, Tenant shall pay to the Landlord such sums as may be required by law for payment of leasehold or other tenant tax as required by the State of Washington or other tax entity, as such laws now exists or as they hereafter be amended (such leasehold tax currently being 12.84%) . If leasehold tax is increased or decreased, the total amount payable for rent plus leasehold tax shall increase or decrease, but the amount of Base Rent shall not be changed as a result of any change in the leasehold tax rate.

3.4 In the event the lease term commences or terminates on a date that is not the first or last day of the month, respectively, Tenant shall pay a pro-rated monthly installment, in advance, on the first day of the lease term or the first day of the last month of the lease term, respectively, at the then current rate, based on the number of days of actual occupancy during the first or last calendar month of the lease term.

3.5 Tenant shall pay, before the same become delinquent, all taxes assessed against Tenant's personal property, furniture, equipment, inventory and other property on the Leased Premises.

3.6 Prior to taking possession of the Leased Premises, Tenant shall deposit with Landlord a security deposit in an amount equal to one (1) months' rent ($2,415.84) to be held by Landlord as security for the full and faithful performance by Tenant of each and every term, covenant and condition of the Lease. If Tenant breaches any of the lease terms, including the

obligation to pay Rent, Landlord may, at Landlord's option, make demand upon such security and apply the proceeds thereof to the breach.

3.7 In the event any rental amount called for herein, including the leasehold tax, is not paid within ten (10) days from the date it is due Tenant shall pay to Landlord a late charge of five percent (5%) of the rental amount per month for each unpaid Lease payment until such payment is paid. The late charge is due immediately and is in addition to all of Landlord's other rights in this Lease. In the event Landlord gives written notice of Tenant's default, delinquency or other Lease violations, Tenant agrees to pay Landlord's actual costs and attorneys' fees reasonably incurred in providing such notice, in addition to the late charge and all other payments and obligations called for herein.

4. **POSSESSION.**

4.1 Possession of the Leased Premises pursuant to this Lease shall commence on September 1, 2020.

5. **ACCEPTANCE OF FACILITIES.**

5.1 Tenant hereby accepts the Leased Premises and the CTC in their present condition.

5.2 No representation, statement or warranty, expressed or implied, is or shall be made by or on behalf of the Landlord as to the Leased Premises' condition, or as to the use that may be made of the CTC or Leased Premises unless specifically set forth in writing. Tenant releases Landlord from any responsibility for any representation that may have been made to the Tenant about the Leased Premises or the CTC that is not specifically set out in this Lease Agreement.

6. **USE OF LEASED PREMISES.** The Leased Premises shall be used by Tenant for general office purposes, and for no other purpose unless agreed to in advance by Landlord. Further, the Tenant agrees that:

6.1 Tenant shall not allow the use of the Leased Premises in a manner which would increase Landlord's insurance premiums unless Tenant agrees to reimburse Landlord for such increase, or for any illegal purpose.

6.2 Tenant shall comply with all laws and shall observe all applicable rules and regulations related to the use of the Leased Premises, including (a) the Building Operating Policies and Procedures for the Confluence Technology Center, and any amendments thereto; a copy of which has been received and reviewed by Tenant and which Building Operating Policies and Procedures is incorporated herein by this reference, (b) present and future rules and regulations of the Landlord regarding the use of Leased space in the CTC, and (c) the present and future rules and regulations of the Confluence Technology Center including security access limitations and security badging requirements required by the CTC, acting by and through the CTC Manager. Landlord shall not be responsible to Tenant for the non-performance by any other Tenant or occupant of the Confluence Technology Center of the Building Operating Policies and Procedures or any rules and regulations adopted by the CTC. Tenant understands

and agrees that Landlord may amend the Building Operating Policies and Procedures, and that such amendments shall be binding upon Tenant.

7. **SERVICES AND UTILITIES**.

7.1 In addition to Rent, the Tenant shall make all arrangements for and pay all phone, internet, fiber and other telecommunications costs and expenses, of any kind or nature.

7.2 As part of the Rent, Landlord shall provide the following basic utilities and services to the Leased Premises: electricity, water, sewer, janitorial service, and garbage collection.

7.3 Landlord does not warrant that any utilities and services mentioned above will be free from interruption. The Landlord shall not be liable to Tenant for any loss or damage caused by or resulting from any variation, interruption, or failure of heat or any utility or service due to any cause, other than Landlord's negligent or willful acts. No temporary interruption or failure of services due to the making of repairs, alterations, or improvements, or due to accident, strike or conditions or events beyond Landlord's control shall be deemed an eviction of Tenant or relieve Tenant from any of Tenant's obligations under this Lease.

8. **ALTERATIONS AND IMPROVEMENTS.** Tenant shall make no changes, improvements or alterations, to the Leased Premises without the Landlord's prior written consent, which Landlord is not required to give.

9. **REPAIR AND MAINTENANCE.**

9.1 Unless otherwise agreed, Tenant shall, at its own expense, maintain the Leased Premises in the condition that existed at the commencement of this Lease. Such maintenance (including repairs and replacements necessary to maintain the Leased Premises as set forth herein) shall be made promptly as and when necessary. All repairs and replacements shall be approved in advance by Landlord and must be of quality and class at least equal to the original work as reasonably determined by Landlord. Notwithstanding the foregoing, the Landlord shall be responsible for maintaining, repairing, and replacing the roof, heating, air conditioning, fire protection system and plumbing systems; provided said maintenance, repair, or replacement is not caused by the negligence or other wrongful conduct of the Tenant.

9.2 In the event Tenant fails to maintain the Leased Premises as required above, the Landlord may, but shall not be required to, conduct such work and make such repairs and replacements for the Tenant's account, and the expense thereof shall constitute and be collectible as additional rent.

9.3 Landlord shall not be obligated to repair or replace any fixtures or equipment installed by Tenant and Landlord shall not be obligated to make any repair or replacement occasioned by any act or omission of Tenant, its employees, agents, invitees or licensees.

10. **RIGHT OF ENTRY.** Landlord may enter the Leased Premises, including the Leased Premises, at all times for emergencies, and at reasonable times during or after business hours, for the purpose of inspecting, cleaning, repairing, altering, improving or exhibiting the Leased

Premises, but nothing in this Lease shall be construed as imposing any obligation on the Landlord to perform any repair or improvement to the Leased Premises.

11. **DAMAGE OR DESTRUCTION.**

11.1 All damage or injury done to the Leased Premises of the Leased Premises by Tenant or by any persons who may be in or upon the Leased Premises or in or upon the Leased Premises at the invitation of Tenant shall be paid for by Tenant.

11.2 If the Property is destroyed or damaged by fire or any other casualty (except as set forth in Section 11.1) to the extent the cost of repairing the damage to the Property or Leased Premises exceeds $10,000, either Landlord or Tenant may terminate this Lease by notice in writing to the other within thirty (30) days after the destruction or damage, unless Landlord agrees in writing within 30 days after the destruction to pay the cost of repair, in which case the Lease shall not terminate. In the meantime, the monthly rent shall be abated in the same proportion as the untenantable portion of the Leased Premises bears to the whole of the Leased Premises.

11.3 Notwithstanding the foregoing, Landlord shall have no obligation to repair, reconstruct, or restore the Leased Premises.

11.4 Landlord's liability shall be limited to its contractual obligation in this Lease.

12. **INDEMNITY.**

12.1 The Tenant shall indemnify the Landlord from and against any and all claims, demands, cause of actions, suits or judgments (including fees, costs and expenses [including attorney fees] incurred in connection therewith and in enforcing the indemnity) for deaths or injuries to persons or for loss of or damage to property arising out of or in connection with the condition, use or occupancy of the Leased Premises or any improvements thereon; or by Tenant's non-observance or non-performance of any law, ordinance or regulation applicable to the Leased Premises; or incurred in obtaining possession of the Leased Premises after a default by the Tenant, or after the Tenant's default in surrendering possession upon expiration or earlier termination of the term of the Lease, or enforcing any of the Tenant's covenants in this Lease. This includes, without limitation, any liability or injury to the person or property of Tenant, its agents, officers, employees, or invitees. **The tenant specifically waives any immunity provided by Washington's Industrial Insurance Act. This indemnification covers claims by Tenant's own employees.**

12.2 In the event of any such claims made or suits filed, Landlord shall give Tenant prompt written notice thereof and Tenant shall have the right to defend or settle the same to the extent of its interests thereunder.

12.3 Tenant, as a material part of the consideration to be rendered to Landlord, waives all claims against Landlord for damages to goods, wares, merchandise and loss of business in, upon or about the Leased Premises and for injury to Tenant, its agents, employees, invitees or their persons in or about the Leased Premises from any cause arising at any time; except for Landlord's negligence or wrongful conduct.

13. **INSURANCE.**

13.1 Tenant shall be solely responsible for insuring its own personal property.

13.2 From and after the commencement date of the term of this Lease, Tenant shall provide general commercial liability insurance at its sole cost and expense, against claim for bodily injury and property damage under a policy of general liability insurance, with limits of $500,000.00 single limit or its equivalent for bodily injury, and $500,000.00 for property damage for matters occurring at the Leased Premises or the CTC as a result of Tenant's occupancy or use. Such policy shall name Landlord and Tenant as insureds. Before taking possession of the Leased Premises, the Tenant shall furnish the Landlord with a certificate evidencing the aforesaid insurance coverage.

13.3 The aforementioned minimum limits of policies shall in no event limit the liability of Tenant hereunder. No policy of Tenant's insurance shall be cancelable or subject to reduction of coverage or other modification except after thirty (30) days prior written notice to Landlord by the insurer. Tenant shall, at least thirty (30) days prior to the expiration of the policies, furnish Landlord with renewals or binders.

13.4 The insurance shall be issued by carriers acceptable to the Landlord, and Landlord's approval shall not be unreasonably withheld.

13.5 Tenant agrees that if Tenant does not take out and maintain such insurance, Landlord may (but shall not be required to) procure such insurance on Tenant's behalf and charge Tenant the premiums together with a twenty-five percent (25%) handling charge, payable upon demand.

14. **RELEASE.**

14.1 In addition to, and not by way of limitation of, the Tenant's obligation to indemnify Landlord, Tenant waives its right of recovery against the Landlord for any loss insured by fire, extended coverage, and other property insurance policies existing for the benefit of the Leased Premises. The Tenant shall obtain any special endorsements, if required, by its insurer to evidence compliance with the waiver.

14.2 Each insurance policy obtained by the Tenant shall provide that the insurance company waives all rights of recovery by way of subrogation against the Landlord in connection with any damage covered by the policy. The Landlord shall not be liable to the Tenant for any damage caused by fire or any other risk insured against under any property insurance policy carried under the terms of this Lease.

15. **ASSIGNMENT AND SUBLETTING.**

15.1 The Tenant may not assign, transfer, mortgage, pledge, hypothecate or encumber this Lease or any interest therein, and may not sublet the Leased Premises or any part thereof without Landlord's prior written consent which Landlord is not required to give. Any attempt to assign or sublet without such consent shall be null and void and shall constitute a breach of this

Lease. If the Landlord does give written consent to an assignment or sublet, Tenant shall still be liable for full performance of all the Tenant's obligations in this Lease.

15.2 An assignment or sublet includes the following: (1) any action which causes a change in control of the Tenant corporation at any time during the Term; (2) if all or substantially all of the assets of Tenant shall be sold, assigned or transferred with or without a specific assignment of the Lease; or (3) if Tenant shall merge or consolidate with any firm or corporation.

15.3 Landlord, at its option, may, by giving fifteen (15) days' prior written notice to Tenant after discovery of the action, declare such change to be an assignment or subletting in violation of this Lease, subject to the remedies provided for in event of breach of this Lease.

16. **QUIET ENJOYMENT.** Landlord covenants that Tenant, upon performance of all Tenant's obligations under this Lease, shall lawfully and quietly hold, occupy and enjoy the Leased Premises during the term of this Lease without disturbance by the Landlord or from any person claiming through the Landlord, except as expressly set forth in this Lease.

17. **SIGNS.**

17.1 All signs must comply with sign ordinances, be placed in accordance with the required permits and the Condominium Declaration, and require the advance written approval of the CTC Manager, which approval the CTC Manager is not required to give.

17.2 The Landlord may demand the removal of any signs which do not receive its prior written approval. Tenant's failure to comply with Landlord's demand to remove within forty-eight (48) hours of such demand shall constitute a breach of this paragraph and shall entitle Landlord to cause the sign to be removed and the building repaired at the Tenant's sole expense.

17.3 At the termination of this Lease, Tenant shall remove all signs placed by it upon the Leased Premises, and shall repair any damage caused by such removal.

18. **VACATING UPON TERMINATION.** Tenant covenants and agrees that upon the expiration of the Lease or renewal term, or upon the termination of the Lease for any cause, Tenant shall at once peacefully surrender and deliver the whole of the above-described Leased Premises together with all improvements thereon to the Landlord, or Landlord's agents or assigns unless Tenant shall have expressly acquired the right to remain through another written extension of this Lease. Tenant shall make all reasonable and necessary repairs to return the Lease Premises to the same or better condition as at the initial time of occupancy.

19. **PRESENCE AND USE OF HAZARDOUS SUBSTANCES.** Tenant shall not, without Landlord's prior written consent, keep on or around the Leased Premises, for use, disposal, treatment, generation, storage or sale, any substances designated as, or containing designated as hazardous, dangerous, toxic or harmful (collectively referred to as "Hazardous Substances"), and/or which are subject to regulation by any federal, state or local law, regulation, statute or ordinance.

19.1 With respect to any Hazardous Substance, Tenant shall:

19.1.1 Comply promptly, timely, and completely with all governmental requirements for reporting, keeping and submitting manifests, and obtaining and keeping current identification numbers;

19.1.2 Submit to Landlord true and correct copies of all reports, manifests and identification numbers at the same time as they are required to be submitted to the appropriate governmental authorities;

19.1.3 Within five (5) days of Landlord's request, submit written reports to Landlord regarding Tenant's use, storage, treatment, transportation, generation, disposal or sale of Hazardous Substances and provide evidence satisfactory to Landlord of Tenant's compliance with the applicable governmental regulation;

19.1.4 Allow Landlord or Landlord's agents or representatives to come on the Leased Premises at all times, after reasonable notice, to check Tenant's compliance with all applicable governmental regulations regarding Hazardous Substances;

19.1.5 Comply with minimum levels, standards or other performance standards or requirements which may be set forth or established for certain Hazardous Substances (if minimum standards or levels are applicable to Hazardous Substances present on the Leased Premises, these levels or standards shall be established by an on-site inspection by the appropriate governmental authorities and shall be set forth in an addendum to this Lease);

19.1.6 Comply with all governmental rules, regulations and requirements regarding the proper and lawful use, sale, transportation, generation, treatment and disposal of Hazardous Substances; and

19.1.7 Landlord shall have the right, at reasonable times and upon reasonable notice to Tenant, to inspect the Leased Premises to monitor Tenant's compliance with this section. Landlord shall pay and be responsible for the costs of its own inspection. Notwithstanding the foregoing, if an inspection reveals the use or presence of Hazardous Substances requiring clean-up or other action, then Tenant shall pay, as part of the clean-up cost incorporated in Paragraph 19.1.8 below, Landlord's actual costs, including reasonable attorney's fees and costs, incurred in making or providing for such inspection and any follow-up inspections.

19.1.8 Tenant shall be fully and completely liable to Landlord for any and all clean-up costs and any and all charges, fees, penalties (civil and criminal) imposed by any governmental authority with respect to Tenant's use, disposal, transportation, generation and/or sale of Hazardous Substances, in or about the Leased Premises.

19.1.9 Tenant shall indemnify, defend and hold Landlord harmless from any and all costs, fees, penalties and charges assessed against or imposed upon Landlord including Landlord's reasonable attorneys' fees and costs as a result of Tenant's use, disposal, transportation, generation and/or sale of Hazardous Substances.

19.1.10 Upon Tenant's default under this article, in addition to the rights and remedies set forth elsewhere in this Lease, Landlord shall be entitled to the following rights and remedies.

19.1.10.1 At Landlord's option, to terminate this Lease immediately; and

19.1.10.2 To recover any and all damage associated with the default, including, but not limited to clean-up costs and charges, civil and criminal penalties and fees, loss of business and sales by Landlord and any and all damages and claims asserted by third parties together with reasonable attorneys' fees and costs.

20. **LICENSES AND PERMITS.** Tenant, at its sole expense, shall obtain all licenses or permits which may be required for conducting its business within the terms of this Lease.

21. **DEFAULT AND RE-ENTRY.**

21.1 If Tenant defaults in any rent payment due under the terms of this Lease, and such default is not cured within three (3) calendar days after written notice from Landlord or if the default is other than the payment of rent and the default is not cured within fifteen (15) calendar days after written notice from Landlord, Landlord may terminate this Lease and re-enter the Leased Premises; or Landlord may, without terminating this Lease, re-enter said Leased Premises, and relet the whole or any part upon as favorable terms and conditions as the market will allow for the balance of the lease term.

21.2 Notwithstanding any re-entry, the liability of the Tenant for the full amounts payable by the Tenant under this Lease shall not be extinguished for the balance of the Lease or renewal term. Tenant shall make good to Landlord any deficiency arising from a reletting of the Leased Premises at a lesser rental or on different economic terms plus the reasonable costs and expenses of re-letting the Leased Premises including, but not limited, to commissions, advertising, attorneys' fees, and the costs of renovating or altering the Leased Premises.

21.3 Each of the following events is a default by Tenant and a breach of this Lease:

21.3.1 Any failure by Tenant to make any payment required to be made by Tenant on or before the time the payment is due.

21.3.2 The abandonment or vacation of the Leased Premises by the Tenant.

21.3.3 A failure by Tenant to observe and perform any provision of this Lease or any other lease or agreement between Tenant or any subsidiaries of Tenant and Landlord which is to be observed or performed by the Tenant or any subsidiary of Tenant.

21.3.4 The appointment of a receiver to take possession of all or substantially all the assets of the Tenant.

21.3.5 A general assignment by Tenant for the benefit of creditors.

21.3.6 Any action taken or suffered by Tenant under any insolvency or bankruptcy act. If Tenant becomes insolvent, bankrupt, or if a receiver, assignee, or other liquidating officer is appointed for the Tenant's business, Landlord may cancel this Lease, subject to Section 365 of Bankruptcy Code, 11 U.S.C. 365.

21.3.7 A default under this Lease may, at Landlord's discretion, be declared to be a default under any other lease or agreement between Tenant and Landlord, or between any subsidiary of Tenant and Landlord.

22. **LANDLORD'S EXPENSES ON TENANT'S DEFAULT.** Except as otherwise provided, if either party to this Lease fails (the "Defaulting Party") to make any payment or perform any obligations under this Lease, the non-defaulting party, with reasonable notice to or demand upon the Defaulting Party and without waiving or releasing the Defaulting Party from any obligations under this Lease, may make any payment or perform any other obligation of the Defaulting Party, in such manner and to such extent as the non-defaulting party deems desirable. All costs and expenses paid by the non-defaulting party in connection with the performance of any such obligations, together with interest at the rate of 12% per annum, compounded annually, from the date of making such expenditure by the non-defaulting party, shall be payable to the non-defaulting party upon demand.

23. **REMOVAL OF PROPERTY.**

23.1 If the Landlord, after Tenant's default, lawfully re-enters the Leased Premises, Landlord shall have the right, but not the obligation, to remove all property located therein and to place such property in storage at the Tenant's expense and risk. If the Tenant does not pay the storage cost, after it has been stored for a period of thirty (30) calendar days or more and after giving Tenant ten (10) days' written notice of sale, Landlord may, at its sole discretion, sell, or permit to be sold, any or all of the property at public or private sale.

23.2 Landlord, at its sole discretion, may retain any trade fixtures and other items of Tenant's property, which are not removed by the Tenant at the expiration of the lease term or any renewal period or at such earlier time as Tenant's rights under this Lease may be terminated for default. At Landlord's option, title to the fixtures and other property shall be vested in the Landlord without any duty to account or pay to Tenant for the value of the property or for any other matter in connection for the Landlord's acquisition of the fixtures and attached property.

24. **HOLDOVER.**

24.1 If Tenant, with the implied or expressed consent of the Landlord, shall holdover after the expiration of the term of this Lease, Tenant, shall remain bound by all this Lease's covenants and agreements, except that the tenancy shall be from month to month, and the monthly rent shall be the rent amount due the last month of the immediately preceding term plus twenty-five percent (25%).

24.2 If Tenant should holdover beyond the expiration of this lease term, or the renewal thereof, without consent of the Landlord, Tenant shall pay as liquidated damages a sum equal to treble the rent amount due the last month of the immediately preceding term. This paragraph

shall not affect any of the Landlord's rights to terminate this Lease and declare a forfeiture or to otherwise take possession of the Leased Premises.

25. **NON-WAIVER OF COVENANTS.** The Landlord's failure to insist upon the strict performance of any provision of this Lease shall not be construed as depriving the Landlord of the right to insist on strict performance of such provision in the future. The subsequent acceptance of rent, whether full or partial payment, by the Landlord shall not be deemed a waiver of any preceding breach by the Tenant of any term, covenant, or condition of this Lease, other than the failure of the Tenant to pay the particular part of the rent accepted, regardless of the Landlord's knowledge of the preceding breach at the time of the acceptance of that part of the rent.

26. AS-IS. NO WARRANTY. TENANT ACKNOWLEDGES IT IS FAMILIAR WITH THE LEASED PREMISES AND THE CTC, HAS INVESTIGATED SAME, AND HAS BEEN PROVIDED WITH ADDITIONAL OPPORTUNITIES TO INVESTIGATE THE LEASED PREMISES AND THE CTC PRIOR TO SIGNING THIS LEASE. TENANT ACKNOWLEDGES AND AGREES THAT IT IS RELYING SOLELY ON ITS INSPECTION AND INVESTIGATION OF THE LEASED PREMISES AND THE CTC, AND ACCEPTS THE LEASED PREMISES "AS IS, WHERE IS" IN ITS PRESENT CONDITION WITH NO WARRANTIES OF ANY KIND, EXPRESS OR IMPLIED, EITHER ORAL OR WRITTEN, MADE BY LANDLORD OR ANY EMPLOYEE, AGENT OR REPRESENTATIVE OF LANDLORD WITH RESPECT TO THE PHYSICAL CONDITION OF THE LEASED PREMISES. TENANT SHALL HAVE DETERMINED TO ITS SATISFACTION PRIOR TO SIGNING THIS LEASE, THAT THE LEASED PREMISES CAN BE USED FOR THE PURPOSES TENANT INTENDS. TENANT ACKNOWLEDGES AND AGREES THAT NEITHER LANDLORD NOR LANDLORD'S AGENTS OR EMPLOYEES HAVE MADE, AND DO NOT MAKE, ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, WITH RESPECT TO THE SUITABILITY FOR COMMERCIAL OR BUSINESS PURPOSES, MERCHANTABILITY, POTENTIAL USE OF THE LEASED PREMISES, OR FITNESS FOR A PARTICULAR PURPOSE OF THE LEASED PREMISES, ALL OF WHICH WARRANTIES LANDLORD HEREBY EXPRESSLY DISCLAIMS.

27. **COST AND ATTORNEYS' FEES.** In the event it is necessary for either party to utilize the services of an attorney to enforce any of the terms of this agreement, such enforcing party shall be entitled to compensation for its reasonable attorneys' fees and costs. In the event of litigation regarding any of the terms of this agreement, the substantially prevailing party shall be entitled, in addition to other relief, to such reasonable attorneys' fees and costs as determined by the court.

28. **CAPTIONS AND CONSTRUCTION.** The titles to sections of the Lease are not a part of this Lease and shall have no effect upon the construction and interpretation of any part of the Lease.

29. **TIME.** TIME IS OF THE ESSENCE IN THIS LEASE.

30. **BINDING ON HEIRS, SUCCESSORS AND ASSIGNS.** All the covenants, agreement terms and conditions contained in this Lease shall apply to and be binding upon Landlord and

Tenant and their respective heirs, executors, administrators, successors and assigns, except as may be provided to the contrary in other sections of this Lease.

31. **SAVINGS CLAUSE.** Nothing in this Lease shall be construed so as to require the commission of any act contrary to law, and wherever there is any conflict between any provisions of this Lease and any statute, law, public regulation or ordinance, the latter shall prevail, but in such event, the provisions of this Lease affected shall be curtailed and limited only to the extent necessary to bring it within legal requirements.

32. **INCORPORATION.** This agreement represents the entire agreement of the parties. Unless set forth herein in writing, neither party shall be bound by any statements or representations made, and each agrees that there are no such statements or representations being relied upon in making this Lease. No alterations, changes, or amendments to this Lease will be binding upon either party unless such party has executed a written statement acknowledging such alteration, change or amendment.

33. **GOVERNING LAW.** This Lease shall be governed by the laws of the State of Washington and venue for any action arising from this Lease shall be in Chelan County, Washington.

34. **REMEDIES CUMULATIVE.** The specified remedies to which the Landlord and Tenant may resort under the terms of this Lease are cumulative and are not intended to be exclusive of any other remedies or means of redress to which the Landlord and Tenant may be lawfully entitled in case of any breach or threatened breach by Tenant or Landlord, as the case may be, of any provision of this Lease. In addition to the other remedies provided in this Lease, Landlord and Tenant shall be entitled to the restraint by injunction of the violation, or attempted or threatened violation, of any of the covenants, conditions, or provisions of this Lease. The Landlord's or Tenant's selection of one or more remedies shall not constitute an election of remedies to the exclusion of any other remedies.

35. **STATUS OF TENANT.** If applicable, each individual executing this Lease on behalf of Tenant, if Tenant is a corporation or limited liability company, represents and warrants that he/she is duly authorized to execute and deliver this Lease on behalf of said corporation or limited liability company in accordance with a duly adopted resolution of the Board of Directors or the Members, as the case may be, and that this Lease is binding upon said corporation or the limited liability company in accordance with its terms.

36. **NOTICES.**

36.1 Any notices shall be effective if personally served upon the other party or if mailed by registered or certified mail, return receipt requested, to the following addresses:

Landlord: Chelan Douglas Regional Port Authority
1 Campbell Parkway, Suite A
East Wenatchee, Washington 98802

Tenant: Advanced Home Health
285 Technology Center Way, Suite 104

Wenatchee, WA 98801

36.2 Upon possession by Tenant of the Leased Premises, notices shall be sent to new address of Tenant in the Leased Premises.

36.3 Notices mailed shall be deemed given on the date of mailing. Landlord and Tenant shall notify each other of any change of address.

37. **INTERPRETATION.**

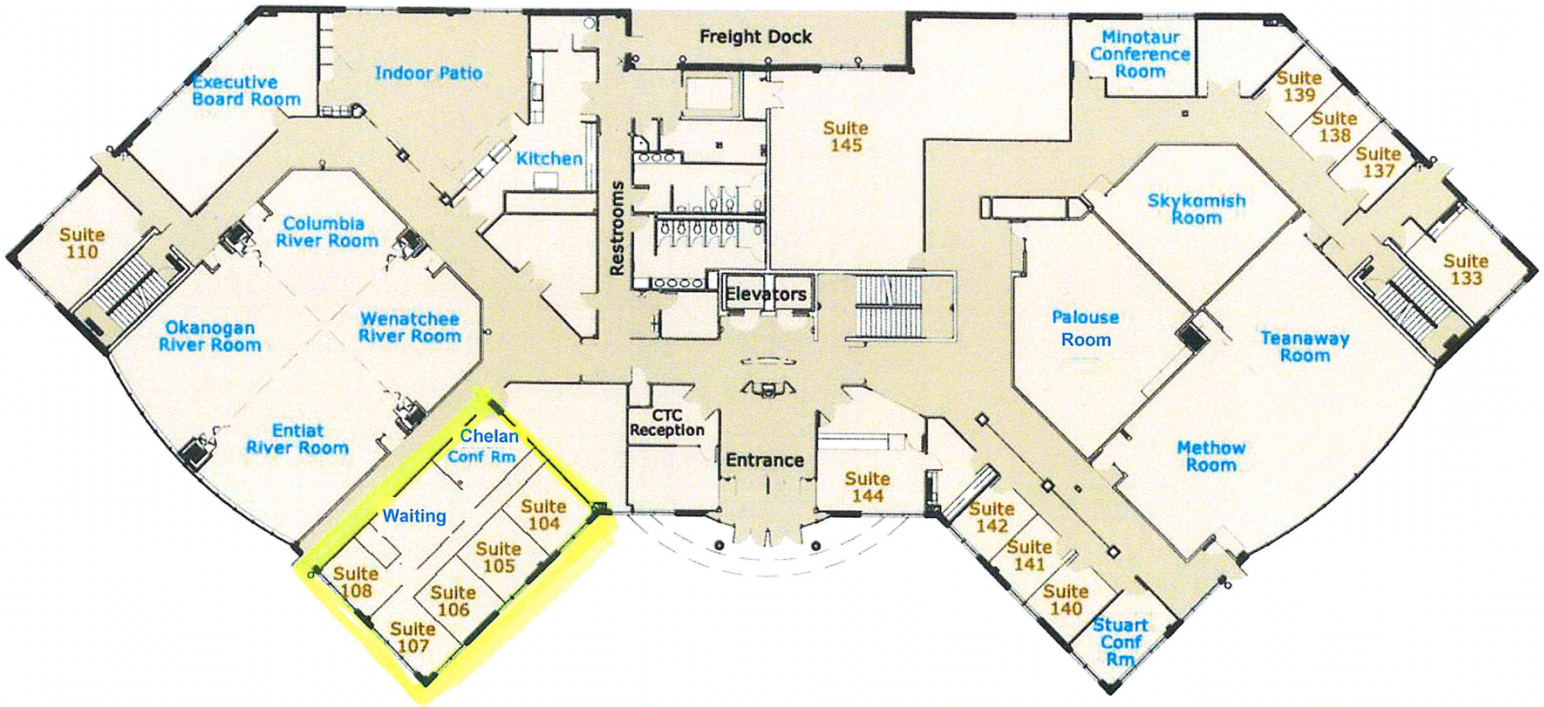
37.1 This Lease has been submitted to the scrutiny of all parties and their counsel, if desired, and it shall be given a fair and reasonable interpretation in accordance with its words, without consideration to or weight given to its being drafted by any party or its counsel.

37.2 All words used in the singular shall include the plural; the present tense shall include the future tense; and the masculine gender shall include the feminine and neuter genders.

IN WITNESS WHEREOF, the parties state that they are authorized to execute this Lease and agree that the effective date of this Lease shall be the date of the last signature set forth below.

LANDLORD	TENANT
CHELAN DOUGLAS REGIONAL PORT AUTHORITY	ADVACED HOME HEALTH WENATCHEE
JAMES M. KUNTZ, CEO 9-5-2020	PAETON BANGART, Executive Director

Exhibit A



Confluence Technology Center - First Floor Map

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 16

Letter of Financial Commitment

STRIDE

HEALTH CARE, LLC

December 23, 2021

Eric Hernandez, Program Manager
Washington State Department of Health
Health Facilities and Certificate of Need
111 Israel Rd., SE
Tumwater, WA 98501

Dear Mr. Hernandez,

This letter of financial commitment is submitted to the Washington Certificate of Need Program on behalf of Wenatchee Hospice, LLC.

Stride Health Care, LLC ("Stride"), by and through its Members, has agreed to provide the necessary working capital to finance Wenatchee Hospice, LLC's proposed project. I am Stride's chief operating officer, and as such, have intimate knowledge regarding Stride's financial affairs. Accordingly, on behalf of Stride and its members, I submit this letter confirming Stride's commitment to provide Wenatchee Hospice, LLC with funding for the proposed project.

Once the Washington Certificate of Need is approved Stride will contribute sufficient funds for startup and financing costs, which are currently estimated at $145,000 to Wenatchee Hospice Holdings, LLC which is the sole member and owner of Wenatchee Hospice, LLC. Thereafter, Wenatchee Hospice Holdings, LLC will oversee the implementation of Wenatchee Hospice's proposed project.

Please do not hesitate to contact me if you have any questions or need additional information.

Sincerely,

Matt Ham
COO
Stride Health Care, LLC

4240 S ST. CLAIRE MESA AZ 85212 480-710-7323

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 17

Financial Status Information

STRIDE HEALTH CARE, LLC
4240 S St Claire
Mesa, AZ 85212

We have prepared from information provided to us by management the accompanying balance sheet-income tax basis of Stride Health Care, LLC (a limited liability company) as of November 30, 2021, and the related statement of income and member's equity-income tax basis for the eleven months then ended and Supplementary Information – Schedule I – General and Administrative Expenses-income tax basis for the eleven months ended November 30, 2021. These financial statements were not subjected to any audit, review or compilation standards nor did we verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any assurance on these financial statements.

JONES, HAM & CLUFF, P.C.

Jones Ham & Cluff P.C.

December 28, 2021

14475 SW ALLEN BLVD. SUITE A | BEAVERTON, OR 97005
WWW.JONESANDHAM.COM | T (503) 643-6333 | F (503) 643-6396

Stride Health Care LLC
BALANCE SHEET - INCOME TAX BASIS
November 30, 2021

ASSETS		
CURRENT ASSETS		
Cash	$ 112,487	
Accounts receivable	501,484	
Prepaid Insurance	5,462	
TOTAL CURRENT ASSETS		$ 619,433
INTANGIBLE ASSETS		
Intangible assets	50,000	
Accumulated amortization	(5,000)	
TOTAL INTANGIBLE ASSETS		45,000
OTHER ASSETS		
Deposits	2,416	
TOTAL OTHER ASSETS		2,416
TOTAL ASSETS		$ 666,849
LIABILITIES AND EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 56,970	
Accrued payroll and payroll taxes	58,691	
Demand note - member	113,307	
Accrued interest	9,165	
TOTAL CURRENT LIABILITIES		$ 238,133
TOTAL LIABILITIES		238,133
MEMBERS' EQUITY		428,716
TOTAL LIABILITIES AND MEMBERS' EQUITY		$ 666,849

See accompanying notes. No assurance is provided on these financial statements

Stride Health Care LLC

STATEMENT OF INCOME AND MEMBERS' EQUITY - INCOME TAX BASIS

For The Eleven Months Ended November 30, 2021

REVENUES	$ 1,728,519
EXPENSES	
General and administrative expenses	1,433,874
NET INCOME FROM OPERATIONS	294,645
OTHER INCOME/(EXPENSES)	
Interest expense	(9,049)
PPP Debt forgiveness income	405,737
TOTAL OTHER INCOME/(EXPENSES)	396,688
NET INCOME	691,333
Members' Equity December 31, 2020	(74,617)
Distributions to members	(188,000)
Members' Equity November 30, 2021	$ 428,716

See accompanying notes. No assurance is provided on these financial statements

Stride Health Care LLC

SCHEDULE I - GENERAL AND ADMINISTRATIVE EXPENSES - INCOME TAX BASIS

For The Eleven Months Ended November 30, 2021

GENERAL AND ADMINISTRATIVE EXPENSES:		
Amortization	$	3,056
Advertising and promotion		2,306
Bank charges		287
Dues and subscriptions		33,530
Employee benefits		14,639
Insurance expense		16,910
Meals and entertainment		3,371
Miscellaneous expense		1,791
Outside labor		58,870
Payroll taxes		106,550
Property & excise taxes		29,185
Postage		435
Professional fees		9,491
Rents		29,283
Salaries and wages		1,079,656
Supplies		23,005
Telephone		20,614
Travel		895
TOTAL EXPENSES	$	1,433,874

See accompanying notes. No assurance is provided on these financial statements

Stride Health Care LLC

NOTES TO FINANCIAL STATEMENTS

November 30, 2021

Note 1 – MANAGEMENT'S ELECTION TO OMIT DISCLOSURES

Management has elected to omit substantially all of the disclosures ordinarily included in financial statements prepared in accordance with the tax financial reporting framework. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's assets, liabilities, equity, revenue and expenses. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Note 2 – ACCRUED COMPENSATED ABSENCES

The company maintains its books on the accrual basis of accounting for financial statement and income tax purposes. Due to the nature and timing of the company's accrued compensated absences, Management has elected to accrue compensated absences once per year on its annual financial statements. Therefore, these interim financial statements do not contain an accrual for compensated absences.

No assurance is provided on these financial statements.

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 18

Closing the Gap in Hospice Utilization for the Minority Medicare Population Study

Gerontology & Geriatric Medicine
Volume 5: 1–8

DOI: 10.1177/2333721419855667
journals.sagepub.com/home/ggm
SAGE

Closing the Gap in Hospice Utilization for the Minority Medicare Population

M. Courtney Hughes, PhD, MS[1,2] and Erin Vernon, PhD, MA[3]

Abstract

Background: Medicare spends about 20% more on the last year of life for Black and Hispanic people than White people. With lower hospice utilization rates, racial/ethnic minorities receive fewer hospice-related benefits such as lesser symptoms, lower costs, and improved quality of life. For-profit hospices have higher dropout rates than nonprofit hospices, yet target racial/ethnic minority communities more through community outreach. This analysis examined the relationship between hospice utilization and for-profit hospice status and conducted an economic analysis of racial/ethnic minority utilization. **Method**: Cross-sectional analysis of 2014 Centers for Medicare & Medicaid Services (CMS), U.S. Census, and Hospice Analytics data. Measures included Medicare racial/ethnic minority hospice utilization, for-profit hospice status, estimated cost savings, and several demographic and socioeconomic variables. **Results**: The prevalence of for-profit hospices was associated with significantly increased hospice utilization among racial/ethnic minorities. With savings of about $2,105 per Medicare hospice enrollee, closing the gap between the White and racial/ethnic minority populations would result in nearly $270 million in annual cost savings. **Discussion**: Significant disparities in hospice use related to hospice for-profit status exist among the racial/ethnic minority Medicare population. CMS and state policymakers should consider lower racial/ethnic minority hospice utilization and foster better community outreach at all hospices to decrease patient costs and improve quality of life.

Keywords

hospice, Medicaid/Medicare, health care disparity, race/ethnicity

Manuscript received: June 29, 2018; **final revision received:** March 10, 2019; **accepted:** April 4, 2019.

Introduction

On average, one quarter of individual Medicare expenditures take place during the patient's last year of life (Riley & Lubitz, 2010), with end-of-life Medicare costs for Black people exceeding those for White people by 20% (Byhoff, Harris, Langa, & Iwashyna, 2016). Several studies have examined why such racial disparities in spending exist, pointing some of the causes to geographic, sociodemographic, and morbidity differences (Baicker, Chandra, Skinner, & Wennberg, 2004; Hanchate, Kronman, Young-Xu, Ash, & Emanuel, 2009; Kelley et al., 2011). Through patient interviews, Martin et al. (2011) found racial/ethnic minorities were more likely than White people to expend their financial resources to extend life. Medicare expenditure data showed Black and Hispanic people were significantly more likely than White people to be admitted to the intensive care unit. Black people were also more likely to receive more intensive procedures such as resuscitation and cardiac conversion, mechanical ventilation, and gastrostomy for artificial nutrition (Hanchate et al., 2009).

An alternative to pursuing costly, life-sustaining strategies for terminally ill patients is enrolling in hospice. Hospice care uses a team-oriented medical approach and emphasizes pain management and emotional support for the patient with a life expectancy of 6 months or less. Most hospice care takes place in the patient's home (56% of hospice care) or a nursing facility (42% of hospice care) (National Hospice and Palliative Care Organization, 2018) and provides support to the patient's family. Benefits from such care include lower costs, lesser symptoms, and a higher quality of life (Institute of Medicine, 1997; Kelley, Deb, Du, Aldridge Carlson, & Morrison, 2013; Steinhauser et al., 2000). Two surveys conducted by Gallup 4 years apart both showed 9 out of 10 terminally ill patients with less

[1]Northern Illinois University, DeKalb, USA
[2]Relias Institute, Morrisville, NC, USA
[3]Seattle University, WA, USA

Corresponding Author:
M. Courtney Hughes, Wirtz Hall 209, DeKalb, IL 60115, USA.
Email: courtneyhughes@niu.edu

than 6 months to live would prefer to be cared for at home (Institute of Medicine, 1997). American Hospice Foundation (n.d., para. 2) cites two common reasons patients choose hospice care: (a) to stay at home and (b) avoid curative treatments that are painful or require hospitalization.

A recent analysis of Medicare's new payment structure that began in January 2016 showed hospice enrollment would still provide the potential for cost savings. Medicare's new payment structure, designed to align payments with service costs and ensure quality care in the last days of life, consists of a two-tiered per diem structure with payments increasing through Days 1 to 60 then decreasing for Days 61 and beyond. The last 7 days of life may have add-on payments retrospectively (Taylor et al., 2018).

Racial/ethnic minority hospice utilization has been found to be lower than that of the White population (Haines et al., 2018; Hardy et al., 2011; Ramey & Chin, 2012) when controlling for other socioeconomic factors such as income, area population, education, and age. Pan, Abraham, Giron, LeMarie, and Pollack (2015) showed Asian and Hispanic people were less familiar than White people with hospice services. In that study, most of the Asian and Hispanic respondents were open to receiving information about hospice in the future and reported they would tell friends and family members about hospice (Pan et al., 2015). One variable that relates to a greater number of racial/ethnic minorities receiving information about hospice is hospice ownership status. For-profit hospices tend to engage in greater community outreach to low-income and racial/ethnic minority communities than nonprofit hospices (Aldridge et al., 2014; Stevenson, Grabowski, Keating, & Huskamp, 2016). Stevenson et al. (2016) found this relationship persisted despite its chain status. With the growth in the proportion of hospices having for-profit ownership from 5% in 1990 to over 60% in 2014, it is important to compare measures such as utilization between hospices with different ownership status.

This study compares hospice utilization by racial/ethnic minorities between for-profit and nonprofit hospices, examining whether there is an association between the proportion of Medicare racial/ethnic minority patients enrolling in hospice per state and the proportion of for-profit hospices in that state. Also included are estimated projected cost savings if racial/ethnic minority Medicare hospice utilization levels were to increase to that of the White Medicare hospice utilization levels.

Method

Data Sources

The 2014 hospice utilization data were obtained from the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Data Warehouse (CCW; 2018), a database that has 100% of Medicare enrollment and fee-for-service claims data. CCW was launched to aid researchers in analyzing CMS data to help improve quality of care, decrease health care costs, and curb medical utilization for chronically ill Medicare beneficiaries. CCW contains 17 years' worth of data and includes enrollment/eligibility, assessment data, and fee-for-service institutional and noninstitutional claims. The U.S. Census Medicare beneficiary data (U.S. Census Bureau, 2015) are obtained from the March 2015 Current Population Survey Annual Social and Economic Supplement based on 2014 data.

Data for the percentage of individuals identifying as religious in 2014 were obtained from the Pew Research Center (Smith et al., 2015), whereas the measures for the 2014 per capita state income levels and 2010 education levels were accessed from the Bureau of Economic Analysis (2018) and the American Community Survey (U.S. Census Bureau, n.d.), respectively. Data on 2014 hospice by owner type and state-level racial/ethnicity measures were obtained from Hospice Analytics (2018) and the Kaiser Family Foundation (n.d.), respectively. The authors used Taylor et al.'s (2018) estimated cost savings per hospice enrollee based on the updated 2016 Medicare hospice payment structure. Taylor et al.'s study derived its findings from 2009 to 2010 Medicare claims data from North Carolina Medicare beneficiaries (N = 36,035).

Measures

The independent variable of for-profit hospice prevalence was calculated by the total amount of for-profit hospices per 10,000 Medicare beneficiaries for each state. The same calculation was used for nonprofit hospice prevalence for each state. Medicare beneficiaries include Medicare Advantage and fee-for-service beneficiaries. The percentage of individuals identifying as religious, the percentage of adults with at least a high school education, per capita income, and the percentage of racial/ethnic minorities within a state were included as covariates in the statistical model to control for state-level socioeconomic factors. The racial/ethnic minority hospice utilization disparity measure was calculated by dividing the percentage of racial/ethnic minorities using hospice by the percentage of racial/ethnic minorities enrolled in Medicare for each state. States were assigned a "1" if they possessed less of a disparity between racial/ethnic minority hospice Medicare patients and overall racial/ethnic minority Medicare enrollees compared with the median of all states (states with a value above 0.70) and a "0" otherwise.

For the projected cost savings from closing the gap between White and racial/ethnic minority Medicare hospice utilization, the breakdown by ethnicity followed the Kaiser Family Foundation Medicare beneficiary categories of Black, White, Hispanic, and Other. The Other category included Asians, Native Hawaiians and Pacific Islanders, American Indians, Aleutians, Eskimos, and

Table 1. Descriptive Statistics of Independent Variables.

Variable	Definition	*M* (*SD*)
Prevalence of for-profit hospices	Ratio of for-profit hospices per 10,000 Medicare beneficiaries	0.59 (0.67)
Prevalence of nonprofit hospices	Ratio of nonprofit hospices per 10,000 Medicare beneficiaries	0.65 (0.63)
Per capita income	Average per capita income per state (in thousands)	$45.65 (7.72)
Percentage religious	Percentage state population stating they are religious	0.77 (0.06)
Percentage racial/ethnic minority	Percentage of state population identified as non-White	0.31 (0.16)
High school education or higher	Percentage with high school degree or higher	0.87 (0.03)

Note. Calculations were performed by state.

people of two or more races (Kaiser Family Foundation, 2017). To calculate the Medicare hospice participation rate by ethnicity, Medicare hospice beneficiaries within each racial group (CCW, 2018) were divided by the total number of Medicare beneficiaries within the same year (Kaiser Family Foundation, 2017). Then, the number of additional hospice enrollees necessary to match the higher White hospice utilization rate was calculated. Next, the projected mean cost savings of $2,105 per hospice enrollee (Taylor et al., 2018) was applied to estimate the potential cost savings from closing the racial/ethnic minority hospice utilization gap.

Analysis

Multivariate logistic regression was performed with the dependent variable being a dichotomous measure of whether or not a state had a relatively large racial/ethnic minority hospice usage gap. The independent variables of the study included the prevalence of for-profit and nonprofit hospices within a state as well as state-level socioeconomic measures of religiosity, racial/ethnic diversity, income, and education. All 50 U.S. states and Washington, D.C., were included in the analysis. StataSE version 15 (StataCorp LP, College Station, TX, USA) was utilized for statistical analyses.

Results

State Variable Summary Statistics

Table 1 displays the descriptive statistics of the study independent variables across the 50 states plus Washington, D.C. States tended to have more nonprofit hospices (0.65 per 10,000 state Medicare beneficiaries) versus for-profit hospices (0.59 per 10,000 state Medicare beneficiaries). In 2014, states on average had per capita incomes of $45,650 with 77% of the population stating they were religious, and 31% of the population representing non-White racial/ethnic categories as defined by the Kaiser Family Foundation (n.d.). In addition, 87% of the population earned a high school education or higher. The hospice utilization disparity was the dependent variable of focus. Nineteen states were assigned a "1" indicating that their minority hospice utilization disparity was below the national median.

Table 2. Multivariate Logistic Regression Results (*N* = 51).

	Coefficient	*SE*	*p*-value
Constant	−0.30	13.50	.98
Prevalence of for-profit hospices*	1.93	0.72	.01
Prevalence of nonprofit hospices	−0.69	0.77	.37
Per capita income	−0.03	0.06	.65
Percentage religious	−1.20	6.22	.85
Non-White population	2.78	2.63	.29
Education—high school graduate	0.27	15.55	.99

Note. Calculations were performed by state. χ^2 (6, *N* = 51) = 17.76, *p* = .007.
*Significant at the 5% level.

Statistical Results. Based on the logistic regression analysis displayed in Table 2, the prevalence of for-profit hospices was positively associated with racial/ethnic minority Medicare beneficiary hospice utilization, χ^2 (6, $N = 51$) = 17.76, $p = .007$. As the prevalence of for-profit hospices per Medicare beneficiary increases within a state, the probability increases that a state would have a lower than average hospice utilization gap between racial/ethnic minorities and the White population. No other coefficients were found to be significant.

The economic analysis found if racial/ethnic minority Medicare hospice utilization were to equal that of the current White Medicare hospice utilization, it would result in an estimated savings of nearly $270 million per year (Table 3).

Discussion

This study indicates a positive association exists between racial/ethnic minority Medicare hospice utilization and the prevalence of for-profit hospices. An estimated nationally representative annual savings of nearly $270 million in projected annual savings would result from closing the Medicare hospice utilization gap between racial/ethnic minority and White Medicare beneficiaries.

The finding of the positive relationship between the prevalence of for-profit hospices and racial/ethnic minority Medicare utilization is not surprising given previous research showed for-profit hospices engage in greater community outreach to racial/ethnic minorities and low-income communities than nonprofit hospices

Table 3. Estimated Cost Savings From Closing Medicare Hospice Utilization Gap.

	White	Black	Hispanic	Other[a]	Total
Medicare beneficiaries[b]	38,505,300	5,160,600	4,137,400	2,742,900	50,546,200
Hospice beneficiaries[c]	1,112,625	107,461	68,776	43,499	1,332,361
Hospice beneficiaries/Medicare beneficiaries	2.89%	2.08%	1.66%	1.59%	2.64%
Racial/ethnic minority enrollment that closes disparity		41,656	50,776	35,758	
Estimated cost savings from closing disparity[d]		$87,686,851	$106,882,881	$75,270,839	$269,840,571

[a]Other includes Asians, Native Hawaiians and Pacific Islanders, American Indians, Aleutians, Eskimos, and people of two or more races.
[b]*Source*. Kaiser Family Foundation (2017).
[c]*Source*. Chronic Conditions Data Warehouse (CCW; 2018).
[d]*Source*. Utilizes Taylor et al.'s (2018) cost savings estimate of $2,105 per beneficiary.

(Aldridge et al., 2014; Stevenson et al., 2016). Prior research showed that both lower income and lower education were associated with lower rates of hospice care enrollment and at-home hospice death when holding other covariates constant (Barclay, Kuchibhatla, Tulsky, & Johnson, 2013; Jenkins et al., 2011; Silveira, Connor, Goold, McMahon, & Feudtner, 2011). The current study did not find significant relationships between state-level education and income measures and the minority hospice utilization gap. That said, the correlations in the individual-level studies between lower socioeconomic status and lower hospice utilization are not surprising given the significant role social determinants of health plays in end-of-life care decisions (Koroukian et al., 2017). A potential strategy for increasing hospice enrollment among groups across socioeconomic levels is to include offering short bouts of increased emotional and physical support for the patient and/or caregiver(s) during times of crisis in end-of-life care (Barclay et al., 2013). In addition, given informational materials hospices provide are not written at a level understood by most Americans (Kehl & McCarty, 2012), hospices should also focus on developing materials that comply with the Clear Communication initiative established by the National Institutes of Health. Clear Communication involves incorporating plain language and new technologies with accessible formats and content, all grounded in cultural respect (National Institutes of Health, n.d., para. 1).

Although policies targeting increased hospice enrollment levels for low-income populations with no specific focus on racial/ethnic minority populations would contribute to the economic savings discussed in this article, prior research has indicated that they would not eliminate the racial disparities within hospice enrollment. Brown et al. (2018) showed the effects of race/ethnicity on the intensity of end-of-life care are only partly mediated by other social determinants of health. Another study showed removing racial and ethnic disparities is complex and sometimes well-intended reform initiatives might inadvertently reinforce racial/ethnic disparities (Alegria, Alvarez, Ishikawa, DiMarzio, & McPeck, 2016). Strategies hospices could use for specifically addressing racial disparities in hospice utilization may include offering materials in languages spoken by the targeted racial/ethnic minorities (Kehl & McCarty, 2012; Young, 2014) and employing bilingual and bicultural clinicians or trained staff who act as interpreters and provide cultural context for the clients' beliefs and behaviors (Jackson & Gracia, 2014; Substance Abuse and Mental Health Services Administration, 2016).

This study estimated a projected savings of around $270 million annually from increasing the Medicare racial/ethnic minority hospice usage rate to that of the White population. Several studies have estimated the higher end-of-life expenditures among racial/ethnic minority groups (Baicker et al., 2004; Byhoff et al., 2016; Hanchate et al., 2009; Kelley et al., 2011) and savings from hospice utilization, in general (Kelley et al., 2013; Taylor et al., 2018; Taylor, Ostermann, Van Houtven, Tulsky, & Steinhauser, 2007). However, to the authors' knowledge, no other study has estimated the cost savings that could result from closing the hospice utilization gap. In addition to achieving cost savings, increasing Medicare racial/ethnic minority hospice use could potentially improve patient quality of care (Meier, 2011). As Livne (2014) states, "Limiting spending means helping people face their imminent death and avoiding prolonged aggressive treatment; in the context of hospice, it becomes a way of caring" (p. 906).

For terminally ill Medicare patients, hospice often provides a lower cost care option emphasizing quality of life that meets patients' preconceived wishes for end-of-life care (e.g., dying at home and being comfortable/without pain) (Kelley et al., 2013; Taylor et al., 2018; Teno et al., 2004; Wright et al., 2010; Zuckerman, Stearns, & Sheingold, 2016). Why racial/ethnic minority populations utilize this option less is subject to much discussion and debate (Elliott, Alexander, Mescher, Mohan, & Barnato, 2016; Pan et al., 2015). A systematic review of hospice use of Black people cited multiple factors contributing to relatively lower hospice utilization levels, including lack of hospice awareness, monetary concerns, mistrust of the health care system, a conflict in value with hospice care, and expected lack of racial/ethnic minority staff within hospice care (Washington, Bickel-Swenson, & Stephens, 2008). Alternately, Koss and Baker (2017) reported findings that question the common assertion that mistrust of the

health system by Black older adults contributes to lower rates of advance care planning (a practice associated with receiving hospice care earlier and longer) (Bischoff, Sudore, Miao, Boscardin, & Smith, 2013; Teno, Gruneir, Schwartz, Nanda, & Wetle, 2007). Adams, Horn, and Bader (2007) emphasized the lack of access to health services prior to hospice admission for the U.S. Hispanic population as a significant reason for lower hospice use by that group.

Simply closing the gap on hospice enrollment will not eliminate racial disparities observed within hospice care. Research finds once in hospice care, Black people experience higher levels of disenrollment, often to pursue costly, more invasive end-of-life treatment (Aldridge, Canavan, Cherlin, & Bradley, 2015; Johnson, Kuchibhatla, & Tulsky, 2008). Research in this area is ongoing with one study finding, on average, Black and Hispanic people tended to enroll in hospices that provided a lower quality of care. However, within a particular hospice, Black and Hispanic people receive care that is similar to that of White people (Price, Parast, Haas, Teno, & Elliott, 2017). In contrast, another study found disparities existed between the quality of care for Black and White people within the same hospice setting (Rizzuto & Aldridge, 2018). Barclay et al. (2013) found Black people enrolled in hospice were also less likely to die at home compared with White people even when accounting for other socioeconomic factors such as income, location, and education. The explanation for the lower rate of at-home deaths for Black hospice patients is inconclusive, with some studies suggesting potential differences in culture, caretaker support, and hospice care communication may be contributors (Barclay et al., 2013).

This article discusses potential advantages (e.g., quality of life, lesser symptoms, and cost savings) from closing the current gap between racial/ethnic minority and White Medicare hospice utilization (Institute of Medicine, 1997; Kelley et al., 2013; Steinhauser et al., 2000). Recent research based on national survey data shows the disparities in health care access between Black and Hispanic people and White people have significantly narrowed from 2013 to 2015 after the passage of the Affordable Care Act (ACA). In addition to reducing racial and ethnic disparities, the ACA was associated with increased access for all three groups examined—Black, Hispanic, and White people, partly through Medicaid expansion (Hayes, Riley, Radley, & McCarthy, 2017). The racial and ethnic disparity within hospice is slightly different given that all citizens over 65 years of age, at least in theory, have access to hospice via their automatic Medicare enrollment. The disparities seen in hospice go beyond insurance accessibility or income (Harris et al., 2017; Ornstein et al., 2016). The hospice community outreach efforts discussed above (e.g., access improvements, materials at a lower reading level) would likely improve participation among people of all racial and ethnic backgrounds, including White people. Such increased enrollment across all racial and ethnic Medicare groups has the potential for even greater improvements in health and cost outcomes than addressed in this analysis.

This research has some limitations. First, due to a lack of variation estimates in the existing literature, it was assumed a similar proportion of Medicare beneficiaries would be eligible for hospice care across all racial groups. There is also the possibility the racial/ethnic minority Medicare beneficiaries, who would comprise the additional hospice enrollees, would have a different average length of stay, disease prevalence estimates, and disenrollment rates. The authors chose not to project these statistics because of the uncertainty as to the types of patients (e.g., diagnoses) greater hospice community outreach to racial/ethnic minorities would most attract. Second, this research is limited to state-level data. Future research is recommended examining the relationship between racial/ethnic minority Medicare hospice utilization and the prevalence of for-profit hospices that include additional variables of hospice utilizers such as metropolitan status (e.g., rural vs. urban), gender, and income.

Another limitation is for-profit hospices have been shown to have higher levels of dementia patients compared with nonprofit hospices (Wachterman, Marcantonio, Davis, & McCarthy, 2011). Studies suggest dementia hospice patients have higher costs compared with nonhospice counterparts on account of relatively longer hospice stays and fewer invasive end-of-life treatments for this type of disease regardless of a patient's hospice status (Taylor et al., 2018; Zuckerman et al., 2016). Another risk is enrolling patients in hospice too early, increasing chances of live discharge which research has shown is positively associated with both hospice profit margins and the proportion of patients from racial/ethnic minority groups (Dolin et al., 2017; Stevenson et al., 2016). If for-profit hospices improve racial/ethnic minority hospice enrollment by focusing solely on dementia patients and/or engage in too early enrollment practices—both of which are practices more associated with for-profit hospices than nonprofit hospices (Dolin et al., 2017; Stevenson et al., 2016)—and nonprofit hospices do not improve their racial/ethnic minority recruiting efforts across all primary diagnosis levels, the estimated cost savings discussed in this article could be overstated. Policymakers should be aware of this potential issue and ensure racial/ethnic minority hospice recruitment programs encourage hospice use across all eligible diseases. In addition, mechanisms should be in place to monitor both for-profit and nonprofit hospices to ensure quality of care remains paramount in decisions about recruiting and care.

Conclusion

With average per capita end-of-life medical spending in the last year of life at $80,000 in the United

States—comprising a larger fraction of its gross domestic product than that for all eight other countries examined in a 2017 study (French et al., 2017), implementing strategies to increase the inclusiveness of all racial/ethnic groups to hospice may be one way Medicare can simultaneously lessen its financial burden and improve the quality of life for its beneficiaries. This research finds a positive association between the prevalence of for-profit hospices and racial/ethnic minority Medicare hospice utilization, highlighting a potential business ownership model to further examine when developing strategies for racial/ethnic minority Medicare enrollees' inclusion in hospice care. With the potential to provide nearly $270 million in annual cost savings while also improving health outcomes, further research on specific programs that successfully reduce the racial/ethnic minority hospice enrollment gap is paramount. In addition, collaboration between hospices, health systems, and community organizations is needed to reduce the disparities between racial/ethnic minority and White Medicare beneficiary hospice utilization.

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ORCID iD

M. Courtney Hughes https://orcid.org/0000-0002-8699-5701

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Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

Certificate of Need Application

APPENDIX 19

Medicare Cost in Matched Hospice and Non-Hospice Cohorts Study

NHPCO *Original Article*

Medicare Cost in Matched Hospice and Non-Hospice Cohorts

Bruce Pyenson, FSA, MAAA, Stephen Connor, PhD, Kathryn Fitch, RN, MA, Med, and Barry Kinzbrunner, MD
Milliman, Inc. (B.P., K.F.), New York, New York; National Hospice and Palliative Care Organization (S.C.), Alexandria, Virginia; and VITAS Healthcare Corporation (B.K.), Miami, Florida, USA

Abstract
Hospice care is perceived as enhancing life quality for patients with advanced, incurable illness, but cost comparisons to non-hospice patients are difficult to make. The very large Medicare expenditures for care given during the end of life, combined with the pressure on Medicare spending, make this information important. We sought to identify cost differences between patients who do and do not elect to receive Medicare-paid hospice benefits. We introduce an innovative prospective/retrospective case-control method that we used to study 8,700 patients from a sample of 5% of the entire Medicare beneficiary population for 1999–2000 associated with 16 narrowly defined indicative markers. For the majority of cohorts, mean and median Medicare costs were lower for patients enrolled in hospice care. The lower costs were not associated with shorter duration until death. For important terminal medical conditions, including non-cancers, costs are lower for patients receiving hospice care. The lower cost is not associated with shorter time until death, and appears to be associated with longer mean time until death. J Pain Symptom Manage 2004;28:200–210. © *2004 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words
Medicare, costs, hospice, duration until death

Introduction

The Medicare Hospice Benefit, enacted in 1982, was intended to provide compassionate and cost-effective care for Medicare beneficiaries with incurable advanced illnesses. Medicare's very large expenditures on dying beneficiaries,[1] combined with federal funding pressures, have given new prominence to end-of-life care. Since Medicare began its hospice benefit, it has been thought to be unethical to conduct randomized hospice/non-hospice studies, as a right to hospice care is presumed. Therefore, investigations have been limited to studies that can very closely match populations and overcome selection bias.

The Medicare hospice benefit is potentially available to all Medicare beneficiaries after a physician certifies that the beneficiary is expected to live fewer than 180 days. Hospice services are provided by the patient's choice of the

Address reprint requests to: Bruce Pyenson, FSA, MAAA, Principal and Consulting Actuary, Milliman USA, Inc., One Pennsylvania Plaza, New York, NY 10119, USA.

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Medicare-certified hospice agencies available in the patient's locale. Under the program, the vast majority of services are provided in the patient's place of residence. Approximately 95% of the days of hospice care delivered in the US are at the routine home care level.[2] The hospice provides all needed services, including prescription drugs and palliative care and receives a flat payment amount for each day the patient is enrolled in hospice. The amount varies somewhat by locale. The patient can elect to stop receiving hospice care and return to traditional Medicare coverage at any time.

The cost analysis of patients enrolled in the Medicare Hospice Benefit has been debated since the benefit began in 1982. Changes in hospice care such as the growth of palliative treatments (e.g., chemotherapy, radiation and pain management therapies) and increased enrollment of non-cancer beneficiaries (e.g., end-stage chronic obstructive pulmonary disease [COPD], congestive heart failure [CHF], Alzheimer's disease) have created a new context for the debate. Early studies of hospice care[3,4] implied Medicare savings with increased home care and reduced hospitalization, futile treatment and diagnostics. These studies were criticized for lack of rigorous matching criteria and the effects of selection bias.[5] More recent studies find mixed results. Hospice use is associated with decreased cost in oncology populations but may not be for some other diagnoses.[6–8]

The costs for patients enrolled in the Medicare Hospice Benefit vary depending on where services are rendered (home, nursing home or hospital) and duration of hospice enrollment, among other factors. Substituting hospice for conventional care is more likely to show hospice most favorably if patients are on hospice just long enough to avoid unnecessary services. Hospice services provided to patients just before death can be an additional expense, as can hospice care provided for many months or years. A period of at least 2–3 months of hospice care may be optimal from both a cost and clinical standpoint.[9,10]

In addition to cost analysis, the effect of hospice care on length of life has been raised in connection with the quality of care. Anecdotal evidence suggests that some patients live longer after receiving hospice care.[11–14] Patients with chronic organ failure may benefit from attention to psychosocial concerns and personal care from hospice programs. Terminally ill oncology patients who forego aggressive cure-directed therapies and who receive greater psychosocial support may have greater survival.[15] No definitive survival data has been previously presented to support these findings and reports of increased survival of breast cancer patients in support groups have been questioned.[16]

Effectively matching populations for cost and longevity comparisons requires identifying a similar point in patients' terminal decline.[17] Attempts to develop accurate tools to predict the timing of death have generally been unsuccessful.[18] SUPPORT investigators used a computer-generated algorithm to model the probability of death.[19] This method found that estimating probabilities of death was not clinically useful. The National Hospice and Palliative Care Organization (NHPCO) published expert opinion guidelines for determining 6-month prognosis for selected non-cancer terminal illnesses.[20] These guidelines were modified by Centers for Medicare and Medicaid Services (CMS) fiscal intermediaries for use as local medical review policies that define payment criteria. However, the NHPCO guidelines and subsequent payment policies have also been found to have weak predictive validity.[21] "Look-back studies," which compare costs for hospice and non-hospice patients for a set period before death, have been criticized because of inadequate control for potential selection bias and failure to account for survival differences. The use of algorithms applied to administrative data to predict future costs has likewise had limited success[22] and we have avoided such approaches. For these reasons, we conceived the methodology of the present study to examine cost for subsets of patients that most clinicians would recognize as suitable for hospice care.

Methods

In this study, we used established actuarial methods and administrative data to measure both costs and time until death starting from dates narrowly defined by claims data. We established cohorts of patients with diagnoses and, in most cases, paired treatments that indicated advanced illness. For each patient, unique dates for specific clinical events were used to measure the beginning point for time until death and cost through death.

The goal of our methodology was to identify patients who might, within days or months, reasonably choose hospice care. For each disease cohort, we sought to identify patients and, for each patient, a similar point in time from which we could begin to measure costs and length of life. Such a methodology avoids the biases of an approach of tabulating costs backwards from the date of death for a specified preceding time period, where the treatments received could bias the time until survival.

The use of administrative data allowed us to identify relatively large numbers of patients, even for very narrowly defined cohorts. The Medicare 5% sample database contains demographic and medical claim details for almost 2 million Medicare beneficiaries, of which about 100,000 die each year. While these data contain details of dates of service, diagnostic (ICD-9) and procedural (CPT or HCPCS) information, the data do not contain typical clinical information (such as laboratory values or stage of disease).

Physician advice is often an important element in a patient's decision to join a hospice, and we assembled a group of physicians active in hospice care who worked with medical coding and data experts. The group was charged with identifying patient characteristics, recognizable through the Medicare data that would strongly suggest the patient would soon be eligible for hospice care. While the majority of patients who choose the Medicare hospice benefit are dying of cancer, we did not limit the study to cancer patients. The advisory group ultimately developed subsets of 16 diagnoses (Table 1) where some combination of medical claims would define an unambiguous starting point for tabulating cost and time until death and where the patient could soon face a decision about enrolling in the Medicare Hospice Benefit. Within each diagnosis, we selected *an indicative marker* in the end-stage of these incurable, advanced diseases on the basis of specific diagnosis, treatments and response to treatments. These *indicative markers* represented unambiguous (from a data standpoint) points in the end stage of these 16 diagnoses. The criteria for creating indicative markers were:

- the defining event had to appear as medical claims. In practice, this generally meant some combination of a hospital admission or physician intervention, and
- the defining event would generally occur near the end of life but before an individual would have made a choice to enroll in the Medicare hospice benefit.

For most diagnoses, a minority of patients was selected for inclusion in the analysis, because most did not receive the pre-defined medical interventions. Within a given diagnostic cohort, we compared cost and time until death for patients choosing or not choosing hospice care—starting with the date of the indicative marker. We restricted the cohorts to patients who died within the calendar year of the indicative marker or the next calendar year.

The diagnostic definitions both described relatively narrow cohorts and allowed identification of a unique date for each individual. Our indicative marker methodology produced cohorts that, for most diseases, represent small subsets of patients who died of the disease. We believe that the complicated set of circumstances we used to define the cohorts provides a very significant degree of homogeneity within the cohorts. This complexity for identifying patients in effect lessens the need for risk adjustment, which is fortunate because the standard risk adjustment methodologies are not designed for use with dying patients.

Indicative Markers

We used the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the Current Procedural Terminology, Fourth Edition (CPT), and the Health Care Financing Administration Common Procedure Coding System (HCPCS) to create "indicative markers" for 17 diagnoses by an expert panel of oncologists, hospice medical directors, actuaries and Medicare insurance coding specialists. The indicative marker consisted of either an ICD-9-CM code alone or an ICD-9-CM code combined with CPT and/or HCPCS codes.

The panel was instructed to identify the circumstances, which could be identified with the available Medicare claims data, under which a patient could shortly thereafter be advised to consider obtaining hospice care. The majority of suggested circumstances proved impractical because they depended upon data that were

Table 1
Definitions of Indicative Conditions and Markers

Condition	Administrative Claims Data Indicative Marker for Study Inclusion
Malignant neoplasm of esophagus	Beneficiaries with ICD-9-CM (ICD-9) for cancer of the esophagus except those with CPT for radical esophagectomy with interpositioning. The exception was made because that procedure may be performed with the expectation of cure or long-term survival
Malignant neoplasm of stomach	Beneficiaries with ICD-9 for stomach cancer except those with CPT for partial or subtotal gastrectomy and have claims for chemotherapy (chemo) starting within 1st quarter of surgery
Malignant neoplasm of colon	Beneficiaries with ICD-9 for colon cancer and have claims for chemo and either: – no previous colon resection – colon resection >1 quarter before start of chemotherapy
Malignant neoplasm of rectum	Beneficiaries with ICD-9 for cancer of the rectum and have claims for chemotherapy and/or radiation therapy (RT) and either: – no previous rectal resection – rectal resection >1 quarter prior to chemo and/or RT
Malignant neoplasm of liver and intra-hepatic bile ducts	Beneficiaries with ICD-9 for liver and intra-hepatic bile duct cancer
Malignant neoplasm of gallbladder and extra-hepatic bile ducts	Beneficiaries with ICD-9 for gallbladder and extra-hepatic bile duct cancer
Malignant neoplasm of pancreas	Beneficiaries with ICD-9 for pancreatic cancer except cases with islet cell cancer
Malignant neoplasm of trachea, bronchus and lung	Beneficiaries with ICD-9 for lung cancer and have claims for chemotherapy, which indicate a switch to another combination of chemotherapy drugs within 1–2 quarters of the initial chemotherapy
Malignant neoplasm of female breast	Beneficiaries with ICD-9 for breast cancer and have claims for chemotherapy, which indicate a switch to another combination of chemotherapy drugs within 1–2 quarters of the initial chemotherapy
Malignant neoplasm of ovary and other uterine adnexa	Beneficiaries with ICD-9 for ovarian and uterine cancer and claims indicate treatment course (at minimum) of primary abdominal surgery followed by chemotherapy
Malignant neoplasm of prostate	Beneficiaries with ICD-9 for prostate cancer and HCPCs J codes for all chemotherapies except leuprolide (includes cases receiving strontium 89)
Malignant neoplasm of brain	Beneficiaries with ICD-9 for brain cancer and claims indicate a diagnostic/treatment sequence of brain biopsy or debulking or craniotomy, followed by RT
Congestive heart failure (CHF)	Beneficiaries with ICD-9 for CHF and have claims indicating 1 or >hospitalizations involving: – invasive monitoring – intubation and ventilatory management Exclusions: cases with CPT for CABG within 1 quarter prior to hospitalization and cases in which hospitalization for invasive monitoring or intubation indicate primary diagnosis of acute MI
Chronic obstructive pulmonary disease (COPD)	Beneficiaries with ICD-9 for COPD and have claims indicating 1 or more hospitalizations requiring intubation and ventilatory management
Alzheimer's disease	Beneficiaries claims indicating 1 or more admissions with primary diagnosis of sepsis and/or aspiration pneumonia along with a secondary diagnosis of Alzheimer's disease
Stroke	Beneficiaries with 1 or more admissions with primary diagnosis of sepsis and/or aspiration pneumonia along with a secondary diagnosis of stroke

not available in the Medicare 5% sample. For example, any cohort definitions that depended upon laboratory values, stage of a disease or other clinical measure were rejected.

We selected these markers based on the practicality of obtaining the required information from administrative data and perceived relevance to hospice (judged to have a life expectancy of less than one year but not facing imminent death). We established the indicative markers prior to conducting the data analysis. Data extraction for one of the 17 diagnoses resulted in fewer than 20 individuals; therefore, we report the results for 16 out of the 17 diagnoses.

For cancer of the liver, gallbladder and pancreas, the first hospital claim or the first of at least two physician outpatient claims, appearing with ICD-9-CM codes for these "indicative diagnoses," was used as the starting point to tabulate costs and longevity. Because the prognosis is typically poor for these conditions, the first appearance of the diagnosis is an effective starting point for which costs and longevity could be tabulated. For cancer of the esophagus and stomach, we excluded beneficiaries who

appeared to be receiving curative therapy as defined by particular surgical interventions, because certain types of esophagus and stomach cancer are considered curable through surgery.

For the remainder of the diagnoses, an "indicative event" that signaled the terminal phase of an incurable, advanced disease was chosen as the marker. The indicative event consisted of specific treatments (chemotherapy, radiation therapy and surgery as detailed in Table 1) or a hospitalization with specific interventions or diagnoses. The treatments identified for the cancer diagnoses suggested either failure of curative therapy or evidence for palliative therapy. The hospital treatments used to define indicative events for the non-cancer diagnoses suggested a serious decline in health status.

The vast majority of dying patients would not meet the criteria of the indicative diagnoses – whether or not they elected to receive the Medicare Hospice Benefit. The challenge of using the available data to identify a patient at the cusp of being faced with a decision about choosing hospice care severely limited the possible number of cohorts. Hospice physicians, including those who advised us, do not identify patients through medical claims coding, and rarely if ever treat patients before they decide to obtain hospice benefits. Because of these constraints, the authors feel that there was no deliberate bias in our methodology.

Data Source

Our analysis used Medicare health insurance claims and enrollment data from the 5% Sample Beneficiary Standard Analytic Files[23] for the years 1998, 1999, and 2000. The 5% sample, which is created by and available from the Centers for Medicare and Medicaid Services (CMS), was created from the 100% Medicare Standard Analytical Files. The 5% sample is created by CMS as a statistically representative, longitudinal dataset.

The 5% Medicare Sample contains claims for about two million enrollees. Members have unique identifiers that allow patient tracking from year to year. The claims sample comprises seven distinct databases, each containing claims from a particular provider type: Physician Supplier Part B, Outpatient Hospital, Inpatient Hospital, Home Health Agency (HHA), Hospice, Skilled Nursing Facility (SNF), and Durable Medical Equipment (DME). We extracted data from all patients who met our criteria.

Sample Selection

Our data selection criteria were chosen primarily to avoid biasing time until death or cost according to whether an individual chose hospice. Consequently, we caution the reader that the costs and time until death time shown should not be used as a guide for individual patient time until death or cost.

In our algorithm, assignment into one of the 16 diagnostic categories required two physician claims or one inpatient hospital claim with the relevant ICD-9-CM code. We used a disease hierarchy to set the category for a beneficiary who could fall into more than one category. Before applying narrowing criteria, these diagnoses accounted for approximately 55% of all Medicare beneficiaries' deaths in the 5% Medicare sample. Beneficiaries were designated as hospice users if they had one or more hospice claims.

The final sample size did not change significantly from the base sample for beneficiaries diagnosed with esophageal, stomach, liver, gallbladder and pancreatic cancer, as the date of the first appearance of the diagnostic ICD-9-CM code itself was used as the marker for each affected individual. For other diagnoses, the final sample was significantly smaller than the base sample, as specific treatments, "indicative events," were required. The percentage of individuals utilizing hospice services was similar for patients with or without the indicative event.

Because cost comparison analysis was the primary focus of this study, and because the last few days of life can be very expensive, especially if the patient is hospitalized, we included only patients whose death could be observed in the data. Costs (Medicare payments) were tabulated starting with the time of the "indicative diagnosis" or "indicative event" to the time of death. For years prior to 2000, Medicare Part B claims indicate a date of service, which was used as the marker date for cost and longevity comparison. Medicare Part A claims show only the quarter and year of service; Part A claims were attributed to the patient if the claim fell in the quarter of the indicative event or later. Medicare payments are the amounts that

Medicare pays—net of beneficiary coinsurance and deductibles.

We removed certain patients and their claims from the analysis as required by inherent data limitations or in order to avoid bias in favor of patients who chose or did not choose hospice care. In particular, we removed patients who incurred less than $4,000 in claims (approximating the low end cost of one Medicare-paid hospitalization) or greater than $115,000 in claims from the indicative event through death. This reduced the population by about 5% and total cost by about 20%. The removal of these patients reduces the possibility that the results reflect the influence of very large or very small claims. We also removed patients who died within 15 days after the indicative event. This removes from the analysis people who die very quickly, and, as a result, may incur very low costs, and may not have a chance to consider entering hospice. For congestive heart failure, COPD and stroke, the short-stay trim removed a significantly higher portion of patients. This is not surprising, because the indicative marker for each of these cohorts is an acute hospital stay with significant intervention, and those patients who die within 15 days of admission might not have the opportunity to consider hospice care. We note that hospice data show many patients enter hospice with only a few days to live, and hospice executives complain about the quality and cost impact this has.[24] We note that hospice practitioners inform us that many patients do choose hospice care under such circumstances.

We followed individuals identified in 1999 with indicative events through the year 2000. For esophageal, stomach, liver, gallbladder and pancreatic cancers, where we used the first appearance of the ICD-9-CM code in the data as the indicative marker, we examined 1998 data for earlier appearances of these diagnoses among the claims. For the other diseases, we identified each individual's first indicative event in 1999. Individuals with a first indicative event in 2000 were eliminated from our study, to avoid biasing the sample toward short survivors. It is possible, but for most conditions clinically unlikely, that some individuals may have had a first indicative event in 1998 and a second in 1999. We did not examine the data from 1998 to identify any such patients. As a result of this approach, we considered only patients who were age 66 and older if the indicative event occurred in 1999.

We eliminated any individuals who were not observed to die. While the data from such individuals would be useful for a survival study, costs are generally believed to be higher toward the end of life. Because of our focus on cost, we wanted to capture only people with observed deaths. As mentioned above, because the primary purpose of this study was to evaluate cost, we analyzed only patients who died. This limits the usefulness of the data for survival analysis purposes. Nonetheless, we report the mean and median time until death for the cohorts.

Statistical Analysis

We used the *t*-test to evaluate differences in means, which is the goal of this study, to measure the Type I comparison wise error rate. We did not attempt to develop predictive parameters for time until death or cost. We tested for the significance of the following variables: age, sex, Medicaid-eligibility, and use or nonuse of hospice cost. The significance of these variables was tested through a generalized linear model. The *P* values shown in Table 2 are based on unadjusted means tests using cost as the only independent variable. The significance of other variables was determined using multiple regression on hospice use, age, sex and dual eligibility for Medicare and Medicaid. Table 3 shows that the hospice group is slightly more female and slightly younger than the non-hospice group.

We did not perform any analysis to attempt to identify the impact of co-morbidities on cost or time until death. The patient cohorts were very narrowly chosen from approximately 200,000 Medicare deaths, and the hierarchy we used in assigning indicative markers does provide some control over co-morbidities. More fundamentally, the predictive models in commercial use have weak predictive power and all were designed to forecast future costs for general populations, not those with short-term terminal illness.[22] Similarly, the Charlson approach also seems inappropriate given the terminally ill characteristic of the population and the narrow population definitions.[25] The geographic distribution by state of the hospice and non-hospice groups was very similar, with a 93% correlation coefficient, 94% for dual-eligibles and 92% for non-dual-eligibles. Of the cancer cohorts, 53%

Table 2
Medicare Cost Per Patient for Studied Diseases

Disease Cohort	Choice[a]/Patient Count	Mean Cost/SD per Patient (US$)	Median Cost per Patient (US$)	Mean Time Until Death in Days/SD	Median Time Until Death in Days
Alzheimer's disease	H/29	29,828/16,986	29,309	221/177	166
	NH/122	30,925/21,268	24,034	175/155	117
Brain cancer	H/284	35,768/20,743	32,706	203/146	170
	NH/166	38,300/24,729	31,260	159/139	108
Breast cancer	H/144	37,968/22,426	34,428	353/172	362
	NH/111	41,269/24,641	38,349	306/184	293
Congestive heart failure[b]	H/174	46,793/24,469	41,136	185/163	136
	NH/1141	53,528/26,705	50,015	135/145	65
Colon cancer	H/327	31,819/20,727	41,136	310/168	292
	NH/199	33,979/22,283	50,015	266/182	226
Chronic obstructive pulmonary disease	H/33	43,744/22,830	37,495	136/143	96
	NH/292	51,831/26,991	45,458	132/151	57
Esophageal cancer	H/232	33,489/22,749	28,289	252/168	210
	NH/300	36,133/22,833	31,816	209/173	149
Gallbladder cancer	H/70	30,454/17,895	25,725	211/163	159
	NH/58	33,026/22,676	27,596	186/163	139
Liver cancer[b]	H/496	27,364/19,544	22,909	183/158	133
	NH/388	30,402/23,331	21,974	170/167	100
Ovarian cancer	H/24	45,296/22,272	35,946	296/141	303
	NH/17	54,231/30,387	43,197	248/133	246
Pancreatic cancer[b]	H/663	29,621/20,786	23,617	198/160	151
	NH/459	34,784/24,232	27,834	183/164	128
Prostate cancer	H/270	30,573/19,761	25,763	404/180	392
	NH/459	30,382/21,257	25,182	366/177	370
Rectal cancer	H/191	34,478/21,698	31,168	289/174	263
	NH/193	37,917/25,152	32,283	233/179	200
Stomach cancer	H/252	32,004/22,687	25,314	228/175	190
	NH/264	35,658/25,151	29,951	194/171	133
Stroke[b]	H/22	46,910/30,767	40,900	177/127	156
	NH/125	34,579/24,148	28,230	165/168	101
Trachea, bronchial & lung cancer	H/648	36,209/20,136	32,886	262/157	229
	NH/547	37,845/20,808	34,855	225/152	201

[a]H = patients choosing hospice; NH = patients not choosing hospice.
[b]$P < 0.05$ for mean cost differences.

of the patients were in the hospice cohorts, compared to 60% of all Medicare decedents in 2000, while for cancer plus non-cancer cohorts, 44% of patients were in the hospice cohorts compared to 23% for all Medicare decedents in 2000.[24]

SAS™ (SAS Institute Inc, Cary, NC) and Excel™ were used for all analyses. We conducted statistical tests on each disease separately and did not attempt cross-disease analysis to determine whether hospice use, age, sex or dual eligible status had significant impacts.

Results

For the diseases studied, we compared Medicare patients enrolled in the Medicare hospice benefit with those not enrolled in the Medicare hospice benefit for Medicare cost. Table 2

Table 3
Age–Sex Demographics of Cohorts

Age	Female	Male	Total
Patients Receiving Hospice Care			
64–69	412	476	888
70–74	462	578	1,040
75–79	449	481	930
80–84	299	297	596
>85	221	184	405
Total	1,843	2,016	3,859
Patients Not Receiving Hospice Care			
64–69	437	532	969
70–74	497	643	1,140
75–79	464	648	1,112
80–84	400	458	858
>85	401	361	762
Total	2,199	2,642	4,841
Grand Total	4,042	4,658	8,700

shows summaries of these measures for the narrowly defined patient populations shown in Table 1.

For all diseases except prostate cancer and stroke, mean cost was lower for patients who chose hospice but was significant ($P < 0.05$) only for CHF, liver cancer and pancreatic cancer. Patients choosing hospice had higher cost at this significance for stroke (Table 2). Median costs generally followed the same pattern. Mean and median costs for untrimmed data followed the same pattern as for trimmed data with few exceptions.

Because cost was the focus of this study, we included only patients who died during the study period. Consequently, the data are of limited value for a survival study. Nevertheless, the pattern of lower costs for patients who choose hospice does not appear to be associated with shorter survival. Patients who choose hospice showed longer mean and median time until death than their matched non-hospice cohorts—by days to months for all of the diagnoses studied.

We caution the reader that the time until death times shown in Table 2 are means for the cohorts studied. Because the criteria use administrative, not clinical data, clinicians may find it hard to know whether an individual patient meets the detailed criteria we used to select patients, and the results should not be used to predict time until death times for individual patients.

A multiple regression was used to evaluate the effect of the available variables (i.e., hospice/non-hospice, age, sex, and Medicaid dual eligibility status) on time until death, cost, and cost/day by disease category. For each condition, we show whether hospice status, age, sex or Medicaid dual eligibility were significant for cost. Table 3 presents age and sex demographics of the hospice and non-hospice cohorts. Overall, the hospice group had slightly more females than the non-hospice group (48% vs. 45%) and patients in the hospice group were slightly younger than patients in the non-hospice group (74% and 67% of patients were ≤79 years of age, respectively).

Discussion

This study provides evidence that, for certain well-defined terminally ill populations, costs are lower for patients who choose hospice care than for those who do not. Furthermore, for certain well-defined terminally ill populations, among the patients who died, patients who choose hospice care live longer on average than similar patients who do not choose hospice care. This pattern persisted across most of the disease states studied. Hospice care is widely used by patients with cancer, which was reflected in the high proportion of patients choosing hospice care in our cancer diagnoses groups. Notable among the findings, however, is that the CHF-related group, where relatively few patients receive hospice care, shows lower cost and higher time until death for the patients who choose hospice care.

Although the data suggest some longevity benefit to hospice, the causality for reduced cost seems stronger than for greater time until death, because patients who happen to live longer after their indicative event may have greater opportunity to choose hospice. Alternatively, these patients will also have greater opportunity to enter a track of aggressive, non-hospice treatment. While the study's design does not provide comprehensive results for longevity, the hypothesis that longer surviving patients may more likely choose hospice seems counterintuitive to the finding of lower costs for patients choosing hospice. This is an important area for further research.

A critical question is whether the selection criteria—either for the defined cohorts or for the individuals who choose hospice care—biased the results. The administrative data used

do not capture significant clinical measures or psycho-socio-economic data such as education or income. Hospice enrollment was not randomly assigned, and the individuals who choose hospice may have tended to avoid expensive care even if they had no access to the hospice benefit. One approach to identifying such bias is to assume that high spending (or low spending) before hospice enrollment is a predictor of an individual's probability of obtaining (or avoiding) aggressive medical treatment. However, certain of the indicative diagnosis definitions (for example, breast and ovarian cancers) required a history of obtaining aggressive medical treatment, so such look-back methods may have limited value for these cohorts. In addition, the attempt to use pre-hospice treatment to adjust for "propensity to treat" bias would discount the possibility that changes in their medical condition could cause some people to dramatically change their choices about the desired kind of medical care.

Although the Medicare 5% sample contains information about race, we did not include that factor in our analysis. African-American patients have been shown to be less likely to choose hospice services than non-minority patients.[26] Racial disparities deserve further investigation, although the authors do not have a strong intuitive sense of the cost bias that might have been introduced by failure to consider race.

We believe that our "indicative event" definitions identified individuals with similar health status, although the more complicated indicative events, which require a combination of circumstances, probably produced more homogenous cohorts than the simpler indicative events (for example, the first appearance of a pancreatic cancer diagnosis). For most indicative events, the individuals were well enough to have passed medical clearance to receive aggressive treatment. They were all sick enough to die within two years of the event. The limited success of predictive modeling[21] argues against using existing models (or simpler look-back approaches) to create matched cohorts and we did not attempt to do so. The analysis does exclude all individuals who die within 15 days of the indicative event, so that the non-hospice group would not include individuals who die immediately after the intervention, so have no opportunity to choose hospice.

Our trimming rules had almost no impact on which cohort had higher mean or median costs and no impact on which cohort had longer time until death. One of the few exceptions is cost for CHF, where a large number of non-hospice patients died within a few days after the indicative hospitalization event. For CHF, including these very short times until death patients would shift mean and median costs for the non-hospice cohort to be lower than for the hospice cohort. This exception does not weaken our view about the relative costs of hospice patients, as hospice would have had little opportunity to reduce costs for these patients.

The study does raise temporal bias issues. Patients who choose hospice care may incur lower expenses, with or without hospice care, because they may desire to avoid aggressive treatment. This may explain some of the cost findings for cancer of the esophagus, stomach, liver, gallbladder and pancreas, where the indicative event was defined by the appearance of a diagnosis, rather than a more aggressive medical intervention. However, for the other conditions studied, the indicative event screen required that all patients in both the hospice and non-hospice cohorts have a history of choosing aggressive treatment—and access to such aggressive treatment. For example, a diagnosis of brain cancer followed by a surgical intervention and radiation treatment does not suggest a patient who avoids aggressive treatment or one who has little access to aggressive care.

The question "How is it possible that hospice can prolong life?" is critically important to answer. Hospice care promotes itself as providing compassionate care, emphasizing pain management, comfort and quality of life. These kinds of support may tend to prolong life, although the evidence base for much of what hospice achieves has yet to be assembled. Terminally ill patients who choose hospice avoid the hazards of aggressive medical treatment, which may contribute to the longer time until death observed in these patients. We suggest, however, that the longer time until death may be due to significantly longer time until death by a relatively small number of patients, rather than short increases by a large number of patients. This hypothesis may find support through further data analysis or clinical research to identify whether some hospice patients survive

one or more crisis periods better than do non-hospice patients. We hope this study may prompt additional investigation into the appropriate length of hospice enrollment needed to achieve the goals of end-of-life care. The appropriate length continues to be debated, especially as the mean length of hospice enrollment has declined from a high of 74 days in 1992 to 59 days in 1998,[27] although the decline appears to have stopped in more recent years.[28]

Another important question to answer, which our study did not address, is "Do the differences in time until death matter to patients and families?" In our study sample, the average time until death from the indicative event ranged from about 6 months to about 1 year. The hospice patients had an increase in time until death compared with the non-hospice patients that ranged from days to months. This increase in time until death may be particularly important to family members if pain management, comfort and quality of life can be maintained.

Finally, the question "Do these results apply to other kinds of patients?" must be asked. In performing this study, we chose very narrowly defined patient cohorts and removed patients with short or long survival periods. These cohorts were unusual in that administrative data, by itself, was used to identify a precise point in the patient's treatment and course of disease. The diagnoses from which we chose patients account for a majority of Medicare deaths, but the criteria used to choose cohorts generally produce many fewer deaths. Further research should be undertaken to determine whether other kinds of patients follow disease courses similar to those reported in this study. Future research in this area will elucidate the applicability of these findings.

Although the use of administrative data presents some limitations, it also has strengths. Well-known weaknesses include incomplete or inaccurate coding by healthcare providers during the course of billing. However, we believe these weaknesses do not bias the results of our study. One important strength of using the Medicare 5% sample is that this administrative data is taken from actual Medicare payments for actual patients rather than modeled patients or expenses. These data were produced by the Medicare payment adjudication system, so, unlike using data from a small controlled study or charges generated by hospital charge masters, the findings require little translation to make them applicable to likely aggregate results for Medicare as a payer.

Most analyses of the cost of end-of-life care, including this study, have not considered the substantial out of pocket costs to families.[29] Medicare hospice services require minimal cost sharing, and, unlike the regular Medicare program, drugs are covered. Medicare cost sharing practically guarantees that, if our findings are true, the cost to patients will be less for hospice care, although this is a fertile topic for further investigation. Had we considered the value of the Medicare Part A deductible, the Medicare Part B coinsurance and deductible and the cost of prescription drugs, the total cost savings for hospice care would have been more dramatic than shown.

We caution that while the choice of hospice or non-hospice appears to have an important influence on average time until death time, the variance in time until death is very large for both cohorts. In other words, for an individual, the choice of hospice or non-hospice has very low predictive value for individuals. We hope that this study will generate hypotheses that can be tested in a clinical environment to produce evidence-based recommendations.

Predicting the date of an individual's death has been a challenge for the Medicare program's definition of hospice eligibility and the costs of care for Medicare beneficiaries at the end of their life is an immense cost issue for the financially-beleaguered program.[30] This study provides important information that may guide physician recommendations that are both compassionate and cost effective.

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Exhibit 1

Hospice Utilization in Chelan County

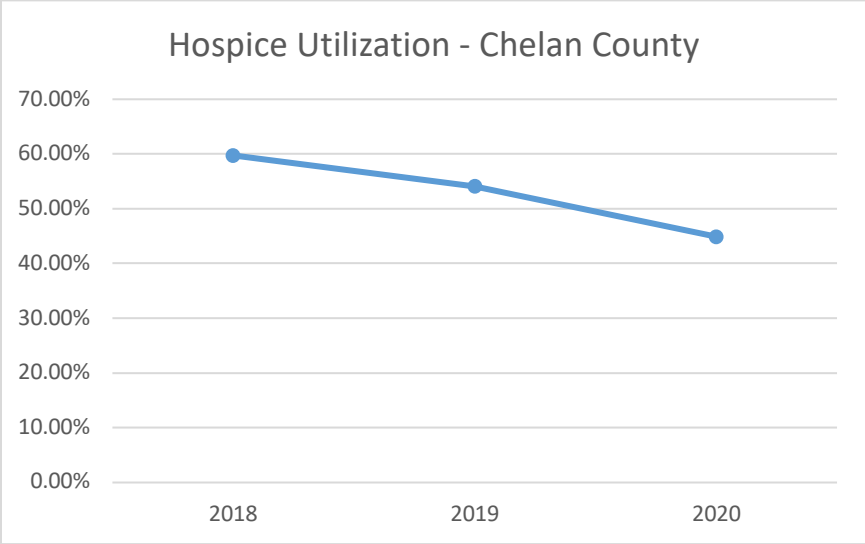

Exhibit 2

Hospice Utilization, Chelan County vs State

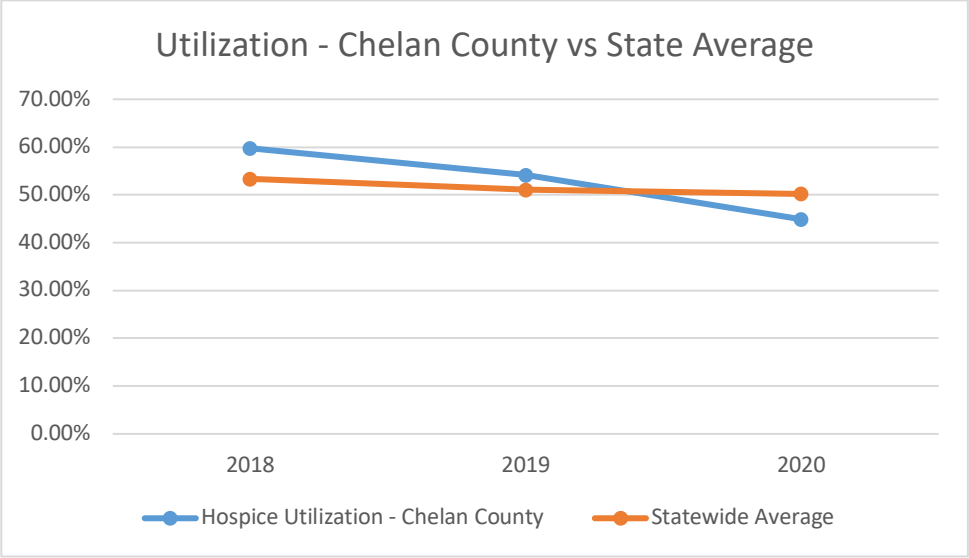

Exhibit 3

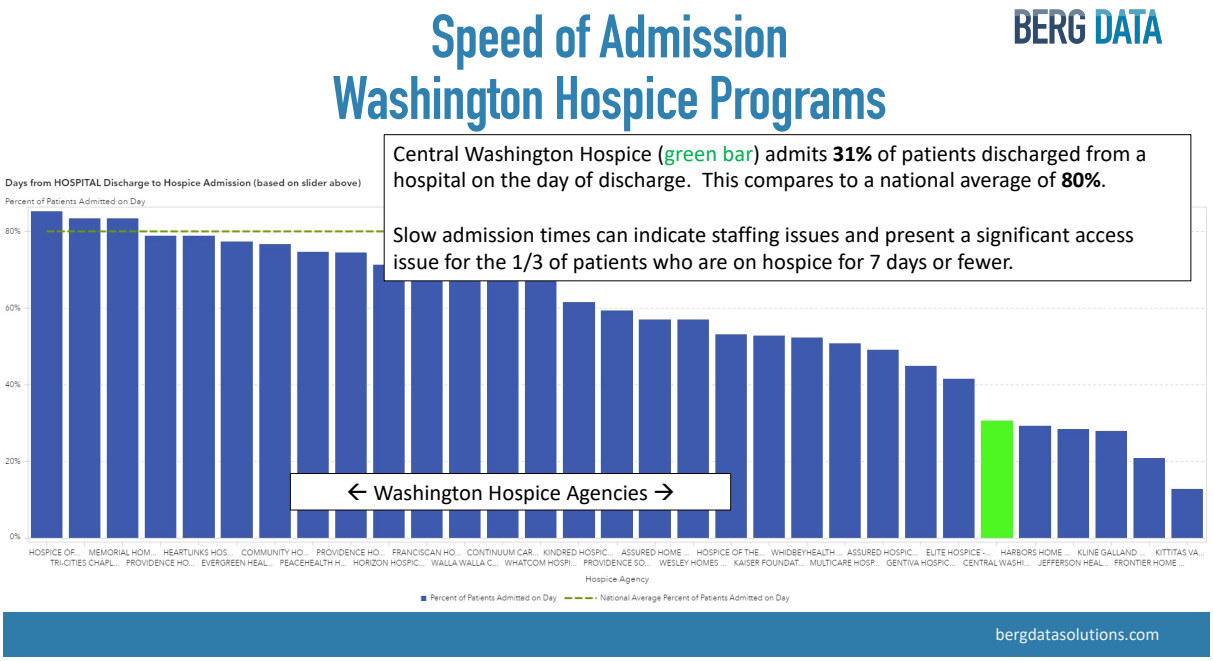
Speed of Admission
Washington Hospice Programs
BERG DATA
Central Washington Hospice (green bar) admits 31% of patients discharged from a hospital on the day of discharge. This compares to a national average of 80%.
Slow admission times can indicate staffing issues and present a significant access issue for the 1/3 of patients who are on hospice for 7 days or fewer.
Days from HOSPITAL Discharge to Hospice Admission (based on slider above)
Percent of Patients Admitted on Day
80%
60%
40%
20%
0%
← Washington Hospice Agencies →
HOSPICE OF... MEMORIAL HOM... HEARTLINKS HOS... COMMUNITY HO... PROVIDENCE HO... FRANCISCAN HO... CONTINUUM CAR... KINDRED HOSPIC... ASSURED HOME ... HOSPICE OF THE... WHIDBEYHEALTH ... ASSURED HOSPIC... ELITE HOSPICE -... HARBORS HOME ... KLINE GALLAND ... KITTITAS VA...
TRI-CITIES CHAPL... PROVIDENCE HO... EVERGREEN HEAL... PEACEHEALTH H... HORIZON HOSPIC... WALLA WALLA C... WHATCOM HOSPI... PROVIDENCE SO... WESLEY HOMES ... KAISER FOUNDAT... MULTICARE HOSP... GENTIVA HOSPIC... CENTRAL WASHI... JEFFERSON HEAL... FRONTIER HOME ...
Hospice Agency
Percent of Patients Admitted on Day
National Average Percent of Patients Admitted on Day
bergdatasolutions.com

Exhibit 4

Chelan County Hospice
Speed of Admission for Hospital Discharges
2016-2020

BERG DATA

The percentage of patients admitted to hospice at Central Washington Hospice on the day of discharge from a hospital has consistently been below the national average and one of the lowest in Washington State.

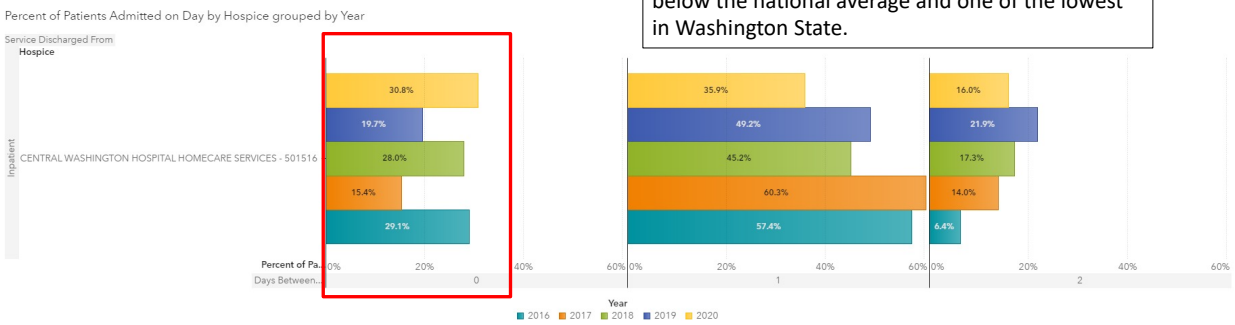

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Exhibit 5

Dual-Eligible Hospice Utilization Rates in Washington State Counties

BERG DATA

Chelan County admits **367** **dual-eligible** patients to hospice per 1,000 Medicare deaths. This is significantly below the national average of **474** for dual-eligible patients. In addition, Chelan County ranks in the bottom third of Washington counties for dual-eligible hospice utilization rates.

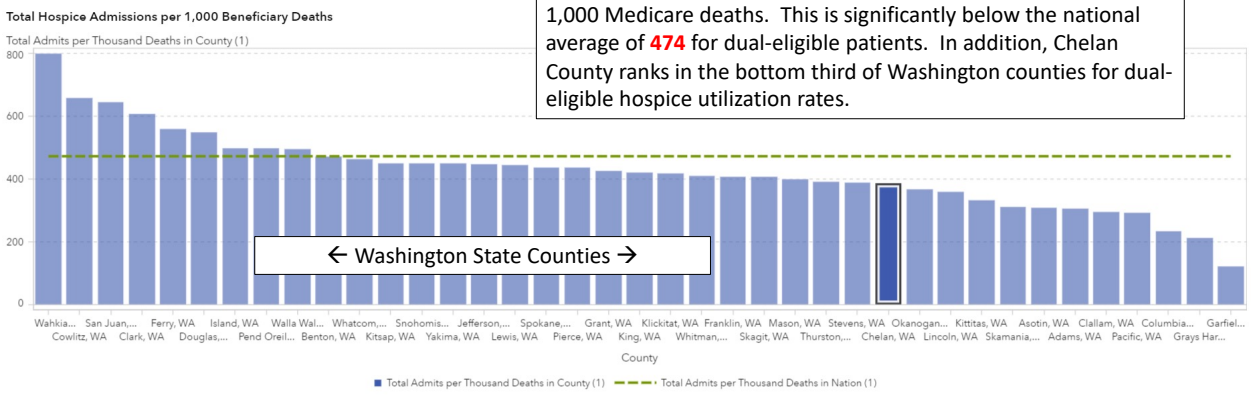

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Exhibit 6

Chelan County Dual-Eligible Hospice Admissions per 1,000 Deaths 2018-2020

BERG DATA

The Chelan County hospice utilization rate for dual-eligible patients is low compared to both the nation and other counties in Washington. In addition, the rate has been declining year over year.

Medicare dual-eligible are an underserved population in Chelan County.

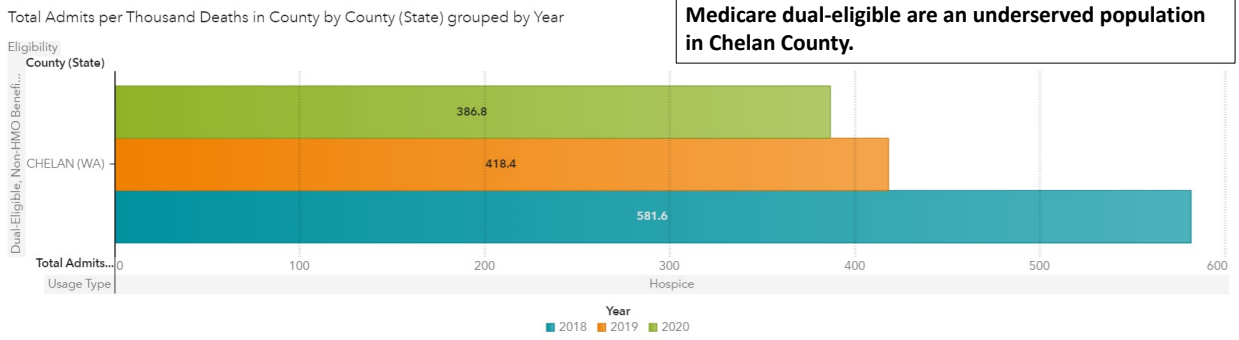

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Exhibit 7

Visit Hours per Patient Day
Washington Hospice Programs

BERG DATA

Central Washington Hospice (green bar) spends an average of **0.41** hours per day with their patients. The national average is **0.52** hours per patient day.

Less time in patient homes can be an indicator of staffing challenges which creates access issues for patients.

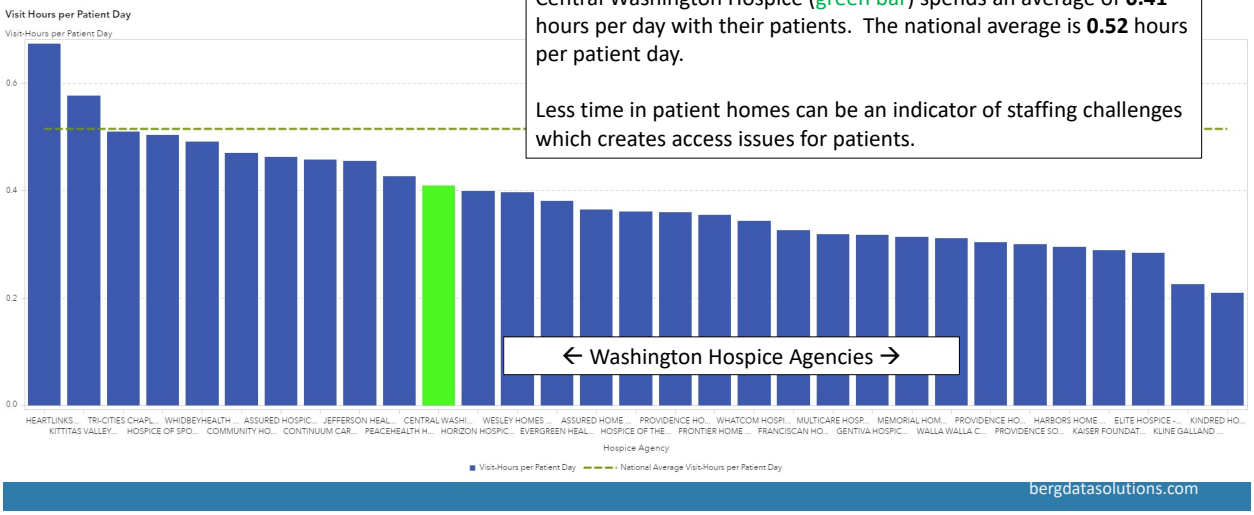

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Exhibit 8

Visit Hours per Patient Day Central Washington Hospice 2016 – 2020

BERG DATA

Central Washington Hospice consistently spends less time in their patient's homes than the national average.

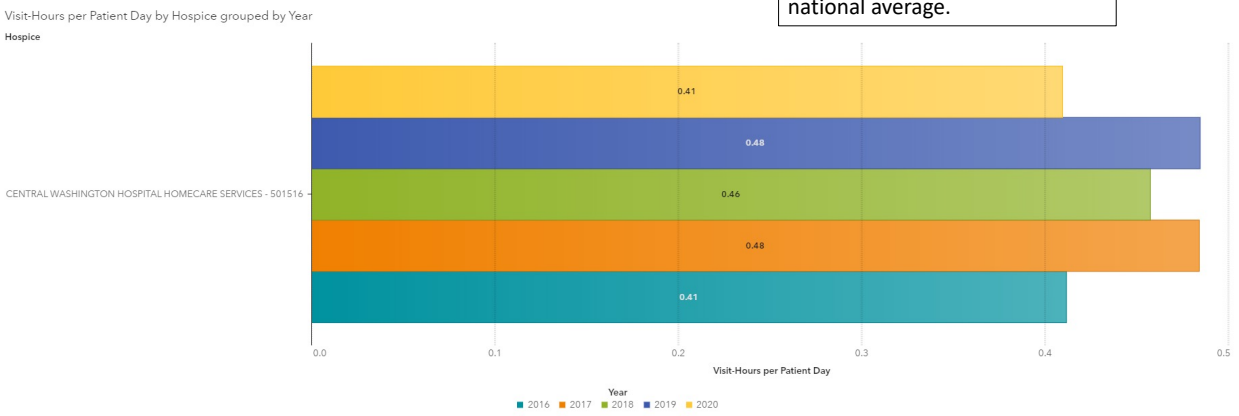

Exhibit 9

Chelan County Hospice Utilization by Race - 2020 - Berg Data Solutions

Race	Chelan County Hospice Patients	State Average Race Percent	National Average Race Percent
White	96.0%	91.1%	84.9%
Asian	0.0%	2.6%	1.5%
Black	0.0%	1.9%	9.0%
Other	0.0%	1.6%	1.3%
North American Native	0.0%	1.0%	0.4%
Unknown	0.0%	0.9%	0.6%
Hispanic	0.0%	0.9%	2.2%

NOTE: Demographic groups with less than 11 patients are suppressed per CMS requirements.