WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310

CN19-56

APPLICATION FOR CERTIFICATE OF NEED
HOSPICE PROJECTS
(excludes amendments)

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form.

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

Signature and Title of Responsible Officer:	**Person To Whom Questions Regarding This Application Should Be Directed:**
Sherie Stewart, MSW Chief Operating Officer **Date:** December 28, 2018	Sherie Stewart, MSW Chief Operating Officer **Telephone Number:** 801-592-7827
Legal Name of Applicant: Envision Hospice of Washington, LLC **Address of Applicant:** 1345 W. 1600 N., Suite 202 Orem, UT 84057 **Telephone Number:** 801-592-7827	**Type of Project (check all that apply):** [ ] New Agency [x] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Hospice Agency to Become Medicare Certified/Medicaid Eligible
Project Summary: Expand an existing Thurston County hospice agency service area to also include Snohomish County, Washington **Estimated capital expenditure:** $ $19,800 .	

INSTRUCTIONS FOR SUBMISSION:

1. Mail an original and one copy of the completed application, with narrative portion to:

Department of Health
Certificate of Need Program
2725 Harrison Avenue, Suite 500
P O Box 47852
Olympia, Washington 98504-7852

The application must be accompanied by a check, payable to: ***Department of Health***. This check is for the review fee as identified on the **enclosed fee schedule**.

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

PROCESSING FEE: $ $21,968

APPLICANT NAME: Envision Hospice of Washington, LLC

DATE OF SUBMISSION: January 31, 2019 CHECK NUMBER: _____

APPLICATION INFORMATION INSTRUCTIONS:

These application information requirements are to be used in preparing a Certificate of Need application. The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 70.38.115 and WAC 246-310-210, 220, 230, and 240.

- The application is to be submitted together with a completed, signed Certificate of Need application face sheet and the appropriate review and processing fee. Please send an original and one copy to:

Department of Health
Certificate of Need Program
2725 Harrison Avenue, Suite #500
P O Box 47852
Olympia, Washington 98504-7852

- Please note that a **Letter of Intent** must be submitted for all projects, within a minimum of 30 days and a maximum of 6 months, prior to submission of the application. If a Letter of Intent is not received prior to application submission, the department will consider the application the Letter of Intent and no further action will be taken until the end of the 30 day Letter of Intent period.

- Please make the narrative information complete and concise. Data sources are to be cited Extensive supporting data, that tends to interrupt the narrative, should be placed in the appendix.

- DO NOT bind the application.

- Please number **ALL** pages consecutively.

- All cost projections are to be in non-inflated dollars. Use the current year dollar value for all program data and projections. **DO NOT** inflate these dollar amounts.

- Capital expenditures should not include contingencies. Certificate of Need statutes and regulations allow a 12 percent or $50,000.00 *(whichever is greater)* margin before an amendment to an approved Certificate is required.

- All subsequent correspondence in relation to the application must be submitted with an original and one copy.

Please contact Facilities and Services Licensing, Department of Health, for information on licensure requirements.

Overview

Envision Hospice of Washington LLC requests approval to expand the services of its existing Thurston County hospice to also provide Medicare-certified and Medicaid approved hospice care to residents of Snohomish County, Washington. Envision Hospice of Washington received Certificate of Need approval to establish its Thurston County hospice in September 2018.

The Washington Department of Health determined in October 2018 there is a need in 2020 for three additional hospice agencies in Snohomish County. The Department's Hospice Need Model forecasts this need when a county's hospice agencies collectively fall below the state average of hospice utilization considering the projected population of the county. Envision Hospice's application provides documentation that many terminally-ill residents of Snohomish County could receive care with better accessibility and availability.

Envision Hospice of Washington is uniquely suited to establish a new hospice in Snohomish County. Its owners are a group of nursing and rehabilitation professionals – nursing, physical therapy, occupational therapy, social work – that established home health and hospice agencies in the Salt Lake City Utah region over ten years ago. Envision Home Health of Washington received Medicare certification for its King County home health agency in June 2015 and added Pierce County home health in January 2017. In only three years, the diverse and energetic staff of the new agency has grown that start-up to nearly 19,000 visits annually in King and Pierce Counties.

In light of the Department's current determination of need, this application emphasizes the manner in which Envision intends to meet it. Envision wishes to bring new ideas and energy to the existing network of care. Beyond its excellent provision of basic hospice services, Envision has adopted four additional goals that support great depth and breadth of services to terminally-ill residents of the county and also to special groups that Envision Hospice intends to serve with compassionate and relevant end-of-life care.

- Goal 1: Provide clinical focus and excellence in palliative care and, especially, in the care of patients with Alzheimer's disease and other dementias.
- Goal 2: Make hospice care as accessible as possible in the broadest array of settings.
- Goal 3: Respond with cultural competence to the needs of special groups among Snohomish County residents.
- Goal 4: Work to reduce suffering.

The program details, resources and financial support for these goals are described below in response to the application outline and in accompanying materials.

I. APPLICANT DESCRIPTION:

A. Provide the legal name(s) of applicant(s).
Note: The term "applicant" for this purpose is defined as any person or individual with a ten percent or greater financial interest in a partnership or corporation or other comparable legal entity that engage in any undertaking which is subject to review under provisions of RCW 70.38.

The legal name of the applicant is Envision Hospice of Washington, LLC.

Applying the percentage definition above, the members that have a 10 percent or greater financial interest in the LLC are:

1. Rhett Andersen
2. Greg Atwood RN
3. Wyatt Cloward OT
4. Jason Crump PT
5. Chad Fullmer PT
6. Darin McSpadden PT
7. Sherie Stewart MSW
8. Derek White PT

B. For existing facilities, provide the name and address of the facility.
Note: The term "existing facility" for this purpose is defined as a home health agency that is currently providing licensed only home health care services OR a home health agency that is seeking to expand its Medicare certified service area.

Envision Hospice of Washington, LLC, is a wholly-owned subsidiary of Envision Home Health of Washington, LLC.

Envision Home Health of Washington, LLC
Washington headquarters
1818 S. Union Ave, Suite 1A
Tacoma, WA 98406

Envision Hospice of Washington, LLC
402 Black Hills Lane SW
Suite 402-B
Olympia WA 98502

Envision Home Health of Washington, LLC
Corporate office address:
1345 W 1600 N
STE 202
Orem, UT 84057

C. Identify the type of ownership (public, private, corporation, non-profit, etc.).

The applicant is a limited liability company whose members are private persons.

D. Provide the name and address of *owning* entity at completion of project (unless same as applicant).

The owning entity at completion of the project is the same as the applicant.

E. Provide the name and address of operating entity at completion of project (unless same as applicant).

The operating entity at completion of the project will be the same as the applicant.

F. Identify the corporate structure and related parties. Attach a chart showing organizational relationship to related parties.

Please see Appendix B for an Envision organization chart.

As the November 26, 2018 Letter of Intent states, Envision Home Health of Washington, LLC is the sole member of Envision Hospice of Washington, LLC. That means that Envision Home Health of Washington, LLC owns 100% of Envision Hospice of Washington, LLC.

The list of the eight members of Envision Home Health of Washington, LLC is provided in response to Question I.A. Each member of Envision Home Health of Washington, LLC holds an equal percentage of its total shares.

G. Provide a general description and address of each facility owned and/or operated by applicant (include out-of-state facilities, if any).

1) Envision Home Health of Washington LLC

Envision Home Health of Washington, LLC is a Medicare-certified and Medicaid-approved home health agency serving King and Pierce Counties, with combined visits of 18,800 in 2018. Envision Home Health provides a broad range of skilled services that includes nursing, physical therapy, occupational therapy, speech therapy, medical social services, and certified nurses' aides. These services are provided in the client's place of residence for the treatment of an illness or injury.

Envision Home Health also operates licensed-only home health in Snohomish and Thurston Counties, Washington.

Envision Home Health of Washington, LLC
1818 S. Union Ave, Suite 1A
Tacoma, WA 98406

2) Envision Hospice of Washington
Envision's Thurston County hospice received it Certificate of Need in September 2018 and is under development. Envision Home Health of Washington, LLC is the sole member of Envision Hospice of Washington, LLC.

Envision Hospice of Washington, LLC
402 Black Hills Lane SW
Suite 402-B
Olympia WA 98502

3) Envision Home Health & Hospice, LLC - Utah
Envision's Utah operations are organized as Envision Home Health LLC, dba Envision Home Health & Hospice, dba Envision Hospice and dba Preferred Medical Group.

a) Envision Home Health is a Medicare-certified home health agency that provides a broad range of skilled services that includes nursing, physical therapy, occupational therapy, speech therapy, medical social services, and certified nurses' aides. These services are provided in the client's place of residence for the treatment of an illness or injury.

b) Envision Hospice is a Medicare-certified hospice agency that serves the residents of five counties in the Salt Lake City region and surrounding area.

Envision Hospice LLC of Utah provides in home nursing; medical social services; physician services; counseling services, including spiritual counseling, dietary counseling, and bereavement counseling; hospice aide; volunteer; and homemaker services; physical therapy, occupational therapy, and speech-language pathology services; short-term inpatient care; medical supplies (including drugs and biologicals) and medical appliances.

Envision Parent Office
1345 W 1600 N
STE 202
Orem, UT 84057

Envision Home Health – Salt Lake Branch
9140 S State St. STE 101, Sandy, UT 84070

Envision Home Health – Northern Utah Branch
2351 Grant Ave, Unit 201,
Ogden, UT 84401

Envision Hospice – Parent Office
9140 S State St. STE 101,
Sandy, UT 84070

Envision Hospice – Northern UT Branch
2351 Grant Ave, Unit 201,
Ogden, UT 84401

c) Preferred Medical Group (PMG)
Envision Home Health LLC operates a physician outreach clinic that provides regular medical care to patients unable to make the trip to a doctor's office. Staffed by physicians and ARNP's, PMG clinics are offered in Salt Lake region and Puget Sound Region assisted living facilities and individual patient homes. PMG has an NPI (National Provider Identifier) number and is able to bill Medicare and other payers for its services as a "physician visit."

H. For existing facilities, identify the geographic primary service area.

The geographic primary service area of the existing hospice facility, Envision Hospice of Washington, LLC, is Thurston County, WA.

The geographic primary service area of the existing home health agency Envision Home Health of Washington, LLC, is King, Pierce with licensed-only services available in Snohomish and Thurston Counties.

I. Identify the facility licensure/accreditation status.

On September 25, 2018 Envision Hospice of Washington received a Certificate of Need to establish a Medicare-certified hospice to serve residents of Thurston County, Washington. Envision's Thurston County hospice will be licensed as a Washington in-home services agency-hospice and will be Medicare-certified via an ACHC accreditation. Envision's Thurston County hospice is also committed to serving Medicaid patients.

Additionally, Envision Hospice of Washington LLC plans to conform to the standards of, and be certified by, ACHC's "Distinction in Palliative Care" specialty accreditation for hospices with additional capacities in pain and symptom management.

For the accreditation standards required for this additional level of accomplishment and recognition, please see Appendix W.

J. Is applicant reimbursed for services under Titles XVIII, and XIX of Social Security Act?

The proposed hospice will be reimbursed under Titles XVIII and XIX of the Social Security Act.

K. Identify the medical director and provide his/her professional license number, and specialty represented.

Dr. Susan Pearson is Envision Hospice of Washington Medical Director for Envision's existing hospice program in Thurston County. On approval of Envision's expansion to serve Snohomish County, she will also be medical director for that program.

Dr. Pearson's Washington medical license number is: OP60698789

Dr. Pearson is board certified in family practice, geriatrics and hospice and palliative medicine. Please see Dr. Pearson's extensive record in administrative management and clinical provision of hospice and palliative care at Appendix C.

Appendix C also includes the current signed medical director contract between Susan Pearson DO and Envision Hospice of Washington LLC.

This agreement was reviewed as part of the approved Thurston County hospice Certificate of Need application. Note that, as stated at Article VIII, the agreement automatically renews for successive one-year terms. The terms of the agreement remain as agreed to when signed. Accordingly, the projection of payments to the hospice medical director for 2020-2022 in Appendices J through N are based on the current language of the contract.

Envision believes the agreement meets the following requirements:

- The Compensation section of the agreement provides a basis for identifying all costs associated with the agreement. These costs are reflected in the projected financial statements at Appendices J though N.
- There are no exhibits referenced in the agreement.
- The agreement contains no redacted sections.

The method for relating those amounts to the agreement is based on the language at 6.1 Compensation:

. *For all services rendered by Physician pursuant to this Agreement, Physician will be paid by Hospice a minimum sum of $2,000.00 per month for an average daily census (ADC) of 1 – 6 patients. When the*

ADC is 7.0 or greater, physician will be paid an additional $300.00/ADC/month per ADC over 6. Payment will be calculated by Hospice and remitted by the last day of the following month, assuming Physician has completed and submitted time sheets or other documentation, if any, required by Hospice to validate the services provided.

. *For example, if Hospice average daily census for a given month is 3, compensation would $2,000.00. If the average daily census for a given month is 16, compensation would be $2,000.00 plus $3,000.00 (10 patients over minimum *300.00) = $5,000.00.*

Envision Snohomish County Hospice Medical Director Compensation	2020	2021	2022
Average ADC per month	18.7	36.0	45.3
Monthly average compensation @$300 per ADC	$5,400	$10,800	$13.500
Annual Medical Director compensation @ 12 months	**$64,800**	**$129,600**	**$162,000**

* The Medical Director Agreement requires a base payment of $2,000 per month and then pays per monthly ADC over 6 once ADC reaches 7 or greater. This table assumes the monthly ADC in Envision's existing Thurston County hospice will be 7 or greater well before the scheduled decision date for this Snohomish County application. Accordingly, the Medical Director compensation for the additional Snohomish County ADC will be paid at $300 per ADC per month.

L. Please identify whether the medical director is employed directly by or has contracted with the applicant. If services are contracted, please provide a copy of the contract.

Envision Hospice of Washington engages its medical director by means of a contract, not direct employment.

See Appendix C for the current Medical Director contract.

M. For existing facilities, please provide the following information for each county currently serving:

1. total number of unduplicated hospice patients served per year for the last three years;
2. average length of stay (days) per patient per year for the last three years;
3. median length of stay; and
4. average daily census per year for the last three years.

The proposed Snohomish County project would be an expansion of Envision Hospice of Washington's Thurston County hospice. The Certificate of Need for the Thurston County hospice was received on September 25, 2018 and development of that agency is currently underway. As of the submission date of this application, the Thurston County hospice is not yet providing patient services.

The table below provides the requested statistics for Envision's Utah hospice.

Envision Hospice - Utah	2015	2016	2017	2018
Total number of unduplicated hospice patients served per year	268	249	354	330
Average length of stay per patient per year	107	98	130	112
Median length of stay	63	64	49	45
Average daily census per year	100	117	102	77
Total patient days	37,284	42,326	69,812	54,533

II. PROJECT DESCRIPTION

Include the following elements in the project description. An amendment to a Certificate of Need is required for certain project modifications as described in WAC 246-310-100(1).

A. Provide the name and address of the proposed facility.

The Snohomish County office location of Envision Hospice - Snohomish will be

Envision Hospice of Washington- Snohomish County
1212-2nd Street, Unit B
Marysville, WA 98270

B. Describe the project for which Certificate of Need approval is sought.

Approval is sought to expand the service area of an existing Certificate of Need-approved hospice to also serve the residents of Snohomish County, Washington.

Envision's Thurston County hospice, which received a Certificate of Need in September 2018, is under development and has offices located in Olympia, Washington.

The proposed Snohomish County hospice office would be located In Marysville, Washington.

In addition to the provision of Medicare and Medicaid hospice services typically provided, Envision has established four goals for serving Snohomish County residents with terminal illness:

Goal 1: Respond with focused capabilities to specific clinical groups with special needs.

Goal 2: Make hospice care as accessible as possible in the broadest array of settings.

Goal 3: Respond with cultural competence to the needs of special groups among Snohomish County residents.

Goal 4: Work to reduce suffering.

C. List new services or changes in services represented by this project. Please indicate which services would be provided directly by the agency and which services would be contracted.

The table below lists the scope of services comprising Medicare hospice and indicates which will be provided directly or will be contracted in Snohomish County.

New Services	**Medicare Hospice**	**Provided directly**	**Contracted**
Nursing care	Required	x	
Medical social worker	Required	x	
Speech-language pathology services	Required		x
Physical and occupational therapies	Required		x
Dietary	Required		x
Pastoral care	Required	x	
Home care aide	Required	x	
Interdisciplinary team	Required	NA	
Case management	Required	x	
Medical Director	Required		x
Medical appliances and supplies, including drugs and biologicals	Required	x	
Inpatient hospital care for procedures necessary for pain control and acute and chronic system management	Required		x
Inpatient (nursing home) respite care to relieve home caregiver as necessary	Required		x
24-hour continuous care in the home at critical periods	Required	x	
Bereavement service for the family for 13 months	Required	x	
Available to nursing home residents??	Yes	x	

The hospice interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

- A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).
- A registered nurse.
- A social worker.
- A pastoral or other counselor.
- Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.
- Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.

A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:

- Nursing services.
- Medical social services.
- Physician services.
- Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling
- Hospice aide, volunteer, and homemaker services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Short-term inpatient care.
- Medical supplies (including drugs and biologicals) and medical appliances.

Envision goals for additional depth and breadth of services

In addition to the standard scope of services required under the Medicare hospice benefit Conditions of Participation, Envision Hospice of Washington LLC provides additional services and/or benefits to Snohomish County residents facing life-ending illness.

Additional depth and breadth of hospice services reflect four Envision service goals beyond the core capabilities of a Medicare-certified hospice. For detail

regarding each of the four goals and Envision's planned activities supporting each, please see Envision Hospice's "Snohomish County Program Detail."

Goal 1: Respond with focused capabilities to specific clinical groups with special needs, in particular:

a. Patients with Alzheimer's or other dementias and their caregivers
b. Support to "pre-hospice" patients with advanced care planning & palliative care

Goal 2: Making hospice care as accessible as possible in the broadest array of settings including:

a. Telemedicine at home
b. Assisted living facilities
c. Adult family homes
d. Nursing homes

Goal 3: Respond to specific cultural and demographic groups with appropriate and relevant communications and care with programming emphasis on:

a. Veterans
b. Latinos and Spanish-speaking residents

Goal 4: Reducing suffering through availability of:

a. Excellence in palliative care
b. "Your Hand in Mine"
c. Death with Dignity

D. General description of types of patients to be served by the project.

Snohomish County patients requiring end-of-life care and support and, in particular, those who have elected to avail themselves of the Medicare hospice program, or Medicaid, or private plans that are similar in organization, benefits, and payment arrangement.

E. List the equipment proposed for the project:
1. description of equipment proposed; and

Envision Hospice of WA, Snohomish County
Total Proposed Capital Expense, 2020-2022

Item	Estimated Expense
Furnishings	$ 10,500.00
Phone System	$ 2,500.00
Computers/Copiers/Printers	$ 6,800.00
Total	**$ 19,800.00**

For calculation of depreciation amounts that are used in the Snohomish County proformas, please see Appendix D.

2. description of equipment to be replaced, including cost of the equipment, disposal, or use of the equipment to be replaced.

Not applicable

F. Provide drawings of proposed project:
a. single line drawings, approximately to scale, of current locations which identify current department and services; and

Envision Hospice of Washington LLC does not currently have an office located in Snohomish County.

a. single line drawings, approximately to scale, of proposed locations which identify proposed services and departments; and

Please see Appendix E for a single line drawing of the Snohomish County office of the proposed hospice.

b. total net and gross square feet of project.

Net square feet: 1,534
Gross square feet: 1,534

C. Identify the anticipated dates of both commencement and completion of project.

Based on WAC 246-310-010(13), anticipated project commencement and completion are both projected for January 2020. 1 This is based on

1. [1]WAC 246-310- 010(13) provides the definition of "commencement" of the project. *"Commencement of the project" means whichever of the following occurs first: In the case of a construction project, giving notice to proceed with construction to a contractor for a construction project provided applicable permits have been applied for or obtained within sixty days of the notice; beginning site preparation or development; excavating or starting the foundation for a construction project; or beginning*

expected receipt of Certificate of Need approval by September 15, 2019 per WAC 246-310-290.

The third full year of Snohomish hospice operation is projected to be 2022.

D. Describe the relationship of this project to the applicant's long-range business plan and long-range financial plan (if any).

As the organization chart at Appendix B illustrates, Envision Hospice of Washington is currently preparing to serve hospice patients in Thurston County, Washington. It is affiliated through common ownership with Envision Home Health of Washington, LLC which operates home health agencies in King, Pierce, Snohomish and Thurston Counties, Washington. It also has common ownership with Envision Home Health, LLC (Utah) a home health and hospice agency serving five counties in the metropolitan area of Salt Lake City Utah and the greater region.

Owned and operated by a group of health care clinicians representing the disciplines of nursing, physical therapy, occupational therapy, and social work, Envision has established a long-range business plan for expansion of its programs and services. The plan reflects the Envision members' interest in identifying underserved communities and expanding its highly-rated in-home services into those communities where they are most needed.

Envision's operation of its Medicare-certified home health agency in King and Pierce Counties has allowed it to observe substantial gaps in access to home health and hospice services for residents across the Puget Sound Region and Western Washington. These gaps include long waits for home health and hospice first visits in every county where they have provided care or to which county's providers their patients may have needed a referral.

Accordingly, Envision has adopted long-range plans to expand both home health and hospice to the region's residents. Envision's findings regarding hospice in this regard:

- The portion of Medicare patients in Washington that receive hospice care is below the national average.
- The hospice length of stay in Washington is one of the lowest nationally.
- The average size of the region's hospice agencies is nearly ten times the average of hospices nationally.

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alterations, modification, improvement, extension, or expansion of an existing building. In the case of other projects, initiating a health service. "[emphasis added] Since construction is not required for this project, commencement and completion of the project is one and the same.

Envision efforts to date and planned additions include:

Hospice

Envision is developing its first Washington hospice in Thurston County, having received its Certificate of Need in September 2018.

It will pursue development of Medicare hospice in all Puget Sound region counties open to Certificate of Need applications or where purchase of an existing agency is possible. Envision's home health agency in King and Pierce Counties sees many terminally-ill patients wishing to elect hospice care but often unable to access hospice on a timely basis. Other Envision home health patients consider electing the Medicare hospice benefit but wish to keep the home health care team to which they have become accustomed.

Envision's hospice initiatives to date include:

King County

CON application filed in December 2019 and currently in screening process.

Thurston County

CON application approved in September 2018 and new hospice agency now under development.

Snohomish County

CON application filed November 2017 and denied in October 2018 for lack of clarity regarding office lease terms.

Pierce and Kitsap Counties

Applications planned in light of revised Washington hospice need projections but put on hold due to shorter planning horizon permitted in new hospice WAC.

Grays Harbor County

Letter of Intent filed in 2015. The existing hospice's error in its hospice provider survey response and Envision's identification of unmet need in Grays Harbor County was made after Letters of Intent were due and therefore deemed too late to affect the hospice need estimates for the annual cycle.

Clallam County

CON application in Clallam County filed in 2015. Special licensing exemption for a local "volunteer hospice" in Clallam County creates substantial barrier to development of viable Medicare hospice services there. Application withdrawn.

Home Health

Envision will pursue development of Medicare home health agencies in Western Washington counties for which the Department of Health home health need methodology demonstrates need. High priority will go to counties adjacent to those already served by Envision home health and those in which Envision is granted a hospice Certificate of Need. Since the home health review cycle is not limited to once annually, letters of intent will be filed at a reasonable pace; as each county is added to the Envision service area, the direction of further expansion will be determined.

King County

Envision Home Health of King County established in 2015. Rapid growth and identification of unmet need in surrounding counties.

Pierce County

King agency received Certificate of Need approval to serve Pierce County in January 2018.

Thurston County

Having received hospice Certificate of Need for a hospice agency in Thurston County, Envision will complement that county's services with expansion of its King/Pierce Medicare-certified home health agency to Thurston County. Currently a licensed-only home health agency.

Snohomish County

Envision is a licensed-only home health agency in Snohomish County and plans to expand its Medicare-certified home health agency to serve that planning area.

E. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "Sufficient interest" shall mean any of the following: clear legal title to the proposed site; or a lease for at least one year with options to renew for not less than a total of three years; or a legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease in the event that a Certificate of Need is issued for the proposed project.

Please see Appendix E for a copy of the lease for the Snohomish County hospice offices to be located in Marysville, Washington.

In the event that this agreement requires any revisions in order to meet the Department's requirements, please consider it a draft. Envision would certainly agree to a condition related to the lease agreement that requires the applicant to provide a copy of a revised lease to contain additional detail or terms as specified by the Department.

Envision Hospice, Marysville WA office rents, 2020-2022

	2020	2021	2022
Total monthly rent	1551.09	1551.09	1591.06
Annual rent	$18,613	$18,613	$19,093

III. PROJECT RATIONALE

Please address each county proposing to be served separately.

A. Need (WAC 246-310-210)

1. Identify and analyze the unmet hospice service needs and/or other problems toward which this project is directed.

   a. identify the unmet hospice needs of the patient population in the proposed service area(s). The unmet patient need should not include physical plant and/or operating (service delivery) deficiencies; and

Envision Hospice of Washington, LLC has undertaken two analyses that demonstrate the current and projected shortfall in hospice care in the proposed service area.

1. DOH published 2018 method projecting need to 2020
2. Extension of DOH 2018 Hospice Need Method to third year of operation in Snohomish County.

The two numerical analyses resulted in the following findings:

1. Application of the Department of Health Hospice Need Methodology for forecasting need for additional hospice agencies in a planning area

First, the applicant calculated the projected Year 2020 need for additional hospice services in Snohomish County as demonstrated through the Department of Health's 2018 interpretation of the Hospice Need Methodology at WAC 246-310-290.

Results of calculating the 8 required steps of the method with the Department's currently-posted results of the most recent hospice provider survey showed the need for three additional Medicare-certified hospice agencies in Snohomish County.

The Snohomish County unmet need for 2020 was calculated by the Hospice Need Method to be an ADC (average daily census) of 127 over the calendar year. This projection of unmet hospice need is a

clear indication that the residents of Snohomish County are underserved with regard to Medicare-certified hospice care. According to the Department of Health finding at Step 8, therefore, three additional Medicare hospice agencies are needed in Snohomish County. (See Appendix F for calculations.) [2]

2. A variation on the Washington Hospice Method that accounts for the lag time between the Department's planning horizon and the development of a new agency's third-year workload.

The Department of Health hospice need methodology generates quite conservative results because its projected increase in a county's hospice need extends only one year into the start-up of a new agency. For example, the DOH Need Method published in October 2018 projects need for 2020, the first full year a hospice approved in the 2018-2019 review cycle could begin operations.

In order to inform a new agency's reasonable growth in the market to 2022, the third year of such an agency's operation, a longer planning horizon was adopted for this second approach to determining unmet need and Envision's third year workload. The graph below shows the assumptions and results of this method:

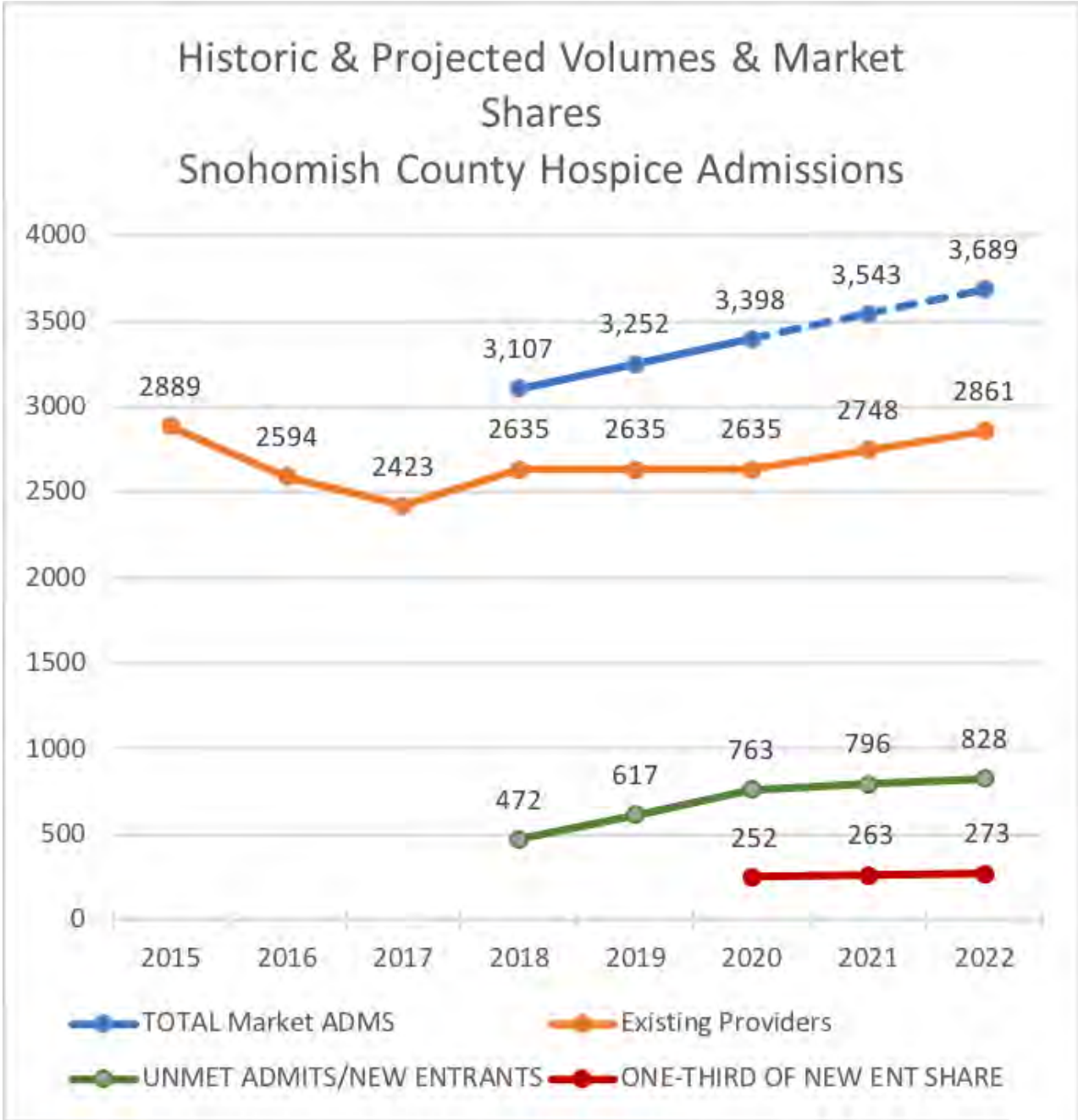
The lines on the graph illustrate four elements of the Snohomish volume projections to 2022:

TOTAL MARKET, **Blue line:** From the DOH Hospice Need Method, 2018, the solid portion of the line and associated values show the Method's projected number of Snohomish County hospice admissions, 2018-2020. The dashed portion of the line show a linear projection of the 2018-2020 trend continued out to 2022.

EXISTING PROVIDER'S PORTION OF MARKET, **Orange line:** From the DOH Hospice Need Method, 2018, the solid portion of the orange line shows Snohomish County actual hospice admissions through 2017, based on the DOH Hospice Provider Survey performed in 2018. The market share of existing providers' "current capacity" as defined in WAC 246 310 290 (7) was compared to the total size of the market the Hospice Need Method identifies for 2020. This calculation is 2,635 ÷ 3107 = 77.5%. This leaves a corresponding 22.5% market share for up to three new providers initiating hospice services in

[2] The published 2018 Hospice Need Method slightly inflates the historical statewide hospice use rate by interpreting the definition of existing "capacity" to permit attributing volumes to new agencies in years prior to their existence. Correcting for this error does not appear to materially change the unmet need for hospice services in Snohomish County.

2020. Rather than "freeze" the existing providers at their "current capacity," the values at the orange line project the existing providers combined hospice admissions at their 77.5% share as the market grows from 2020 through 2022.



:

NEW HOSPICE CAPACITY, **Green line:** The green line represents the potential 22.5% market share of up to three new providers responding to the 2020 unmet need as determined by the Hospice Need Method. The green line trends the

number of admissions starting at the Hospice Method's planning horizon, 2020, and projected through 2022.

ADMISSIONS OF ONE NEW HOSPICE, **Red line:** The red line shows the hospice admissions of one new hospice assuming it achieves a one-third share of the 22.5% of the market available to up to three new providers. The calculations:

828 admissions ÷ 3 = 273 admissions
273 admissions x 60 ALOS ÷ 365 = 44.93 ADC

The table below shows the data portrayed in the graph above.

SNOHOMISH COUNTY HOSPICE ADMISSIONS, HISTORIC AND PROJECTED TO 2022
EXISTING PROVIDERS, THREE NEW ENTRANTS AND ONE-THIRD SHARE OF NEW ENTRANTS

	Historic			From DOH Method		PROJECTED ADMS & SHARES		
	2015	2016	2017	2018	2019	2020	2021	2022
TOTAL MARKET ADMISSIONS				3,107	3,252	3,398	3,543	3,689
EXISTING PROVIDERS ADMS	2889	2594	2423	2,635	2,635	2,635	2,748	2,861
UNMET ADMITS/NEW ENTRANTS				472	617	763	796	828
1/3 OF NEW ENTRANTS' SHARE						252	263	273
MKT SHARE, EXISTING PROVIDERS						77.5%	77.5%	77.5%
MKT SHARE, 3 NEW ENTRANTS						22.5%	22.5%	22.5%
ADC 1 NEW ENTRANT						41	43	45

b. identify the negative impact and consequences of unmet hospice needs and deficiencies.

The Department of Health Hospice Need Method indicates that 2020 unmet hospice need in Snohomish County represents approximately 762 terminally-ill persons whose hospice need is unmet. The calculations:

(a) 127 ADC unmet need from Step 8 x 365 days per year = 46,355 patient days
(b) 14,235 days ÷ ALOS of 60.86 days per patient = 762 patients unmet need.

The negative impact and consequences of unmet hospice needs is best described by listing the benefits of hospice that are not available to those 762 Snohomish County residents whose need is unmet.

Longer lives
Hospice care prolongs the lives of those who choose it compared with those who don't. Terminal patients live from 20 days to more than 2 months longer in hospice, according to studies from 2004 through 2010 noted by the National Hospice and Palliative Care Organization.

Reduced out of pocket expense for patients and their families
Prescription medications are one of the biggest areas of cost savings for hospice patients. Hospice covers the cost of all medications for pain and

comfort management related to the terminal illness. Rental costs of durable medical equipment -- hospital beds, wheelchairs, walkers, wound dressings and catheters -- are included as part of the paid-by-hospice coverage. Without hospice, the patient would need to pay for this equipment or would need to pay a Medicare rental copayment after submitting a doctor's approval for the equipment.

Personalized and coordinated care plan
End-of-life care can be overwhelming, with a patient often seeing multiple health care professionals. Hospice provides each patient a doctor, nurse, home health aide and social worker, who coordinate the patient's daily care. Other provided health care professionals include a dietitian, and physical, occupational and speech therapists

Hospice care available at home
Being in hospice care may allow seniors to stay in their home versus going into long-term care or assisted living. Nearly 90% of people over 65 want to stay in their home for as long as possible, according a 2011 survey by the AARP Public Policy Institute.

Hospice care also can be provided to those in a nursing home or assisted living facility, though the cost of nursing homes or assisted living facilities is not covered by hospice. A 2010 study of cancer patients in hospice by the Mount Sinai School of Medicine found that continuous hospice use leads to a reduction of hospital-based services, including fewer emergency and urgent care visits, and a greater likelihood that a patient will die at home, not in a hospital.

There are respite options for caregivers
Hospice care provides free respite options for caregivers in 2 ways: Respite volunteers can provide patient-sitting services. If the caregiver needs a break for a short time (a few hours at most), they can do so without having to pay. Hospice also provides a longer-term respite care option -- up to 5 consecutive days for the patient in a hospice-approved nursing facility.

Social work and bereavement support
Hospice care also includes a social worker on the hospice team. The social worker can help patients and families find additional care and caregiver support services through local and federal programs. They can also help with finalizing burial plans. In conjunction with a spiritual counselor, social workers may also address the emotional needs of the patient and the family regarding the patient's eventual death. The patient and the family decide whether to use these services. Hospice care doesn't end when the patient dies. Bereavement support for up to 1 year after the patient's death is available to immediate family members.

Coordination of care
Coordinating multiple caregivers and providers is difficult for the healthiest person. For the family or terminally person without access to a Medicare-certified hospice, lack of coordination can create an insurmountable barrier to safe and effective care.

The need to control pain appropriately and address bereavement issues early are two aspects of caring for the terminal patient that many family members would despair of. But under the direction of the Medicare hospice interdisciplinary team, these are required aspects of care included in every patient's plan of care.

Yes, with lots of work and personal funds, one could assemble a team like the Medicare certified hospice team. But this service already exists within the Medicare program and all Medicare patients are eligible for it.

Reduced re-hospitalization
Hospice care reduces re-hospitalization. A study of terminally ill residents in nursing homes showed that residents enrolled in hospice are much less likely to be hospitalized in the final 30 days of life than those not enrolled in hospice (24% vs. 44%).

2. Define the types of patients that are expected to be served by the project. The types of patients expected to be served can be defined according to specific needs and circumstances of patients (i.e., culturally diverse, limited English speaking, etc.) or by the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.

Hospice services will be provided to adult patients requiring end-of-life care; Medicare hospice patients are those terminally ill patients with a life expectancy of 6 months or less.

A large number of these patients will be end-stage cancer patients. The remainder of the patients will have terminal conditions related to a variety of diagnoses. Please see the table at Question 5 in the Need Section above for a percentage breakdown of estimated diagnostic mix for Snohomish County. The majority of patients will be over age 75.

Patients receiving in-home care will include not only those still living in their own private homes but also those who are residents of nursing homes, adult family homes and assisted living facilities.

Hospice services will be provided to patients requiring end-of-life care; Medicare hospice patients are those terminally ill patients with a life expectancy of 6 months or less.

The proposed hospice will provide care to patients regardless of the source or availability of payment for care.

Care will be provided to all patients regardless of culture, language, or sensory disability. Where needed, interpretive services and assistive communication methods and technologies will be used.

As discussed above, the depth and breadth of hospice services reflect four Envision service goals beyond the core capabilities of a Medicare-certified hospice. A number of these goals emphasize special or tailored outreach and services to special populations in Snohomish County: The underlined items below indicate those special populations that Envision's program detail addresses specifically:

Goal 1: Respond with focused capabilities to specific clinical groups with special needs, in particular:

a. Patients with Alzheimer's or other dementias and their caregivers
b. Support to "pre-hospice" patients with advanced care planning & palliative care

Goal 2: Making hospice care as accessible as possible to groups living in the broadest array of settings including:

a. Telemedicine at home
b. Residents of assisted living facilities
c. Residents of adult family homes
d. Residents of nursing homes

Goal 3: Respond to specific cultural and demographic groups with appropriate and relevant communications and care with programming emphasis on:

a. Veterans
b. Latinos and Spanish-speaking residents

Goal 4: Reducing suffering through availability of:

a. Excellence in palliative care
b. "Your Hand in Mine" for persons dying alone
c. Death with Dignity for persons requesting it

For cultural and ethnic minorities, language is a key barrier to optimum hospice care but not the only one. Cultural norms and traditions surrounding illness, death, and dying are major factors in outreach and care. In setting goals for cultural competence, Envision Hospice of Washington determined that a focused effort on a cultural group with large numbers in Snohomish County will be the most effective use of resources. It examined Snohomish County demographics,

census information and hospice utilization. Envision Hospice concluded that the large size, cultural differences, and increasing diversity of the Snohomish County Latino population merits a program of special emphasis and resources in Envision hospice outreach and care.

Fortunately, the National Hospice and Palliative Care Organization has developed useful materials for guiding the development of such a program. But, rather than just adopt such a national model, Envision Hospice is involving existing Latino staff at its affiliated King & Pierce County home health agency to advise it in tailoring the NHPCO recommendations to Puget Sound area Latinos. More detailed description of Envision's approach is provided in Envision Hospice's "Snohomish County Program Detail.".

3. For existing facilities, include a patient origin analysis for at least the most recent three-month period, if such data is maintained, or provide patient origin data from the last statewide patient origin study. Patient origin is to be indicated by zip code. Zip codes are to be grouped by city and county, and include a zip code map illustrating the service area.

   Envision Hospice of Washington, LLC is currently developing its Thurston County hospice services, having received a Certificate of Need on September 25, 2018. Patient origin data is not yet available for this new facility.

4. Please provide utilization forecasts for the following, for each county proposing to serve:

   a. total number of unduplicated hospice patients served per year for the first three years;
   b. average length of stay (days) per patient per year for the first three years;
   c. median length of stay; and
   d. average daily census per year for the first three years.

   A table displaying the requested forecasts is provided below. It is important to note that Envision is providing a conservative projection of volume, one that meets the Hospice Need Method's projection of 127 in 2020 and has minimum impact on existing providers. This conservative approach to volume is carried into the pro forma operating statement and thus provides for a rigorous test of financial feasibility of the proposed agency expansion.[3]

[3] Technical assistance provided by CON staff to Envision leadership recommended adoption of reasonable and supportable King County workloads without being concerned that competing applications with more aggressive volume projections would be deemed more completely meeting the community's health care needs or providing greater breadth or depth of service in tiebreaker comparisons.

Medicare-certified Hospice Utilization Forecast
Envision Hospice of WA LLC, Snohomish County
2020-2022

	2020	2021	2022
Unduplicated patients	114.0	219.0	273.0
Average L.O.S.	60	60	60
Median L.O.S	17	17	17
ADC	18.7	36.0	45.3

Based on its Utah experience and its understanding of the opportunities it will pursue in Snohomish County, the table below estimates the multiple sources of admissions the Envision Hospice in Snohomish County can expect.

Projected Admissions and Sources

Envision Hospice/ Snohomish County

Annual average workload measures	**2020**	**2021**	**2022**
Projected average daily census for financial profoma	18.7	36.0	45.3
Annual admissions at 60 ALOS	114.0	219.0	273.0
Average admissions per month	9.5	18.3	22.8
Hospice Referrals per month by source	**2020**	**2021**	**2022**
Home health & home care agencies referring terminal patients	2	3	4
Hospitals discharging terminal patients - especially Capital	2	4	5
Assisted living & adult family homes residents electing hospice	2	4	6
Nursing home residents electing hospice	0	2	2
Patient and family self-referral from internet search	1	2	3
Physicians referring terminal patients	2	3	3
TOTAL	**9**	**18**	**23**

5. Please provide a forecasted breakdown of patient diagnoses.

The table below shows the national average for 2016 published by the National Hospice and Palliative Care Organization.

Diagnosis	Percent
Cancer	28
Heart/Cardiac/Circulatory	19
Dementia	16
Lung/Respiratory	11
Stroke/Coma	9
Other	17
Total	**100%**

This forecast was based on the 2016 national average diagnostic mix published by the National Hospice and Palliative Care Organization. Envision based its forecast on this national average breakdown of patient diagnoses because it is premature to forecast a different mix until Envision becomes more familiar with the needs in this specific service area.

6. Provide the complete step-by-step quantitative methodology used to construct each utilization forecast. All assumptions related to use rate, market share, intensity of service, and others must be provided.

Please see Appendix F for the Department of Health's calculations of forecasted Snohomish County hospice need for 2022. This document is the October 26 version posted on the Department's web site at the time of this application's submission. [4] This current version of the method conclusively shows the need for three additional hospice agencies to be established in Snohomish County.

WAC 247-310-290

(8) Need projection. The following steps will be used to project the need for hospice services.

(a) Step 1. Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics death data:

(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.

(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 the age of sixty-five by the average number of past three years statewide total deaths under sixty-five.

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

[4] This is pending a correction by the Department of Thurston County historic utilization and "capacity" as required by WAC 246-310-290(7)(b).

(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.

(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 use rate to determine the potential volume of hospice use by the projected population by the two age cohorts identified in Step 1, (a)(i) and (ii) of this subsection using OFM data.

(e) Step 5. Combine the two age cohorts. Subtract the most recent three-year average 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.

(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.

(g) Step 7. Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

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

7. Provide detailed information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "compete" with the applicant.

   a. Identify all existing providers of services (licensed only and certified) similar to those proposed and provide utilization experience of those providers that demonstrates that existing services are not available to meet all or some portion of the forecasted utilization.

Existing Snohomish County hospice providers:

- Evergreen Health Home Care Services
- Providence Hospice and Home Care of Snohomish County
- Hospice of the Northwest
- Kaiser Permanente/formerly Group Health

The Department of Health's 2018 calculation of forecasted 2020 Snohomish County utilization is provided at Appendix F.

1. Step 5 of the method documents substantially more forecasted utilization than the "capacity" of the existing hospices. For 2022, for example, the forecasted 2022 Snohomish County hospice need at Step 5 totals 3,689 admissions annually at Washington's statewide average use rates.

2. This need of 3,689 contrasts with the Department's October 2018 "current capacity" of 2,635 in Snohomish County, also shown in

Appendix F as part of the Department of Health's Survey Results, Hospice Numeric Need Methodology - Released October 2018.

3. This leaves 1,054 (3,689 minus 2,635) persons with an unmet need according to the DOH October 2018 calculation of 2020 need. This translates into a 2020 projected 29% shortfall in hospice availability in Snohomish county. (1054 ÷ 3689 = 29%)

Of the four Snohomish County hospices, none have been recently established. Taken together, they are not achieving the average hospice penetration rate of the hospices across the state of Washington. Calculation of the Department of Health's Hospice Need Methodology indicates that the reach of their services to county residents has not kept pace with the population growth, aging, and resulting end-of-life needs of area residents.

- Kaiser/Group Health hospice services are directed at its enrollees
- Hospice of the Northwest, located in Skagit County, provides a limited number of its services to Snohomish residents.

In light of below-average hospice utilization in Washington, it is safe to say that the unmet average daily census of 127 in 2020 understates real need in Snohomish County. Whereas the statewide average length of stay (ALOS) used in the Hospice Methodology calculations is 60.86 days, MedPac reports the national hospice ALOS is 86.6 days.

In conclusion, Envision adopts a very conservative workload for its financial projections. In doing so, it relies on CON staff having advised Envision to adopt reasonable and supportable volumes and not be concerned that more aggressive applicants that project volumes greater than a third of the unmet need will be deemed more fully meeting community need in tiebreaker comparisons. Adoption of a conservative workload also provides a realistic growth in volumes from start-up and a more stringent test of financial feasibility of the new program.

b. If existing services are available, demonstrate that such services are not accessible. Unusual time and distance factors, among other things, are to be analyzed in this section.

As discussed above and documented in the Department of Health's own 2018 calculation of 2020 Snohomish County hospice need, existing services are not sufficiently available. This question is therefore not applicable.

Definitions of "capacity" and "hospice agency" at WAC 246-310-290, "Hospice services—Standards and need forecasting method" make clear that the capacity of existing hospice providers in Snohomish County is not sufficient to address the unmet need calculated by the Department of Health. .

c. If existing services are available and accessible, justify why the proposed project does not constitute an unnecessary duplication of services.

As documented in the Department of Health's own 2018 calculation of 2020 Snohomish County hospice need, the proposed project is not an unnecessary duplication of services because it responds appropriately to an unmet need of 127 average daily patients per day in 2020.

The Department has expressed interest in how applicants will address barriers to care beyond simple availability of service. Barriers to hospice access in Snohomish County are not significantly different from the barriers encountered nationally. These include:

- Terminally ill patients hesitate to enroll in hospice because they are not ready to give up all curative care which Medicare currently requires. Many die before they are fully prepared to accept palliative care only.
- Many patients and/or their families and caregivers do not know about the hospice benefit or how to access it. Some believe it is only for persons dying of cancer. Some believe "hospice" is a place, not a service. Some are completely unaware of it.
- Many persons are referred to hospice by providers or others too late to get substantial benefit from longer-term hospice care that is available. Though this is changing gradually, the culture of medical care has been more oriented to curing disease and less toward palliation of symptoms and pain.
- Religious and cultural minorities have concerns about hospice care that make them reluctant to sign on.
- Providers differ in their understanding and interpretation of complex Medicare hospice rules. This can dampen referrals by those who see the regulations and paperwork as too burdensome.
- The American culture is only gradually accepting discussion of death and dying. For many, this conversation takes place too late to help.

Envision's plans include a number of approaches to increasing access, that is, improving the hospice use rate and length of stay for Snohomish County. These fall into three categories, or phases, of a patient and family's relationship to the hospice care decision:

- Increasing the number of persons deciding to use hospice (use rate)
- Encouraging earlier sign up for hospice among potential patients so that length of stay will be long enough to provide more benefit to those enrolled. (ALOS and median length of stay)
- Improving accessibility of care to patients while they are enrolled in hospice.

Envision's Approach to Reducing Barriers to Hospice Access in Snohomish County

Envision Access Goals & Program Initiatives	**More patients using hospice**	**Persons enrolling in hospice earlier**	**Improved accessibility within hospice**
Goal 1: Groups with specific clinical needs			
• Patients with Alzheimer's or other dementias	√	√	
• "Pre-hospice" patients & Advanced Care Planning	√	√	
Goal 2: Broadest array of settings			
• Telemedicine at home			√
• Assisted living facilities	√	√	
• Adult family homes	√	√	
• Nursing homes	√	√	√
Goal 3: Cultural competency			
• "We Honor Veterans"	√	√	√
• Latino outreach	√	√	√
Goal 4: Reducing suffering			
• Excellence in palliative care			√
• "Your Hand in Mine"			√
• Death with Dignity			√

The table above lists each of those program initiatives as described in the Program Detail portion of this application and indicates which phase of improved access it addresses. Specific to Envision's methods for actively increasing hospice utilization, the following information provides highlights of those programs and their potential for reducing Snohomish County barriers:

Under Goal 1: Addressing Advanced Care Planning needs of "pre-hospice" patients and early-stage dementia patients is part of Envision's plan to address the needs of specific clinical groups.

In programs specific to "pre-hospice" patients and in support of Advanced Care Planning, Envision will help patients to articulate their end of life wishes through Advanced Care Planning (ACP). They will learn more about their choices and be asked to think directly and communicate about a very difficult topic. This does not change the culture but does give an individual more control if he or she wishes to exercise it. In many cases, persons who participate in Advanced Care Planning before onset of a terminal illness are better prepared and have a clearer idea about whether hospice may or may not be right for them.

One study showed that those who engaged in ACP were less likely to die in a hospital, more likely to be enrolled in hospice at death, and less likely to receive hospice for 3 days or less before death.

Under Goal 2: Envision's plan to serve patients in as many settings as possible is not a passive matter of accepting patients when called or just being available. Rather, Envision Hospice staff will reach out directly to leadership and care providers in each setting such as retirement centers, assisted living, adult family homes and nursing homes. Envision can help the staff at each type of facility understand the benefits, not only to patient, but to the facility and staff of having Envision's hospice professionals and volunteers become part of the care teams there for terminally-ill residents. In addition, where affiliated Envision Physician Services provide primary care to patients in such a facility, the combination of those providers and Envision Hospice providers can help a resident maintain his or her home in the facility without emergency room visits and hospital stays that might otherwise occur.

Under Goal 3: A number of the barriers mentioned above have to do with culture and trust. In its program planning, Envision has prioritized two very large groups in Snohomish County for which cultural sensitivity and recognition of differences is necessary.

Latino

It is humbling for non-Spanish speakers to learn *"in Castilian Spanish hospice or "hospicio" means an orphanage or mental institution. . . . In Spain they do not use the word "hospicio."* They have palliative medicine centers that provide end-of-life care.

It is not surprising that language, religious values and other aspects of Latino culture can work against acceptance of hospice care by a person facing terminal illness and in need of palliative care. By engaging with community leaders, recruiting Latino volunteers, hiring bi-cultural staff, Envision expects to tailor its outreach and care to the increasingly diverse

Spanish-speaking residents of Snohomish County. With appropriate staffing, communication and education - plus diplomacy - Envision will a make a culturally -appropriate case for hospice care to families who otherwise will not consider it. (For more program information, see Envision Program Detail: Cultural Relevance to Latino Community Members.")

Veterans

Studies and clinical experiences documented by palliative care providers have shown that many veterans have unspoken health needs at the end of life. These may include a history of substance abuse, history of post-traumatic stress disorder, depression, and chronic health problems associated with their service. Veterans may also have needs for forgiveness at the end of life for actions during war that were never discussed. By embracing the "We Honor Veterans" program, committing education and training resources, hiring veterans, recruiting veteran volunteers, Envision believes it will help veterans be comfortable choosing hospice earlier and gain more of its benefits. For more program information, see the "Program Detail" section of Envision's CON application.

8. Document the manner in which low-income persons, racial and ethnic minorities, women, people with disabilities, and other under-served groups will have access to the services proposed.

In response to Questions 8 and 9 below:

Please see Appendices G, H and I for copies of Envision Hospice policies relating to

- Non-discrimination
- Acceptance & Admissions of Patients
- Intake Service
- Patients with Special Communications Needs (including language & cultural requirements)

In addition, Envision Hospice's ability to improve Medicare hospice access in Snohomish County will respond to these specific underserved groups:

- As documented by the Department of Health's own hospice need methodology, at least 127 Snohomish County patients per day will go without needed Medicare and Medicaid hospice care in 2020. These are individuals made vulnerable by virtue of their end-of-life status and are precisely the patients that hospice is designed to serve.

- In offering of bereavement services, Envision Hospice will be addressing needs of the family and loved ones of its current and former hospice patients. These individuals have special needs in light of their loss and grieving status.

- Nationally, the majority of hospice patients are very elderly women. Additional Medicare hospice care in Snohomish County will help address the needs of this group.

- Compared to the average population, the group of elderly persons – especially women – who are living on fixed incomes have a higher percentage of low-income persons among them.

- Envision Hospice will reach out to minority communities in Snohomish County - Spanish-speaking groups in particular - to build culturally-competent services to meet their specific needs in hospice care.

- Envision Hospice will develop relationships with veterans' groups and providers of their medical care in tailoring its hospice services to the needs of this large and growing population in the service area.

9. Please provide copies (draft is acceptable) of the following documents:

   a. Admissions policy; and
   b. Charity care policy; and
   c. Patient referral policy, if not addressed in admissions policy.

   Please see Appendices G, H and I attached.

10. As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.

a. The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources, or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.

   Not applicable

b. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

   Not applicable

c. The special needs and circumstances of osteopathic hospitals and non-allopathic services with which the proposed facility/service would be affiliated.

Not applicable

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

WAC 246-310-990(2) defines "total capital expenditure" to mean the total project costs to be capitalized according to generally accepted accounting principles. These costs include, but are not limited to, the following: legal fees; feasibility studies; site development; soil survey and investigation; consulting fees; interest expenses during construction; temporary relocation; architect and engineering fees; construction, renovation, or alteration; total costs of leases of capital assets; labor; materials; fixed or movable equipment; sales taxes; equipment delivery; and equipment installation.

1. Provide the proposed capital expenditures for the project. These expenditures should be broken out in detail and account for at least the following:

- Land acquisition;
- Site survey, tests, inspections;
- Construction contract;
- Financial feasibility studies, architectural fees/engineering fees/consulting fees;
- Fixed equipment (not in construction contract);
- Movable equipment;
- Freight and delivery charges;
- Sales tax;
- Cost of tuning up and trial runs;
- Reconditioning costs (in case of used asset);
- Cost of title investigations, legal fees, brokerage commissions;
- Other activities essential to the acquisition, improvement, expansion, or replacement of plant and equipment due to the project; and
- Financing costs, including interim interest expense, reserve account, interest expense, and other financing costs.

The capital expense estimate for the proposed hospice is:

Envision Hospice of WA, Snohomish County
Total Proposed Capital Expense, 2020-2022

Item	Estimated Expense
Furnishings	$ 10,500.00
Phone System	$ 2,500.00
Computers/Copiers/Printers	$ 6,800.00
Total	**$ 19,800.00**

2. Explain in detail the methods and sources used for estimated capital expenditures.

Estimated capital expenditures are based on the experience of Envision Hospice principals and related organizations in the development and operation of Medicare hospice services.

The estimate of capital expenditures of $19,800 is based on Envision's experience establishing similar offices and on the planned functions and number of staff that will use the office. Prices are based on recent purchases or vendor estimates.

3. Document the project impact on (a) capital costs; and (b) operating costs and charges for health services

Various studies on the cost-effectiveness of hospice, both federally and privately sponsored, provide strong evidence that hospice is a cost-efficient approach to care for the terminally ill.

An early study for CMS concluded that during the first three years of the hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care. The study found that much of these savings accrue over the last month of life, which is due in large part to the substitution of home care days for inpatient days during this period.

Additional research on hospice supports the premise that cost savings associated with hospice care are frequently unrealized because terminally ill Medicare patients often delay entering hospice care until they are within just a few weeks or days of dying, suggesting that more savings and more appropriate treatment could be achieved through earlier enrollment.

4. Provide the total estimated operating revenue and expenses for the first three years of operation (please show each year separately) for the following, as applicable. Include all formulas and calculations used to arrive at totals on a separate page.

Revenue			
Hospice agency	yyyy	yyyy	yyyy
Medicare			
Medicare Managed Care			
Medicaid			
Healthy Options [BHP]			
Private Pay			
Third Party Insurance			

Other [CHAMPUS, Veterans, etc.]			
Non-operating Revenue [United Way, etc.]			
Deductions from Revenue:			
(Charity)			
(Provision for Bad Debt)			
(Contractual Allowances)			
Expenses			
Hospice agency	yyyy	yyyy	yyyy
Advertising			
Allocated Costs			
B & O Taxes			
Depreciation and Amortization			
Dues and Subscriptions			
Education and Training			
Employee Benefits			
Equipment Rental			
Information Technology/Computers			
Insurance			
Interest			
Legal and Professional			
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/Pagers			
Travel (patient care, other)			

Please see Appendices J through N for financial proformas for the following scenarios:

J. Envision Hospice of Washington, LLC – Snohomish County Proposed

K. Envision Home Health of Washington, LLC, Existing Washington Operations

L. Envision Home Health of Washington, LLC, Existing Washington Operations combined with Envision Hospice of Washington, LLC – Snohomish County Proposed

M. Envision Hospice of Washington, LLC – King County Proposed

N. Envision Home Health of Washington, LLC, Existing Washington Operations

combined with Envision Hospice of Washington, LLC – Snohomish County Proposed and Envision Hospice of Washington LLC – King County

The following table provides key methodology and assumptions used for all revenues, costs, and expenses for the proposed Snohomish County hospice. Assumptions underlying more detailed line items are provided as part of Appendix J. Where items are based on costs per Day of Care (DOC), per month, or per year, these are averages from experience in Envision's Utah hospice operations combined with adjustments based on cost experience in the Puget Sound Region in Envision's home health operation in Snohomish and Pierce Counties.

Draft Proforma Operating Statement, Envision Hospice, Snohomish County
Assumptions for calculating line items at Appendix J

Revenue	
Medicaid	includes Healthy Options
Commercial/Other	Commercial, BHP, TriCare, CHAMPUS
Deductions from Revenue	
Contractual Allowances	2% of gross revenue
Bad Debt	1% of gross revenue
Adj. For Charity Care	2% of Total Net Revenue
Patient Care Costs **Salaries and Benefits:**	
Payroll Taxes & Benefits	30% of Salaries
Contract Labor:	
Physician (Medical Director)	See calculations at Question K, Applicant Description Section
Physical Therapy	$0.09 per DOC
Occupational Therapy	$0.03 per DOC
Speech/Language	$0.02 per DOC
Dietary Counseling	$0.08 per DOC
Other Administrative Line Items	
Physician Consulting Fees	1% of net revenue
Pharmacy/IV's	$8.66 per DOC
DME Costs	$5.05 per DOC
Medical Supplies	$2.38 per DOC
Lab Costs	$0.12 per DOC
Chemotherapy	$0.21 per DOC
Radiation Therapy	$0.12 per DOC
Imaging Services	$0.08 per DOC
Ambulance Costs	$0.35 per DOC
General Inpatient Costs	$735.54 per General inpatient day
Inpatient Respite	$151.00 per inpatient respite day
Nursing Home Revenue (net)	DOC x $12 x 5%, 10%, 15%, or 20%, 2018-21

Mileage	$3.35 per DOC
Administrative Costs	
Payroll Taxes & Benefits	30% of Administrative Salaries
B&O Taxes	1.5% of gross revenue
Mileage	$800/month
Advertising	$3,000/month
Travel - admin	$20,000/Year 1, $10,000 afterward
Legal & Professional	$1,000/month
Consulting Fees	$250/month
Software Costs	$2,000/month
Computer & Software Maintenance	$1250/month
Office rent	See calculations for each year at Question E, Project Description
Repairs/Maintenance	$150/month
Cleaning	$50/month
Insurance	$250/month
Office Supplies	$125/month
Equipment Rental	$2,000/year
Postage	$50/month
Telephones/Pagers	$1200/month
Purchased Services/Utilities	$500/month
Books & References Materials	$100/month
Printing	$125/month
Licenses & Certification	$1400/year for WA license; 10,000 in 2020 for Palliative Care Certification
Education and Training	$10,000/year including palliative care, cultural competence, volunteer program
Dues and Subscriptions	$200/month
Corporate Allocation	Lesser of 5% or $60,000/year; includes billing, HR, payroll, recruiting

Please see additional assumptions in the right-hand column of the Snohomish County Pro Forma Revenue and Expense, Appendix J.

Basis for staffing assumptions

Envision Home Health and Hospice in Utah has operated a very successful hospice agency for over ten years. The ratios and assumptions underlying the proposed staffing for Snohomish County are based on:

- Envision's depth of experience in a highly competitive market served by over 70 hospices,
- its preferred staffing model, plus
- alignment with national staffing averages per type of position.

Description of selected line item expenses

a) "Physician consulting fees" These fees are not paid to the medical director but include reimbursement for such physician services as: CMS permitted payments to the hospice patient's primary care physician; for palliative care for pre-hospice patients; and for specialty consultations to the IDT in areas such as neurology for dementia patients, infectious disease, pulmonology, nephrology, etc.

b) "General inpatient costs" include the amounts paid to inpatient facilities for each day one of Envision's hospice patients is cared for under the CMS daily rate for inpatient care, termed "General Inpatient Care" (GIP). GIP is one of the four daily rates under which hospice care is reimbursed by Medicare.

c) "Legal and professional costs" include accounting and auditing fees, attorney fees, etc.

d) "Consulting fees" include cost reporting, systems analysis and planning, benchmarking services for financial and quality measures, etc.

e) Services and costs provided under the "corporate allocation costs" cover overhead expenses such as payer contracting, billing, human resources, and employee recruitment, etc.

Note regarding "combined" scenarios

In a November 2018 Technical Assistance meeting with Envision leadership, CON staff agreed that the formatting for the "parent" or "existing" entity's expenses and revenues, i.e., Envision Home Health of Washington LLC – including Envision Hospice of Washington, Thurston County - may be portrayed with the detailed line items rolled up into more summarized categories of revenue and expense.

Note therefore, that the proformas involving a combination of existing and proposed entities start with the less detailed Existing Operations, 2020-2022, proforma shaded in blue. These 3-part documents show 1) the "existing," 2) the proposed agency, and then 3) the combination of existing with proposed:

- Part 1, the "Existing Operations" proforma operating statement, shaded in blue,
- Part 2, the more detailed proposed hospice proforma operating statement, then
- Part 3, also shaded in blue, the combined less detailed proforma operating statement showing the result of adding together the existing and proposed values in Parts 1 and 2. (Note: Duplicative expenses (examples include rent, accreditation and administrative staffing) that result from the combination have not been reduced.)

5. Identify the source(s) of financing (loan, grant, gifts, etc.) for the proposed project. Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. The proposed lease should be capitalized with interest expense and principal separated. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

Envision Home Health of Washington, LLC, the owner of Envision Hospice of Washington, LLC has existing accounts and funds adequate to fund the working capital needed for startup and hospice operations in both Snohomish and King Counties. Upon approval of Snohomish and/or King County Certificate of Need applications, the required funds will be transferred to an Envision Hospice of Washington, LLC account.

The amount needed in the account will depend on whether Snohomish, King, or both applications are approved. Based on the projected financials including cash flow projections of Envision Home Health of Washington combined with either or both of Snohomish and King County hospices, the required amount of cash is projected as follows:

<u>If only Snohomish is approved:</u> If Snohomish were a stand-alone entity, Appendix J 's Snohomish Cash Flow shows that approximately $135,000 of cash would be needed in 2020 and none thereafter.

<u>If both hospices are approved</u>: If Snohomish and King were stand-alone entities, Appendix J's Snohomish Cash Flow and Appendix M's King Cash Flow, added together, would require approximately $275,000 cash in 2020 and none thereafter.

Since any new CON-approved facility would be combined with existing operations, any cash flow needs would be more than covered by the projected free cash flow from Existing Operations of over $430,000 in 2019 and $1,030,000 in 2020 (see Appendix K, Existing Operations, Washington). Additionally, the existing operations have current cash in excess of $530,000 as shown in the letter from Chase Bank at Appendix O.

These figures do not reflect the areas of cost savings that would be realized from the combination of the two hospices and their combination with existing operations.

6. Provide documentation that the funding is, or will be, available and the level of commitment for this project.

A letter of commitment from Rhett Andersen, Chief Financial Officer of Envision Hospice of Washington, LLC is attached as Appendix P.

Availability of required funds is documented at Appendix O as a letter from Chase Bank demonstrating that Envision Home Health of Washington, LLC (the owner of Envision Hospice of Washington, LLC) has $536,434 in its savings account, which is

substantially greater than the projected cash requirement in any certificate of need approval scenario.

Please see Appendix O for a bank letter from
Blake E. Horton
Business Relationship Manager
Chase
1115 S. 800 E.
Orem, UT 84097
Office: 801-224-9701

7. Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, and interfund loan or bank loan. Provide the rationale for choosing the financing method selected.

Since financing involves unnecessary interest expense, Envision Hospice of Washington, LLC has elected to fund the establishment of the agency with available cash.

8. Provide a pro forma (projected) balance sheet and expense and revenue statements for the first three years of operation.

Please see Appendix J for draft pro forma revenue and expense statements and balance sheet for 2020-2022.

9. Provide a capital expenditure budget through the project completion and for three years following completion of the project.

Please see Appendix D for a capital expenditure budget through project completion and for three years following completion of the project.

10. Identify the expected sources of revenue for the applicant's total operations (e.g., Medicare, Medicare Managed Care, Medicaid, Healthy Options, Blue Cross, Labor and Industries, etc.) for the first three years of operation, with anticipated percentage of revenue from each source. Estimate the percentage of change per year for each payer source.

The table below, "Envision Hospice of Washington, LLC Payer Mix, Percent" indicates the estimated percentage payer mix for the proposed project. The percentages are not expected to change over time.

Please note that Envision Hospice's proforma revenue and expense include a "charity care" line item. For accounting reasons, these amounts are not reflected in the table below.

Envision Hospice of Washington, LLC Payer Mix
Percent

Payer	Percent
Medicare & Medicare Managed Care	85%
Medicaid	10%
Commercial, TriCare, private etc.	5%
Total	**100%**

Envision's observations and assumptions underlying these estimates include:

- Hospice payer mix in Utah
- Better hospice coverage by Medicaid and commercial payers in Washington than in Utah
- Home health payer mix in Utah and Washington
- Lower contractual allowance for Medicaid hospice payments in Washington
- Plan for outreach to disabled and elderly in adult family homes, assisted living and nursing homes
- Rapid growth of elderly population with Medicare relative to younger population with commercial coverage.

11. If applicant is an existing provider of health care services, provide expense and revenue statements for the last three full years.

Please see Appendix Q.

12. If applicant is an existing provider of health care services, provide cash flow statements for the last three full years.

Please see Appendix Q.

13. If applicant is an existing provider of health care services, provide balance sheets detailing the assets, liabilities, and net worth of facility for the last three full fiscal years.

Please see Appendix Q.

14. For existing providers, provide actual costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.

Envision's Thurston County hospice has not initiated patient care as of the date of this application. Accordingly, it cannot provide actual costs and charges per visit as requested. Please see the response to Question 15 below for further explanation.

15. Provide anticipated costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.

Charges for Medicare-certified hospice are set nationally by Medicare; these are based on fixed rates per day depending on the local cost of labor, the hospice patient's setting of care each day and the patient's current length of stay. Of the fixed rates, only one is based on a visit by a specific discipline: The CMS 2019 rate in Snohomish County for Continuous Care during a hospice home visit will be $46.28 per hour.

No other costs nor charges per visit are calculated by Medicare-certified hospices. If the Department of Health prefers a certain methodology of allocating indirect expenses to types of patient visits and can provide that methodology to the applicant, such calculations can be undertaken.

16. Indicate the addition or reduction of FTEs with the salaries, wages, employee benefits for each FTE affected, for the first three years of operation. Please list each discipline separately.

Please see Appendix J Assumptions table for Staffing Input-FTE's that provides FTE's, salaries and wages by job title/discipline for the first three full years of operation.

17. Please describe how the project will cover the costs of operation until Medicare reimbursement is received. Provide documentation of sufficient reserves.

Envision Hospice of Washington, LLC has identified the costs of initial development and startup of the Snohomish County hospice. Sufficient working capital will be provided by the LLC members to cover the costs of operation until Medicare reimbursement is received.

Please see Appendix P for a letter from Rhett Anderson, Chief Financial Officer, committing sufficient LLC funds to the working capital required.

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

1. Please provide the current and projected number of employees for the proposed project, using the following:

	Current FTE		Year 1		Year 2		Year 3	
Staff	FTE	Contracted	FTE	Contracted	FTE	Contracted	FTE	Contracted
RN								
LPN								
Hospice Aide								

NURSING TOTAL								
Admin								
Medical Director								
DNS								
Business/Clerical								
ADMIN. TOTAL								
PT								
OT								
Speech Therapist								
Med Social Work								
Pastoral / Other Counselor								
Volunteers								
Other (specify):								
ALL OTHERS TOTAL								
TOTAL STAFFING								

Please see Appendix J, "Assumptions, Staffing Input – FTE's" for the information regarding projected numbers of staff requested in the table above.

2. Please provide your staff to patient ratio.

Type of Staff	Staff / Patient Ratio
Skilled Nursing (RN & LPN)	1:10
Physical Therapist	Contracted per visit
Occupational Therapist	Contracted per visit
Medical Social Worker	Initially combined with Volunteer Coord. Then 1:35
Speech Therapist	Contracted per visit
Home Health / Hospice Aide	1:10
Other (list)	
Spiritual counselor	Combined position with Bereavement at start up.
Total	

These ratios apply to Envision's employed clinical staffing from the outset, with these exceptions. In year one, 2020:

- Bereavement will be performed by the Spiritual Counselor.
- Volunteer Coordinator will be performed by the MSW.
- QAPI will be performed by the Administrator.
- Manager of Patient Services will be performed by the Administrator until mid 2020.

More generally, members of the Envision administrative and patient care

teams work flexibly with each other to meet patient care needs. Envision's Patient Care Manager and the RN's who fill administrative positions such as QAPI and Administrator are all qualified and prepared to provide direct patient care. Thus, the team is readily able to respond to patient needs when the growing agency experiences peaks in census.

For further staffing detail, please see the Staffing Input – FTE's in the Assumptions section of Appendix J.

3. Explain how this ratio compares with other national or state standards of care and existing providers for similar services in the proposed service area.

   These ratios correspond to national averages as published by the National Hospice and Palliative Care Organization.

4. Identify and document the availability of sufficient numbers of qualified health manpower and management personnel. If the staff availability is a problem, describe the manner in which the problem will be addressed.

   Based on its very successful staffing of Envision's rapidly growing King & Pierce County Medicare home health agency - Envision Hospice of Washington, LLC expects no problems with availability of qualified health manpower and management personnel.

   DOH seeks assurance a CON applicant will successfully staff the proposed project. Accordingly, CON staff frequently seeks additional information about an applicant's experience and plans for staff recruitment and retention.

   Please see Appendix R for Envision's more detailed responses to this concern, including:

   - discussion on the process Envision has used in the past to recruit and retain necessary staff for its home health and hospice agencies
   - discussion on the process Envision intends to use to recruit and retain necessary staff for this Snohomish County project
   - discussion on the process Envision intends to use to recruit and retain necessary staff for the Snohomish County and King County projects if both are approved.

   Recognizing that volunteers are an integral part of hospice, Envision also provides Appendix S, its plan for volunteer recruitment for the Snohomish County hospice.

5. Please identify the number of providers and specialties represented on the interdisciplinary team.

The most recent Medicare Hospice Conditions of Participation state:

The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).

(ii) A registered nurse.

(iii) A social worker.

(iv) A pastoral or other counselor.

Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.

Note: The term "interdisciplinary team" is interchangeable with "interdisciplinary group" here.

Credentials of interdisciplinary team members:

Currently, the only member of the interdisciplinary team that is confirmed is Susan Pearson, DO, PhD. Dr. Pearson will be the Envision Hospice of Washington Medical Director. Her Washington medical license number is: OP60698789

Please see Dr. Pearson's outstanding record in the provision and administration of hospice and palliative care at Appendix C.

6. Please identify, and provide copies of (if applicable) the inservice training plan for staff. (Components of the training plan should include continuing education, home health aide training to meet Medicare criteria, etc.).

Please see Appendix T for copies of the in-service training policies and plan for Envision Hospice of Washington, LLC staff including continuing education and training to meet Medicare criteria.

Additional training components that will reflect service to identified special populations includes:

- Cultural competence including Latino and Spanish-speaking outreach including Diversity Toolbox and NHPCO Latino outreach materials
- Veterans outreach "We Honor Veterans" program training
- Palliative care training corresponding to accreditation specialty
- Understanding "Death with Dignity" law and Envision policies
- Specialized clinical training addressing care of Alzheimer's and dementia patients and caregivers
- Optimizing use of tele-medicine

7. Describe your methods for assessing customer satisfaction and quality improvement.

Envision Hospice of Washington, LLC's methods for assessing customer satisfaction and quality improvement are being put in place for its new Thurston County hospice agency and will be applicable to the Snohomish County hospice as well:

- To assess customer satisfaction for the Snohomish County hospice, Envision Hospice of Washington, LLC will contract with one of the CMS-approved vendors of customer satisfaction surveys which is CMS-certified and works collaboratively with the National Hospice and Palliative Care Organization to establish national norms. This approach allows a hospice to compare itself to others and identify and prioritize benchmark approaches for areas needing improvement.

- Starting with FY 2016-2017, CMS required all Medicare hospices to submit required data needed for a new nation-wide program of hospice quality improvement. Envision Hospice of Washington, LLC will comply with all CMS requirements including training staff in the required submitting all required data.

- Initially the Envision Hospice of Washington, LLC QAPI program will be coordinated by the Manager of Clinical Services. As the new hospice grows larger, it will employ a dedicated RN in the role of Quality and Process Improvement Coordinator.

8. Identify your intended hours of operation. In addition, please explain how patients will have access to services outside the intended hours of operation.

The office hours will be 8 a.m. to 5 p.m. Monday through Fridays.

At all other times, Envision will have paid staff on call and accessible by telephone via a phone call to a main number.

Envision Hospice patients who elect to participate in its tele-medicine option will have 24/7 access through their own dedicated electronic tele-medicine device.

9. Identify and document the relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.

Vendors
Please see Appendix U for a list of proposed vendors. This list is based heavily on vendor relationships already in place for Envision Home Health of Washington in King and Pierce Counties.

Inpatient contractors
For General Inpatient Care and for Respite Care, the proposed hospice will develop contracts with one or more local facilities.

General Inpatient Care
For Snohomish County, Envision will initiate relationships on approval of its Snohomish County CON and anticipates developing "general inpatient care" contracts with local hospitals that serve the area. In particular, Envision expects to develop GIP contracts with

- any Snohomish County hospitals whose physicians and discharge planners refer patients to Envision Hospice and with
- Puget Sound regional referral hospitals that refer Snohomish residents to Envision Hospice

Respite Care
Respite care is typically provided in skilled nursing facility or nursing home beds. In Snohomish County, Envision does has not yet initiated contracts with Snohomish County nursing facilities for respite care. On receipt of a Snohomish County Certificate of Need, Envision will reach out to local nursing facilities to determine the best option for contracting for respite care for Snohomish County hospice patients.

In-home care for nursing home residents
In addition to arranging for General Inpatient Care and Respite Care, Envision will also make arrangements with area nursing homes so that long term residents, for whom the facility is home, are able to receive routine in-home hospice services there.

Criteria for selection
In selecting inpatient providers with which to contract, Envision will apply the following criteria:

Of the potential hospital contracts available, Envision believes each provides high quality care. Envision plans to contract with each facility willing to do so. Criteria for contracting and referral of specific patients will include:

a) availability of inpatient hospice beds appropriate to GIP admissions (i.e., least restrictive environment and/or availability of a home-like setting
b) availability of appropriate clinical resources and beds for Envision's patients
c) relative geographic access of the facility for the patient's primary care team and/or potential visitors.

d) availability of a palliative care in-patient team or a hospitalist team that includes individuals with palliative care expertise.

e) compatibility with Envision's adopted policies honoring a patient's End of Life choices

f) cost containment

Respite Care

a) availability of inpatient hospice beds appropriate to "respite care"

b) availability of clinical resources needed for Envision's patients

c) relative geographic access for the patient's primary care team and/or potential visitors.

d) compatibility with Envision's adopted policies honoring a patient's End of Life choices

e) cost containment

f) availability of a home-like setting

g) nursing facilities already contracting with Envision for it to provide in-home hospice visits to its long-term care residents

10. Explain the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.

It is in the very nature of the Medicare-certified hospice benefit to assure continuity and to avoid unwarranted fragmentation. The core purpose of the inter disciplinary hospice team is to develop the patient's plan of care and to manage the care on a daily basis to support the individual patient's needs. In particular, the per diem payment to the hospice for all services puts the control of the full range of care in the hands of that core team.

One key to effective continuity is to admit patients to hospice as early as appropriate during the course of illness. Waiting until the last week or two of life substantially reduces the ability of the team to plan ahead, to address bereavement issues early, to manage pain effectively, etc. Envision Hospice is committed to community education in support of earlier admission to hospice when needed**.** Its relationship to Envision Physician Services, which can provide regular medical care to residents of assisted living facilities and adult family homes, will increase the potential of earlier identification of persons eligible for hospice**.**

As part of its Latino outreach program, Envision plans to develop working relationship with organization such as Molina, Sea Mar and others that frequently address the needs of minority communities.

Envision Hospice of Washington, LLC is committed to Snohomish County residents' having desired control over their own health care choices. The majority vote by Washington residents for the "death with dignity" statewide ballot measure indicates this is an important value to the community. Envision Hospice of Washington, LLC intends to include in its network providers who will actively support patients pursuing their "death with dignity" options as available under Washington law. As part of this effort, Envision Hospice will continue to reach out to End of Life for their advice and support in locating needed resources.

11. Fully describe any history of the applicant entity and principles in Washington with respect to criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. If there is such history, provide clear, cogent, and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.

    There is no such history.

12. List the licenses and/or credentials held by the applicant(s) and principles in Washington, as well as other states, if applicable. Include any applicable license numbers.

    Please see Appendix V for a copy of Envision Home Health of Washington, LLC license to provide in home health care in Washington.

    Envision Home Health of Washington LLC members with professional licenses:

Name	Specialty	Number	State
Greg Atwood	Registered Nurse	#225342-3102	UT
Wyatt Cloward	Occupational Therapist	#326118-4201	UT
Jason Crump	Physical Therapist	#322503-2401	UT
Chad Fullmer	Physical Therapist	#4877705-2401 #PT 00010369	UT WA
Darin McSpadden	Occupational Therapist	#336131-4201	UT
Sherie Stewart	Certified Social Worker	#276030-3502	UT
Derek White	Physical Therapist	#346435-2401	UT

13. Provide the background experience and qualifications of the applicant(s).

The members of Envision Hospice of Washington, LLC also operate home health and hospice agencies elsewhere as Envision Home Health & Hospice, LLC, as shown at Appendix B. As a group of health care professionals, these members are trained in and have practiced in a variety of health care disciplines as shown in the response to Question 12 above. The clinical training and professional experience of these members provides a core set of values that acknowledges the need for patient-centered care. It also reflects the hands-on background of these members and their ability to grasp the vulnerability of each patient when a caregiver comes into the intimacy of the patient's home environment.

In June 2015, Envision Home Health of Washington LLC received Medicare certification for its new home health agency in King County. An expansion to serve Pierce County received Certificate of Need approval in January 2018. The diverse and energetic staff recruited by Envision to operate this agency has grown it rapidly; it is already on track to provide over 20,000 visits in 2019.

With the same members as Envision Home Health and Hospice in Utah and Envision Home Health of Washington, Envision Hospice of Washington, LLC possesses the clinical and management knowledge to successfully establish a hospice in Snohomish County. By late 2019, when the Snohomish County hospice Certificate of Need decision is due, Envision's Thurston County hospice will be fully operational. Building on the Thurston hospice, Envision's leadership will develop a local Snohomish County team responsible for supporting implementation of the new hospice in accordance with rules and law for the establishment and operations of hospices in Washington.

14. For existing agencies, provide copies of the last three licensure surveys as appropriate evidence that services will be provided (a) in a manner that ensures safe and adequate care, and (b) in accordance with applicable federal and state laws, rules, and regulations.

Envision Hospice of Washington, LLC is not yet an existing provider under the Medicare hospice benefit. Envision's Thurston County hospice received its Certificate of Need in September 2018. .

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

1. Identify the exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, joint ventures, subcontracting, merger, contract services, and different methods of service provision, including different spacial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:

- Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.):*

- Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision-making criteria;

- Capital costs;

- Staffing impact.

The alternatives Envision Hospice of Washington, LLC considered in developing this proposed project included:

- Acquisition vs. start-up
- Postponing action
- No action

The decision-making criteria were:

- Acquisition availability
- Financial feasibility
- Conformance with strategic plan

The advantages and disadvantages identified in deciding to pursue a Certificate of Need now include:

Acquisition available:
No existing hospices were found available for acquisition at this time. It is unlikely one will be available in the near future, but it was determined that area residents should not have to wait to have additional and needed access to hospice care.

Financial feasibility:
Due to the size of the underserved population in Snohomish County, along with the Envision Hospice of Washington, LLC members' extensive experience in hospice development and operation, the new hospice can confidently project steady growth and positive financial results.

Conformance with business plan
The project responds directly to one of the major goals of Envision Hospice of Washington, LLC members.

Capital costs:
Envision Hospice of Washington, LLC has sufficient capital available to support the establishment and start up period of the new Snohomish County hospice. The pro forma revenue and expense statement shows that the initial investment will be recouped within a reasonable time.

Staffing impact:
Acquisition or start up would have the same staffing impact.

Summary: Considering the alternatives available in light of the criteria above, the advantages and disadvantages taken together make it clear that establishment of a new hospice agency now is the preferred alternative.

2. Describe how the proposal will comply with the Medicare conditions of participation, without exceeding the costs caps.

   In operating Medicare hospice in five counties in Utah, the Envision Hospice of Washington, LLC members have experienced no issues regarding compliance with Medicare cost caps. Furthermore, 2017 revisions to CMS payment formulas for hospice care reduce further any potential for exceeding Medicare cost caps.

3. Describe the specific ways in which the project will promote staff or system efficiency or productivity.

   Health care system efficiency is embedded in the hospice concept. Patients who no longer wish to undergo curative treatment have the opportunity to substitute palliative and comfort care for the remaining course of their illnesses. This means the resources expended are more appropriate to the patient and family's goals.

   The avoidance of ICU admissions of terminally ill patients who do not wish to die in a hospital is an example of the cost efficiency of this approach.

   Comprehensive hospice care is covered by a per diem payment across care settings. Coordination of the multi-disciplinary care by the hospice team also fosters system efficiency by providing the right care at the right time. This reduces expensive duplication and unnecessary re-work typical of other parts of the health care system.

   Hospice fosters staff efficiency in the health care system by allocating scarce RN resources to those who need that level of care. Instead of a patient's requiring 1:1 or 1:2 RN staffing for 3 shifts a day in a hospital ICU, the patient is at home with sufficient personal care and nursing resources to provide necessary palliative and comfort care.

4. If applicable, in the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.

Not applicable, the project does not involve any construction.

5. If applicable, in the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.

   Not applicable, the project does not involve any construction.

Envision Goals for Additional Snohomish County Hospice Services and Benefits

Program Detail

Goal 1: Respond with focused capabilities to specific clinical groups with special needs, in particular:

A. Patients with Alzheimer's or other dementias and their caregivers

B. Support to "pre-hospice" patients with advanced care planning & palliative care

Goal 2: Making hospice care as accessible as possible in the broadest array of settings including:

A. Telemedicine at home

B. Assisted living facilities

C. Adult family homes

D. Nursing homes

Goal 3: Respond to specific cultural and demographic groups with appropriate and relevant communications and care with programming emphasis on:

A. Veterans

B. Latinos and Spanish-speaking residents

Goal 4: Reducing suffering through availability of:

A. Excellence in palliative care

B. "Your Hand in Mine"

C. Death with Dignity

Goal 1A: Specialty Program for Patients with End Stage Alzheimer's and Dementia

Approximately 5.5 million Americans have Alzheimer's dementia in 2017 and of the people who have Alzheimer's dementia, 82% are age 75 or older. The anticipated rise in Americans living with Alzheimer's by 2050 could be as high as 16 million. Specifically, in the State of Washington, the percentage change in the number of Americans age 65 and older with Alzheimer's dementia is projected to be over 27%.

In regard to hospice, 16.5% of patients have a principal diagnosis of dementia. Dementia is the third top principle diagnosis after cancer and cardiac; and more hospice patients will have secondary diagnoses of dementia. One in three seniors die with Alzheimer's or another dementia. Dementia disease kill more than breast cancer and prostate cancer combined and it may cause even more deaths than official sources recognize. Furthermore, since the year of 2000, deaths from heart disease (the leading cause of death) have decreased by 14% while deaths from Alzheimer's disease have increased by 89%.

The cost to the nation in 2017 was estimated at $259 billion and alarmingly by 2050 these costs could rise as high as $1.1 trillion. Other health costs that are difficult to measure is the physical decline of the family member or other caregivers caring for people with Alzheimer's or another dementia. 35% of caregivers for people with Alzheimer's or another dementia report that their health has gotten worse due to care responsibilities, compared to 19% of caregivers for older people without dementia.

Hence, due to the anticipated growing needs and financial impact on Medicare costs, Envision Hospice will provide a specialized care program for patients with Alzheimer's and Dementia that sets us apart. Components of this program include:

- Patient and family centered care –
    - Recognize the patient and family as the unit of care.
    - Coordinated care planning includes bereavement needs, interventions, goals and outcomes for both the patient and family.
    - Expectation that care provided conveys respect and dignity that is responsive to the needs of the patient and family.
    - Assessments include acknowledging the individuality, culture, capacity, and abilities of each patient and family.
- Ethical behavior and consumer rights –
    - Education to the patient/family about the dementia disease process to ensure informed consent regarding treatment decisions and care planning
    - Expectation that staff ascertain and honor the wishes, preference, concerns, priorities and values of patients and their families consistent with local laws, regulations, and the organization's values and policies.
    - Ethical committee established to review policies and procedures.

- Clinical excellence and safety –
    - Follows evidence-based Alzheimer's Association Dementia Care Practice Recommendations.
    - Dementia specific care practices may include:
        - Aromatherapy
        - Music therapy
        - Therapeutic touch
        - Advanced feeding techniques
        - Pre-death bereavement support for families and caregivers
        - Other specific evidenced base interventions for dementia care
    - Understanding and assessing pain in patients who can't communicate verbally.
    - Case review with Hospice Medical Director to distinguish dementia from similar symptoms of delirium which may be reversible.
- Inclusion and access –
    - Dementia specific admission criteria are continuously reviewed to ensure best practices are followed (FAST scoring, etc.).
    - Collaboration with Alzheimer Association for patient and family resources.
    - Inclusiveness is assured so that all individuals have access to hospice programs and services regardless of disease or other characteristics.
- Organizational excellence –
    - Organizational leaders will complete Alzheimer Association's Certification Program and ensure services provided are appropriate.
    - Marketing materials describe services available for all patients regardless of diagnosis or disease.
    - Organizational leaders are expected to build and sustain a culture of quality and accountability that values collaboration and ensures ethical business and clinical practices.
    - Follows NHPCO Standards of Practice for Hospice Programs
- Workforce excellence –
    - Interdisciplinary team members have dementia specific training that addresses the following needs by utilizing the Alzheimer's Association essentials training:
        - Physical

        - Emotional
        - Spiritual
        - Grief and bereavement issues.
    - Interdisciplinary team members demonstrate dementia specific competence in?
        - Assessment of prognosis/terminality
        - Documentation of prognosis/terminality
        - Care planning for Alzheimer's and dementia
        - Care interventions for people with Alzheimer's and dementia
        - Evaluation of dementia specific care outcomes.

- Performance measurement for Alzheimer's and dementia specialty program includes –
    - Collecting, analyzing, and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.
    - Collecting performance and outcome data related to patient care.
    - Participating in the collection of hospice comparison data as a means to determine areas for improvement.

Goal 1B: Pre-hospice and Advanced Care Planning

Many persons who face a terminal illness and are eligible for hospice care do not choose it. A combination of regulatory, reimbursement and cultural barriers stand in the way. These barriers result in there being a substantial unmet need that is not filled by the hospice benefit. Among those are three that Envision Hospice plans to address in Snohomish County:

- Many are not aware of hospice or that their specific terminal illness makes them eligible.
- Many are aware of hospice but are uncomfortable with the Medicare hospice requirement to forego curative treatment.
- Many are not involved enough in their own care planning and direction to make a decision either way.

Palliative care - reducing suffering through treatment of pain and discomfort - has always been a cornerstone of hospice care. But the clinical skills available through hospice care are now becoming more widely available throughout the health care system. Over the last twenty years, health care providers including hospitals and physicians have taken the challenge to address their patients' need for palliative care regardless of their stage of illness.

Gradually, hospice organizations have also begun providing palliative care to terminally ill persons outside the hospice benefit. This trend has grown and, nationally, NHPCO reports that a majority of hospice agencies respond to this unmet need by offering "pre-hospice" or palliative care to non-hospice enrollees. The greatest barrier to a broader offering is the lack of reimbursement for these services and the lack of agency knowledge about billing for services outside the Medicare hospice benefit.

The typical setting for "pre-hospice" palliative care is the home or hospital.

Envision's plan to offer its services in a broad array of settings will afford the opportunity to offer "pre-hospice" in patients' homes. Physicians, nurse practitioners and social workers with Envision's hospice or with Envision Physician Group[5] will be able provide services in retirement home, assisted living, adult family home and nursing home settings. Upon start-up, Envision will assess the need in Snohomish County and tailor its services; among those:

- Advanced Care Planning, assistance with determining goals of care
- Pain and symptom management
- End-stage disease management
- Palliative care consultation
- Support and bereavement services to patients and families.

[5] Hospice agencies can choose between offering these services directly through their Medicare agency or through establishment of a separate billing entity.

Hospitals are another location for “pre-hospice” or palliative care provided by the hospice but outside the hospice benefit. As an example, a palliative care consultation by a hospice agency’s palliative care specialist can benefit patients during their hospital stay at a hospital that does not have its own palliative care team or palliative care specialist on its hospitalist team. Such a patient with terminal illness may even elect hospice enrollment, be referred to a hospice and continue his or her hospital stay as a GIP (General Inpatient) patient of the hospice.

Envision is committed to working with local providers to help fill this gap in the health care system. Each community will be different and require that Envision leaders and clinicians practice good communication, coordination, and collaboration with other providers. The specific services Envision can offer will be determined as it learns more about the programs that already exist in Snohomish County.

Goal 2A: Tele-medicine at home

Envision Hospice of Washington will include tele-medicine services as an adjunct to its in-home hospice visits. For patients and their care-givers who have access to Wi-Fi or cellular data in their homes, Envision will offer an electronic tablet to be used to communicate as needed with hospice staff or patients and their care-givers can use their own device.

By using video conferencing technology, an Envision hospice patient will have the ability to call his or her nurse directly and connect face to face with the press of a single button on an electronic tablet. This technology and service permits Envision to connect with and care for hospice patients remotely. Patients and their care-givers may also use a desktop application to connect face to face.

Benefits include:

- Improving response time and reducing hospitalizations – after-hours calls or unscheduled needs can get immediate real-time assessment and education from qualified clinicians that can assist in preventing unnecessary hospitalizations and decrease patient and family anxiety.
- Accurately prioritizing patients – know who needs help now and what kind of help each needs (clinical, behavioral, spiritual) via remote contact.
- Using resources efficiently – reduce windshield time of clinicians' driving by intervening with the right resource (MD, NP, RN, MSW, Spiritual Counselor) the first time, remotely or in person.
- Improving patient care and outcomes – increase patient and family confidence, reduce stress, and improve family satisfaction with care plans and better care team coordination.
- Expanding geographic reach – better serve remote and rural populations with secure video conferencing.
- Proving program value – thru measurable hypotheses based on the above benefits, Envision will collect, aggregate and report on program results to document benefits to patients, to deliver critical metrics for Envision's QAPI (Quality Assurance and Process Improvement), and potentially seek grants or other funding for further program development.

The simplicity of the connection via the electronic tablet in the hospice patient's home - as well as the application being device agnostic - makes Envision Hospice of Washington's tele-medicine project a differentiating factor in its delivery of available, accessible and cost-effective hospice and palliative care.

Snohomish County has 2,845 assisted living/boarding home licensed beds in 43 assisted living facilities in Snohomish County

When a Snohomish County resident moves to an assisted living facility, that becomes the person's home These facilities provide an intermediate level of care for people who need assistance with their daily activities but wish to remain as independent as possible for as long as possible.

When a resident of an assisted living facility requires more care than can be provided by the facility he or she may require admission to a hospital or nursing home. But more and more services can be brought to the assisted living facility including hospice.

Envision has extensive experience providing hospice services, in concert with the staff at assisted living facilities, to the residents with terminal illness. Just as care is provided to residents in their own homes, hospice care is also provided in assisted living facilities.

Envision's affiliated mobile medical clinics operated as Envision Physician Services, provides regular medical care using the services of contracted physicians and ARNP's. These services are designed for the resident who has difficulty making the trip to the doctor's office and are billed as regular "physician visit." These mobile clinic services in Snohomish County assisted living facilities will be able to offer Advanced Care Planning and pre-hospice palliative care to residents who have not yet made the decision to enter hospice.

Once a resident selects hospice care, the resident may be able to remain in the facility during their last months of life instead of transferring to a facility with a more intense level of care. Envision's affiliated hospice, serving five counties in Utah has extensive experience providing hospice care in ALF's. Envision and the ALF staffs work closely together to provide the best possible care for the ALF resident. Good communication between the family, the assisted living staff, hospice staff and paid caregivers (if they are involved) can make all the difference in the hospice experience.

Goal 2C: Serving residents of Adult Family Homes

The Washington Department of Health reports active licenses for 493 Adult Family Homes in Snohomish County. Department inventory shows the licensed beds in the county total 2756. Residential Care Services, the agency that regulates these homes, reports that 70% of the adult family home residents are over age 65. Assuming an occupancy rate of 80% overall, this means over 2,205 vulnerable persons ages 65 and over lived in these facilities in Snohomish County in 2018.

If one adopts the very conservative assumption that the death rate among this vulnerable population matches that of Snohomish County's population over age 65, then 4%, or 88 of those residents over age 65, will die in 2020.

Through planned outreach to Snohomish County adult family homes, Envision Hospice of Washington will provide additional information about hospice and its benefits to both patients and to the managers and caregivers of those facilities. Since a very large number of adult family home residents are living with dementia, this outreach also corresponds to Envision of Washington's specialized program for hospice patients with Alzheimer's or other forms of dementia.

Goal 2D: Serving residents of Nursing Homes

The Washington Department of Health's latest data show that 1,676 persons died in Snohomish County nursing homes out of a total of 4,958 county deaths for the year. This means 39% , or over a third, of all 2015 Snohomish County deaths occurred in nursing homes. Yet, only 10% of the 2016 deaths by patients of hospices that serve Snohomish County took place in nursing homes. This comparison suggests there is substantial unmet need for hospice care among Snohomish County nursing home residents.

Envision Hospice of Washington will reach out to Snohomish County nursing homes with the goal of developing formal agreements with them to offer hospice care to their long-term residents. Under those arrangements, Envision hospice team members work closely with the nursing home staff to augment and support the care being provided.

In light of the great number of nursing home residents that suffer from Alzheimer's disease and other dementias, the nursing home resident population will be a focus of Envision's plan to provide specialized care and comfort to that clinical group and their families. Studies have shown that having hospice staff visit nursing home residents results in nursing home staff more quickly recognizing the need for hospice among more of their patients. Additionally, the Envision emphasis on expertise in palliative care will benefit not only its own hospice patients but will influence nursing home staff's awareness of pain management strategies for their other patients.

Goal 3A: Specialized services for Veterans

Nearly 1 in 4 deaths today is that of a veteran. Envision's hospice experience includes service to many veterans and their families.

Envision Hospice of Washington will adopt a focus on the veteran population of Snohomish County and is committed to providing compassionate care to terminally ill veterans and their families. The service and sacrifices that many veterans made results in trauma that shapes their needs at the end of life. Our services and capabilities tailored to veterans will include:

Training

Envision Hospice of Washington LLC will participate in "We Honor Veterans," an organized program developed by the National Hospice and Palliative Care Organization in collaboration with the Department of Veterans Affairs to improve the quality of care for US military veterans.

"We Honor Veterans" involves education and training to recognize the unique needs of veterans and their families. As part of the program Envision Hospice staff will receive training regarding the needs of veterans based on where and when they served, to better tailor services and understand the unique circumstances of each conflict and generation.

Training will address the difficult circumstances faced by some veterans near the end of life, including financial and benefit concerns, post-traumatic stress disorder, unresolved issues associated with the stresses of military service, depression and suicide.

Volunteer program

As part of its special services for veterans, Envision Hospice will develop a veteran-to-veteran volunteer program for both hospice outreach and information and for in home visits for veterans who are hospice patients whether they live in assisted living, adult family home or nursing home. Volunteer Program will include additional training for veteran services and we will recruit veterans as hospice volunteers.

Veteran outreach

Outreach and education to veteran groups and community providers to increase awareness and earlier access to hospice care for veterans.

Veterans Administration

Familiarity with the VA system and how to identify and access benefit options for veterans. Coverage of hospice care for veterans by the VA, TRICARE, Medicare, Medicaid, private insurance and other forms of reimbursement. Coordination of care with the staff of the local VA medical center, including joint visits when appropriate.

Bereavement and recognition

A full range of bereavement support, including grief and loss programs, support groups and memorial services for veterans' loved ones. Recognition and celebration of important events, including holidays such as Veteran's Day and military anniversaries.

Goal 3B: Latino Outreach

For cultural and ethnic minorities, language is a key barrier to optimum hospice care but not the only one. Cultural norms and traditions surrounding illness, death, and dying are major factors in outreach and care. In setting goals for cultural competence, Envision Hospice of Washington determined that a focused effort on a cultural group with large numbers in Snohomish County will be the most effective use of resources. It examined Snohomish County demographics, census information and hospice utilization. Envision Hospice concluded that the large size, cultural differences, and increasing diversity of the Snohomish County Latino population merits a program of special emphasis and resources in Envision hospice outreach and care.

Fortunately, the National Hospice and Palliative Care Organization has developed useful materials for guiding the development of such a program. But, rather than just adopt such a national model, Envision Hospice is involving existing Latino staff at its affiliated Snohomish County home health agency to advise it in tailoring the NHPCO recommendations to Snohomish County residents.

Envision recognizes the Department's interest in using the Certificate of Need Program and its decisions to expand hospice use among Washington's underserved groups. Its tiebreakers for concurrent review clearly call for applicants to

- identify groups in need in the selected service area
- quantify that need and
- describe their plans and resources to effectively meet that need.

In setting goals for cultural competence, Envision Hospice of Washington determined that a focused effort on a cultural group with large numbers in Snohomish County will be the most effective use of resources and have the potential to have the greatest impact. It examined Snohomish County demographics, census information and hospice utilization.

The table below is based on "Table 2 of OFM's series "Estimates of April 1 Population by Race and Hispanic Origin, 2016." It shows 2016 Snohomish population by race and Hispanic origin. Envision's additional analysis of it provides the percentage of each group as a portion of the total Snohomish County population.

A table of this type is required since census-identified minority groups can be distinguished by either race, by cultural/language minority, or by both. This combined table allowed Envision to consider where its minority outreach efforts might result in the most impact on hospice utilization and end of life experiences in Snohomish County

Looking at this data along with other sources, Envision Hospice concluded that the large size of the Snohomish County Hispanic population merits a program of special emphasis and resources in Envision hospice outreach and care. At 10.3% of the Snohomish population, the Hispanic population is the largest of the minority race and ethnic groups with the Asian being second largest at 10.2%.

Table 2. Population by Race and Hispanic Origin
Washington State Office of Financial Management, Forecasting and Research Division

	OFM 2017 Estimate								
		----------Non-Hispanic ----------							
	Total	**Total Non-Hispanic**	**White**	**Black**	**AIAN**	**Asian**	**NHOPI**	**Two or More Races**	**Total Hispanic**
Snohomish #	789,400	707,787	558,795	21,557	9,029	80,437	4,009	33,960	81,613
Snohomish %	100.0%	89.7%	70.8%	2.7%	1.1%	10.2%	0.5%	4.3%	10.3%

The chart on the following page further points out the thousands of Snohomish County Spanish-speaking residents whose use of health care services can be hindered by language preference and use. While these statistics helped Envision chose its outreach priority based on race and language, they only begin to speak to the cultural differences its efforts must also address.

Fortunately, the National Hospice and Palliative Care Organization has developed useful materials for guiding the development of such a program. But, rather than just adopt such a national model, Envision Hospice involved existing Latino staff at its affiliated Snohomish County home health agency to advise it in tailoring the NHPCO recommendations to Snohomish County residents.

Both Envision's Latino staff in Snohomish County and NHPCO guidance emphasized a central theme:

"Build trust and develop plans together before acting on Latino outreach."

The outline below reflects Envision's plans to understand and build relationships with the goal of providing appropriate care that emphasizes the dignity of each person:

1. Research the geographic and national origin of Snohomish County Spanish-speakers. While the majority of Washington's Latino population of nearly a million persons is Mexican by heritage, Central America is a growing source.

2. Recruit Spanish-speaking outreach staff and/or volunteers to assist in building initial relationships and trust. Incorporate Latino volunteers into Envision's ongoing corps of volunteers.

3. Interview local Latino leaders and hold focus groups in a learning mode. Explore interest in and create an advisory committee to guide planning and receive progress reports.

4. Interview local Latino leaders and hold focus groups in a learning mode. Explore interest in and create an advisory committee to guide planning and receive progress reports.

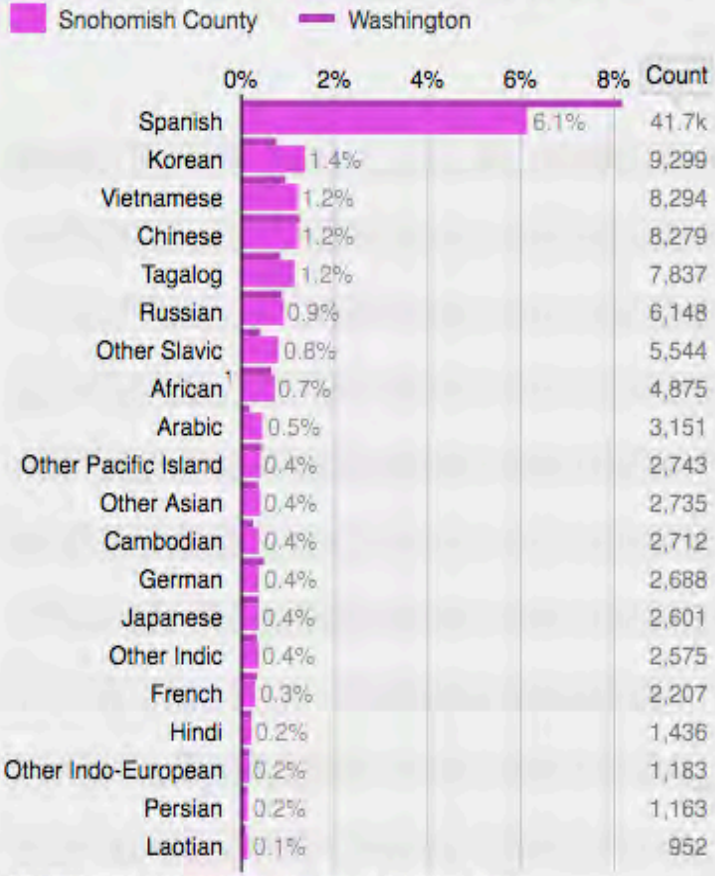
Languages in Snohomish County, Washington (County)

Language Spoken At Home

#1

Percentage of the total population living in households in which a given language is spoken at home.

Scope: population of Washington and Snohomish County



Count *number of people speaking given language at home*

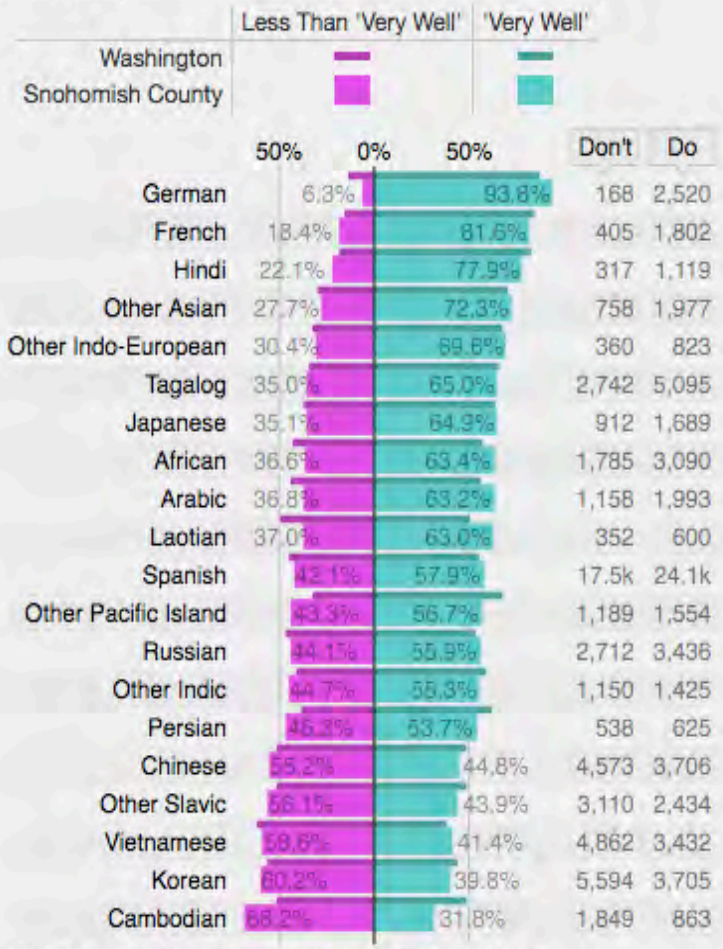
[1] *Amharic, Ibo, Twi, Yoruba, Bantu, Swahili, Somali*

Speaking English 'Very Well'

#2

Percentage of people living in households in which a given language is spoken at home.

Scope: population of Washington and Snohomish County



Don't *number of people that don't speak English 'very well'*

Do *number of people that do speak English 'very well'*

5. Provide cultural competence training to all Envision staff. Emphasize the importance of non-verbal communication for non-Spanish speakers.

6. Connect with other providers that serve Latinos and learn from them.

7. Based on what is learned, develop appropriate print material and media plan, e.g. use of Spanish-speaking radio or TV, social media, etc.

8. Building on relationships and advice, plan detailed outreach plan tailored to Latino community values and cultural norms. Prioritize groups for connections, e.g., churches, ESL classes, Latino providers, etc.

9. As a learning organization, seek feedback from Envision's Latino hospice patients and adjust outreach materials and approaches as needed.

10. Provide progress reports to Latino leadership and advisors, inviting suggestions for continual improvement.

Goal 4A: Distinction in Palliative Care

Palliative medicine provides patients with relief from the symptoms, pain and stress of a serious illness. It is appropriate for patients suffering from any diagnosis; it can be provided along with curative treatment or to a patient that has elected hospice. Palliative care is provided by a team of doctors, nurses and other specialists who work with a patient's primary care physician and specialists to provide an extra layer of support. Both palliative care and hospice address the wide range of quality of life issues. In particular, hospice is palliative medicine for patients for whom curative care is no longer viable and who have a prognosis of six months or less to live.

While there is a movement among hospitals and outpatient clinics to offer palliative care more broadly to patients, it has always been a cornerstone of hospice care. Any hospice team must have training and experience in pain and symptom management.

Envision Hospice of Washington will seek accreditation by ACHC as part of its Medicare-certification process. Additionally, Envision Hospice will meet the standards for and apply for ACHC's hospice "Distinction in Palliative Care." ACHC reports that only one other hospice in Washington has achieved this distinction. Please see Appendix W for the ACHC standards for achieving this level of palliative care recognition.

Of particular interest are standards that relate to other Envision goals, e.g.,

- Written policies and procedures describe the mechanisms the palliative care program uses to provide care for patient/families of different cultural backgrounds beliefs, and religious. Team members make efforts to understand how cultural beliefs, perceptions and practices may affect treatment options., services and the plan of care. Team members make efforts to understand and accommodate dietary and ritual practices.
- The program supports a multi-cultural work environment. It does not discriminate on the basis of race, color, religion, sex, sexual orientation or national origin.

Other pertinent standards address:

- Complex ethical issues
- Role of volunteers in palliative care
- Discussion of emotional stress by patient care team
- Addressing misconceptions regarding use of opioids
- Addressing mental health issues of patients and family members
- Plan of care for the dying process developed with patient and family

Goal 4B: "Your Hand in Mine"

"Your Hand in Mine" is a volunteer program at Envision Hospice that provides the reassuring presence of a volunteer companion to dying patients who would otherwise be alone. Where Envision clinicians are providing Continuous Care to the dying patient, the Your Hand in Mine volunteer becomes an additional source of the comfort to the patient and family in the final hours of life.

The premise is that no one is born alone and therefore, no one should die alone. "Your Hand in Mine" also adds companionship and support to family members or other caregivers during the sacred time of the patient's last hours of life.

"Your Hand in Mine" objectives include:

- reducing anxiety and fear by being present and providing education,
- providing respite and companionship,
- advocating for the requests of the patient or family,
- providing communication conduit to the hospice interdisciplinary team, and
- providing balance/respite during a time of transition.

With the support of the nursing staff, companions are thus able to help provide patients with the most valuable of human gifts: a dignified death.

Volunteer training for "Your Hand in Mine" includes

- learning about the stages at end-of-life, including emotional, physical, and spiritual changes that often occur.
- an emphasis on how to provide simple, direct comfort care strategies, ways to create a sensitive environment,
- methods of self-care for those offering support in bedside situations, and
- sharing case examples of volunteer experiences to learn from and to train regarding near-death awareness.

"Your Hand in Mine" is unique program, exclusive to Envision Hospice. It is different than other similar programs with the optional use of music and/or essential oils diffused in the room to create a calming environment. Patients also receive a new home-made quilt donated by a local quilting guild.

"Your Hand in Mine" program is critical in providing support to patients and families at end-of-life and in helping to carry out its Envision Hospice belief that no one should die alone.

Goal 4C: Support terminally ill patients seeking Death with Dignity

Envision Hospice of Washington supports a patient's choice in planning and directing his or her end-of-life care. Envision Hospice will become familiar with the Washington law known as Death with Dignity and will adopt policies that support patient choice and autonomy.

Its policies once developed, will encourage employees and contractors to use compassionate inquiry in answering questions, in counseling, and in providing information. Once it has become sufficiently familiar with the law, Envision expects it will adopt policies that permit providers to participate in the "Washington State Death with Dignity Act" if they so choose and to encourage referral to other providers in the community when necessary.

Envision Physician Services (EPS) is a mobile outreach clinic - staffed by physicians and ARNP's - that provides regular medical care to persons who have difficulty traveling to a doctor's office. EPS providers can support terminally ill Snohomish residents in at least two ways:

1. In many cases, terminally-ill patients referred to hospice upon hospital discharge (e.g. by a hospitalist) or by family members have not been referred by their own physicians and may not have regular physicians. Under the Medicare hospice program, a patient may have an "attending physician" in addition to the hospice medical director who is responsible for the patient's hospice plan of care. Regular attending physician visits can be made by EPS practitioners to hospice patients in their places of residence

2. While home bound Snohomish residents have the entire medical community from which to choose, Envision Physician Services will provide such mobile services to residents of assisted living facilities, adult family homes and in patients' own homes. For patients who have not selected the hospice option, EPS practitioners can provide regular medical care in their places of residence and in addition:
   - Advanced Care Planning (as defined by CMS Medicare Benefits)
   - Palliative care/pre-hospice pain and symptom management

List of Appendices
Envision Hospice of Washington, LLC - Snohomish County

Appendix A	Letter of intent
Appendix B	Envision organization chart of entities
Appendix C	Medical Director, employment contract Resume of Susan Pearson DO, PhD
Appendix D	Proposed Capital Expense & Depreciation Schedule
Appendix E	Marysville office lease
Appendix F	DOH Hospice Need Method, October 2018
Appendix G	Admissions policy
Appendix H	Charity care policy
Appendix I	Patient referral policy
Appendix J	ProForma Financials, Snohomish Hospice only • Assumptions & Methods including Staffing Summary • Operating Statement • ProForma Cash Flow and Balance Sheet
Appendix K	ProForma Financials, Existing Operations of Envision Home Health of Washington, LLC • Assumptions & Methods including Staffing Summary • Operating Statement • ProForma Cash Flow and Balance Sheet
Appendix L	ProForma Financials, Envision Home Health of Washington, LLC Existing Operations combined with Envision Hospice of Washington – Snohomish County • Operating Statement • ProForma Cash Flow and Balance Sheet
Appendix M	ProForma Financials, King Hospice only • Assumptions & Methods including Staffing Summary • Operating Statement • ProForma Cash Flow and Balance Sheet

Appendix N	ProForma Financials, Existing Operations of Envision Home Health of Washington, LLC combined with Envision Hospice of Washington LLC, Snohomish and King Proposed Hospices • Operating Statement • ProForma Cash Flow and Balance Sheet
Appendix O	Chase Bank letter
Appendix P	Commitment letter from Chief Financial Officer
Appendix Q	Historical financials, 2015-2017 Envision Home Health of Washington LLC
Appendix R	Staff recruitment detail
Appendix S	Envision Hospice Volunteer Recruitment Plan
Appendix T	Envision Hospice Training Policies
Appendix U	List of proposed vendors
Appendix V	Copy of DOH In-Home Service License, Envision Home Health of Washington, LLC
Appendix W	Accreditation standards for ACHC Palliative Care Distinction

Appendix A	Letter of intent

ENVISION

1345 W 1600 N, STE 202
Orem UT 84057

December 28, 2018

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
PO Box 47852
Olympia, Washington 98504-7852

Dear Ms. Sigman,

This letter is written to notify the Department of Health that Envision Hospice of Washington, of which Envision Home Health of Washington, LLC is the sole member, intends to seek Certificate of Need approval to establish a Medicare-certified hospice agency to serve residents of Snohomish County, Washington.

Upon receipt of a Certificate of Need, Envision Hospice of Washington, LLC will provide Medicare and Medicaid hospice services to terminally-ill residents of Snohomish County, Washington.

Our current estimate of capital costs is $19,800.

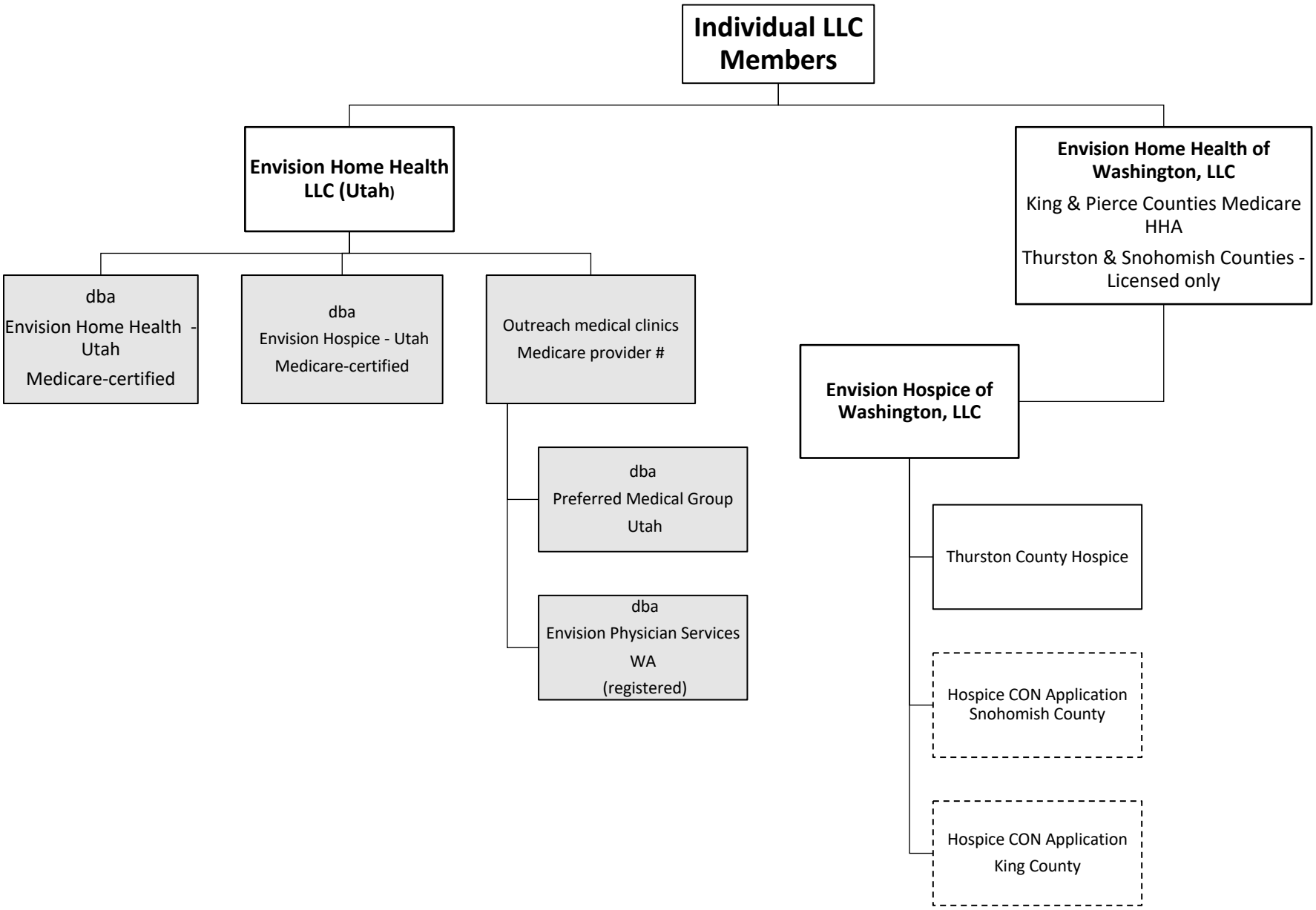
Will you please provide us with all criteria and standards by which you will evaluate our application?

Thank you very much,

Sherie Stewart
Chief Operating Officer

Appendix B	Envision organization chart of entities

Envision Hospice of Washington, LLC, Chart of Related Organizations



Appendix C	Medical Director, employment contract Resume of Susan Pearson DO, PhD

Envision Hospice of Washington LLC

HOSPICE MEDICAL DIRECTOR AGREEMENT

THIS HOSPICE MEDICAL DIRECTOR AGREEMENT ("Agreement") is made effective this 1st day of January, 2018 ("Effective Date") by and between Envision Hospice of Washington LLC and Susan E. Pearson, DO, PhD ("Physician").

WHEREAS, Hospice provides a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of terminally ill patients and/or family members, as delineated in a specific plan of care; and

WHEREAS, Physician is a doctor of osteopathy licensed to practice medicine in the State of Washington; and

WHEREAS, Hospice desires to contract with Physician to serve as Hospice's Physician Designee to provide certain clinical and administrative services in Snohomish and Thurston County, Washington; and

WHEREAS, Physician desires to provide such services to Hospice.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein set forth, the parties agree as follows:

ARTICLE I

DEFINITIONS

1.1 "Attending Physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs that function or action and who is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

1.2 "Hospice Patient" means an individual who elects, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

1.3 "Hospice Medical Director" means a doctor of medicine or osteopathy who is an employee or is under contract with the Hospice, and is designated by the hospice as having the responsibility for the medical component of the Hospice's patient care program.

1.4 "Hospice Plan of Care" means an individualized written plan of care established, reviewed and revised by the Interdisciplinary Group ("IDG"), in collaboration with the Attending Physician (if any), the patient or representative and the primary caregiver in accordance with the patient's needs if any of them so desire. The Hospice Plan of Care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: (a) interventions to manage pain and symptoms; (b) a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs; (c) measurable outcomes anticipated from implementing and coordinating the Hospice Plan of Care; (d) drugs and treatment necessary to meet the needs of the patient; (e) medical supplies and appliances necessary to meet the needs of the patient; and (f) the IDG's documentation in the clinical record of the patient's or representative's level of understanding, involvement, and agreement with the Hospice Plan of Care, in accordance with the Hospice's own policies.

1.5 "Hospice Services" means those services provided to a Hospice Patient for the palliation and management of such Hospice Patient's terminal illness, whether directly or under arrangement by Hospice, as specified in the Hospice Plan of Care. Hospice Services include nursing care and services by or under the supervision of a registered nurse; medical social services provided by a qualified social worker under the direction of a

physician; physician services to the extent that these services are not provided by the Attending Physician; counseling services (including bereavement, dietary and spiritual counseling); physical therapy, occupational therapy, and speech language pathology services; hospice aide, volunteer, and homemaker services; medical supplies (including drugs and biologicals) and medical appliances; and short-term inpatient care when needed for pain control, symptom management and respite purposes.

1.6 "Interdisciplinary Group or IDG" means a group of individuals designated by the Hospice who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the Hospice Patients and families facing terminal illness and bereavement. IDG members must provide the care and services offered by the Hospice, and the group, in its entirety, must supervise the care and services. The Hospice must designate a registered nurse that is a member of the IDG to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the Hospice Plan of Care. The IDG must include, but is not limited to, the following qualified and competent individuals: (a) a doctor of medicine or osteopathy who is an employee or under contract with the Hospice; (b) a registered nurse; (c) a social worker; (d) a pastoral or other counselor; and (e) as otherwise may be required by State law.

1.7 "Physician Designee" means a doctor of medicine or osteopathy designated by the Hospice who assumes the same responsibilities and obligations as the Hospice Medical Director when the Hospice Medical Director is not available.

1.8 "Short-Term Inpatient Care" means general inpatient care and respite care.

ARTICLE II

QUALIFICATIONS OF PHYSICIAN

2.1 Physician represents, warrants and covenants as follows:

(a) Personnel Qualifications. Physician is legally authorized (licensed, certified or registered) in accordance with applicable federal, state and local laws to provide the services described in this Agreement, shall act only within the scope of his or her license, certification or registration, and shall ensure that such license, certification or registration is properly maintained and kept current during the term of this Agreement. Physician shall provide proof of current license, certification or registration at the request of Hospice.

(b) Compliance with Rules and Regulations. Physician shall at all times during the term of this Agreement comply with all applicable federal, state and local laws, rules and regulations, and canons of professional ethics applicable to the services described in this Agreement, as well as with Hospice's policies and procedures.

(c) Drug Enforcement Administration. Physician shall obtain and maintain current registration with the Drug Enforcement Administration ("DEA") and any applicable state agency, without any limitation on his or her authority to prescribe drugs under such registration(s), and shall provide current proof of such registration(s) upon Hospice's request.

(d) Medicare and Medicaid. Physician shall be a qualified physician provider under the rules and regulations for, and be eligible to receive, Medicare and Medicaid reimbursement.

(e) Criminal Background Checks. Physician agrees that Hospice may conduct a background check.

ARTICLE III

RESPONSIBILITIES OF PHYSICIAN

3.1 The Medical Director has the responsibility for the medical component of the Hospice's Patient care program including, but not limited to, the following:

(a) Management of Terminal Illness. Physician, in conjunction with the Hospice Patient's Attending Physician, if any, is responsible for the palliation and management of the terminal illness and conditions related to the terminal illness of the Hospice Patient. Such services shall either be provided directly by Physician or through coordinating the patient care with the Attending Physician.

(b) Policies and Procedures. Physician, in conjunction with the Hospice administrator and/or his or her designee(s), agrees to participate in developing, executing, and periodically reviewing Hospice's written policies, procedures, palliative care protocols, and the services provided to Hospice Patients.

(c) Interdisciplinary Group. Physician agrees to be an active member of the IDG, and meet with the other members of the IDG to develop, periodically review and update a written plan of care for each Hospice Patient in accordance with applicable federal and state law and Hospice policy.

(d) Licensed Professionals. Licensed professional services must be authorized, delivered, and supervised only by health care professionals who are licensed, certified or registered in accordance with Paragraph 2.1(a), and who practice under Hospice's policies and procedures. Physician agrees to actively participate in the coordination of all aspects of the Hospice Patient's care, in accordance with current professional standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education. Physician agrees to participate in Hospice's quality assessment and performance improvement program and Hospice sponsored in-service training.

(e) Authorization of Services. All Hospice Services provided by Physician must be authorized by Hospice, furnished in a safe and effective manner, and delivered in accordance with the Hospice Patient's Hospice Plan of Care.

(f) Initial Certification of Terminal Illness. Physician will review the clinical information for each Hospice Patient and provide written certification, as appropriate and in accordance with state and federal guidelines, that it is anticipated that the Hospice Patient's life expectancy is 6 months or less if the illness runs its normal course. Physician must consider the following when making this determination, and document his or her findings in the clinical record:

(i) The primary terminal condition;

(ii) Related diagnosis(es), if any;

(iii) Current subjective and objective medical findings;

(iv) Current medication and treatment orders; and

(v) Information about the medical management of any of the Hospice Patient's conditions unrelated to the terminal illness.

(g) Recertification of Terminal Illness. Before the recertification period for each Hospice Patient, as described in 42 CFR §418.21(a), Physician must review the Hospice Patient's clinical information, and agrees to document, as appropriate and in accordance with state and federal guidelines, the Hospice Patient's continued eligibility for Hospice Services. For patients entering the 3rd or

subsequent benefit period, the physician will perform a Face to Face visit with the patient to assist in determining continued eligibility.

(h) Supervision. Physician is responsible for supervising all physician employees and those under contract with Hospice, if any.

(i) Unavailability of Attending Physician. Physician is responsible for meeting the medical needs of the Hospice Patient if the Hospice Patient's Attending Physician is unavailable.

(j) Availability During Surveys. Physician agrees to be reasonably available during licensure, certification and/or accreditation surveys, at the request of Hospice, for those matters associated with the provision of medical services under this Agreement.

(k) In-service Training. Physician agrees to provide periodic in-service training for Hospice employees at the request of Hospice.

(l) Committees. Physician agrees to participate in Hospice committees, at the request of Hospice.

(m) Admissions. In consultation with the Hospice Patient's Attending Physician, if any, Physician agrees to participate in the admission of the Hospice Patient, including admission to the Hospice, as well as admissions to inpatient settings, as applicable.

(n) Discharges. In consultation with the Hospice Patient's Attending Physician, if any, Physician agrees to participate in the discharge of the Hospice Patient.

(o) Community Education. Physician agrees to participate with Hospice in developing strategies to build relationships with local healthcare providers, including physician education on Hospice Services.

(p) Documentation. Physician agrees to complete all documentation, including timesheets or other documentation that may be required by Hospice to verify the services provided hereunder, and entries in the Hospice Patient's clinical record, in accordance with accepted standards of practice, Hospice policies and procedures, and applicable federal and state laws and regulations.

(q) Call Coverage. In conjunction with other Hospice physicians, Physician agrees to provide on-call coverage through direct telecommunication for consultation, assistance with medical emergencies, or patient referrals, and to ensure the availability of such coverage twenty-four (24) hours a day, seven (7) days a week.

(r) Attending Physician. At the request of Hospice, and subject to consent by the Hospice Patient or his or her legal representative, Physician agrees to become the Hospice Patient's Attending Physician for those Hospice Patients admitted without an attending physician.

(s) Consultations. Physician agrees to provide hospice consultations as requested by Hospice.

(t) Other Services. Physician agrees to provide any other medical services which may be necessary to comply with state or federal regulations governing Hospice Services.

3.2 Performance of Services. In performing the services described herein, Physician represents that those services to be performed shall be performed faithfully, diligently and to the best of Physician's ability, and in such a manner as is customarily performed by one holding a similar medical position. Physician represents and warrants that neither execution and delivery of this Agreement nor the rendering of services by Physician hereunder is precluded by any other agreement to which Physician is bound or which would impose any liability or obligation upon Hospice for accepting such services. In the performance of such duties, Physician shall be accountable to the administrator of Hospice. Physician warrants that he or she is not presently

conducting, nor in the future shall conduct, his or her medical practice in such a manner as to cause Physician to be suspended, excluded, barred or sanctioned under the Medicare or Medicaid programs. Hospice shall not attempt to direct the medical care provided by Physician to Hospice patients.

ARTICLE IV

RESPONSIBILITIES OF HOSPICE

4.1 Professional Management Responsibility. Hospice assumes the professional management responsibility of the Hospice Patient, and retains the administrative and financial management and oversight of staff and services to ensure the provision of quality care.

4.2 Competency and Training. Hospice will assess the skills and competency of all individuals furnishing care under this Agreement, and any amendments thereto, in accordance with its policies and procedures, provide in-service training and education programs where required, and maintain a written description of the in-service training provided during at least the previous twelve (12) months. Hospice shall provide orientation about the hospice philosophy to Physician. Physician shall cooperate with Hospice in conducting the skills and competency assessments and in-service training.

4.3 Coordination of Services. Hospice, in accordance with its policies and procedures, will a) ensure that the IDG maintains responsibility for directing, coordinating, and supervising the care and services provided; b) ensure that the care and services are provided in accordance with the Hospice Patient's Hospice Plan of Care; c) ensure that the care and services provided are based on all assessments of the Hospice Patient and Hospice Patient's family needs; d) provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement; and e) provide for an ongoing sharing of information with other non-hospice providers furnishing services unrelated to the terminal illness and related conditions.

4.4 Support Services. Hospice will provide reasonable administrative support services, supplies, and equipment in order for Physician to perform his duties hereunder.

ARTICLE V

RECORDS

5.1 Compilation of Records.

(a) Preparation. Physician and Hospice shall each prepare and maintain complete, correct and detailed clinical records concerning each Hospice Patient receiving Physician services under this Agreement as required by applicable Medicare and Medicaid program requirements, and state law. The Hospice Patient's clinical records shall be made available to the Attending Physician and hospice staff. Physician and Hospice shall cause each entry made for services provided hereunder to be legible, clear, complete and appropriately authenticated and dated in accordance with applicable policy and currently accepted standards of practice. Each such record shall be readily available on request by an authorized federal, state or local government or regulatory agency.

(b) Retention. Physician and Hospice shall each retain Hospice Patient records for at least six (6) years from the date of death or discharge of each Hospice Patient unless state law or other federal law stipulates a longer period of time.

(c) Access. Subject to any required authorization(s) by the Hospice Patient (or his/her legal representative), Physician and Hospice shall each permit the other party or its authorized representative(s), upon reasonable notice, to review and make photocopies of records maintained by Physician or Hospice, as the case may be, relating to the provision of services under this Agreement,

including, but not limited to, the Hospice Plan of Care, medical records and records relating to billing and payment.

(d) Inspection. Until the expiration of four (4) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, in accordance with 42 U.S.C. 1395x(v)(1)(I) and 42 CFR 420.300 *et seq.*, Physician and Hospice and any respective agents thereof shall make available, upon proper written request, to the Comptroller General of the United States, the Secretary of Health and Human Services, or any of their duly authorized representatives, access to this Agreement and the Physician's and Hospice's books, documents and records necessary to certify the nature and extent of costs of Medicare-reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare-reimbursable services provided by Physician and Hospice and any respective agents under this Agreement are carried out by means of a subcontract related to Physician and Hospice, and such related organization provides the services at a value or cost of $10,000.00 or more over a twelve-month period, then the subcontract between Physician and Hospice and the related organization shall contain a clause comparable to the clause specified in the preceding sentence.

5.2 Protection of Information and HIPAA. Physician and Hospice shall safeguard the clinical record, its contents and the information contained therein, against loss, destruction, or unauthorized use. Physician and Hospice agree to comply with and to cause their employees, subcontractors and agents to comply with, applicable state and federal laws and regulations relating to the security, protection, and privacy of individually identifiable health information, including without limitation, the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, as set forth in Title 45, Parts 160 and 164, of the Code of Federal Regulations (collectively "HIPAA") and amend this Agreement as necessary to ensure such compliance.

ARTICLE VI

COMPENSATION AND BILLING

6.1 Compensation. For all services rendered by Physician pursuant to this Agreement, Physician will be paid by Hospice a minimum sum of $2,000.00 per month for an average daily census (ADC) of 1 – 6 patients. When the ADC is 7.0 or greater, physician will be paid an additional $300.00/ADC/month per ADC over 6. Payment will be calculated by Hospice and remitted by the last day of the following month, assuming Physician has completed and submitted time sheets or other documentation, if any, required by Hospice to validate the services provided.

For example, if Hospice average daily census for a given month is 3, compensation would $2,000.00. If the average daily census for a given month is 16, compensation would be $2,000.00 plus $3,000.00 (10 patients over minimum *300.00) = $5,000.00.

6.2 Billing for Patient Care Services. Medicare hospice regulations require that Hospice bill Medicare directly for treatment services that Physician provides to Medicare Hospice Patients, as an attending or consulting physician, if the treatment is related to the terminal illness. When Physician is an Attending Physician or consulting physician to Hospice Patients, Physician shall submit claims for such treatment services to Hospice, and shall assign his or her fees as paid by Medicare for such services to Hospice. Physician shall not submit claims directly to Medicare for those treatment services that Physician provides to Medicare Hospice patients as the Attending Physician or consulting physician, if the treatment is related to the terminal illness. Physician shall neither submit claims to Hospice nor to Medicare for the administrative and general supervisory services required of Physician under this Agreement, including participating in the establishment of the Hospice Plan of Care, supervising the Hospice care and services, periodic review and updating of the Hospice Plan of Care, and establishing Hospice's governing policies.

ARTICLE VII

INSURANCE AND INDEMNIFICATION

7.1 Physician Insurance. Physician shall obtain and maintain, at his or her sole cost and expense, professional liability insurance, including coverage for any acts of professional malpractice covering Physician in an amount not less than $1,000,000 per claim and $3,000,000 in the aggregate. At the request of Hospice, Physician shall furnish to Hospice satisfactory evidence of his or her liability insurance coverage and shall notify Hospice thirty (30) days prior to any material change in or termination of insurance coverage.

7.2 Hospice Insurance. Hospice shall obtain and maintain, at its sole cost and expense, professional liability insurance, including coverage for any acts of professional malpractice, covering Hospice, its directors, officers, employees, volunteers and agents in an amount not less than $1,000,000 per claim and $3,000,000 in the aggregate. At the request of Physician, Hospice shall furnish to Physician satisfactory evidence of its liability insurance coverage and shall notify Physician thirty (30) days prior to any material change in or termination of insurance coverage.

7.3 Indemnification. Physician and Hospice, each at their sole expense, shall indemnify and hold harmless the other party, its officers, agents, servants and employees, from and against any and all lawsuits, claims, causes of action, actions, liability and judgments for injury or damages (including, but not limited to, expenses for reasonable attorneys' fees and disbursements and liabilities assumed by the other party in connection therewith) to persons or property, in any way arising out of or through the negligence, or intentional acts or omissions of the indemnifying party, its officers, agents, servants and employees, except to the extent caused by the negligence, intentional actions or omissions of the other party, its officers, agents, servants or employees. Physician and Hospice each shall give the other party immediate written notice of any lawsuit, claim, cause of action, action, liability and judgment which may be subject to this provision. This provision shall survive termination of this Agreement.

ARTICLE VIII

TERM AND TERMINATION

8.1 Term of Agreement. The initial term of this Agreement shall be for one (1) year beginning on the Effective Date, unless terminated earlier by either party as set forth below. Following the initial term, this Agreement shall automatically renew for successive one (1) year terms, unless terminated by either party as set forth below. For each renewal term of this Agreement, the fees payable hereunder may be renegotiated in good faith by the parties; provided, that written notice of such fee increase or decrease must be given at least thirty (30) days prior to the end of the then current term.

8.2 Termination Without Cause. Either party may terminate this Agreement for any reason prior to the expiration of its initial or renewal term by providing written notice of termination to the other party at least thirty (30) days prior to the date of such termination. If either party terminates this Agreement prior to the end of the initial or renewal term, then each party shall agree not to enter into a similar agreement with each other until after the term would have naturally expired.

8.3 Breach. Either party shall have the right to terminate this Agreement in the event of the other party's breach of this Agreement by providing at least thirty (30) days written notice to the other party. Any such notice shall specify the cause upon which it is based. The violating party shall have the thirty (30) day notice period in which to rectify the cause specified in the notice of termination or, if such cause is not rectified to the satisfaction of the non-breaching party within such thirty (30) day period, this Agreement shall thereupon automatically terminate.

8.4 Immediate Termination. Either party may terminate this Agreement upon the occurrence of any of the following events: (a) loss or suspension of any license of the other party required for the provision of services pursuant to this Agreement or the imposition of any sanction against the other under federal or state fraud and abuse laws and regulations or any other federal or state laws or regulations relating to such party's

participation in the Medicare or Medicaid programs; (b) appointment of a receiver for the other party's assets, an assignment by the other party for the benefit of its creditors or any relief taken or suffered by the other party under any bankruptcy or insolvency act; or (c) any jeopardy to the health or safety of the Hospice Patients.

8.5 Automatic Termination. This Agreement shall automatically terminate in the event either party is excluded from participation in any federally-funded health care program, including Medicare or Medicaid, as of the effective date of such exclusion.

8.6 Effect of Termination. In the event this Agreement is terminated, Physician shall cooperate with Hospice in coordinating the continuation of services provided hereunder and, if requested by Hospice, continue to provide such services after this Agreement is terminated until Hospice secures such services from another qualified physician. In such case, physician services shall continue to be provided and compensated in accordance with the terms and conditions set forth in this Agreement. Termination of this Agreement shall not relieve any party of obligations incurred prior to the effective date of termination, or which survive termination of this Agreement. This section shall survive termination of this Agreement.

ARTICLE IX

PROPRIETARY ITEMS

9.1 It is expressly understood that the systems, methods, procedures, written materials and controls, including this Agreement (collectively "Confidential Information") employed by Physician or Hospice in connection with the performance of services under the Agreement are proprietary in nature and shall remain the property of Physician or Hospice, as the case may be. Unless prior written approval is obtained from the party owning the information, Physician and Hospice's respective Confidential Information shall not, at any time, be utilized, distributed, copied, disclosed to any third party or otherwise employed or acquired by the other party except in the performance of each party's respective obligations under this Agreement. This provision shall survive termination of this Agreement.

ARTICLE X

GENERAL PROVISIONS

10.1 Notices. Except as otherwise specified herein, all notices, demands, requests, or other communications which may be or are required to be given, served, or sent by any party pursuant to this Agreement shall be in writing and shall be delivered by mail via first-class, registered or certified mail, return receipt requested, postage prepaid, or transmitted by facsimile, addressed as follows:

(i) If to Hospice

Email:
coo@envhh.com

Mailing Address:
1345 W 1600 N, STE 202
Orem, UT 84057

(ii) If to Physician:

Email:
ltcpearson@gmail.com

Mailing Address:
12033 176th Ave NE

Arlington, WA 98223

Either party may change the address to which notices are sent by sending written notice of such change of address to the other party.

10.2 Waiver. Neither the waiver by either of the parties hereto or a breach of, or a default under, any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasions, to enforce any of the provisions of this Agreement or to exercise any right or privilege hereunder shall thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights or privileges hereunder.

10.3 Successors and Assignment. This Agreement will be binding upon and inure to the benefit of both parties and their respective successors and assigns. This Agreement shall not be assigned by either party without the prior written consent of the other party, which will not be unreasonably withheld.

10.4 Limitation on Benefits of This Agreement. It is the explicit intention of the parties hereto that no person or entity other than the parties hereto is or shall be entitled to bring any action to enforce any provision of this Agreement against either of the parties hereto, and that the covenants, undertakings, and agreements set forth in this Agreement shall be solely for the benefit of, and shall be enforceable only, by the parties hereto or their respective successors and assigns as permitted hereunder.

10.5 Amendment. This Agreement shall not be amended, altered, or modified, except by an instrument in writing duly executed by the parties hereto.

10.6 Entire Agreement. This Agreement, including all Schedules, Exhibits, or Addenda attached hereto, if any, constitutes the entire agreement between the parties hereto with respect to the subject matter hereof, and it supersedes all prior oral or written agreements, commitments or understandings with respect to the matters provided for herein.

10.7 Headings. Article and Section headings contained in this Agreement are inserted for convenience of reference only, shall not be deemed to be a part of this Agreement for any purpose, and shall not in any way define or affect the meaning, construction, or scope of any of the provisions hereof.

10.8 Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Washington, without regard to the conflict-of-law rules of Washington or any other state.

10.9 Non-Exclusive Agreement. This Agreement is intended to be non-exclusive, and either party may use any provider for the same or similar services.

10.10 Relationship of Parties. It is expressly acknowledged by the parties that Hospice and Physician are independent contractors and nothing in this Agreement is intended, and nothing shall be construed, to create an employer/employee relationship, a joint venture relationship, a partnership, or other similar relationship. Neither Physician nor any of his or her employees, contractors or agents are authorized to enter into contracts or agreements on behalf of Hospice. Physician agrees to indemnify and hold Hospice harmless from any and all taxes, penalties and interest due and payable on the compensation paid to Physician. As an independent contractor, Physician is not eligible for or entitled to, and shall not participate in, Hospice's health or other benefit plans.

10.11 Severability. If any part of any provision of this Agreement or any other agreement, document or writing given pursuant to or in connection with this Agreement, shall be invalid or unenforceable under applicable law, said part shall be ineffective to the extent of such invalidity or unenforceability only, without in any way affecting the remaining parts of said provision or the remaining provisions of this Agreement.

10.12 Civil Rights. The parties each agree to comply with the following as amended from time to time: Title VI of the Civil Rights Act of 1964; Section 503 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Americans with Disabilities Act of 1990; and any similar state or federal laws, regulations or other legal mandates applicable to the end that no person in the United States shall, on the grounds of race, color, religion, national origin, Vietnam era and disabled veteran status, sexual orientation, age, gender, marital status, or disability be excluded from admission to, participation in, or otherwise be denied the benefits of, or otherwise subjected to discrimination under, any program or activity for which federal funds are used.

10.13 Change in Law. In the event that any federal or state law or regulation is enacted, promulgated, modified, or interpreted to prohibit, materially restrict, or otherwise affect the duties and obligations of one or both of the parties to this Agreement, the parties agree promptly to negotiate in good faith to amend or substitute the Agreement to permit the parties to carry out their original intentions. In the event that the parties cannot reach agreement within sixty (60) days, then the Agreement shall immediately terminate after written notification of such termination has been sent by either party to the other.

10.14 Arbitration. The parties agree to submit any dispute arising hereunder to binding arbitration in accordance with the rules of the American Health Lawyers Association Alternative Dispute Resolution Service or such other arbitration or dispute resolution authority as may be mutually agreed upon by the parties hereto. Judgment upon the award of the arbitrator shall be final and may be entered in any court having jurisdiction thereof. During the pendency of any such arbitration, and until such final judgment thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated as provided in this Agreement.

10.15 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same document.

10.16 Use of Name or Marks. Neither Physician nor Hospice shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party; provided, that one party may use the name, symbols or marks of the other party in written materials previously approved by the other party for the purpose of informing a prospective Hospice Patient (or his or her legal representative), and his or her Attending Physician, of the availability of the services described in this Agreement.

10.17 Force Majeure. Hospice and Physician each shall be excused from performance and liability under this Agreement to the extent that such performance is prevented by an Act of God, strike or other labor dispute, war condition, act of terrorism, civil disorder, embargo, fire, flood, accident or any other casualty beyond the reasonable control of such party, but the term of this Agreement shall not be extended accordingly.

10.18 Fraud and Abuse Compliance. Hospice and Physician acknowledge and agree that the services described in this Agreement are being provided and paid for at fair market value and do not represent in any fashion an improper or illegal inducement, solicitation, payment or remuneration for the referral of services or items reimbursable by a federal health care program. Moreover, Hospice and Physician will comply with all applicable federal, state and local laws and regulations, including fraud and abuse laws and regulations.

10.19 Program Representations. Hospice and Physician hereby represent, warrant and covenant to each other that as of the date of this Agreement, and for the entire term and any renewal hereof, with respect to any federal health care program as defined in section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(f)) or any state health care program as defined in section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(h)) (collectively the "Programs"): neither (a) the representing party; (b) any individual with a direct or indirect ownership or control interest of five percent (5%) or more of the representing party; nor (c) any director, officer, agent or employee of the representing party is currently debarred, suspended or excluded from any Program. Each party covenants to immediately notify the other in writing if this representation is no longer true, or if such party is sanctioned or has a civil monetary penalty levied under any Program.

10.20 Cooperation with Surveys, Investigations and Audits. If Hospice is surveyed by a federal, state or local regulatory body, Physician will provide any information from its records that may be reasonably requested

by the regulatory body regarding the services provided by Physician for Hospice under this Agreement during the time period in question. If Hospice is surveyed, inspected, audited and/or alleged to have committed any legal or regulatory violation by any federal, state or local government or regulatory agency with respect to any service provided by Physician under this Agreement, Physician agrees to cooperate fully in the investigation and/or defense of any such survey, inspection, audit or defense of alleged violation, including making its employees and contractors available for inspection and review by Hospice or its designee(s) and participating and cooperating in any other manner which is reasonably requested by Hospice or its designee(s).

IN WITNESS WHEREOF, the undersigned have duly executed this Agreement, or have caused this Agreement to be duly executed on their behalf, as of the day and year first herein set forth.

	Envision Hospice of Washington LLC
Susan E. Pearson	Sherie Stewart
Name	**Name**
Doctor of Osteopathy	Chief Operating Office
Title	**Title**

CURRICULUM VITAE

SUSAN E. PEARSON, DO, PhD

HOME ADDRESS
12033 176th Ave NE
Arlington, WA 98223

Cell 314/393-2552
Email: Ltcpearson@gmail.com

EDUCATION:

D.O.	Doctor of Osteopathy Kansas City University of Medicine and Biosciences (Formerly: The University of Health Sciences) Kansas City, Missouri	1992
PhD	Doctorate in Business Administration Southwest University Emphasis: Marketing and Economics New Orleans, Louisiana *Dissertation: Sales Forecasting for Radiology-Development of a Model*	1986
M.S.	Master of Science in Health Care Administration Central Michigan University Mount Pleasant, Michigan	1984
B.F.A.	Bachelor of Fine Arts in Journalism Southern Methodist University Dallas, Texas	1977
Licensures:	Missouri State Board of Healing Arts, License: 101139 Washington State Medical License: OP60698789	1993-present 2016-present
Board Certifications:	American Board of Osteopathic Family Practice CAQ (Certificate of Added Qualifications), Geriatrics CAQ, Hospice and Palliative Medicine	1996-present 1999-present 2010-present
Certifications:	Basic Cardiac Life Support Certified Medical Director, AMDA Diplomat, American Board of Quality Assurance And Utilization Review Physicians	2006-present 1996-present 1999-present

PROFESSIONAL EXPERIENCE

2016-present The Everett Clinic serving Providence Regional Medical Center
Everett, WA (Snohomish County)

Palliative Medicine Hospitalist, seeing Palliative consults at the hospital.

2007-present **MERCY MEDICAL CENTER**
St. Louis, Missouri

A 900+ bed community and teaching hospital offering a full range of children's, primary and specialty medical services; part of a 25 facility, 4-state health system

Section Chair, Mercy Clinic: Palliative and Post-Acute Medicine

Introduced the concept of a Palliative Medicine service to Mercy and, using Mercy data, illustrated the need and positive impact this service could have across the hospital.

Developed a budget neutral service and expanded it to a full interdisciplinary team averaging 2,800 consults/year.

LiveSTRONG Grant recipient 2012 to assist with pursuing Joint Commission Certification

On November 29, 2012 we achieved Joint Commission Certification of our inpatient St. Louis Palliative Care program, the 24th in the country and first in Missouri/Midwest to receive this honor.

Results: generate around $2 million/year in revenue
The hospital realizes reduction in return to acute (RTA);
a full day decrease in length of stay (LOS) in ICU;
direct cost savings of over $2 million/year

Service line, which started with my idea, myself and an RN enjoys strong hospital support and has grown to 3 physicians, 5 ANPs, chaplain and LCSW.

Expanded from inpatient to an outpatient clinic and outpatient clinic in Cancer Center. Expanded to select Post-Acute facilities. Currently working to add "virtual visits" via telemedicine.

Furthering the idea of a "continuum of care" I created a Post-Acute Service line, merged it with Palliative Medicine and qualified as an independent Specialty Section. We serve 12 SNF/ALF/NF/Dementia with a staff of 4 physicians, 5 ANPs, and a Triage LPN.

Currently integrating another 4 physician, 4 ANP group into our service from a different hospital Mercy just acquired.

2006 to 2008 **SUSAN E. PEARSON, LLC**
St. Louis, Missouri

Corporation providing medical and consulting services to clients. Projects include:

St. John's Mercy Medical Center
St. Louis, Missouri
February 2007-July 2008

Retained by Senior VP Business Development to design a Palliative Medicine Program coordinate and enhance existing directed at creating a more robust post acute program. After successful design phase, implemented program as The Mercy Center for Palliative Care.

Evercare Hospice/United Health Care
St. Louis, Missouri
April 2007 to February 2008

Market Medical Director
Reports to the Corporate VP-Medical Services. Responsible for clinical team building, marketing to physicians and long term care facilities and short term planning.

- Business start up in competitive market; involved in budgeting and planning
- Developed and implemented marketing effort resulting in average daily census growth from 2 to 17 patients/daily in 2 months
- Designed and facilitated clinical care pathways to organize and provide consistent, quality clinical care
- Established local pharmaceutical formulary and emergency kits to control costs
- Established local quality measures and monitoring program
- Managed relationships with 10 other UHC agencies to integrate Evercare with existing UHC product lines
- Recruited 2 additional part time Medical Directors to assure clinical coverage, provide marketing assistance and broaden clinical specialty base (Oncology and Pulmonary Medicine)
- Hospice patient visits and Clinical Team Leadership

Palliative Medicine Consult Service
(2007)

Provides clinical palliative medicine consults to patients and families in defined St. Louis metro area for Evercare Hospice, area nursing homes and physicians.

- Developed "Functional Matrix", an assessment tool to chart patient decline in activities of daily living
- Implemented EMR

Normandy Nursing Center, Consultant
(2007)

Retained by Administrator to develop and implement Medical Direction Oversight Program augmenting local Medical Director, per 2007 CMS guidelines.

Saint Mary's Hospital, Decatur, Illinois, Consultant
(2007)

Contracted with CEO of a multi-hospital system to develop Geriatric Service Line.

- Feasibility study including market and hospital financial data analysis
- Designed Geriatric Service Line Clinical and Financial Model demonstrating $300,000 in cost savings and $250,000 in new revenue opportunities
- Developed 3 year Business Plan and presentation for the Board

National Hospice Management, Headquarters, Arnold, Missouri
(2006)

Reported to CEO and Board of a regional hospice organization that had grown, through acquisition, to a 4-state operation. My role was to improve the infrastructure and standardize processes to support additional growth.

- Completed market and financial analysis
- Developed and implemented decision tree and processes to identify appropriate hospice patients
- Designed and implemented billing and collection protocols resulting in a 36% improvement in monthly cash flow
- Implemented clinical guidelines and quality oversight program
- Designed and delivered physician training program for care of hospice patients and team medical direction resulting in improved documentation and increased hospice referrals
- Assisted CEO in designing organizational chart and policies to assure clear communication responsibility and authority
- Negotiated with external vendors on behalf of the organization including pharmacy benefit manager, managed care organizations and state surveyors

June 2004- **SAINT LOUIS CONNECTCARE HEALTH SYSTEM**
May 2006 St. Louis, MO - Temporary between Iraq deployments

Reported to CEO of this local health care organization providing services to uninsured and underinsured residents in cooperation with CMS, local hospitals, state and city health departments. Operated 4 Primary and Ancillary Care Clinics, an Urgent Care Center and expanded the multi-specialty clinic. Acted as Chief of Staff developing and maintaining credentialing, ethics, quality and pharmacy therapeutics' committees. Designed and implemented Case Management and Utilization Review department to manage uninsured inpatient admission and testing.

Vice President, Medical Affairs

- Managed multi-disciplinary staff and ancillary services at 4 remote sites. All providers honored their contract and remained through the transition
- Implemented provider credentialing process resulting in collection of $500,000 in outstanding charges due to lack of credentialing
- Working with finance department, designed and implemented a superbill and procedure to assure timely and accurate clinical charge submission
- Developed presentations for and relationships with several hospital CEO's, CFO's and physician groups during organizational re-tooling
- Responsible for design, marketing and contracting for specialty services. Expanded specialty care from 6 to 16 disciplines. This created a robust, multifunctional 16 specialty group, including resident training opportunities, to serve the local uninsured
- Worked with architects to redesign Specialty clinic space and create a GI lab
- Expanded Urgent Care hours and services increasing revenues 50% to $1M
- Created an uninsured case management and utilization review service to manage uninsured hospital inpatient stays and provide prior authorization for certain specialty care based on M+R criteria. The UR oversight allowed redirection of $250,000 in funds for other uses
- Responsible for budgeting/staffing clinical services and various committees

July 2003-
June 2004

CAPITAL HOSPICE (Formerly, Hospices of the National Capital Region)
Arlington, VA – Temporary while waiting to deploy to Iraq

Chief Medical Director

Reported to the corporate VP of Medical Affairs of a large non-profit hospice, operating 6 offices and a free-standing inpatient unit serving 2 states and D.C. I served as director of long term care services and assisted in designing a palliative care program.

- Designed, trained and implemented nursing home hospice teams resulting in lower employee turnover and greater patient service satisfaction
- Provided direct patient care at the inpatient site and in nursing homes
- Developed the organizational structure and marketing plan for new palliative care program
- Interfaced with pharmacy benefit manager to arrange more cost effective delivery method for nursing homes

- Elected and served as Chief of Staff

1999 to 2003 **SUSAN E. PEARSON, PC**
St. Charles (St. Louis), Missouri

Corporation providing medical and consulting services to clients after LTC closed

Medical Director, Legacy Health Care
1999 to 2003

Lead physician providing marketing, patient care, medical director services in nursing homes for 3 physician/3 Nurse Practitioner geriatric practice. Also served as medical director for a satellite laboratory.

- Designed and implemented successful group without walls to share call and practice overhead
- Developed practice from an original 65 inherited nursing home patients to over 1,200 in two years representing 1,500 encounters monthly
- Secured 10 Medical Directorships assuring the majority of patients for our service in each facility
- Provided education to clinical and physician staff regarding frail elder care
- Interfaced with managed care organizations and state surveyors

Medical Director, Heartland Hospice (St. Louis, a division of Manor Care)
May 2000-May 2003

- Developed practice from an average daily census of 40 to average of 100
- Expanded services to 16 additional nursing homes
- Expanded home care hospice by 50%, requiring an additional medical director

1995 to 1999 **LONG TERM CARE PHYSICIANS**
Kansas City, Missouri – Company Closed

Corporate VP-Specialty Services
Regional VP-Operations

Reported to the Corporate VP-Operations of a regional practice management company focusing on geriatrics. LTCP declared bankruptcy in early 1999, giving catalyst to the formation of Legacy Health Care.

- Responsible for budgeting, clinical and business operations for 2 offices in Missouri. Both offices maintained positive revenue/expense ratio and cash flow
- Provided business oversight and team building for Specialty Services (Podiatry, Optometry, Dental and Mental Health) in 8 states
- Member of Corporate Executive Committee representing Midwest Operations and involved with Electronic Medical Record project

- Involved with due diligence and practice acquisition during growth mode and integration of the practices into LTC structure
- Designed and Implemented Documentation and Coding standards

MILITARY EXPERIENCE

1988 to 2015 **UNITED STATES ARMY - Retired**

Twenty -six year veteran of the Missouri Army National Guard; joined as a Second Lieutenant when accepted to medical school as a way to provide community service. Served three 4-month tours in Iraq. Current rank: Colonel

STATE SURGEON, Missouri Army National Guard **COLONEL**

STATE FLIGHT SURGEON **COLONEL**

Brigade Flight Surgeon, 36th Combat Aviation Brigade **COLONEL**
Balad, Iraq
(Dec 2006-April 2007)

Commanded the medical support elements for 5 Aviation Battalions, including Medivac and served as Medical Counsel to Aviation Brigade Commander. We reported directly to General Petraus' staff

- Restructured clinical care for 24/7 operation meeting clinic and 5 battalion medical requirements; implemented EMT ambulance service
- Senior leader responsible for supervising 12 physicians and 40 medics at 4 installations
- Liaison between Army and Air Force theatre hospital evacuation mission

Physician Officer in Charge (OIC) 206th Area Support **COLONEL**
Balad, Iraq
(Aug 2006-Dec 2006)

Full service clinical operation, including pharmacy serving all uniformed personnel (army, air force and navy) and civilian support personnel stationed at Balad.

- Integrated Electronic Medical Record (EMR) into battlefield care; wrote Army Standard Operating Procedure (SOP) for use of EMR in battle zone. Use of EMR allows access to battlefield records by all other military points of care worldwide
- Created Clinical Model for the first deployed Multifunctional Medical Battalion
- Identified and corrected pharmacy protocols for dispensing civilian medication resulting in $100,000 savings to government

Flight Surgeon, 150th General Aviation Battalion **LT COLONEL**
Tikrit, Iraq
(Jan 2005-April 2005)

- Responsible for physical and mental health of 500 aviators and support personnel
- Medical Counsel to Aviation Battalion Commander

Detachment Commander, TMC 2 **LT COL, COLONEL**
Jefferson City, Missouri
(2004 - 2007)

- Responsible for validating of physical readiness of deploying soldiers
- Conduct Medical Review Board to determine fitness to serve for flagged soldiers

Commander, 205th Area Support Medical Battalion **LT COLONEL**
Kansas City, Missouri
(2000-2004)

- Redesigned command structure to place responsibility and authority resulting in increased retention and production
- Developed the model program for 61B (Medic) transition to 91W (EMT) for the 4 state region
- Responsible for 500 soldiers in 4 companies in 3 states and $1M in equipment

Commander, Company F (206th) **MAJOR**
Springfield, Missouri
(1996-1999)

- Responsible for $3.5 M in equipment
- Implemented yearly soldier satisfaction survey; results improved yearly
- Improved EEO and retention

135th MASH **2LT, 1LT, Captain**
Kansas City, Missouri
(1988-1995)

- Served as Field Surgeon on multiple 2 week humanitarian exercises
- Completed Army Flight Surgeon training
- Deployed to Ft. Carson, Colorado during Desert Storm

PROFESSIONAL AFFILIATIONS:

Society for Post- Acute/LTC Medicine (AMDA)
American Osteopathic Association

American Academy of Osteopathic Family Physicians
American Academy of Hospice and Palliative Care
Association of Military Surgeons

HONORS

Bronze Star Medal (2)	2006, 2007
Meritorious Service Medal	2002
Champion of Older Adults Award, SSM Health System	2001
Chief Resident	1994

BOARD POSITIONS

Board Member, St. John's Health (for profit)	2009-2012
State Board Member, VOYCE (Ombudsman program)	2014-2016
National Board, Society for Post Acute/LTC	2015-present
Advisory Board, Nurses & Co Home Health/Hospice	2014-present

PRIOR EXPERIENCE

Neighborhood Family Care	Physician	1996
Blue Cross/Blue Shield	Consultant	1995
Kansas City Free Health Clinic	Physician	1993-95
Johnson County Imaging Center	Marketing Director	1986-88
Dilley's Family Restaurants	Partner	1982-86
AT&T Corporation	Account Executive	1980-83
University of Texas	Instructor	1978-80
Drilling Oil Magazine	Graphics Manager	1976-78

LECTURES

Telemedicine: the next frontier in Post-Acute/LTC Medicine	2015
Advanced Directive: Why do I need one? St. Peters Senior Fair	2014
Ombudsman's role in Palliative Care, Ombudsman Regional Conven.	2014
What Nurse Practitioners can do for you, St. Charles Senior Expo	2014
Adding Palliative Care Services in your Hospital	6/2012 -14
Integrating Palliative Care in the Post- Acute Setting (nursing home)	6/2012 -14
Webinar: MO Hospice Association: Integrating Palliative Care in ICU	5/2012
Midwest Regional Conference on Palliative and End of Life Care	10/10, 11/11
Frail Geriatrics and the Interact2 Tools	9/2011,12,13,14

(St. John's) Mercy Medical Center St. Louis

Grand Rounds: Pain and Palliative Care	2011-2014
Communication Series: Family Meetings, Breaking News	2011-2015
Pain and Nausea for Critical Care Fellows/Residents	9/2008-2010

Symptom Management: Beyond the Basics, Grand Rounds	7/2008-2014
"Do Everything" Doesn't Mean Full Code	7/2008-2014
When to Refer to Hospice	2007
Principles of Battlefield Medicine	2006, 2007
Documentation and Coding Update	2006
Palliative Care v Hospice	2006
Role of the Hospice Medical Director	2005
Hospice: Treating Pain and Related Symptoms	2005
Long Term Care for Family Practitioners	2001, 02, 03
Physical Assessment for Nursing Professionals	2001, 02, 03
DNR & End of Life Issues	2000, 01, 02
Successful Placement of High Acuity Placement	5/2000
Caring for the Caregiver in Alzheimer's Disease	3/2000
HCFA Guidelines/Medication Risks in the Elderly	10/1999
Advanced Directives: Are you prepared?	11/1998
Prospective Payments System, integration	10/1998

American Academy of Family Practice National Meeting:

Long Term Care Medical Practice Issues	10/2001

University of Health Sciences, 3rd year Medicine Lectures:

Chronic Fatigue Syndrome	7/1996
HIV Management in the Institutional Setting	6/1996
Management of the Nursing Home Patient	6/1996
Documentation and Coding	6/1996

Women in Medicine Symposium, Provincetown, MA:

Documentation and Coding in Primary Care	5/1996

Trinity Hospital Noon Didactic Lectures:

Skin Disorders in Primary Care	8/1996
Documentation and Coding	8/1995
HIV in Women: Family Matters	5/1995
Management of Low Back Pain	6/1994

PUBLICATIONS

"PCPs May Impact Returning Veterans by Screening for TBI, PTSD" 9/2008
SJMMG/SJMAP Newsletter, St. John's Mercy Medical Center, St. Louis, MO

" The FUNCTIONAL MATRIX" – a tool to help families recognize decline 2010
Mercy, EPIC

" A better way to access pain: FACES then Numbers – a brief study" 2015

Appendix D	Proposed Capital Expense & Depreciation Schedule

Envision Hospice of WA, Snohomish County
Total Proposed Capital Expense, 2020-2022

Item	Estimated Expense
Furnishings	$10,500.00
Phone System	$ 2,500.00
Computers/Copiers/Printers	$ 6,800.00
Total	**$19,800.00**

Envision of WA, Depreciation Schedule

	Items	Years		Annual
Furnishings	10,500	7	$	1,500
Phone System	2,500	7	$	357
Computers/Copiers/Printers	6,800	3	$	2,267
Total:	**19,800**		**$**	**4,124**

Appendix E	Marysville office lease

J & I Schoentrup Office Building

Office Space Lease

1. Basic Lease Terms

Section 1 represents a summary of the basic terms of the Office Space Lease for the Schoentrup Office Building in Marysville, Washington "The Property"". The terms as used in Section 1 shall have the meanings provided in this section, unless otherwise specifically modified by the provisions of the Lease. In the event of any inconsistency between the terms contained in Section 1 and any specific provision of this Lease the terms of the more specific provision shall prevail.

A.	Date of the Lease:	December 1st, 2018
B.	Tenant:	Envision Hospice of WA, LLC
	Address of Leased Premises	1212-2nd Street, Unit B Marysville, WA 98270
	Address for Billing and Notices	Envision Hospice of WA, LLC Attn: Michele Gill 1818 S. Union Street, Suite 1A Tacoma, WA 98405 253-509-5004 (office) 907-301-4994 (direct cell)
C.	Landlord	Jim and Ina Schoentrup
	Address for Notices:	25325 20th Dr. NE Arlington, WA 98223
D.	Premises Area:	1534 Square Feet
E.	Property Area	3168 square feet
F.	Tenant's Percentage of Property and Pro Rata Share:	50%
G.	Terms of the Lease:	
	Commencement Date:	January 1st, 2019
	Expiration Date:	December 31st, 2021
H.	Option Terms:	Tenant shall have options for three (3) additional one year lease extensions
I.	Monthly rent shall be	1/01/2019-12/31/2019 $1,551.09 1/01/2020-12/31/2020 $1,551.09 1/01/2021-12/31/2021 $1,551.09

These rent amounts are the sum of a base amount of $1,227.00 plus $324.09 which is a monthly flat amount for water, sewer, garbage, insurance and taxes and assessments.

J. Should the Lessee choose to move forward with a lease extension following monthly rates would apply:

1/01/2022-12/31/2022	$1,591.06
1/01/2023-12/31/2023	$1,628.97

- The 1/01/2022-12/31/2022 rent amounts is the sum of a base amount of $1,263.81 (3% increase to base of $1,227) plus $327.25 "additional rent" for the year 2022.
- The 1/01/2023-12/31/2023 rent amounts is the sum of a base amount of $1,301.72 (3% increase to base of $1,263.81) plus $327.25 "additional rent" for the year 2023.

K. The Lessee must give the Lessor notice of their intent to renew the Agreement of the Lease no less than 60 days prior to renewal period.

L. Should the Lessee not be selected to receive the Certificate of Need from the State of Washington, The Lessee has the right to terminate the lease agreement with written notice to the Landlord, with no rights or obligations to either party to the other to remain.

2. Premises

Subject to the terms, covenants, and conditions of this Lease, Landlord hereby leases to Tenant and Tenant hereby leases from Landlord the Premises constituting a portion of a building described in Section 1 located on the Property Legally described on Exhibit A hereto. The Parties agree that the Premises, as outlined on Exhibit B hereto, constitute the rentable square feet identified in Section 1.d., and that Tenant's pro rata share 01 Common Operating Expenses, as defined in Section 5.2, shall be the percentage identified in Section 1 J. Said initial calculations have been made, and any subsequent calculations of the rentable square feet of the Premises or the Property required by changes in either shall be made by Landlord, in accordance with the method of measuring "Rentable Area" specified in BOMA American National Standard Institute Publication, .ANSI, Z65.1-1980 (Reaffirmed 1989).

3. Lease Term

Subject to the terms and conditions set forth herein, and the terms and conditions of the Work Letter Agreement executed contemporaneously by the parties hereto, if any, the term of this Lease shall be for the period designated in Section 1.g., commencing on the Commencement Date therein provided, and ending at the expiration of such period. In the event a Work Letter Agreement is not executed by the parties hereto, and should the Premises not be ready for occupancy by the Commencement Date for any reason, Landlord shall not be liable for any claims, damages, or liabilities in connection therewith, and the term of this :"ease shall be for the same number of months as previously set forth in this section, but the Commencement Date shall be the date on which the Premises are ready for occupancy in accordance with the terms and conditions set forth herein.

Expenses:

Separate Utilities. During the Term, Tenant shall pay for all electricity, heat, telephone, internet used by the Tenant in the Leased space.

4. Real Property Taxes and Assessments Defined.

The term "Real Property Taxes and Assessments" as used In Section 1.m above shall include, without limitation. all real estate taxes, assessments and other charges levied with respect to real end personal property payable during any calendar year with respect to the Property, and all property of Landlord, real or personal. used directly in the operation of the Premises and located in or on the Property, together with any charges levied or assessed In addition to or in lieu of any such taxes or assessments, or any tax

upon the leasing of the Property or the rents collected (excluding any net income or franchise tax), and including costs and expenses oi contesting the validity or amount of any such taxes and assessments.

5. Prepaid Rent and Security Deposit:

   No monies will be collected.

6. Late Charge: Lessee may be charged a late fee of 5% of monthly rent for payments made after the 5th of each month at the Lessor's discretion.

7. Tenant's Property: All articles of personal property and all business and trade fixtures owned by Tenant or installed by Tenant at its expense in the Premises shall remain the property of Tenant and may be removed by Tenant at any time during the Lease term, provided Tenant is not in default. Upon expiration or sooner termination of the Lease. Tenant shall remove any such property, together with any such property of any party other than landlord. Tenant shall repair the damage to the Premises resulting from the installation or removal of such property.

8. Improvements and Alterations by Tenant: Without prior written consent of the Landlord, Tenant shall make, no alterations in or additions to the Premises. All alterations or improvements made by Tenant to the Premises shall be the property of Landlord and shall remain upon and be surrendered with the Premises at the termination of this Lease. Landlord may, however. require Tenant to remove any alterations or improvements made to the Premises by Tenant. In such event, Landlord shall so state at the time of granting its approval with respect to Tenant's request to make such alterations or improvements. If removal of alterations or improvements is required by Landlord, Tenant shall do so prior to surrendering possession of the Premises to Landlord, and repair any damage caused to tile Premises thereby, all at Tenant's sole cost and expense.

9. Permitted Use. Tenant shall use the Premises for the purposes set forth in Section 1.r., and Tenant hereby agrees that by taking possession of the Premises, it has determined to its satisfaction that the Premises can be used for those purposes. Tenant waives any right to terminate this Lease ii the Premises cannot be used for such purposes. The Premises may not be used for any other purpose without Landlord's prior written consent.

10. Restrictions on Use. Tenant's use of the Premises as provided in this lease shall be in accordance with the following: Tenant shall not use or occupy the Premises or the Property in violation of any law, ordinance, regulation or the certificate of occupancy issued for the Property or Premises and shall not do, bring or keep anything in or about the Premises that will cause an increased premium for or cancellation of any insurance covering the Property: provided, however, that if Tenant causes any such increase in insurance premium, Tenant shall payor reimburse Landlord for the entire amount of any such increase: without regard to whether Landlord elects to terminate this Lease by reason thereof. Tenant shall not use the Premises in any manner that will constitute waste, nuisance or unreasonable annoyance to other tenants In the Property, nor shall Tenant do anything that will cause damage to such Property or Premises
    A. Tenant shall not place upon or install in windows or other openings, or in interior hallways or on the exterior of the Premises or Property any signs, symbols, drapes or other materials without prior written approval of Landlord. Tenant shall not permit floor loading in excess of the pounds per square foot limitation which Landlord notifies Tenant is the maximum permissible for the Premises.

11. Common Areas: Landlord gives to Tenant and its employees authorized representatives and business invitees, a non-exclusive right to reasonable use and enjoyment of the common areas of the Property, subject to Landlord's rights set forth in this Lease. Tenant shall be entitled to parking in common with other Tenants or Landlord. Tenant agrees not to overburden the parking facilities and agrees to

cooperate with the Landlord and other tenants in the use of the parking facilities. Landlord may promulgate rules relating to use of the parking facilities in which case the Tenant shall abide by, if Landlord promulgates rules relating to the use of the parking facilities. Landlord may monitor compliance with such rules.

12. Tenant Maintenance: By taking possession of the Premises, Tenant accepts the Premises as being in good and sanitary order, condition and repair. Tenant shall at its expense, clean maintain and keep in "first class" condition and repair throughout the term of this Lease. Tenant is responsible for damages caused by Tenant. Landlord is responsible for damages to situations out of the Tenant's control, such as broken window due to windstorm, heat/AC system malfunction, etc.

13. Insurance and Indemnification: Tenant may not do or permit to be done any act or thing upon the Premises that will invalidate or be in conflict with Landlord's fire insurance policies covering the Property and fixtures and property therein, or which would increase the rate of fire insurance applicable to the Property to an amount higher than it otherwise would be. Tenant may neither do not permit to be done any act or thing upon the Premises which could subject Landlord to any liability or responsibility for injury to any person or persons or to the property by reason of any business or operation being carried on within the Premises.

14. Waiver of Subrogation: Each party shall, at its sole cost and expense, include in its property insurance policies appropriate clauses to which insurance companies.
    A. In the case of Tenant's insurance policies, waive all rights of subrogation against Landlord and any tenant of space in the Property with respect to losses payable under such policies.
    B. in the case of Landlord's insurance policies, waive all right of subrogation against Tenant with respect to losses payable under such policies.
    C. In each case, agree that such policies will not be invalidated if prior to a loss the insured waives in writing any or all right of recovery against any party for losses covered by such policies.

15. Waiver of Claims: Provided that Landlord's right of full recovery under Its fire insurance policy is not adversely affected or prejudiced thereby, Landlord hereby waives any and all right of recovery which might otherwise have against Tenant, its servants, agents and employees, for loss or damages occurring to the Property and the fixtures, appurtenances and equipment therein. to the extent the same is covered by Landlord's insurance, notwithstanding that such loss or damage may result from negligence or fault of Tenant, its servants, agents or employees. Provided that Tenant's right of full recovery under Its fire insurance policy is not adversely affected or prejudiced thereby Tenant hereby waives any and all right of recovery which it might otherwise have against Landlord, its servants and employees, and against every other tenant at the Properly who has executed a waiver similar to the waiver set forth in this section for loss or damage to Tenant's furniture, furnishings, fixtures and other property removable by Tenant to the extent the same is covered by Tenant's insurance, notwithstanding that such loss or damage may result from the negligence or fault of Landlord, its servants, agents or employees, or such other tenant and the servants

16. Landlord's Insurance Obligations: Landlord agrees to maintain insurance covering the building located on the Property in an amount not less than 80% (or such greater percentage as may be necessary) to comply with the provisions of any co-insurance clauses in the policy of the "replacement cost" thereof as such term is defined in the Replacement Cost Endorsement to be attach thereto, insuring against the perils of Fire, Lighting, Extended Coverage, Vandalism and Malicious Mischief, extended by Special Extended Coverage Endorsement to insure against all other Risks of Direct Physical Loss such coverages and endorsements to be as defined, provided and limited in the standard bureau forms prescribed by the insurance regulatory authority for Washington State for use by insurance companies admitted in Washington for the writing of such insurance on risks located within Washington. Such insurance shall be for the sole benefit of Landlord and under its sole control.

17. Tenant's Insurance Obligations: Tenant covenants and agrees to provide, at Its expense, on or before the Commencement Date, and to keep in force during the Term, the following insurance coverages naming Landlord, Landlord's mortgagee, if any, and Tenant as insured parties:
    A. A comprehensive general liability insurance policy ("Liability Policy"). including without limitation blanket contractual liability coverage, broad form property damage, independent contractor's coverage and personal injury coverage of no less than $1,000,000 combined single limit per occurrence for bodily or personal injury (including death) and property damage protecting Landlord, its agents, and Tenant against any liability whatsoever occasioned by an) occurrence on or about the Premises or any appurtenances thereto: and
    B. A fire and other casualty policy ("Fire Policy") insuring the full replacement value of tenant improvements on the Premises and all of the furniture, trade fixtures. and other personal property of Tenant located in the Premises, equal to the value of tenant improvements on the Premises. and all of the furniture, trade fixtures and other persor.al property of Tenant on the Premises with a deductible of no more than $1,000, against loss or damage by fire, theft and such other risks or hazards as are insurable under present and future forms of "All Risks" insurance policies.

18. Destruction: In the event the Premises are destroyed or injured by fire or earthquake or other casualty, to the extent that they are untenantable in whole or in part, then Landlord may, at Landlord's option, proceed with reasonable diligence to build and restore said Premises or such part thereof, provided that within sixty (60) days after such destruction or injury Landlord shall notify Tenant in writing of Landlord's intention to do so. During the period from destruction or damage to restoration, the rent shall be abated in the same ratio as that portion of the Premises which Landlord determines is unfit for occupancy bears to the whole Premises.

19. Assignment, Subletting and Succession: Tenant shall not assign, let or sublet this lease or the Premises, or any part of either, without first obtaining written consent of Landlord. This Lease shall not be assignable by operation of Law.

20. Rules and Regulations: Tenant shall use the Premises and the common areas of the Property in accordance with such reasonable rules and regulations as may from time to time be adopted by Landlord for the general safety, care and cleanliness of the Premises or the Property, and the preservation of good order and convenience and shall cause Tenant's employees, agents, invitees and visitors to abide by such rules and regulations.

21. Defaults· Remedies:
    Defaults by Tenant: The occurrence of any one or more of the following events shall constitute a material default and breach of this Lease by Tenant:

    A. Failure by Tenant to make any payment of rent when due, or failure to make any other payment required hereunder when due when such failure shall continue for a period of five (5) days after written notice from Landlord
    B. Failure by Tenant to observe or perform any of the covenants, conditions or provisions of this Lease, other than the making of any payment, where such failure shall continue for a period of thirty (30) days after written notice from Landlord
    C. The making by Tenant of any general assignment or general arrangement for the benefit of creditors
    D. Tenant's failure to comply with the same Lease term or covenant on three occasions during the Term, even if such breach is cured within applicable cure period
    E. Tenant's failure to comply with the Rules, unless such failure is cured within 5 days after notice.

Remedies: In the event of any such default, Landlord may at any time without further notice, re-enter and take possession of the Premises or terminate this lease, accelerate its rent payments or pursue any other remedy allowed by law. Tenant shall pay Landlord the costs of recovering possession of the Premises, the expenses of reletting or any other costs or damages arising out of the Tenant's default

22. Default by Landlord: Landlord shall not be in default unless Landlord fails to perform all obligations within thirty (30) days after notice by Tenant, specifying wherein Landlord has failed to perform provided, that if the nature of the Landlord's obligation is such that more than thirty (30) days are required for performance. Landlord shall not be in default if Landlord commences performance within thirty (30) days of Tenant's notice.

23. Access: Landlord reserves and shall at any and all times have access to the Premises to inspect or access for needs of repairs or showing the space to prospective tenants.

24. Notices: Any notice required or permitted hereunder must be in writing and shall be effective when delivered or mailed by certified mail addressed to Tenant or to Landlord at the address for such Party Landlord's address is designated in Section 1 of this Lease. Landlord may specify a different address for notice purposes by written notice to the Tenant.

25. Amendment· No Waiver: All the terms. covenants and conditions effective between Landlord and Tenant are set forth herein. This Lease may not be amended or modified except in writing signed by both Parties. Failure to exercise any right In one or more instances shall not be construed as a waiver of the right to require strict performance or effect an amendment to this Lease.

26. Attorney's Fees. Costs: In the event either Party requires the services of an attorney in connection with enforcing the terms of this Lease. or in the event suit is brought for the recovery of any sums due under this Lease or for the breach of any covenant or condition of this Lease, or for the restitution of the Premises to Landlord or eviction of Tenant during said term or after the expiration thereof, the prevailing Party shall be entitled to reasonable attorneys' fees and all costs incurred in connection therewith, including, without limitation, the fees of accountants. appraisers and other professionals, whether at trial on appeal or without resort to suit.

ENTIRE AGREEMENT

It is expressly understood and agreed Lessor that ther are no promises, agreements, conditions, understandings, warranties, or representations, oral or written, expressed or implied, between them other than as herein set forth and that this Lease shall not be modified in any manner except by an instrument in writing and executed by the parties.

WHEREOF, Lessor and Lessee have executed this lease.

Lessor:

Jim Schoentrup

Dec 17, 2018

Jim or Ina Schoentrup

Ina Schoentrup

JIM SCHOENTRUP

Printed Name/Title

Ina Schoentrup

Lessee:

Michele Gill

Dec 12, 2018

Michele Gill

Date

Michele Gill / Administrator

Printed Name/Title

Appendix F	DOH Hospice Need Method, October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	
2015	4,455	
2016	3,768	
2017	3,757	
	average:	**3,993**

Deaths ages 0-64		
Year	Deaths	
2015	14,365	
2016	13,557	
2017	14,113	
	average:	**14,012**

Use Rates	
0-64	28.50%
65+	60.91%

Hospice admissions ages 65+		
Year	Admissions	
2015	24,527	
2016	24,738	
2017	26,365	
	average:	**25,210**

Deaths ages 65+		
Year	Deaths	
2015	40,149	
2016	41,104	
2017	42,918	
	average:	**41,390**

Source:
2018 Survey for CY2017 Hospice Data-facility self-report to department
Vital Statistics 2017
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	2015	2016	2017	2015-2017 Average Deaths
Adams	35	34	38	**36**
Asotin	62	50	49	**54**
Benton	372	352	385	**370**
Chelan	152	123	124	**133**
Clallam	203	172	180	**185**
Clark	881	781	883	**848**
Columbia	14	12	19	**15**
Cowlitz	280	290	351	**307**
Douglas	82	56	71	**70**
Ferry	23	20	30	**24**
Franklin	111	115	133	**120**
Garfield	4	4	6	**5**
Grant	197	191	203	**197**
Grays Harbor	238	233	238	**236**
Island	165	134	166	**155**
Jefferson	67	69	69	**68**
King	3,397	3,204	3,256	**3,286**
Kitsap	537	518	485	**513**
Kittitas	82	59	91	**77**
Klickitat	33	50	63	**49**
Lewis	236	194	210	**213**
Lincoln	20	26	20	**22**
Mason	184	164	169	**172**
Okanogan	128	110	119	**119**
Pacific	71	59	88	**73**
Pend Oreille	41	35	34	**37**
Pierce	1,892	1,883	1,936	**1,904**
San Juan	32	36	18	**29**
Skagit	279	248	271	**266**
Skamania	34	39	16	**30**
Snohomish	1,478	1,440	1,483	**1,467**
Spokane	1,230	1,168	1,147	**1,182**
Stevens	127	103	96	**109**
Thurston	581	485	530	**532**
Wahkiakum	5	10	3	**6**
Walla Walla	122	123	123	**123**
Whatcom	371	365	367	**368**
Whitman	74	42	57	**58**
Yakima	525	560	586	**557**

65+				
County	2015	2016	2017	2015-2017 Average Deaths
Adams	102	92	78	**91**
Asotin	212	192	190	**198**
Benton	1,103	1,075	1,081	**1,086**
Chelan	543	535	556	**545**
Clallam	754	762	842	**786**
Clark	2,553	2,589	2,579	**2,574**
Columbia	48	48	116	**71**
Cowlitz	864	863	917	**881**
Douglas	230	227	232	**230**
Ferry	54	64	60	**59**
Franklin	257	242	284	**261**
Garfield	28	20	17	**22**
Grant	488	479	509	**492**
Grays Harbor	555	606	622	**594**
Island	597	565	630	**597**
Jefferson	313	293	308	**305**
King	9,308	9,766	10,039	**9,704**
Kitsap	1,610	1,704	1,780	**1,698**
Kittitas	223	243	237	**234**
Klickitat	119	145	151	**138**
Lewis	667	676	721	**688**
Lincoln	78	102	105	**95**
Mason	499	494	550	**514**
Okanogan	340	303	350	**331**
Pacific	258	222	262	**247**
Pend Oreille	101	120	133	**118**
Pierce	4,550	4,751	5,019	**4,773**
San Juan	118	126	115	**120**
Skagit	909	979	1,007	**965**
Skamania	53	64	65	**61**
Snohomish	3,833	3,857	4,118	**3,936**
Spokane	3,361	3,356	3,527	**3,415**
Stevens	359	336	376	**357**
Thurston	1,651	1,661	1,768	**1,693**
Wahkiakum	39	39	37	**38**
Walla Walla	468	485	501	**485**
Whatcom	1,262	1,353	1,329	**1,315**
Whitman	223	212	236	**224**
Yakima	1,419	1,458	1,471	**1,449**

Source:
Vital Statistics 2017
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	2015-2017 Average Deaths	Projected Patients - 28.50% of Deaths
Adams	36	10
Asotin	54	15
Benton	370	105
Chelan	133	38
Clallam	185	53
Clark	848	242
Columbia	15	4
Cowlitz	307	87
Douglas	70	20
Ferry	24	7
Franklin	120	34
Garfield	5	1
Grant	197	56
Grays Harbor	236	67
Island	155	44
Jefferson	68	19
King	3,286	936
Kitsap	513	146
Kittitas	77	22
Klickitat	49	14
Lewis	213	61
Lincoln	22	6
Mason	172	49
Okanogan	119	34
Pacific	73	21
Pend Oreille	37	10
Pierce	1,904	543
San Juan	29	8
Skagit	266	76
Skamania	30	8
Snohomish	1,467	418
Spokane	1,182	337
Stevens	109	31
Thurston	532	152
Wahkiakum	6	2
Walla Walla	123	35
Whatcom	368	105
Whitman	58	16
Yakima	557	159

65+		
County	2015-2017 Average Deaths	Projected Patients - 60.91% of Deaths
Adams	91	55
Asotin	198	121
Benton	1,086	662
Chelan	545	332
Clallam	786	479
Clark	2,574	1,568
Columbia	71	43
Cowlitz	881	537
Douglas	230	140
Ferry	59	36
Franklin	261	159
Garfield	22	13
Grant	492	300
Grays Harbor	594	362
Island	597	364
Jefferson	305	186
King	9,704	5,911
Kitsap	1,698	1,034
Kittitas	234	143
Klickitat	138	84
Lewis	688	419
Lincoln	95	58
Mason	514	313
Okanogan	331	202
Pacific	247	151
Pend Oreille	118	72
Pierce	4,773	2,907
San Juan	120	73
Skagit	965	588
Skamania	61	37
Snohomish	3,936	2,397
Spokane	3,415	2,080
Stevens	357	217
Thurston	1,693	1,031
Wahkiakum	38	23
Walla Walla	485	295
Whatcom	1,315	801
Whitman	224	136
Yakima	1,449	883

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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.

0-64								
County	Projected Patients	2015-2017 Average Population	2018 projected population	2019 projected population	2020 projected population	2018 potential volume	2019 potential volume	2020 potential volume
Adams	10	17,768	18,029	18,160	18,291	10	10	10
Asotin	15	16,906	16,779	16,715	16,652	15	15	15
Benton	105	163,693	166,554	167,984	169,415	107	108	109
Chelan	38	61,520	61,991	62,227	62,463	38	38	38
Clallam	53	52,661	52,550	52,494	52,439	53	53	53
Clark	242	393,291	405,282	411,278	417,273	249	253	257
Columbia	4	2,947	2,863	2,822	2,780	4	4	4
Cowlitz	87	85,517	85,717	85,817	85,917	88	88	88
Douglas	20	33,938	34,732	35,130	35,527	20	21	21
Ferry	7	5,782	5,680	5,628	5,577	7	7	7
Franklin	34	81,742	85,922	88,012	90,102	36	37	38
Garfield	1	1,644	1,602	1,581	1,560	1	1	1
Grant	56	82,660	84,909	86,033	87,158	58	58	59
Grays Harbor	67	58,675	57,817	57,387	56,958	66	66	65
Island	44	62,664	62,964	63,114	63,264	44	44	45
Jefferson	19	20,653	20,688	20,705	20,722	20	20	20
King	936	1,820,215	1,863,482	1,885,115	1,906,749	959	970	981
Kitsap	146	214,045	217,040	218,538	220,035	148	149	150
Kittitas	22	36,768	37,892	38,453	39,015	23	23	23
Klickitat	14	16,082	15,828	15,702	15,575	14	14	13
Lewis	61	61,796	62,398	62,700	63,001	61	62	62
Lincoln	6	8,042	7,923	7,864	7,805	6	6	6
Mason	49	49,162	50,142	50,632	51,122	50	51	51
Okanogan	34	32,906	32,545	32,364	32,183	34	33	33
Pacific	21	14,972	14,688	14,545	14,403	20	20	20
Pend Oreille	10	9,998	9,905	9,859	9,812	10	10	10
Pierce	543	729,937	747,538	756,339	765,139	556	562	569
San Juan	8	11,194	10,974	10,863	10,753	8	8	8
Skagit	76	98,616	100,076	100,807	101,537	77	77	78
Skamania	8	9,266	9,254	9,248	9,242	8	8	8
Snohomish	418	672,806	694,793	705,787	716,781	432	439	445
Spokane	337	416,684	421,066	423,256	425,447	340	342	344
Stevens	31	34,459	34,226	34,109	33,992	31	31	31
Thurston	152	228,261	234,880	238,190	241,500	156	158	160
Wahkiakum	2	2,669	2,555	2,498	2,441	2	2	2
Walla Walla	35	50,111	50,546	50,763	50,981	35	35	36
Whatcom	105	178,234	183,023	185,418	187,812	108	109	110
Whitman	16	42,965	43,137	43,222	43,308	17	17	17
Yakima	159	217,605	221,051	222,774	224,497	161	163	164

Source:
OFM, "2017 County Age and Sex Projections, five-year intervals and age groups"
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	2015-2017 Average Population	2018 projected population	2019 projected population	2020 projected population	2018 potential volume	2019 potential volume	2020 potential volume
Adams	**55**	**1,887**	2,114	2,227	2,341	62	65	69
Asotin	**121**	**5,233**	5,619	5,812	6,005	129	134	138
Benton	**662**	**27,492**	29,821	30,986	32,150	718	746	774
Chelan	**332**	**14,279**	15,343	15,876	16,408	356	369	381
Clallam	**479**	**20,401**	21,334	21,800	22,267	501	512	523
Clark	**1568**	**68,044**	75,085	78,605	82,125	1,730	1,811	1,892
Columbia	**43**	**1,135**	1,202	1,236	1,269	46	47	48
Cowlitz	**537**	**19,684**	21,326	22,148	22,969	582	604	626
Douglas	**140**	**6,831**	7,595	7,976	8,358	156	163	171
Ferry	**36**	**1,949**	2,095	2,168	2,241	39	40	42
Franklin	**159**	**7,921**	8,765	9,188	9,610	176	184	193
Garfield	**13**	**607**	633	645	658	14	14	14
Grant	**300**	**13,011**	14,244	14,861	15,477	328	342	356
Grays Harbor	**362**	**14,535**	15,594	16,123	16,653	388	402	415
Island	**364**	**18,625**	19,701	20,239	20,777	385	395	406
Jefferson	**186**	**10,580**	11,252	11,588	11,924	197	203	209
King	**5911**	**268,307**	296,484	310,572	324,660	6,531	6,842	7,152
Kitsap	**1034**	**47,697**	51,788	53,833	55,878	1,123	1,167	1,212
Kittitas	**143**	**6,760**	7,351	7,647	7,943	155	161	168
Klickitat	**84**	**5,051**	5,570	5,829	6,088	93	97	102
Lewis	**419**	**15,576**	16,398	16,808	17,219	441	452	463
Lincoln	**58**	**2,687**	2,823	2,891	2,959	61	62	64
Mason	**313**	**14,123**	15,311	15,905	16,499	340	353	366
Okanogan	**202**	**9,198**	10,050	10,475	10,901	220	230	239
Pacific	**151**	**6,258**	6,584	6,747	6,910	158	162	166
Pend Oreille	**72**	**3,378**	3,742	3,925	4,107	80	84	87
Pierce	**2907**	**114,409**	125,262	130,688	136,114	3,183	3,321	3,459
San Juan	**73**	**5,099**	5,545	5,768	5,991	79	82	86
Skagit	**588**	**24,021**	26,595	27,881	29,168	651	682	714
Skamania	**37**	**2,286**	2,542	2,670	2,798	41	43	45
Snohomish	**2397**	**101,674**	113,447	119,333	125,219	2,675	2,814	2,952
Spokane	**2080**	**77,325**	84,343	87,852	91,361	2,269	2,363	2,457
Stevens	**217**	**9,930**	10,884	11,360	11,837	238	249	259
Thurston	**1031**	**44,534**	48,683	50,757	52,832	1,127	1,176	1,224
Wahkiakum	**23**	**1,316**	1,441	1,503	1,565	26	27	28
Walla Walla	**295**	**10,819**	10,944	11,006	11,068	299	300	302
Whatcom	**801**	**35,688**	39,164	40,902	42,640	879	918	957
Whitman	**136**	**4,659**	5,237	5,526	5,815	153	162	170
Yakima	**883**	**34,949**	36,670	37,530	38,391	926	948	970

Source:
OFM, "2017 County Age and Sex Projections, five-year intervals and age groups"
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	2018 potential volume	2019 potential volume	2020 potential volume	Current Capacity	2018 Admits (Unmet)	2019 Admits (Unmet)	2020 Admits (Unmet)
Adams	72	76	79	**33.67**	39	42	45
Asotin	145	149	153	**73.33**	71	76	80
Benton	825	854	883	**902.67**	(78)	(49)	(20)
Chelan	395	407	420	**371.67**	23	36	48
Clallam	553	564	575	**129.67**	424	434	445
Clark	1,979	2,064	2,148	**1,881.00**	98	183	267
Columbia	50	51	52	**19.33**	30	32	33
Cowlitz	669	692	714	**774.67**	(105)	(83)	(60)
Douglas	176	184	192	**144.33**	32	40	48
Ferry	46	47	48	**27.33**	18	20	21
Franklin	212	221	230	**148.67**	63	72	82
Garfield	15	15	16	**4.00**	11	11	12
Grant	386	401	416	**225.00**	161	176	191
Grays Harbor	455	467	480	**280.33**	174	187	200
Island	429	440	450	**307.33**	122	133	143
Jefferson	217	223	229	**168.00**	49	55	61
King	7,490	7,812	8,133	**7,847.23**	(357)	(36)	286
Kitsap	1,271	1,317	1,362	**1,152.67**	119	164	209
Kittitas	178	185	191	**135.00**	43	50	56
Klickitat	107	111	115	**156.63**	(50)	(46)	(42)
Lewis	503	514	525	**438.33**	64	76	87
Lincoln	67	68	70	**19.00**	48	49	51
Mason	390	403	417	**241.67**	148	162	175
Okanogan	254	263	272	**190.33**	63	73	82
Pacific	179	183	186	**97.00**	82	86	89
Pend Oreille	90	94	98	**58.00**	32	36	40
Pierce	3,739	3,883	4,028	**3,895.33**	(157)	(12)	132
San Juan	87	90	93	**75.33**	12	15	18
Skagit	728	760	792	**628.67**	99	131	163
Skamania	50	52	54	**39.00**	11	13	15
Snohomish	3,107	3,252	3,398	**2,635.33**	471	617	763
Spokane	2,609	2,705	2,801	**2,664.00**	(55)	41	137
Stevens	269	279	290	**138.33**	131	141	151
Thurston	1,283	1,334	1,384	**1,104.30**	179	229	280
Wahkiakum	27	28	29	**6.33**	21	22	23
Walla Walla	334	336	338	**317.00**	17	19	21
Whatcom	986	1,027	1,067	**858.67**	128	168	208
Whitman	170	178	187	**227.33**	(58)	(49)	(41)
Yakima	1,087	1,110	1,133	**1,123.67**	(36)	(13)	10

Source:
2016-2018 Surveys for CY2015-2017 Historical Data - facility self-report to department
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	**2018 Admits (Unmet)**	**2019 Admits (Unmet)**	**2020 Admits (Unmet)**	**Statewide ALOS**	**2018 Patient Days (unmet)**	**2019 Patient Days (unmet)**	**2020 Patient Days (unmet)**
Adams	39	42	45	**60.86**	2,344	2,551	2,758
Asotin	71	76	80	**60.86**	4,341	4,608	4,875
Benton	(78)	(49)	(20)	**60.86**	(4,732)	(2,971)	(1,209)
Chelan	23	36	48	**60.86**	1,400	2,162	2,924
Clallam	424	434	445	**60.86**	25,779	26,442	27,105
Clark	98	183	267	**60.86**	5,959	11,119	16,278
Columbia	30	32	33	**60.86**	1,850	1,924	1,997
Cowlitz	(105)	(83)	(60)	**60.86**	(6,413)	(5,044)	(3,674)
Douglas	32	40	48	**60.86**	1,917	2,407	2,897
Ferry	18	20	21	**60.86**	1,115	1,194	1,272
Franklin	63	72	82	**60.86**	3,840	4,409	4,978
Garfield	11	11	12	**60.86**	672	688	703
Grant	161	176	191	**60.86**	9,782	10,693	11,604
Grays Harbor	174	187	200	**60.86**	10,615	11,387	12,160
Island	122	133	143	**60.86**	7,419	8,065	8,711
Jefferson	49	55	61	**60.86**	2,974	3,333	3,693
King	(357)	(36)	286	**60.86**	(21,735)	(2,169)	17,397
Kitsap	119	164	209	**60.86**	7,217	9,978	12,739
Kittitas	43	50	56	**60.86**	2,613	3,014	3,414
Klickitat	(50)	(46)	(42)	**60.86**	(3,048)	(2,791)	(2,535)
Lewis	64	76	87	**60.86**	3,907	4,598	5,288
Lincoln	48	49	51	**60.86**	2,919	3,005	3,092
Mason	148	162	175	**60.86**	9,011	9,842	10,674
Okanogan	63	73	82	**60.86**	3,863	4,419	4,976
Pacific	82	86	89	**60.86**	4,979	5,205	5,432
Pend Oreille	32	36	40	**60.86**	1,947	2,180	2,413
Pierce	(157)	(12)	132	**60.86**	(9,530)	(740)	8,050
San Juan	12	15	18	**60.86**	727	916	1,105
Skagit	99	131	163	**60.86**	6,025	7,975	9,925
Skamania	11	13	15	**60.86**	641	766	892
Snohomish	471	617	763	**60.86**	28,686	37,548	46,411
Spokane	(55)	41	137	**60.86**	(3,355)	2,497	8,348
Stevens	131	141	151	**60.86**	7,957	8,586	9,215
Thurston	179	229	280	**60.86**	10,905	13,963	17,021
Wahkiakum	21	22	23	**60.86**	1,269	1,334	1,399
Walla Walla	17	19	21	**60.86**	1,026	1,139	1,251
Whatcom	128	168	208	**60.86**	7,769	10,228	12,687
Whitman	(58)	(49)	(41)	**60.86**	(3,512)	(2,996)	(2,480)
Yakima	(36)	(13)	10	**60.86**	(2,201)	(802)	598

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	**2018 Patient Days (unmet)**	**2019 Patient Days (unmet)**	**2020 Patient Days (unmet)**	**2018 ADC (unmet)**	**2019 ADC (unmet)**	**2020 ADC (unmet)**
Adams	2,344	2,551	2,758	6	7	8
Asotin	4,341	4,608	4,875	12	13	13
Benton	(4,732)	(2,971)	(1,209)	(13)	(8)	(3)
Chelan	1,400	2,162	2,924	4	6	8
Clallam	25,779	26,442	27,105	71	72	74
Clark	5,959	11,119	16,278	16	30	45
Columbia	1,850	1,924	1,997	5	5	5
Cowlitz	(6,413)	(5,044)	(3,674)	(18)	(14)	(10)
Douglas	1,917	2,407	2,897	5	7	8
Ferry	1,115	1,194	1,272	3	3	3
Franklin	3,840	4,409	4,978	11	12	14
Garfield	672	688	703	2	2	2
Grant	9,782	10,693	11,604	27	29	32
Grays Harbor	10,615	11,387	12,160	29	31	33
Island	7,419	8,065	8,711	20	22	24
Jefferson	2,974	3,333	3,693	8	9	10
King	(21,735)	(2,169)	17,397	(60)	(6)	48
Kitsap	7,217	9,978	12,739	20	27	35
Kittitas	2,613	3,014	3,414	7	8	9
Klickitat	(3,048)	(2,791)	(2,535)	(8)	(8)	(7)
Lewis	3,907	4,598	5,288	11	13	14
Lincoln	2,919	3,005	3,092	8	8	8
Mason	9,011	9,842	10,674	25	27	29
Okanogan	3,863	4,419	4,976	11	12	14
Pacific	4,979	5,205	5,432	14	14	15
Pend Oreille	1,947	2,180	2,413	5	6	7
Pierce	(9,530)	(740)	8,050	(26)	(2)	22
San Juan	727	916	1,105	2	3	3
Skagit	6,025	7,975	9,925	17	22	27
Skamania	641	766	892	2	2	2
Snohomish	28,686	37,548	46,411	79	103	127
Spokane	(3,355)	2,497	8,348	(9)	7	23
Stevens	7,957	8,586	9,215	22	24	25
Thurston	10,905	13,963	17,021	30	38	47
Wahkiakum	1,269	1,334	1,399	3	4	4
Walla Walla	1,026	1,139	1,251	3	3	3
Whatcom	7,769	10,228	12,687	21	28	35
Whitman	(3,512)	(2,996)	(2,480)	(10)	(8)	(7)
Yakima	(2,201)	(802)	598	(6)	(2)	2

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	**2018 ADC (unmet)**	**2019 ADC (unmet)**	**2020 ADC (unmet)**	**Numeric Need?**	**Agencies Needed?**
Adams	6	7	8	FALSE	FALSE
Asotin	12	13	13	FALSE	FALSE
Benton	(13)	(8)	(3)	FALSE	FALSE
Chelan	4	6	8	FALSE	FALSE
Clallam	71	72	74	**TRUE**	**2.12**
Clark	16	30	45	**TRUE**	**1.27**
Columbia	5	5	5	FALSE	FALSE
Cowlitz	(18)	(14)	(10)	FALSE	FALSE
Douglas	5	7	8	FALSE	FALSE
Ferry	3	3	3	FALSE	FALSE
Franklin	11	12	14	FALSE	FALSE
Garfield	2	2	2	FALSE	FALSE
Grant	27	29	32	FALSE	FALSE
Grays Harbor	29	31	33	FALSE	FALSE
Island	20	22	24	FALSE	FALSE
Jefferson	8	9	10	FALSE	FALSE
King	(60)	(6)	48	**TRUE**	**1.36**
Kitsap	20	27	35	FALSE	FALSE
Kittitas	7	8	9	FALSE	FALSE
Klickitat	(8)	(8)	(7)	FALSE	FALSE
Lewis	11	13	14	FALSE	FALSE
Lincoln	8	8	8	FALSE	FALSE
Mason	25	27	29	FALSE	FALSE
Okanogan	11	12	14	FALSE	FALSE
Pacific	14	14	15	FALSE	FALSE
Pend Oreille	5	6	7	FALSE	FALSE
Pierce	(26)	(2)	22	FALSE	FALSE
San Juan	2	3	3	FALSE	FALSE
Skagit	17	22	27	FALSE	FALSE
Skamania	2	2	2	FALSE	FALSE
Snohomish	79	103	127	**TRUE**	**3.63**
Spokane	(9)	7	23	FALSE	FALSE
Stevens	22	24	25	FALSE	FALSE
Thurston	30	38	47	**TRUE**	**1.33**
Wahkiakum	3	4	4	FALSE	FALSE
Walla Walla	3	3	3	FALSE	FALSE
Whatcom	21	28	35	FALSE	FALSE
Whitman	(10)	(8)	(7)	FALSE	FALSE
Yakima	(6)	(2)	2	FALSE	FALSE

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology

Effective 10/15/2018

	0-64			65+		
County	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
ADAMS	35	34	38	102	92	78
ASOTIN	62	50	49	212	192	190
BENTON	372	352	385	1,103	1,075	1,081
CHELAN	152	123	124	543	535	556
CLALLAM	203	172	180	754	762	842
CLARK	881	781	883	2,553	2,589	2,579
COLUMBIA	14	12	19	48	48	116
COWLITZ	280	290	351	864	863	917
DOUGLAS	82	56	71	230	227	232
FERRY	23	20	30	54	64	60
FRANKLIN	111	115	133	257	242	284
GARFIELD	4	4	6	28	20	17
GRANT	197	191	203	488	479	509
GRAYS HARBOR	238	233	238	555	606	622
ISLAND	165	134	166	597	565	630
JEFFERSON	67	69	69	313	293	308
KING	3,397	3,204	3,256	9,308	9,766	10,039
KITSAP	537	518	485	1,610	1,704	1,780
KITTITAS	82	59	91	223	243	237
KLICKITAT	33	50	63	119	145	151
LEWIS	236	194	210	667	676	721
LINCOLN	20	26	20	78	102	105
MASON	184	164	169	499	494	550
OKANOGAN	128	110	119	340	303	350
PACIFIC	71	59	88	258	222	262
PEND OREILLE	41	35	34	101	120	133
PIERCE	1,892	1,883	1,936	4,550	4,751	5,019
SAN JUAN	32	36	18	118	126	115
SKAGIT	279	248	271	909	979	1,007
SKAMANIA	34	39	16	53	64	65
SNOHOMISH	1,478	1,440	1,483	3,833	3,857	4,118
SPOKANE	1,230	1,168	1,147	3,361	3,356	3,527
STEVENS	127	103	96	359	336	376
THURSTON	581	485	530	1,651	1,661	1,768
WAHKIAKUM	5	10	3	39	39	37
WALLA WALLA	122	123	123	468	485	501
WHATCOM	371	365	367	1,262	1,353	1,329
WHITMAN	74	42	57	223	212	236
YAKIMA	525	560	586	1,419	1,458	1,471

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	**2015**	**2016**	**2017**
Adams	8	6	4
Asotin	12	10	7
Benton	108	106	110
Chelan	49	35	44
Clallam	13	6	14
Clark	257	310	282
Columbia	3	0	1
Cowlitz	119	105	124
Douglas	19	19	19
Ferry	2	3	7
Franklin	26	16	15
Garfield	0	0	1
Grant	31	42	44
Grays Harbor	29	66	72
Island	33	32	35
Jefferson	16	15	14
King	1,125	906	862
Kitsap	177	132	104
Kittitas	15	20	46
Klickitat	9	30	17
Lewis	76	53	45
Lincoln	2	4	3
Mason	47	18	34
Okanogan	38	35	34
Pacific	13	15	17
Pend Oreille	12	11	8
Pierce	747	453	419
San Juan	5	11	3
Skagit	77	62	61
Skamania	11	14	4
Snohomish	450	366	339
Spokane	386	367	397
Stevens	24	13	25
Thurston	161	132	144
Wahkiakum	1	0	1
Walla Walla	39	45	45
Whatcom	129	122	139
Whitman	2	9	29
Yakima	184	179	188
Grand Total	**4,455**	**3,768**	**3,757**

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	**2015**	**2016**	**2017**
Adams	28	25	30
Asotin	59	47	85
Benton	758	751	875
Chelan	363	305	319
Clallam	103	110	143
Clark	1,159	1,737	1,898
Columbia	18	19	17
Cowlitz	636	645	695
Douglas	145	102	129
Ferry	15	18	37
Franklin	157	110	122
Garfield	7	3	1
Grant	163	179	216
Grays Harbor	118	264	292
Island	263	195	364
Jefferson	172	120	167
King	6,788	6,510	6,739
Kitsap	951	938	1,156
Kittitas	111	79	134
Klickitat	71	72	82
Lewis	343	378	420
Lincoln	9	17	22
Mason	203	191	232
Okanogan	199	133	132
Pacific	41	99	106
Pend Oreille	32	56	55
Pierce	3,310	3,401	3,356
San Juan	67	70	70
Skagit	479	591	616
Skamania	32	35	21
Snohomish	2,439	2,228	2,084
Spokane	2,199	2,176	2,467
Stevens	105	120	128
Thurston	887	880	899
Wahkiakum	8	5	4
Walla Walla	273	273	276
Whatcom	708	712	766
Whitman	187	207	248
Yakima	921	937	962
Grand Total	**24,527**	**24,738**	**26,365**

Total Admissions by County - Not Adjusted for New Approvals

Column1	Total 2015	Total 2016	Total 2017	Average
Adams	36	31	34	**33.67**
Asotin	71	57	92	**73.33**
Benton	866	857	985	**902.67**
Chelan	412	340	363	**371.67**
Clallam	116	116	157	**129.67**
Clark	1,416	2,047	2,180	**1,881.00**
Columbia	21	19	18	**19.33**
Cowlitz	755	750	819	**774.67**
Douglas	164	121	148	**144.33**
Ferry	17	21	44	**27.33**
Franklin	183	126	137	**148.67**
Garfield	7	3	2	**4.00**
Grant	194	221	260	**225.00**
Grays Harbor	147	330	364	**280.33**
Island	296	227	399	**307.33**
Jefferson	188	135	181	**168.00**
King	7,913	7,416	7,601	**7,643.33**
Kitsap	1,128	1,070	1,260	**1,152.67**
Kittitas	126	99	180	**135.00**
Klickitat	80	102	99	**93.67**
Lewis	419	431	465	**438.33**
Lincoln	11	21	25	**19.00**
Mason	250	209	266	**241.67**
Okanogan	237	168	166	**190.33**
Pacific	54	114	123	**97.00**
Pend Oreille	44	67	63	**58.00**
Pierce	4,057	3,854	3,775	**3,895.33**
San Juan	72	81	73	**75.33**
Skagit	556	653	677	**628.67**
Skamania	43	49	25	**39.00**
Snohomish	2,889	2,594	2,423	**2,635.33**
Spokane	2,585	2,543	2,864	**2,664.00**
Stevens	129	133	153	**138.33**
Thurston	1,048	1,012	1,043	**1,034.33**
Wahkiakum	9	5	5	**6.33**
Walla Walla	312	318	321	**317.00**
Whatcom	837	834	905	**858.67**
Whitman	189	216	277	**227.33**
Yakima	1,105	1,116	1,150	**1,123.67**

Total Admissions by County - Adjusted for New

Column1	Total 2015	Total 2016	Total 2017	Average
Adams	36	31	34	**33.67**
Asotin	71	57	92	**73.33**
Benton	866	857	985	**902.67**
Chelan	412	340	363	**371.67**
Clallam	116	116	157	**129.67**
Clark	1,416	2,047	2,180	**1,881.00**
Columbia	21	19	18	**19.33**
Cowlitz	755	750	819	**774.67**
Douglas	164	121	148	**144.33**
Ferry	17	21	44	**27.33**
Franklin	183	126	137	**148.67**
Garfield	7	3	2	**4.00**
Grant	194	221	260	**225.00**
Grays Harbor	147	330	364	**280.33**
Island	296	227	399	**307.33**
Jefferson	188	135	181	**168.00**
King	8,123	7,626	7,793	**7,847.23**
Kitsap	1,128	1,070	1,260	**1,152.67**
Kittitas	126	99	180	**135.00**
Klickitat	80	102	288	**156.63**
Lewis	419	431	465	**438.33**
Lincoln	11	21	25	**19.00**
Mason	250	209	266	**241.67**
Okanogan	237	168	166	**190.33**
Pacific	54	114	123	**97.00**
Pend Oreille	44	67	63	**58.00**
Pierce	4,057	3,854	3,775	**3,895.33**
San Juan	72	81	73	**75.33**
Skagit	556	653	677	**628.67**
Skamania	43	49	25	**39.00**
Snohomish	2,889	2,594	2,423	**2,635.33**
Spokane	2,585	2,543	2,864	**2,664.00**
Stevens	129	133	153	**138.33**
Thurston	1,048	1,012	1,253	**1,104.30**
Wahkiakum	9	5	5	**6.33**
Walla Walla	312	318	321	**317.00**
Whatcom	837	834	905	**858.67**
Whitman	189	216	277	**227.33**
Yakima	1,105	1,116	1,150	**1,123.67**

Agencies that have operated for <3 years:
Wesley Homes Hospice - approved in 2015, operational since 2017 in King County
Heart of Hospice - approved in August 2017. Operational since August 2017 in Klickitat County.
Envision Hospice - approved in September 2018.

Calculation for "default values" per WAC 246-310-290(7)(b), assumption of 35 ADC, 60.86 ALOS per CMS

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/60.86 ALOS = 209.9 default admissions

For both affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

Appendix G	Admissions policy

Human Rights Assurance

POLICY

Hospice states human rights assurance.

PURPOSE

To establish guidelines for assurance of human rights.

REFERENCE

The Joint Commission CAMHC Standards: PC.01.01.01, HR.01.02.01; Medicare CoP #s: 418.20, 418.25; CHAP Standards: CI.5c, CIII.1a, HII.1b

PROCEDURE

1. Hospice will not discriminate against recipients of services on the basis of race, color, religion, national origin, sex, sexual preference, physical or mental handicap, political belief, veteran status or age.

2. Hospice will not discriminate against any employee or applicant for employment on the basis of race, color, religion, national origin, sex, sexual preference, political belief, veteran status, age or physical or mental handicapped status.

3. Hospice will not discontinue or reduce care provided to a Medicare or Medicaid patient because of the patient's inability to pay for care.

4. All employees and subcontractors employed by this Hospice will conform to these policies of human rights assurances.

Patient Admission Criteria

POLICY

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's needs can be met adequately by Hospice in the patient's place of residence. Patients will be accepted for care only if Hospice can meet a patient's identified needs.

PURPOSE

To establish criteria for the admission of patients to Hospice.

REFERENCE

The Joint Commission CAMHC Standard: PC.01.01.01; Medicare CoP #s: 418.20, 418.25; CHAP Standard: CI.5c; ACHC Standards: HSP2-1A, HSP5-2A.01, HSP5-2B.01, HSP5-2B.02, HSP5-9A.01

PROCEDURE

1. Criteria for admission are:
   - The patient must reside within Hospice's service area.
   - The patient must be entitled to receive covered Hospice services under the Social Security Act (Medicare and Medicaid) or have other funding source.
   - Medicare patients must be certified as being terminally ill with a prognosis of six (6) months or less, if the terminal illness runs its normal course.
   - Targeted patients are primarily adults.

2. Hospice admits a patient only on the recommendation of the Medical Director in consultation with, or input from the patient's attending physician (if any). In reaching a decision to certify that the patient is terminally ill, the Medical Director must consider at least the following information:
   - Diagnosis of the terminal condition of the patient.
   - Other health conditions, whether related or unrelated to the terminal condition.
   - Current clinically relevant information supporting all diagnoses.

3. Hospice will not deny admission to patients with communicable disease, including, but not limited to, HIV, MRSA, TB and Hepatitis B.

4. Care follows a written plan of care established by the IDG and reviewed at least every 15 days and IDG. Care will continue under the general supervision of the Medical Director.

5. Care will be available to all patients who can benefit regardless of race, color, religion, national origin, sex, sexual preference, disability, age, socioeconomic level, marital status, source of payment or diagnostic status. Information to be gathered to determine eligibility includes:
   - Hospice has resources to provide the services required by the patient.
   - Attitudes of the patient and family toward care are appropriate.
   - Qualified personnel to provide needed services are available.
   - Reasonable expectations that the patient's needs can be met adequately.
   - Care can be provided safely and effectively in the patient's home.
   - Adequate physical facilities in the patient's residence for proper care exist.
   - Family or caregiver is available, able and willing to participate in the patient's care when conditions warrant.

6. Patient referrals may be made by anyone including the family, physician, discharge planners, healthcare workers, friends, relatives or the patient.

7. When a telephone or verbal referral is received by Hospice, a referral form is completed by a RN. Referrals may also be received by fax, in person or in the mail. The referral form includes at least the following information from the attending physician:
   - Patient identification information, e.g., name, address, telephone number, date of birth, sex, Medicare or social security number, insurance information, emergency contact and telephone number.
   - Physician's name, address and telephone number and alternative physician to contact is attending is not available.
   - Referral source.
   - Primary admitting terminal diagnosis and other diagnosis(es).
   - Medications and treatments required, including orders for treatments and symptom management.
   - Date of hospital discharge, if applicable.
   - Care or treatments to be provided, including frequency and duration.
   - Dietary restrictions.
   - Any other information reported, e.g., medical management of conditions unrelated to the terminal illness.
   - Current medical findings.

8. Each referral is evaluated by the Manager of Patient Services and/or Director to determine the appropriateness of Hospice care.

9. One home evaluation visit may be made before deciding to accept the patient for Hospice care.

10. During the initial assessment, the RN will:
    - Perform initial assessment.
    - Provide information relevant to physician's orders and services to be provided so that patient/caregiver can give consent.

- Obtain the patient's signature on the consent and other required forms.
- Verify the information on the referral form.
- Explain and provide a copy of the *Patient's Bill of Rights/Responsibilities* and advance directives. If patient has an advance directive, a copy will be obtained or the patient's wishes will be documented.
- Provide a copy of the HIPAA Privacy Notice.
- Explain the visit procedures to the patient and the patient's family.
- Provide a copy of Hospice's scope of services, mission statement, office hours and how to access the on-call system.
- Perform a safety and environmental assessment.
- Develop a medication profile.
- Discuss emergency operations plan with the patient/caregiver.
- Explain the patient's liability for payment of services. Give the patient in writing his/her expected payment responsibility.
- Refer patient to other disciplines, as appropriate.
- Obtain past medical information, as appropriate.
- Obtain and implement the physician's orders.
- Submit the completed admission paperwork to the Manager of Patient Services or the Director for review.

11. A log of all referrals received is maintained by Hospice.

12. If Hospice is not able to provide the needed care, the referral source will be notified. Hospice will assist the referral source in alternative care.

Admission Information

POLICY

During the initial assessment (and on an ongoing basis when changes occur), Hospice will provide each patient and family with written information about Hospice.

PURPOSE

To provide patients with accurate information to make informed decisions regarding care or services.

REFERENCE

The Joint Commission CAMHC Standards: PC.01.01.01, RI.01.02.01; Medicare CoP #s: 418.20, 418.25, 418.52 c; CHAP Standards: HII.1a, HII.1i, HII.1j; ACHC Standards: HSP1-2A, HSP2-1A

PROCEDURE

1. During the initial assessment (and on an ongoing basis when changes occur), staff will provide the patient verbal and written information including:
   - Mission statement.
   - The scope of services:
     - Nursing.
     - Hospice Aide and Homemaker.
     - Physical Therapy.
     - Occupational Therapy.
     - Speech Language Pathology.
     - Social Worker.
     - Physician services/Medical Director.
     - Counselor.
     - Volunteers.
     - Dietary counseling.
     - Home medical equipment related to the terminal illness.
     - Drugs and biologicals related to the terminal illness.
     - Short-term general inpatient care.
     - Respite care.
     - Continuous care.
     - Bereavement counseling.
     - Medical supplies.

2. At time of initial assessment, Hospice will provide each patient with a statement of the scope of services provided directly and/or through contractual/written agreement.

3. Services are available 24 hours per day, seven (7) days a week.
   - Office hours are 8 a.m. to 5 p.m. Monday through Friday. Hospice telephone number is _____.
   - Telephone calls, after office hours, are answered by Hospice answering service. The on-call number is the same as the office Hospice telephone number.
   - Each patient will be provided in writing the actual dollar amount, if any, of payment responsibility.
   - An on-call nurse is available and may be contacted by the answering service 24 hours a day, seven (7) days a week.

Medicare Reimbursement Criteria

POLICY

In order for Hospice to provide Medicare approved services, the patient must meet Medicare qualifying criteria.

PURPOSE

To describe the Medicare reimbursement criteria.

REFERENCE

The Joint Commission CAMHC Standard: PC.01.01.01; Medicare CoP #: 418.20; CHAP Standards: CI.1a, CI.2a

PROCEDURE

1. Hospice must be a "Medicare certified" Hospice. The patient must be certified as being terminally ill with a life expectancy of six months or less, if the terminal illness runs its normal course.

2. All care must be furnished according to the written plan of care established by the IDG and reviewed at least every 15 days.

Appendix H	Charity care policy

Charity Care

POLICY

To provide medically necessary hospice care at a reduced rate or without charge to patients or their legal financial sponsors, when adequate income or assets are not available to pay for hospice services. Hospice will provide charity care as dictated by its available resources and consistent with the following procedure. Hospice will not deny palliative or hospice care to any individual based on that individual's ability to pay, national origin, age physical disabilities, race, color, sex, or religion.

PURPOSE

Hospice is committed to its local communities and recognizes our communities' need to provide necessary hospice care at a reduced rate or without charge to patients or their legal financial sponsors, when there is inadequate income or assets to cover such services. Additionally, Hospice is committed to provide quality care to our patients and such commitment dictates that clinical needs override economic factors in individual care decisions.

PROCEDURE

General Description:

1. Charity care is generally secondary to all other financial resources available to the patient including: group or individual medical plans, workers' compensation, Medicare, Medicaid or medical assistance programs, other state, federal or military programs, third party liability situations, or any other situation in which another person or entity may have a legal responsibility to pay for the cost of medical services.

2. In those situations where appropriate payment sources for necessary care are not available, patients shall be considered for charity care under this policy based on the following criteria as calculated for the 12 months prior to the date of charity application.

    - Determination of eligibility of a patient for charity care shall be applied regardless of the source of referral and without discrimination as to race, color, creed, or national origin.
    - Full charity care will be provided to patients with gross family income below 200% of the Federal Poverty Guidelines as adjusted for family size.
    - Partial charity care may be provided to patients with gross family income above 200% of the Federal Poverty Guidelines as adjusted for family size when circumstances determined by Envision Home Health indicate that full payment may cause social and financial hardship so as to significantly harm the patient or family unit.

Process for Eligibility Determination:

1. Cases for consideration may be proposed by the patient or family, by the patient's physician, by Hospice personnel, or by recognized social agencies. Application forms and instructions to complete them will be furnished to patients when charity care is requested or when need is indicated. It is preferred that the application form be completed prior to admission or upon admission. However, when circumstances prevent early completion, the application form may be completed after discharge. These application forms are available upon request to all patients.

2. Confidential financial information will be requested, including:
   - Gross income – current and prospective
   - Net worth – emphasis on liquidity
   - Employment status
   - Family size and ages of dependents
   - Other financial obligations
   - Amounts of other health care bills
   - All other support sources

3. All applications shall be accompanied by documentation to verify family income. When returned, the application shall be accompanied by one or more of the following types of documentation for purposes of verifying income. This documentation may be verified through a credit-reporting agency.
   - W2 Withholding statements for all employment during the relevant time period
   - Payroll check stubs from all employment during the relevant time period
   - IRS tax returns from the most recently filed calendar year
   - Forms approving or denying eligibility for Medicaid and or state-funded Medical assistance
   - Forms approving or denying unemployment; compensation
   - Written statements from employers or welfare agencies

4. All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.

5. Hospice will make final eligibility determination and will notify the patient within 14 days of receipt of the completed application and related documentation and material (proof of income, etc.).

6. Designation of charity care, while generally determined at time of admission may occur at any time upon Hospice's learning of facts that would indicate medical indigence. Should charity care be provided after the patient has made full or partial payment, said payment shall be refunded to the patient within 30 days of the charity care designation.

Process for Notification:

1. Whether or not the patient received verbal notification, a notification letter is mailed not later than 14 days following application submission date. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined eligible for charity care. Denials will be written and include instructions for appeal or reconsideration.

2. Hospice's decision to provide partial or full charity care in no way affects the patient's financial obligations to his or her other health care providers.

Appeals Procedure:

1. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size within 30 calendar days of receipt of notification. The Administrator of Envision Home Health will review all appeals for final determination.

2. Catastrophic medical costs, sizable other medical bills, or other patient specific circumstances (based on fairness and ability to pay) may justify granting charity care, even when a patient exceeds the indigence standards.

Policy Administration:

1. The Hospice Administrator shall oversee this policy.

2. Hospice Administer shall responsible for:
   - assuring that current Federal poverty guidelines are available to applicants and to staff assisting with administering this policy;
   - assuring that initial determinations for charity care meet the requirements of the policy;
   - for reviewing applications for charity care;
   - for assuring that a timely determination of eligibility is made;
   - for notifying the applicant of the results of determination;
   - and for considering any appeals.

Appendix I	Patient referral policy

Patient Admission Criteria

See items #6 - #8 below for Referral Policies

POLICY

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's needs can be met adequately by Hospice in the patient's place of residence. Patients will be accepted for care only if Hospice can meet a patient's identified needs.

PURPOSE

To establish criteria for the admission of patients to Hospice.

REFERENCE

The Joint Commission CAMHC Standard: PC.01.01.01; Medicare CoP #s: 418.20, 418.25; CHAP Standard: CI.5c; ACHC Standards: HSP2-1A, HSP5-2A.01, HSP5-2B.01, HSP5-2B.02, HSP5-9A.01

PROCEDURE

1. Criteria for admission are:
   - The patient must reside within Hospice's service area.
   - The patient must be entitled to receive covered Hospice services under the Social Security Act (Medicare and Medicaid) or have other funding source.
   - Medicare patients must be certified as being terminally ill with a prognosis of six (6) months or less, if the terminal illness runs its normal course.
   - Targeted patients are primarily adults.

2. Hospice admits a patient only on the recommendation of the Medical Director in consultation with, or input from the patient's attending physician (if any). In reaching a decision to certify that the patient is terminally ill, the Medical Director must consider at least the following information:
   - Diagnosis of the terminal condition of the patient.
   - Other health conditions, whether related or unrelated to the terminal condition.
   - Current clinically relevant information supporting all diagnoses.

3. Hospice will not deny admission to patients with communicable disease, including, but not limited to, HIV, MRSA, TB and Hepatitis B.

4. Care follows a written plan of care established by the IDG and reviewed at least every 15 days and IDG. Care will continue under the general supervision of the Medical Director.

5. Care will be available to all patients who can benefit regardless of race, color, religion, national origin, sex, sexual preference, disability, age, socioeconomic level, marital status, source of payment or diagnostic status. Information to be gathered to determine eligibility includes:
   - Hospice has resources to provide the services required by the patient.
   - Attitudes of the patient and family toward care are appropriate.
   - Qualified personnel to provide needed services are available.
   - Reasonable expectations that the patient's needs can be met adequately.
   - Care can be provided safely and effectively in the patient's home.
   - Adequate physical facilities in the patient's residence for proper care exist.
   - Family or caregiver is available, able and willing to participate in the patient's care when conditions warrant.

6. Patient referrals may be made by anyone including the family, physician, discharge planners, healthcare workers, friends, relatives or the patient.

7. When a telephone or verbal referral is received by Hospice, a referral form is completed by a RN. Referrals may also be received by fax, in person or in the mail. The referral form includes at least the following information from the attending physician:
   - Patient identification information, e.g., name, address, telephone number, date of birth, sex, Medicare or social security number, insurance information, emergency contact and telephone number.
   - Physician's name, address and telephone number and alternative physician to contact is attending is not available.
   - Referral source.
   - Primary admitting terminal diagnosis and other diagnosis(es).
   - Medications and treatments required, including orders for treatments and symptom management.
   - Date of hospital discharge, if applicable.
   - Care or treatments to be provided, including frequency and duration.
   - Dietary restrictions.
   - Any other information reported, e.g., medical management of conditions unrelated to the terminal illness.
   - Current medical findings.

8. Each referral is evaluated by the Manager of Patient Services and/or Director to determine the appropriateness of Hospice care.

9. One home evaluation visit may be made before deciding to accept the patient for Hospice care.

10. During the initial assessment, the RN will:
    - Perform initial assessment.
    - Provide information relevant to physician's orders and services to be provided so that patient/caregiver can give consent.

- Obtain the patient's signature on the consent and other required forms.
- Verify the information on the referral form.
- Explain and provide a copy of the *Patient's Bill of Rights/Responsibilities* and advance directives. If patient has an advance directive, a copy will be obtained or the patient's wishes will be documented.
- Provide a copy of the HIPAA Privacy Notice.
- Explain the visit procedures to the patient and the patient's family.
- Provide a copy of Hospice's scope of services, mission statement, office hours and how to access the on-call system.
- Perform a safety and environmental assessment.
- Develop a medication profile.
- Discuss emergency operations plan with the patient/caregiver.
- Explain the patient's liability for payment of services. Give the patient in writing his/her expected payment responsibility.
- Refer patient to other disciplines, as appropriate.
- Obtain past medical information, as appropriate.
- Obtain and implement the physician's orders.
- Submit the completed admission paperwork to the Manager of Patient Services or the Director for review.

11. A log of all referrals received is maintained by Hospice.

12. If Hospice is not able to provide the needed care, the referral source will be notified. Hospice will assist the referral source in alternative care.

Appendix J	ProForma Financials, Snohomish Hospice only • Assumptions & Methods including Staffing Summary • Operating Statement • ProForma Cash Flow and Balance Sheet

Revenue Assumptions & Staffing Summary, Envision Hospice, Snohomish County

	2020	2021	2022	
Admissions (Unduplicated Patients	114	219	275.4	See Need Section, Question #4
Patient Days at ALOS 60	6,840	13,140	16,524	ALOS assumption based on 60 ALOS
AVERAGE DAILY CENSUS (ADC)	18.7	36.0	45.3	DOC/365
DAYS OF CARE (DOC)				
Routine Home Care	6,669	12,812	16,111	97.5% based on Utah & WA averages from CMS
Inpatient Care	68	131	165	1.0% based on Utah & WA averages from CMS
Continuous Care	68	131	165	1.0% based on Utah & WA averages from CMS
Respite Care	34	66	83	0.5% based on Utah & WA averages from CMS
TOTAL	6,840	13,140	16,524	100%
Per Diem Rates				
Routine Home Care	$ 206.84	$ 206.84	$ 206.84	blend base rate with 61+ rate (.75 x 218.54.30)+(.25 x 171.72) = 206.84
Inpatient Care	$ 838.28	$ 838.28	$ 838.28	CMS 2019 Snohomish County hospice rate
Continuous Care	$ 1,110.66	$ 1,110.66	$ 1,110.66	CMS 2019 Snohomish County hospice rate
Respite Care	$ 191.76	$ 191.76	$ 191.76	CMS 2019 Snohomish County hospice rate
Gross Revenue by Type of Care				
Routine Home Care	$ 1,379,416	$ 2,649,931	$ 3,332,379	Days of Care x Per Diem Rates
Inpatient Care	$ 57,338	$ 110,150	$ 138,517	Days of Care x Per Diem Rates
Continuous Care	$ 75,969	$ 145,941	$ 183,525	Days of Care x Per Diem Rates
Respite Care	$ 6,558	$ 12,599	$ 15,843	Days of Care x Per Diem Rates
TOTAL	$ 1,519,282	$ 2,918,620	$ 3,670,265	
Payer Mix				
Medicare Fee For Service	50%	50%	50%	Based on Utah experience & WA payers
Medicare Managed Care	35%	35%	35%	Based on Utah experience & WA payers
Medicaid	10%	10%	10%	Based on Utah experience & WA payers
Commercial /Other (b)	5%	5%	5%	Based on Utah experience & WA payers
TOTAL	100%	100%	100%	
Gross Revenue per Payer				
Medicare Fee For Service	$ 759,641	$ 1,459,310	$ 1,835,132	Gross Revenue Total x % Payer Mix
Medicare Managed Care	$ 531,749	$ 1,021,517	$ 1,284,593	Gross Revenue Total x % Payer Mix
Medicaid	$ 151,928	$ 291,862	$ 367,026	Gross Revenue Total x % Payer Mix
Commercial	$ 75,964	$ 145,931	$ 183,513	Gross Revenue Total x % Payer Mix

STAFFING SUMMARY - SNOHOMISH

STAFFING INPUT - BY FTE'S		2020	2021	2022	
CLINICAL OPERATIONS	Salary				
Bereavement	60,000	-	0.40	0.80	done by spiritual counselor until ADC reaches 40
Spiritual Counselor	60,000	0.51	0.97	1.22	does bereavement until monthly ADC reaches 40
Volunteer coordinator	42,000	-	0.60	1.00	starts at .4 when MSW gets to .75
Manager of Patient Services	95,000	0.50	1.00	1.00	done by admin until 20 adc; starts at .5 ; .75 at 40 adc; 1.0 at 50 adc
RN's	90,000	1.87	3.60	4.53	1 per 10 ADC
Medical Social Worker	80,000	0.80	1.03	1.29	does vol coord until reaching .75 then MSW formula
HHA's	30,160	1.87	3.60	4.53	1 HHA per 10 ADC
TOTAL		5.55	11.20	14.37	
ADMINISTRATIVE					
Administrator	120,000	1.00	1.00	1.00	
Admin Asst./Medical Records	52,000	1.00	1.25	1.75	
Facility Liaison/Community Outreach	65,000	2.00	2.50	3.00	
QAPI Coordinator	95,000	-	0.50	1.00	Administrator does this until ADC of 30
TOTAL		4.00	5.25	6.75	
TOTAL FTE'S		9.55	16.45	21.12	

Envision Hospice of Washington LLC
Snohomish County Certificate of Need
Projected Statement of Operations

	2020	2021	2022	Notes and Assumptions
Average Daily Census	18.7	36.0	45.3	
Days of Care	6,840	13,140	16,524	
REVENUE				
Medicare Fee For Service	759,641	1,459,310	1,835,132	
Medicare Managed Care	531,749	1,021,517	1,284,593	
Medicaid	151,928	291,862	367,026	includes Healthy Options
Commercial/Other	75,964	145,931	183,513	Comm.,BHP,TriCare, CHAMPUS
Total Gross Revenue	1,519,282	2,918,620	3,670,265	
Deductions from Revenue				
Contractual Allowances	(30,386)	(58,372)	(73,405)	2% of gross revenue
Bad Debt	(15,193)	(29,186)	(36,703)	1% of gross revenue
Adj. For Charity Care	(29,474)	(56,621)	(71,203)	2% of Total Net Revenue
Total Net Revenue	1,444,229	2,774,440	3,488,954	
PATIENT CARE COSTS				
Salaries and Benefits:				
Bereavement	-	24,000	48,000	See Staffing Summary
Spiritual Counselor	30,407	58,413	73,457	See Staffing Summary
Volunteer coordinator	-	25,200	42,000	See Staffing Summary
Manger of Patient Services	47,500	95,000	95,000	See Staffing Summary
RN's	168,658	324,000	407,441	See Staffing Summary
Medical Social Worker	64,000	82,286	103,477	See Staffing Summary
HHA's	56,519	108,576	136,538	See Staffing Summary
Payroll Taxes & Benefits	110,125	215,243	271,774	30% of Salaries
Total Salaries and Benefits	477,209	932,718	1,177,687	
Contract Labor:				
Physician (Medical Director)	67,463	129,600	162,976	$300 x ADC/mo.
Physical Therapy	616	1,183	1,487	$ 0.09 per DOC
Occupational Therapy	205	394	496	$ 0.03 per DOC
Speech/Language	137	263	330	$ 0.02 per DOC
Dietary Counseling	547	1,051	1,322	$ 0.08 per DOC
Total Contract Labor	68,968	132,491	166,612	
Physician Consulting Fees	14,442	27,744	34,890	1% of net revenue
Pharmacy/IV's	59,234	113,792	143,098	$8.66 DOC
DME Costs	34,542	66,357	83,446	$5.05 DOC
Medical Supplies	16,279	31,273	39,327	$2.38 DOC
Lab Costs	821	1,577	1,983	$0.12 DOC
Chemotherapy	1,436	2,759	3,470	$0.21 DOC
Radiation Therapy	821	1,577	1,983	$0.12 DOC
Imaging Services	547	1,051	1,322	$0.08 DOC
Ambulance Costs	2,394	4,599	5,783	$0.35 DOC
General Inpatient Costs	50,311	96,650	121,541	$ 735.54 per General inpatient day
Inpatient Respite	10,328	19,841	24,951	$ 151.00 per inpatient respite day
Net SNF Medicaid Costs	8,208	23,652	39,658	DOC x $12 x 5%,10%,15%,20%
Mileage	22,914	44,019	55,355	$3.35 DOC
Total Other Costs	222,278	434,893	556,807	
Total Patient Care Costs	768,455	1,500,101	1,901,106	
ADMINISTRATIVE COSTS				
Payroll Taxes & Benefits	90,600	118,500	150,300	30% of Administrative Salaries
B&O Taxes	22,789	43,779	55,054	1.5% of gross revenue
Salaries - Administrative	172,000	185,000	211,000	Staffing Summary
Salaries - Facility/Comm. Outreac	130,000	162,500	195,000	Staffing Summary
QAPI Coordinator	-	47,500	95,000	Staffing Summary
Mileage	9,600	9,600	9,600	$800/month
Advertising	36,000	36,000	36,000	$3,000/month
Travel - admin	20,000	10,000	10,000	$20,000/year first year and $10,000 therafter
Legal & Professional	12,000	12,000	12,000	$1,000/month
Consulting Fees	3,000	3,000	3,000	$250/month
Software Costs	24,000	24,000	24,000	$2,000/month
Computer @ Software Maintenanc	15,000	15,000	15,000	$1250/month
Office rent	18,613	18,613	19,093	As per lease
Repairs/Maintenance	1,800	1,800	1,800	$150/month
Cleaning	600	600	600	$50/month
Insurance	3,000	3,000	3,000	$250/month
Office Supplies	2,250	1,500	1,500	$125/month
Equipment Rental	2,000	2,000	2,000	$2,000/year

Postage	600	600	600	$50/month
Telephones/Pagers	14,400	14,400	14,400	$1200/month
Purchased Services/Utilities	6,000	6,000	6,000	$500/month
Books & References Materials	1,200	1,200	1,200	$100/month
Printing	1,500	1,500	1,500	$125/month
Licenses & Certification	11,400	1,400	1,400	$1400/year for WA license; 10,000 in 2018 for Palliative Care Certification
Education and Training	24,000	24,000	24,000	$24,000/year including palliative care, cultural competence, volunteer prograr
Dues and Subscriptions	2,400	2,400	2,400	$200/month
Corporate Allocation	60,000	60,000	60,000	Lesser of 5% or $60,000/year; includes billing, HR, payroll, recruiting
Total Administrative Costs	684,752	805,892	955,447	
Total Costs	1,453,207	2,305,993	2,856,552	
EBITDA	(8,978)	468,447	632,401	
EBITDA Margin %	-0.6%	16.9%	18.1%	
Depreciation	3,360	3,360	3,360	See Depreciation Schedule
Amortization	-	-	-	None
EBIT	(12,338)	465,087	629,041	
Interest Expense	-	-	-	None
Earnings before Taxes	(12,338)	465,087	629,041	

Envision Hospice of Washington LLC - Snohomish
Proforma Cash Flow
For The Periods Ending December 31, 2020 Through 2022

	2020	2021	2022
Cash Flows from operating activities			
Net Income After Depreciation and Amortization	(12,338)	465,087	629,041
Adjustments to reconcile net income to cash provided by Operations			
Depreciation & Amortization Change	3,360	3,360	3,360
Accounts Receivable Change	(180,529)	(166,276)	(89,314)
Accounts Payable Change	40,160	15,979	10,194
Payroll Payable Change	40,452	28,275	18,001
Total Adjustments	(96,557)	(118,662)	(57,759)
Net Cash provided by Operations	(108,895)	346,424	571,283
Cash Flows from investing activities Used For:			
Capital equipment and furniture	(19,800)	-	-
Net cash used in investing	(19,800)	-	-
Cash Flows from financing activities			
Proceeds From:			
Capital Contributions	135,000	-	-
Used For:			
Dividends	-	-	(400,000)
Net cash used in financing	135,000	-	(400,000)
Net increase <decrease> in cash	6,305	346,424	171,283
Summary			
Cash Balance at Beg of Period	-	6,305	352,729
Cash Balance at End of Period	6,305	352,729	524,012

Envision Hospice of Washington, LLC - Snohomish
Proforma Balance Sheet
For The Periods Ending December 31, 2020 Through 2022

	2020	2021	2022
ASSETS			
Current Assets			
Cash & Cash Equivalents	6,305	352,729	524,012
Accounts Receivable (Net)	180,529	346,805	436,119
Total Current Assets	186,834	699,534	960,131
Property and Equipment			
Fixed Assets	19,800	19,800	19,800
Accumulated Depreciation	(3,360)	(6,720)	(10,080)
Total Property and Equipment	16,440	13,080	9,720
Other Assets	-	-	-
Total Assets	203,274	712,614	969,851
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	40,160	56,139	66,333
Accrued Payroll & Related Payables	40,452	68,727	86,728
Total Current Liabilities	80,612	124,866	153,061
Long-Term Liabilities	-	-	-
Total Liabilities	80,612	124,866	153,061
Shareholder Equity (Deficit)	122,662	587,749	816,790
Total Liabilities & Capital	203,274	712,614	969,851

Appendix K	ProForma Financials, Existing Operations of Envision Home Health of Washington, LLC • Assumptions & Methods including Staffing Summary • Operating Statement • ProForma Cash Flow and Balance Sheet

Proforma Operating Statement - EXISTING: Envision HHA & Envision Hospice (Thurston) 2019-2022

	2019	2020	2021	2022	NOTES
VOLUMES					
Total Home Health Admissions	1,190	1,350	1,400	1,450	
Total Visits @ 16.81 visits per adm.	20,004	22,694	23,534	24,375	
Average Daily Hospice Census	20.1	29.1	34.0	41.6	
REVENUE					
Total Gross Revenue	5,774,352	7,066,923	7,642,205	8,431,469	
Total Deductions from Revenue	(210,089)	(263,836)	(289,097)	(324,928)	
Total Net Revenue	5,564,263	6,803,087	7,353,108	8,106,541	
EXPENSES					
Total W2 Salaries and Benefits	1,441,197	1,763,523	1,873,815	2,080,014	
Total Contract Labor	1,247,177	1,435,957	1,502,701	1,579,126	
Other Patient Care costs	523,196	667,425	744,475	855,466	
Total Direct Patient Care Costs	3,211,570	3,866,905	4,120,991	4,514,605	
Total Administrative Costs	1,631,762	1,708,434	1,935,267	2,112,345	
Total Costs	4,843,333	5,575,340	6,056,259	6,626,950	
EBITDA	$ 720,930	$ 1,227,747	$ 1,296,849	$ 1,479,590	
EBITDA Margin %	13.0%	18.0%	17.6%	18.3%	
Depreciation	6,074	6,074	4,938	1,857	
Amortization	0	0	0	0	
Net Income	$ 714,856	$ 1,221,673	$ 1,291,911	$ 1,477,733	

Proforma Operating Statement - EXISTING: Envision HHA & Envision Hospice (Thurston) 2019-2022
Proforma Balance Sheet
For The Periods Ending December 31, 2019 Through 2022

	2019	2020	2021	2022
ASSETS				
Current Assets				
Cash & Cash Equivalents	786,366	1,518,774	1,746,238	2,136,270
Accounts Receivable (Net)	1,317,586	1,556,077	1,650,966	1,771,282
Total Current Assets	2,103,952	3,074,850	3,397,204	3,907,552
Property and Equipment				
Fixed Assets	29,552	29,552	29,552	29,552
Accumulated Depreciation	(11,112)	(17,186)	(22,124)	(23,981)
Total Property and Equipment	18,440	12,366	7,428	5,571
Other Assets	-	-	-	-
Total Assets	2,122,392	3,087,217	3,404,633	3,913,123
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	96,787	109,291	116,865	126,973
Accrued Payroll & Related Payables	196,035	226,682	244,614	265,263
Total Current Liabilities	292,823	335,974	361,479	392,236
Long-Term Liabilities	-	-	-	-
Total Liabilities	292,823	335,974	361,479	392,236
Shareholder Equity (Deficit)	1,829,570	2,751,243	3,043,154	3,520,887
Total Liabilities & Capital	2,122,392	3,087,217	3,404,633	3,913,123

Proforma Operating Statement - EXISTING: Envision HHA & Envision Hospice (Thurston) 2019-2022
Proforma Cash Flow
For The Periods Ending December 31, 2019 Through 2022

	2019	2020	2021	2022
Cash Flows from operating activities				
Net Income After Depreciation and Amortization	714,856	1,221,673	1,291,911	1,477,733
Adjustments to reconcile net income to cash provided by Operations				
Depreciation & Amortization Change	6,074	6,074	4,938	1,857
Accounts Receivable Change	(367,586)	(238,490)	(94,889)	(120,316)
Accounts Payable Change	11,787	12,504	7,573	10,108
Payroll Payable Change	86,035	30,647	17,932	20,649
Total Adjustments	(263,690)	(189,266)	(64,446)	(87,702)
Net Cash provided by Operations	451,166	1,032,408	1,227,465	1,390,031
Cash Flows from investing activities Used For:				
Capital equipment and furniture	(19,800)	-	-	-
Net cash used in investing	(19,800)	-	-	-
Cash Flows from financing activities				
Proceeds From:				
Capital Contributions	-	-	-	-
Used For:				
Dividends	(300,000)	(300,000)	(1,000,000)	(1,000,000)
Net cash used in financing	(300,000)	(300,000)	(1,000,000)	(1,000,000)
Net increase <decrease> in cash	131,366	732,408	227,465	390,031
Summary				
Cash Balance at Beg of Period	655,000	786,366	1,518,774	1,746,238
Cash Balance at End of Period	786,366	1,518,774	1,746,238	2,136,270

Appendix L	ProForma Financials, Envision Home Health of Washington, LLC Existing Operations combined with Envision Hospice of Washington – Snohomish County • Operating Statement • ProForma Cash Flow and Balance Sheet

Proforma Operating Statement - Combination of Envision Home Health with Envision Hospice with Snohomish County

Part 1 of 3: Proforma Operating Statement - Envision HHA & Hospice

	2019	2020	2021	2022
VOLUMES				
Total Home Health Admissions	1,190	1,350	1,400	1,450
Total Visits @ 16.81 visits per adm.	20,004	22,694	23,534	24,375
Average Daily Hospice Census	20.1	29.1	34.0	41.6
REVENUE				
Total Gross Revenue	5,774,352	7,066,923	7,642,205	8,431,469
Total Deductions from Revenue	(210,089)	(263,836)	(289,097)	(324,928)
Total Net Revenue	5,564,263	6,803,087	7,353,108	8,106,541
EXPENSES				
Total W2 Salaries and Benefits	1,441,197	1,763,523	1,873,815	2,080,014
Total Contract Labor	1,246,980	1,435,611	1,502,603	1,579,126
Other Patient Care costs	523,196	667,425	744,475	855,466
Total Direct Patient Care Costs	3,211,373	3,866,560	4,120,893	4,514,605
Total Administrative Costs	1,631,762	1,708,434	1,935,267	2,112,345
Total Costs	4,843,136	5,574,995	6,056,160	6,626,950
EBITDA	$ 721,127	$ 1,228,092	$ 1,296,948	$ 1,479,590
EBITDA Margin %	13.0%	18.1%	17.6%	18.3%
Depreciation	6,074	6,074	4,938	1,857
Amortization	-	-	-	-
Earnings Before Taxes	$ 715,053	$ 1,222,018	$ 1,292,010	$ 1,477,733

Part 2 of 3: Envision Hospice of Washington LLC
Snohomish County Certificate of Need
Projected Statement of Operations

	2020	2021	2022	Notes and Assumptions
Average Daily Census	18.7	36.0	45.3	
Days of Care	6,840	13,140	16,524	
REVENUE				
Medicare Fee For Service	759,641	1,459,310	1,835,132	
Medicare Managed Care	531,749	1,021,517	1,284,593	
Medicaid	151,928	291,862	367,026	includes Healthy Options
Commercial/Other	75,964	145,931	183,513	Comm.,BHP,TriCare, CHAMPUS
Total Gross Revenue	1,519,282	2,918,620	3,670,265	
Deductions from Revenue				
Contractual Allowances	(30,386)	(58,372)	(73,405)	2% of gross revenue
Bad Debt	(15,193)	(29,186)	(36,703)	1% of gross revenue
Adj. For Charity Care	(29,474)	(56,621)	(71,203)	2% of Total Net Revenue
Total Net Revenue	1,444,229	2,774,440	3,488,954	
PATIENT CARE COSTS				
Salaries and Benefits:				
Bereavement	-	24,000	48,000	See Staffing Summary
Spiritual Counselor	30,407	58,413	73,457	See Staffing Summary
Volunteer coordinator	-	25,200	42,000	See Staffing Summary
Manger of Patient Services	47,500	95,000	95,000	See Staffing Summary
RN's	168,658	324,000	407,441	See Staffing Summary
Medical Social Worker	64,000	82,286	103,477	See Staffing Summary
HHA's	56,519	108,576	136,538	See Staffing Summary
Payroll Taxes & Benefits	110,125	215,243	271,774	30% of Salaries
Total Salaries and Benefits	477,209	932,718	1,177,687	
Contract Labor:				
Physician (Medical Director)	67,463	129,600	162,976	$300 x ADC/mo.
Physical Therapy	616	1,183	1,487	$ 0.09 per DOC
Occupational Therapy	205	394	496	$ 0.03 per DOC
Speech/Language	137	263	330	$ 0.02 per DOC
Dietary Counseling	547	1,051	1,322	$ 0.08 per DOC
Total Contract Labor	68,968	132,491	166,612	
Physician Consulting Fees	14,442	27,744	34,890	1% of net revenue
Pharmacy/IV's	59,234	113,792	143,098	$8.66 DOC
DME Costs	34,542	66,357	83,446	$5.05 DOC
Medical Supplies	16,279	31,273	39,327	$2.38 DOC
Lab Costs	821	1,577	1,983	$0.12 DOC
Chemotherapy	1,436	2,759	3,470	$0.21 DOC
Radiation Therapy	821	1,577	1,983	$0.12 DOC
Imaging Services	547	1,051	1,322	$0.08 DOC
Ambulance Costs	2,394	4,599	5,783	$0.35 DOC
General Inpatient Costs	50,311	96,650	121,541	$ 735.54 per General inpatient day

Proforma Operating Statement - Combination of Envision Home Health with Envision Hospice with Snohomish County

Part 1 of 3: Proforma Operating Statement - Envision HHA & Hospice

	2019	2020	2021	2022
VOLUMES				
Total Home Health Admissions	1,190	1,350	1,400	1,450
Total Visits @ 16.81 visits per adm.	20,004	22,694	23,534	24,375
Average Daily Hospice Census	20.1	29.1	34.0	41.6
REVENUE				
Total Gross Revenue	5,774,352	7,066,923	7,642,205	8,431,469
Total Deductions from Revenue	(210,089)	(263,836)	(289,097)	(324,928)
Total Net Revenue	5,564,263	6,803,087	7,353,108	8,106,541
EXPENSES				
Total W2 Salaries and Benefits	1,441,197	1,763,523	1,873,815	2,080,014
Total Contract Labor	1,246,980	1,435,611	1,502,603	1,579,126
Other Patient Care costs	523,196	667,425	744,475	855,466
Total Direct Patient Care Costs	3,211,373	3,866,560	4,120,893	4,514,605
Total Administrative Costs	1,631,762	1,708,434	1,935,267	2,112,345
Total Costs	4,843,136	5,574,995	6,056,160	6,626,950
EBITDA	$ 721,127	$ 1,228,092	$ 1,296,948	$ 1,479,590
EBITDA Margin %	13.0%	18.1%	17.6%	18.3%
Depreciation	6,074	6,074	4,938	1,857
Amortization	-	-	-	-
Earnings Before Taxes	$ 715,053	$ 1,222,018	$ 1,292,010	$ 1,477,733

Part 2 of 3: Envision Hospice of Washington LLC
Snohomish County Certificate of Need
Projected Statement of Operations

	2020	2021	2022	Notes and Assumptions
Average Daily Census	18.7	36.0	45.3	
Days of Care	6,840	13,140	16,524	
REVENUE				
Medicare Fee For Service	759,641	1,459,310	1,835,132	
Medicare Managed Care	531,749	1,021,517	1,284,593	
Medicaid	151,928	291,862	367,026	includes Healthy Options
Commercial/Other	75,964	145,931	183,513	Comm.,BHP,TriCare, CHAMPUS
Total Gross Revenue	1,519,282	2,918,620	3,670,265	
Deductions from Revenue				
Contractual Allowances	(30,386)	(58,372)	(73,405)	2% of gross revenue
Bad Debt	(15,193)	(29,186)	(36,703)	1% of gross revenue
Adj. For Charity Care	(29,474)	(56,621)	(71,203)	2% of Total Net Revenue
Total Net Revenue	1,444,229	2,774,440	3,488,954	
PATIENT CARE COSTS				
Salaries and Benefits:				
Bereavement	-	24,000	48,000	See Staffing Summary
Spiritual Counselor	30,407	58,413	73,457	See Staffing Summary
Volunteer coordinator	-	25,200	42,000	See Staffing Summary
Manger of Patient Services	47,500	95,000	95,000	See Staffing Summary
RN's	168,658	324,000	407,441	See Staffing Summary
Medical Social Worker	64,000	82,286	103,477	See Staffing Summary
HHA's	56,519	108,576	136,538	See Staffing Summary
Payroll Taxes & Benefits	110,125	215,243	271,774	30% of Salaries
Total Salaries and Benefits	477,209	932,718	1,177,687	
Contract Labor:				
Physician (Medical Director)	67,463	129,600	162,976	$300 x ADC/mo.
Physical Therapy	616	1,183	1,487	$ 0.09 per DOC
Occupational Therapy	205	394	496	$ 0.03 per DOC
Speech/Language	137	263	330	$ 0.02 per DOC
Dietary Counseling	547	1,051	1,322	$ 0.08 per DOC
Total Contract Labor	68,968	132,491	166,612	
Physician Consulting Fees	14,442	27,744	34,890	1% of net revenue
Pharmacy/IV's	59,234	113,792	143,098	$8.66 DOC
DME Costs	34,542	66,357	83,446	$5.05 DOC
Medical Supplies	16,279	31,273	39,327	$2.38 DOC
Lab Costs	821	1,577	1,983	$0.12 DOC
Chemotherapy	1,436	2,759	3,470	$0.21 DOC
Radiation Therapy	821	1,577	1,983	$0.12 DOC
Imaging Services	547	1,051	1,322	$0.08 DOC
Ambulance Costs	2,394	4,599	5,783	$0.35 DOC
General Inpatient Costs	50,311	96,650	121,541	$ 735.54 per General inpatient day

Inpatient Respite	10,328	19,841	24,951	$ 151.00 per inpatient respite day
Net SNF Medicaid Costs	8,208	23,652	39,658	DOC x $12 x 5%,10%,15%,20%
Mileage	22,914	44,019	55,355	$3.35 DOC
Total Other Costs	222,278	434,893	556,807	
Total Patient Care Costs	768,455	1,500,101	1,901,106	
ADMINISTRATIVE COSTS				
Payroll Taxes & Benefits	90,600	118,500	150,300	30% of Administrative Salaries
B&O Taxes	22,789	43,779	55,054	1.5% of gross revenue
Salaries - Administrative	172,000	185,000	211,000	Staffing Summary
Salaries - Facility/Comm. Outreach	130,000	162,500	195,000	Staffing Summary
QAPI Coordinator	-	47,500	95,000	Staffing Summary
Mileage	9,600	9,600	9,600	$800/month
Advertising	36,000	36,000	36,000	$3,000/month
Travel - admin	20,000	10,000	10,000	$20,000/year first year and $10,000 therafter
Legal & Professional	12,000	12,000	12,000	$1,000/month
Consulting Fees	3,000	3,000	3,000	$250/month
Software Costs	24,000	24,000	24,000	$2,000/month
Computer @ Software Maintenance	15,000	15,000	15,000	$1250/month
Office rent	18,613	18,613	19,093	As per lease
Repairs/Maintenance	1,800	1,800	1,800	$150/month
Cleaning	600	600	600	$50/month
Insurance	3,000	3,000	3,000	$250/month
Office Supplies	2,250	1,500	1,500	$125/month
Equipment Rental	2,000	2,000	2,000	$2,000/year
Postage	600	600	600	$50/month
Telephones/Pagers	14,400	14,400	14,400	$1200/month
Purchased Services/Utilities	6,000	6,000	6,000	$500/month
Books & References Materials	1,200	1,200	1,200	$100/month
Printing	1,500	1,500	1,500	$125/month
Licenses & Certification	11,400	1,400	1,400	$1400/year for WA license; 10,000 in 2018 for Palliative Care Cert
Education and Training	24,000	24,000	24,000	$24,000/year including palliative care, cultural competence, volunt
Dues and Subscriptions	2,400	2,400	2,400	$200/month
Corporate Allocation	60,000	60,000	60,000	Lesser of 5% or $60,000/year; includes billing, HR, payroll, recrui
Total Administrative Costs	684,752	805,892	955,447	
Total Costs	$ 1,453,207	$ 2,305,993	$ 2,856,552	
EBITDA	(8,978)	468,447	632,401	
EBITDA Margin %	-1%	17%	18%	
Depreciation	3,360	3,360	3,360	See Depreciation Schedule
Amortization	-	-	-	None
EBIT	(12,338)	465,087	629,041	
Interest Expense	-	-	-	None
Earnings Before Taxes	(12,338)	465,087	629,041	

PART 3 of 3: COMBINATION OF PARTS 1 AND 2: ENVISION HOME HEALTH OF WA PLUS ENVISION HOSPICE - SNOHOMISH COUNTY

	2019	2020	2021	2022
REVENUE				
Total Gross Revenue	5,774,352	8,586,205	10,560,825	12,101,734
Total Deductions from Revenue	(210,089)	(338,889)	(433,277)	(506,240)
Total Net Revenue	5,564,263	8,247,316	10,127,548	11,595,494
EXPENSES				
Total W2 Salaries and Benefits	1,441,197	2,240,732	2,806,532	3,257,701
Total Contract Labor	1,246,980	1,504,579	1,635,094	1,745,738
Other Patient Care costs	523,196	889,704	1,179,368	1,412,272
Total Direct Patient Care Costs	3,211,373	4,635,015	5,620,994	6,415,711
Total Administrative Costs	1,631,762	2,393,187	2,741,160	3,067,792
Total Costs	4,843,136	7,028,202	8,362,154	9,483,503
EBITDA	721,127	1,219,114	1,765,394	2,111,991
EBITDA Margin %	13.0%	14.8%	17.4%	18.2%
Depreciation	6,074	9,434	8,298	5,217
Amortization	-	-	-	-
Earnings Before Taxes	715,053	1,209,680	1,757,096	2,106,774

Envision Home Health Combined with Envision Hospice of Washington, LLC - Snohomish
Proforma Balance Sheet
For The Periods Ending December 31, 2019 Through 2022

	2019	2020	2021
ASSETS			
Current Assets			
Cash & Cash Equivalents	786,547	1,390,593	1,964,601
Accounts Receivable (Net)	1,317,586	1,736,605	1,997,771
Total Current Assets	2,104,133	3,127,198	3,962,372
Property and Equipment			
Fixed Assets	29,552	49,352	49,352
Accumulated Depreciation	(11,112)	(20,546)	(28,844)
Total Property and Equipment	18,440	28,806	20,508
Other Assets	-	-	-
Total Assets	2,122,573	3,156,004	3,982,880
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	96,787	149,451	173,003
Accrued Payroll & Related Payables	196,019	267,105	313,333
Total Current Liabilities	292,806	416,557	486,336
Long-Term Liabilities	-	-	-
Total Liabilities	292,806	416,557	486,336
Shareholder Equity (Deficit)	1,829,767	2,739,448	3,496,544
Total Liabilities & Capital	2,122,573	3,156,004	3,982,880

Envision Home Health Combined with Envision Hospice of Washington, LLC - Snohomish
Proforma Cash Flow
For The Periods Ending December 31, 2019 Through 2022

	2,019	2020	2021
Cash Flows from operating activities			
Net Income After Depreciation and Amortization	715,053	1,209,680	1,757,096
Adjustments to reconcile net income to cash provided by Operations			
Depreciation & Amortization Change	6,074	9,434	8,298
Accounts Receivable Change	(367,586)	(419,019)	(261,166)
Accounts Payable Change	11,787	52,664	23,552
Payroll Payable Change	86,019	71,087	46,227
Total Adjustments	(263,706)	(285,835)	(183,088)
Net Cash provided by Operations	451,347	923,846	1,574,008
Cash Flows from investing activities Used For:			
Capital equipment and furniture	(19,800)	(19,800)	-
Net cash used in investing	(19,800)	(19,800)	-
Cash Flows from financing activities			
Proceeds From:			
Capital Contributions	-	-	-
Used For:			
Dividends	(300,000)	(300,000)	(1,000,000)
Net cash used in financing	(300,000)	(300,000)	(1,000,000)
Net increase <decrease> in cash	131,547	604,046	574,008
Summary			
Cash Balance at End of Period	655,000	786,547	1,390,593
Cash Balance at Beg of Period	786,547	1,390,593	1,964,601

Appendix M	ProForma Financials, King Hospice only • Assumptions & Methods including Staffing Summary • Operating Statement • ProForma Cash Flow and Balance Sheet

Assumptions and Methods, Envision Hospice, King County

	2020	2021	2022	
Admissions (Unduplicated Patients)	109.50	219.00	292.00	
Patient Days at ALOS 60	6,570	13,140	17,520	ALOS assumption based on WA average
AVERAGE DAILY CENSUS (ADC)	18.0	36.0	48.0	2018, ADC = days of care /91
DAYS OF CARE (DOC)				
Routine Home Care	6,406	12,812	17,082	97.5% based on Utah & WA averages from CMS
Inpatient Care	66	131	175	1.0% based on Utah & WA averages from CMS
Continuous Care	66	131	175	1.0% based on Utah & WA averages from CMS
Respite Care	33	66	88	0.5% based on Utah & WA averages from CMS
TOTAL	6,570	13,140	17,520	100%
Per Diem Rates				
Routine Home Care	$ 206.84	$ 206.84	$ 206.84	blend base rate with 61+ rate (.75 x 218.54.30)+(.25 x 171.72) = 206.84
Inpatient Care	$ 838.28	$ 838.28	$ 838.28	CMS 2019 King County hospice rate
Continuous Care	$ 1,110.66	$ 1,110.66	$ 1,110.66	CMS 2019 King County hospice rate
Respite Care	$ 191.76	$ 191.76	$ 191.76	CMS 2019 King County hospice rate
Gross Revenue by Type of Care				
Routine Home Care	$ 1,324,965	$ 2,649,931	$ 3,533,241	Days of Care x Per Diem Rates
Inpatient Care	$ 55,075	$ 110,150	$ 146,867	Days of Care x Per Diem Rates
Continuous Care	$ 72,970	$ 145,941	$ 194,588	Days of Care x Per Diem Rates
Respite Care	$ 6,299	$ 12,599	$ 16,798	Days of Care x Per Diem Rates
TOTAL	$ 1,459,310	$ 2,918,620	$ 3,891,493	
Payer Mix				
Medicare	50%	50%	50%	Based on Utah experience & WA payers
Medicare	35%	35%	35%	Based on Utah experience & WA payers
Medicaid	10%	10%	10%	Based on Utah experience & WA payers
Commercial /Other (b)	5%	5%	5%	Based on Utah experience & WA payers
TOTAL	100%	100%	100%	
Gross Revenue per Payer				
Medicare Fee For Service	$ 729,655	$ 1,459,310	$ 1,945,747	Gross Revenue Total x % Payer Mix
Medicare Managed Care	$ 510,759	$ 1,021,517	$ 1,362,023	Gross Revenue Total x % Payer Mix
Medicaid	$ 145,931	$ 291,862	$ 389,149	Gross Revenue Total x % Payer Mix
Commercial	$ 72,966	$ 145,931	$ 194,575	Gross Revenue Total x % Payer Mix

STAFFING INPUT - BY FTE'S		2020	2021	2022	
CLINICAL OPERATIONS	Salaries				
Bereavement	60,000	-	0.40	1.00	done by spiritual counselor until ADC reaches 40

Spiritual Counselor	60,000	0.49	0.97	1.30	does bereavement until monthly ADC reaches 40
Volunteer coordinator	42,000	-	0.60	1.00	starts at .4 when MSW gets to .75
Manager of Patient Services	95,000	0.50	1.00	1.00	done by admin until 20 adc; starts at .5 ; .75 at 40 adc; 1.0 at
RN's	90,000	1.80	3.60	4.80	1 per 10 ADC
Medical Social Worker	80,000	0.80	1.03	1.37	does vol coord until reaching .75 then MSW formula
HHA's	30,160	1.80	3.60	4.80	1 HHA per 10 ADC
TOTAL		5.39	11.20	15.27	

ADMINISTRATIVE				
Administrator	120,000	1.00	1.00	1.00
Admin Asst./Medical Records	52,000	1.00	1.25	2.00
Facility Liaison/Community Outreach	65,000	2.00	2.50	3.00
QAPI Coordinator	95,000	-	0.50	1.00
TOTAL		4.00	5.25	7.00

TOTAL FTE'S		4.00	10.64	18.20

Envision Hospice of Washington LLC
King County Certificate of Need
Projected Statement of Operations

	2020	2021	2022	Notes and Assumptions
Average Daily Census	18.0	36.0	48.0	
Days of Care	6,570	13,140	17,520	
REVENUE				
Medicare Fee For Service	729,655	1,459,310	1,945,747	
Medicare Managed Care	510,759	1,021,517	1,362,023	
Medicaid	145,931	291,862	389,149	includes Healthy Options
Commercial/Other	72,966	145,931	194,575	Comm.,BHP,TriCare, CHAMPUS
Total Gross Revenue	1,459,310	2,918,620	3,891,493	
Deductions from Revenue				
Contractual Allowances	(29,186)	(58,372)	(77,830)	2% of gross revenue
Bad Debt	(14,593)	(29,186)	(38,915)	1% of gross revenue
Adj. For Charity Care	(28,311)	(56,621)	(75,495)	2% of Total Net Revenue
Total Net Revenue	1,387,220	2,774,440	3,699,254	
PATIENT CARE COSTS				
Salaries and Benefits:				
Bereavement	-	24,000	60,000	See Staffing Summary
Spiritual Counselor	29,207	58,413	77,885	See Staffing Summary
Volunteer coordinator	-	25,200	42,000	See Staffing Summary
Manger of Patient Services	47,500	95,000	95,000	See Staffing Summary
RN's	162,000	324,000	432,000	See Staffing Summary
Medical Social Worker	64,000	82,286	109,714	See Staffing Summary
HHA's	54,288	108,576	144,768	See Staffing Summary
Payroll Taxes & Benefits	107,098	215,243	288,410	30% of Salaries
Total Salaries and Benefits	464,093	932,718	1,249,777	
Contract Labor:				
Physician (Medical Director)	64,800	129,600	172,800	$300 x ADC/mo.
Physical Therapy	591	1,183	1,577	$ 0.09 per DOC
Occupational Therapy	197	394	526	$ 0.03 per DOC
Speech/Language	131	263	350	$ 0.02 per DOC
Dietary Counseling	526	1,051	1,402	$ 0.08 per DOC
Total Contract Labor	66,245	132,491	176,654	
Physician Consulting Fees	13,872	27,744	36,993	1% of net revenue
Pharmacy / IV's	56,896	113,792	151,723	$8.66 DOC
DME Costs	33,179	66,357	88,476	$5.05 DOC
Medical Supplies	15,637	31,273	41,698	$2.38 DOC
Lab Costs	788	1,577	2,102	$0.12 DOC
Chemotherapy	1,380	2,759	3,679	$0.21 DOC
Radiation Therapy	788	1,577	2,102	$0.12 DOC
Imaging Services	526	1,051	1,402	$0.08 DOC
Ambulance Costs	2,300	4,599	6,132	$0.35 DOC

General Inpatient Costs	48,325	96,650	128,867	$ 735.54 per General inpatient day
Inpatient Respite	9,921	19,841	26,455	$ 151.00 per inpatient respite day
Net SNF Medicaid Costs	7,884	23,652	42,048	DOC x $12 x 5%,10%,15%,20%
Mileage	22,010	44,019	58,692	$3.35 DOC
Total Other Costs	213,504	434,893	590,369	
Total Patient Care Costs	743,843	1,500,101	2,016,800	
ADMINISTRATIVE COSTS				
Payroll Taxes & Benefits	90,600	118,500	154,200	30% of Administrative Salaries
B&O Taxes	21,890	43,779	58,372	1.5% of gross revenue
Salaries - Administrative	172,000	185,000	224,000	Staffing Summary
Salaries - Facility/Comm. Outreach	130,000	162,500	195,000	Staffing Summary
QAPI Coordinator	-	47,500	95,000	Staffing Summary
Mileage	9,600	9,600	9,600	$800/month
Advertising	36,000	36,000	36,000	$3,000/month
Travel - admin	20,000	10,000	10,000	$20,000/year first year and $10,000 therafter
Legal & Professional	12,000	12,000	12,000	$1,000/month
Consulting Fees	3,000	3,000	3,000	$250/month
Software Costs	24,000	24,000	24,000	$2,000/month
Computer @ Software Maintenance	15,000	15,000	15,000	$1250/month
Office rent	6,000	6,000	6,000	$500/month per lease
Repairs/Maintenance	1,800	1,800	1,800	$150/month
Cleaning	600	600	600	$50/month
Insurance	3,000	3,000	3,000	$250/month
Office Supplies	2,250	1,500	1,500	$125/month
Equipment Rental	2,000	2,000	2,000	$2,000/year
Postage	600	600	600	$50/month
Telephones/Pagers	14,400	14,400	14,400	$1200/month
Purchased Services/Utilities	6,000	6,000	6,000	$500/month
Books & References Materials	1,200	1,200	1,200	$100/month
Printing	1,500	1,500	1,500	$125/month
Licenses & Certification	11,400	1,400	1,400	$1400/year for WA license; 10,000 in 2019 for Palliative Care Certification
Education and Training	24,000	24,000	24,000	$24,000/year including palliative care, cultural competence, volunteer program
Dues and Subscriptions	2,400	2,400	2,400	$200/month
Corporate Allocation	60,000	60,000	60,000	Lesser of 5% or $60,000/year; includes billing, HR, payroll, recruiting
Total Administrative Costs	671,240	793,279	962,572	
TOTAL COSTS	1,415,082	2,293,380	2,979,373	
EBITDA	(27,862)	481,060	719,881	
EBITDA Margin %	-2.0%	17.3%	19.5%	
Depreciation	1,471	1,471	1,471	See Depreciation Schedule
Amortization	-	-	-	None
EBIT	(29,333)	479,589	718,410	
Interest Expense	-	-	-	None
Earnings before Taxes	(29,333)	479,589	718,410	

Envision Hospice of Washington LLC - King
Proforma Cash Flow
For The Periods Ending December 31, 2020 Through 2022

	2020	2021	2022
Cash Flows from operating activities			
Net Income After Depreciation and Amortization	(29,333)	479,589	718,410
Adjustments to reconcile net income to cash provided by Operations			
Depreciation & Amortization Change	1,471	1,471	1,471
Accounts Receivable Change	(173,403)	(173,403)	(115,602)
Accounts Payable Change	38,378	16,710	12,950
Payroll Payable Change	39,686	29,041	22,389
Total Adjustments	(93,868)	(126,181)	(78,792)
Net Cash provided by Operations	(123,201)	353,408	639,618
Cash Flows from investing activities Used For:			
Capital equipment and furniture	(10,000)	-	-
Net cash used in investing	(10,000)	-	-
Cash Flows from financing activities			
Proceeds From:			
Capital Contributions	140,000	-	-
Used For:			
Dividends	-	-	(400,000)
Net cash used in financing	140,000	-	(400,000)
Net increase <decrease> in cash	6,799	353,408	239,618
Summary			
Cash Balance at Beg of Period	-	6,799	360,207
Cash Balance at End of Period	6,799	360,207	599,825

Envision Hospice of Washington, LLC - King
Proforma Balance Sheet
For The Periods Ending December 31, 2020 Through 2022

	2020	2021	2022
ASSETS			
Current Assets			
Cash & Cash Equivalents	6,799	360,207	599,825
Accounts Receivable (Net)	173,403	346,805	462,407
Total Current Assets	180,201	707,012	1,062,232
Property and Equipment			
Fixed Assets	10,000	10,000	10,000
Accumulated Depreciation	(1,471)	(2,942)	(4,413)
Total Property and Equipment	8,529	7,058	5,587
Other Assets	-	-	-
Total Assets	188,730	714,070	1,067,819
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	38,378	55,088	68,037
Accrued Payroll & Related Payables	39,686	68,727	91,116
Total Current Liabilities	78,064	123,815	159,154
Long-Term Liabilities	-	-	-
Total Liabilities	78,064	123,815	159,154
Shareholder Equity (Deficit)	110,667	590,255	908,665
Total Liabilities & Capital	188,730	714,070	1,067,819

Appendix N	ProForma Financials, Existing Operations of Envision Home Health of Washington, LLC combined with Envision Hospice of Washington LLC, King and Snohomish Proposed Hospices • Operating Statement • ProForma Cash Flow and Balance Sheet

Proforma Operating Statement - Combination of Envision Existing WA Operatons with both Snohomish and King Counties proposed hospices

Part 1 of 3: Proforma Operating Statement - Envision Exising Ops in WA

	2019	2020	2021	2022
VOLUMES				
Total Home Health Admissions	1,190	1,350	1,400	1,450
Total Visits @ 16.81 visits per adm.	20,004	22,694	23,534	24,375
Average Daily Hospice Census	20.1	29.1	34.0	41.6
REVENUE				
Total Gross Revenue	5,774,352	7,066,923	7,642,205	8,431,469
Total Deductions from Revenue	(210,089)	(263,836)	(289,097)	(324,928)
Total Net Revenue	5,564,263	6,803,087	7,353,108	8,106,541
EXPENSES				
Total W2 Salaries and Benefits	1,441,197	1,763,523	1,873,815	2,080,014
Total Contract Labor	1,247,177	1,435,957	1,502,701	1,579,126
Other Patient Care costs	523,196	667,425	744,475	855,466
Total Direct Patient Care Costs	3,211,570	3,866,905	4,120,991	4,514,605
Total Administrative Costs	1,631,762	1,708,434	1,935,267	2,112,345
Total Costs	4,843,333	5,575,340	6,056,259	6,626,950
EBITDA	$ 720,930	$ 1,227,747	$ 1,296,849	$ 1,479,590
EBITDA Margin %	13.0%	18.0%	17.6%	18.3%
Depreciation	6,074	6,074	4,938	1,857
Amortization	-	-	-	-
Earnings Before Taxes	$ 714,856	$ 1,221,673	$ 1,291,911	$ 1,477,733

Part 2 of 3: Envision Hospice of Washington LLC
Snohomish And King Counties proposed hospices, Combining Individual Proformas of Each
Projected Statement of Operations, without economies of scale

	2019	2020	2021	2022	Notes and Assumptions
Average Daily Census	-	36.7	72.0	93.3	
Days of Care	-	13,410	26,280	34,044	
REVENUE					
Medicare Fee For Service		1,489,296	2,918,620	3,780,879	
Medicare Managed Care		1,042,507	2,043,034	2,646,615	
Medicaid		297,859	583,724	756,176	
Commercial/Other		148,930	291,862	378,088	
Total Gross Revenue		2,978,592	5,837,240	7,561,758	
Deductions from Revenue					
Contractual Allowances		(59,572)	(116,745)	(151,235)	2% of gross revenue
Bad Debt		(29,786)	(58,372)	(75,618)	1% of gross revenue
Adj. For Charity Care		(57,785)	(113,242)	(146,698)	2% of Total Net Revenue

Total Net Revenue	2,831,449	5,548,880	7,188,207	
PATIENT CARE COSTS				
Salaries and Benefits:				
Bereavement	-	48,000	108,000	Combined Snohomish & Thurston salaries
Spiritual Counselor	59,614	116,827	151,342	Combined Snohomish & Thurston salaries
Volunteer coordinator	-	50,400	84,000	Combined Snohomish & Thurston salaries
Manger of Patient Services	95,000	190,000	190,000	Combined Snohomish & Thurston salaries
RN's	330,658	648,000	839,441	Combined Snohomish & Thurston salaries
Medical Social Worker	128,000	164,571	213,191	Combined Snohomish & Thurston salaries
HHA's	110,807	217,152	281,306	Combined Snohomish & Thurston salaries
Payroll Taxes & Benefits	217,223	430,485	560,184	30% of Salaries
Total Salaries and Benefits	941,302	1,865,435	2,427,464	
Contract Labor:				
Physician (Medical Director)	132,263	259,200	335,776	$300 x ADC/mo.
Physical Therapy	1,207	2,365	3,064	$ 0.09 per DOC
Occupational Therapy	402	788	1,021	$ 0.03 per DOC
Speech/Language	268	526	681	$ 0.02 per DOC
Dietary Counseling	1,073	2,102	2,724	$ 0.08 per DOC
Total Contract Labor	135,213	264,982	343,266	
Physician Consulting Fees	28,314	55,489	71,882	1% of net revenue
Pharmacy/IV's	116,131	227,585	294,821	$8.66 DOC
DME Costs	67,721	132,714	171,922	$5.05 DOC
Medical Supplies	31,916	62,546	81,025	$2.38 DOC
Lab Costs	1,609	3,154	4,085	$0.12 DOC
Chemotherapy	2,816	5,519	7,149	$0.21 DOC
Radiation Therapy	1,609	3,154	4,085	$0.12 DOC
Imaging Services	1,073	2,102	2,724	$0.08 DOC
Ambulance Costs	4,694	9,198	11,915	$0.35 DOC
General Inpatient Costs	98,636	193,300	250,407	$ 735.54 per General inpatient day
Inpatient Respite	20,249	39,683	51,406	$ 151.00 per inpatient respite day
Net SNF Medicaid Costs	16,092	47,304	81,706	DOC x $12 x 5%,10%,15%,20%
Mileage	44,924	88,038	114,047	$3.35 DOC
Total Other Costs	435,783	869,785	1,147,175	
Total Patient Care Costs	1,512,298	3,000,202	3,917,906	
ADMINISTRATIVE COSTS				
Payroll Taxes & Benefits	181,200	237,000	304,500	Snohomish & Thurston expenses combined
B&O Taxes	44,679	87,559	113,426	Snohomish & Thurston expenses combined
Salaries - Administrative	344,000	370,000	435,000	Snohomish & Thurston expenses combined
Salaries - Facility/Comm. Outreach	260,000	325,000	390,000	Snohomish & Thurston expenses combined
QAPI Coordinator	-	95,000	190,000	Snohomish & Thurston expenses combined
Mileage	19,200	19,200	19,200	Snohomish & Thurston expenses combined
Advertising	72,000	72,000	72,000	Snohomish & Thurston expenses combined
Travel - admin	40,000	20,000	20,000	Snohomish & Thurston expenses combined
Legal & Professional	24,000	24,000	24,000	Snohomish & Thurston expenses combined
Consulting Fees	6,000	6,000	6,000	Snohomish & Thurston expenses combined
Software Costs	48,000	48,000	48,000	Snohomish & Thurston expenses combined
Computer @ Software Maintenance	30,000	30,000	30,000	Snohomish & Thurston expenses combined
Office rent	24,613	24,613	25,093	Snohomish & Thurston expenses combined
Repairs/Maintenance	3,600	3,600	3,600	Snohomish & Thurston expenses combined

Cleaning	1,200	1,200	1,200	Snohomish & Thurston expenses combined
Insurance	6,000	6,000	6,000	Snohomish & Thurston expenses combined
Office Supplies	4,500	3,000	3,000	Snohomish & Thurston expenses combined
Equipment Rental	4,000	4,000	4,000	Snohomish & Thurston expenses combined
Postage	1,200	1,200	1,200	Snohomish & Thurston expenses combined
Telephones/Pagers	28,800	28,800	28,800	Snohomish & Thurston expenses combined
Purchased Services/Utilities	12,000	12,000	12,000	Snohomish & Thurston expenses combined
Books & References Materials	2,400	2,400	2,400	Snohomish & Thurston expenses combined
Printing	3,000	3,000	3,000	Snohomish & Thurston expenses combined
Licenses & Certification	22,800	2,800	2,800	Snohomish & Thurston expenses combined
Education and Training	48,000	48,000	48,000	Snohomish & Thurston expenses combined
Dues and Subscriptions	4,800	4,800	4,800	Snohomish & Thurston expenses combined
Corporate Allocation	120,000	120,000	120,000	Snohomish & Thurston expenses combined
Total Administrative Costs	1,355,992	1,599,172	1,918,019	Snohomish & Thurston expenses combined
Total Costs	2,868,290	4,599,374	5,835,925	
EBITDA	(36,840)	949,507	1,352,282	
EBITDA Margin %	-1%	17%	19%	
Depreciation	4,831	4,831	4,831	
Amortization	-	-	-	None
EBIT	(41,671)	944,676	1,347,451	
Interest Expense	-	-	-	None
Earnings before Taxes	(41,671)	944,676	1,347,451	

PART 3 of 3: COMBINATION OF PARTS 1 AND 2: ENVISION EXISTING WA OPERATIONS PLUS ENVISION HOSPICES PROPOSED - SNOHOMISH & KING COUNTY

	2019	2020	2021	2022
REVENUE				
Total Gross Revenue	5,774,352	10,045,515	13,479,445	15,993,227
Total Deductions from Revenue	(210,089)	(410,979)	(577,457)	(698,479)
Total Net Revenue	5,564,263	9,634,536	12,901,988	15,294,748
EXPENSES				
Total W2 Salaries and Benefits	1,441,197	2,704,825	3,739,250	4,507,478
Total Contract Labor	1,247,177	1,571,170	1,767,683	1,922,392
Other Patient Care costs	523,196	1,103,208	1,614,261	2,002,641
Total Direct Patient Care Costs	3,211,570	5,379,203	7,121,194	8,432,511
Total Administrative Costs	1,631,762	3,064,426	3,534,439	4,030,364
Total Costs	4,843,333	8,443,629	10,655,633	12,462,875
EBITDA	720,930	1,190,907	2,246,355	2,831,872
EBITDA Margin %	13.0%	12.4%	17.4%	18.5%
Depreciation	6,074	10,905	9,769	6,688
Amortization	-	-	-	-
Earnings Before Taxes	714,856	1,180,002	2,236,586	2,825,184

Envision Existing WA Operations plus both King & Snohomish Proposed Hospices
Proforma Balance Sheet
For The Periods Ending December 31, 2019 Through 2022

	2019	2020	2021	2022
ASSETS				
Current Assets				
Cash & Cash Equivalents	786,366	1,256,878	2,184,175	2,985,107
Accounts Receivable (Net)	1,317,586	1,910,008	2,344,576	2,669,808
Total Current Assets	2,103,952	3,166,886	4,528,751	5,654,915
Property and Equipment				
Fixed Assets	29,552	59,352	59,352	59,352
Accumulated Depreciation	(11,112)	(22,017)	(31,786)	(38,474)
Total Property and Equipment	18,440	37,335	27,566	20,878
Other Assets	-	-	-	-
Total Assets	2,122,392	3,204,221	4,556,317	5,675,794
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	96,787	187,829	228,091	261,343
Accrued Payroll & Related Payables	196,035	306,820	382,068	443,108
Total Current Liabilities	292,823	494,649	610,159	704,451
Long-Term Liabilities	-	-	-	-
Total Liabilities	292,823	494,649	610,159	704,451
Shareholder Equity (Deficit)	1,829,570	2,709,572	3,946,158	4,971,343
Total Liabilities & Capital	2,122,392	3,204,221	4,556,317	5,675,794

Envision Existing Operations in WA plus - both King & Snohomish proposed hospices
Proforma Cash Flow
For The Periods Ending December 31, 2019 Through 2022

	2,019	2020	2021	2022
Cash Flows from operating activities				
Net Income After Depreciation and Amortization	714,856	1,180,002	2,236,586	2,825,184
Adjustments to reconcile net income to cash provided by Operations				
Depreciation & Amortization Change	6,074	10,905	9,769	6,688
Accounts Receivable Change	(367,586)	(592,422)	(434,568)	(325,232)
Accounts Payable Change	11,787	91,042	40,262	33,252
Payroll Payable Change	86,035	110,785	75,248	61,040
Total Adjustments	(263,690)	(379,690)	(309,289)	(224,252)
Net Cash provided by Operations	451,166	800,312	1,927,297	2,600,933
Cash Flows from investing activities Used For:				
Capital equipment and furniture	(19,800)	(29,800)	-	-
Net cash used in investing	(19,800)	(29,800)	-	-
Cash Flows from financing activities				
Proceeds From:				
Capital Contributions	-	-	-	-
Used For:				
Dividends	(300,000)	(300,000)	(1,000,000)	(1,800,000)
Net cash used in financing	(300,000)	(300,000)	(1,000,000)	(1,800,000)
Net increase <decrease> in cash	131,366	470,512	927,297	800,933
Summary				
Cash Balance at End of Period	655,000	786,366	1,256,878	2,184,175
Cash Balance at Beg of Period	786,366	1,256,878	2,184,175	2,985,107

Appendix O	Chase Bank letter

CHASE

Blake E. Horton
Business Relationship Manager III
Business Banking

12/12/2018

ENVISION HOME HEALTH OF WASHINGTON, LLC

To whom it may concern:
This letter is to confirm that ENVISION HOME HEALTH OF WASHINGTON, LLC has an open and active account with Chase Bank and has a current balance of $536,434.

Checking Account # 3301208335
Routing # 124001545

If you have any questions or concerns regarding this, feel free to contact me directly.
Thanks,

Blake E. Horton
Business Relationship Manager
1115 S 800 E
Orem, UT 84097
801-224-9701

Appendix P	Commitment letter from Chief Financial Officer

ENVISION

1345 W 1600 N
Suite 202
Orem, UT 85057

December 17, 2018

Ms. Janis Sigman, Manager
Certificate of Need Program
Office of Certification and Enforcement
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

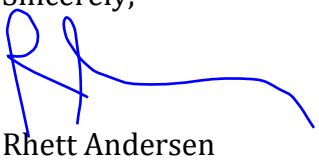
Dear Ms. Sigman,

The Certificate of Need program's application for a Medicare-certified hospice agency asks for a financial letter of commitment.

The Board of Envision Hospice of Washington, LLC has committed the necessary working capital to finance the establishment and operation of a Medicare-certified hospice agency in Snohomish County, Washington.

In the event that Certificates of Need are granted to Envision Hospice of Washington, LLC for new hospice agencies in both King and Snohomish Counties, the Board is committed to simultaneously funding the required working capital for both projects.

Sincerely,



Rhett Andersen
Finance Partner
rhett@envhh.com

Appendix Q	Historical financials, 2015-2017 Envision Home Health of Washington LLC

Envision Home Health of Washington, LLC
Historical Revenues and Expenses
For The Periods Ending December 31, 2015 Through 2017

	2015	2016	2017
REVENUE			
Medicare	483,773	1,607,198	3,485,863
Medicaid		13,980	143,638
Commercial/Other		53,135	126,917
Deductions & Adjustments		(85,340)	(204,255)
Total Net Revenue	483,773	1,588,972	3,552,163
PATIENT CARE COSTS			
Nursing	142,052	380,075	479,060
HHA		1,337	56,794
Physical Therapy	42,047	362,901	655,846
Occupational Therapy	46,891	93,109	164,670
Speech Therapy		13,035	100,927
Med Soc Svcs/Social Worker		7,759	99,505
Other Labor	602	1,279	2,146
Benefits	711	31,578	111,639
Mileage Reimbursment	5,445	18,823	45,266
Total Direct Labor Costs	237,748	909,896	1,715,853
Medical Supplies	10,677	21,489	45,474
External Coding	810	25,897	49,891
Other Costs	3,122	4,539	6,416
Total Patient Care Costs	**252,357**	**961,821**	**1,817,635**
ADMINISTRATIVE COSTS			
Benefits	11,082	19,525	57,105
B&O Taxes & Licenses	4,322	48,818	131,339
Salaries & Wages-General and Admin	231,066	231,016	479,228
Salaries & Wages-Sales & Marketing	23,045	136,404	368,213
Mileage	351	7,838	15,403
Computer/Software & Other Equip	7,383	14,360	36,722
Consulting/Outside Services/Legal	6,069	51,474	56,477
Dues and Subscriptions		12,636	1,775
Facilities	33,904	36,273	40,668
Insurance		4,254	4,483
Marketing & PR	10,443	9,571	29,260
Office Materials & Supplies	3,889	6,287	13,040
Postage and Delivery	325	615	521
Printing and Reproduction	1,291	1,431	2,145
Repairs & Matinenance		320	474
Telecommunications	5,868	10,812	23,284
Travel & Ent	35,267	37,773	17,742
Corporate Allocation	60,000	60,000	60,000
Total Administrative Costs	**434,305**	**689,407**	**1,337,879**
Total Costs	**686,662**	**1,651,228**	**3,155,514**
EBITDA	**(202,889)**	**(62,256)**	**396,649**
Depreciation Expense	1,138	1,950	1,950

Envision Home Health of Washington, LLC
Historical Cash Flows
For The Periods Ending December 31, 2015 Through 2017

	2015	2016	2017
Cash Flows from operating activities			
Net Income After Depreciation and Amortization	(204,027)	(64,206)	394,698
Adjustments to reconcile net income to cash provided by Operations			
Depreciation & Amortization Change	1,138	1,950	1,625
Accounts Receivable Change	(365,862)	(130,017)	(213,532)
Accounts Payable Change	6,876	199	18,072
Payroll Payable Change	10,576	35,151	26,169
Total Adjustments	(347,273)	(92,717)	(167,667)
Net Cash provided by Operations	(551,300)	(156,923)	227,032
Cash Flows from investing activities Used For:			
Capital equipment and furniture	(9,752)	-	-
Net cash used in investing	(9,752)	-	-
Cash Flows from financing activities			
Proceeds From:			
Capital Contributions	506,360	298,426	
Used For:			
Dividends	-	-	(13,890)
Net cash used in financing	506,360	298,426	(13,890)
Net increase <decrease> in cash	(54,692)	141,503	213,142
Summary			
Cash Balance at Beg of Period	71,093	16,402	157,904
Cash Balance at End of Period	16,402	157,904	371,046

Envision Home Health of Washington, LLC
Historical Balance Sheets
For The Periods Ending December 31, 2015 Through 2017

	2015	2016	2017
ASSETS			
Current Assets			
Cash & Cash Equivalents	16,402	157,904	371,046
Accounts Receivable (Net)	365,862	495,880	709,412
Total Current Assets	382,264	653,784	1,080,458
Property and Equipment			
Fixed Assets	9,752	9,752	9,752
Accumulated Depreciation	(1,138)	(3,088)	(5,038)
Total Property and Equipment	8,614	6,664	4,714
Security Deposits and Prepaids	15,862	15,289	30,756
Total Assets	**406,740**	**675,737**	**1,115,927**
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	9,099	9,298	27,370
Accrued Payroll & Related Payables	10,576	45,727	71,896
Total Current Liabilities	19,675	55,025	99,266
Long-Term Liabilities	-	-	-
Total Liabilities	19,675	55,025	99,266
Shareholder Equity (Deficit)	387,065	620,712	1,016,662
Total Liabilities & Capital	**406,740**	**675,737**	**1,115,927**

Appendix R	Staff recruitment detail

Additional Envision information about recruitment and retention in both Snohomish and King Counties

Fortunately, neither Envision in Utah nor Envision Home Health in King and Pierce Counties have had difficulty recruiting and retaining the staff required. In both Utah and Washington, Envision places a high priority on its recruitment and retention efforts.

At start-up in King County, Envision HHA successfully used the wide range of available resources to attract, screen, select, and hire both clinical and administrative employees. These included: local job fairs; the online job-search websites; using recruitment agencies; word of mouth through existing employees; outreach through existing employee relationships with professional organizations.

Due to its ownership and operation by clinicians and rehabilitation specialists themselves, Envision has been very successful in attracting and retaining the clinical staffing it requires. Envision-HHW has access to an active recruiting function for the relevant professionals.

Envision has also been very fortunate that its existing staff has been a substantial source of professional contacts in the area and that those have frequently resulted in new hires.

The greatest factor in Envision's success has been an extremely low turnover rate in staff:

- Envision-HHW's pay and benefits are competitive for both recruitment and retention. Benefits include medical, dental/orthotics, vision, life insurance, and 401k with company matching.
- At start-up. Envision adopted the practice of paying stable, reliable salaries to its professionals rather than just paying them for hourly work. This resulted in a committed group of employees from the outset and has reduced turnover to near zero.
- Rather than taking an "agency" or "pay per visit" approach to staffing, Envision uses a "primary care" model where possible. If an RN takes on a specific patient, that patient's prescribed Plan of Care becomes his or hers to manage. The primary care nurse that cannot make it to a patient's scheduled visit will take responsibility to find coverage from other appropriate Envision staff. This model appeals to the staff's professionalism and increases employee satisfaction and sense of control over the work environment.

As Envision has grown rapidly, its strong reputation has too. It relies less on the typical recruitment practices it used at start-up. Now, word of mouth among employees and their social and professional networks provide Envision with ample numbers of

candidates when agency growth permits addition of new positions. Word of mouth has resulted in numerous inquiries and new hires when conditions change at other area agencies.

Adding hospice in Snohomish County - and King County if both are approved

Envision's reputation as a good place to work is allowing it to build a "brand" name that is becoming familiar in the region among health care professionals attracted to the provision of in-home care services. It has attracted experienced, mid-career nurses who are comfortable meeting the varied demands of in-home nursing. Since many current Envision home health patients are terminally ill, existing Envision staff is accustomed to pain management and palliative care protocols. In King County, Envision found it took about a year before its own employees become the chief source of potential employment candidates. Envision expects its home health presence in the region and its existing staff will both contribute to successful recruitment of hospice staff.

Envision's current local employees have colleagues and friends throughout the region, including Snohomish County, and that can generate strong candidates for many positions. It has been Envision's consistent experience that satisfied employees not only bolster its recruitment efforts but also reduce the volume of recruitment needed when so few employees leave and need to be replaced.

Nevertheless, Envision's Snohomish hospice would serve a county in which it is not yet well known. For that reason, recruitment in Snohomish will be based on more traditional methods until word of mouth reputation begins to generate interest among both professional and administrative candidates for new positions.

In each county, Envision's office location will be a draw for recruitment:

- In Snohomish County, the Marysville office location will be attractive to many in that area of booming population north of the congested Everett area.
- In King County, the Envision hospice office location in Normandy Park, near Sea-Tac, provides an appealing alternative to potential recruits who are currently commuting to Tacoma or Seattle.

Appendix S	Envision Hospice Volunteer Recruitment Plan

Envision Hospice
Volunteer Recruitment Plan and Timeline

WEEK 1

- Finalize calendar, benchmarks, logistics for volunteer recruitment.
- Review forms, volunteer recruitment activities, and application process.
- Review and update information to be posted on website regarding volunteer opportunities.
- Review and update if needed volunteer job description for both direct care and administrative positions.
- Print volunteer applications, flyers, or any other needed forms to have in stock.

WEEK 2

- Go LIVE with website information for volunteer opportunities in Washington and information with link for on-line application.
- Initiate campaign activities to recruit volunteers; special emphasis on military veteran volunteers and Spanish speaking volunteers. These activities include may include involvement with the following:
    - VFW (Veterans of Foreign Wars)
    - American Legion
    - Branch specific leagues (i.e. Marine Corps League)
    - Assisted Living Facilities – veteran clubs
    - VA Clinics and Hospitals
    - Veteran Centers
    - Veteran Events
    - Radio/Other Media
    - Hospitals
    - Churches/Faith Communities
    - Parish Nurse Ministry/Assoc
    - Senior Centers
    - Barber Shops/Hair Salons
    - Grocery Stores
    - Social Media
    - Health Fairs
    - Employee referrals
    - On-line Recruitment Websites
- Initiate other campaign activities to recruit volunteers that can assist with Palliative arts (i.e. pet visits, music, and massage):
    - Pet certification organizations (i.e. American Kennel Club)
    - Pet rescue groups
    - Veterinarians
    - Pet specialty stores
    - Music Stores
    - Music club/groups
    - College/Universities' School of Music
    - Spas/massage studios
- Document all volunteer recruitment and retention activities.
- Document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Receive and process applications.

WEEK 3

- Continue outreach campaign to recruit volunteers.
- Interview any applicants.
- Ensure background check is submitted after any successful interview.
- Continue to document all volunteer recruitment and retention activities.
- Continue to document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Continue to receive and process applications.
- Analyze recruitment data: what gives best outcomes; what can be replicated; what efforts can be increased.

WEEK 4

- Initiate training and orientation for volunteers.
- Continue outreach campaign to recruit volunteers.
- Continue to document all volunteer recruitment and retention activities.
- Continue to document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Continue to receive and process applications.
- Continue interviewing applicants and ensuring background check is submitted after any successful interview.
- Continue to analyze recruitment data.
- Adjust volunteer opportunities and programs as needed.

WEEK5 AND ONGOING CONTINUOUS PROCESS

- Induct them into their roles, providing support and feedback regularly.
- Place volunteers after completion of orientation.
- Involve volunteers in team meeting and in matters that affect them.
- Manage, support, and evaluate volunteer performances. Provide opportunities for training.
- Reward and recognize volunteers appropriately.
- Create volunteer database with volunteers' availability and specialties; update routinely.
- Continue training and orientation for on-boarding volunteers.
- Continue outreach campaign to recruit volunteers. Conduct a "Refer a Friend" lunch every 6 months for employees and volunteers to bring in prospective volunteers to learn more about volunteer opportunities.
- Continue to document all volunteer recruitment and retention activities.
- Continue to document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Continue to receive and process applications.
- Continue interviewing applicants and ensuring background check is submitted after any successful interview.
- Continue to analyze recruitment data. Review recruitment strategies regularly.
- Adjust volunteer opportunities and programs as needed.

Appendix T	Envision Hospice Training Policies

Appendix U	List of proposed vendors

Vendor List, Envision Hospice of Washington LLC

Alphagraphics	business cards
BKD CPA's/Advisors	cost reports and consulting services
Blue Fin Office Group	office supplies
Briggs Corporation	medical forms
Comcast Business	Communications technology
Comprehensive Home & Companion Svcs. LLC	Temporary staffing agency
Copiers NorthWest	Copier service
Corporation Service Company	Marketing services
De Lage Landen	Office equipment
Ducky's Office Furniture	Office furniture
FastSigns	Signage
First Advantage Background Services Corp	Background checks
GoDaddy.com	Website design
Gordon's Copy Print	Printing
Gulf South Medical Supply	medical supplies
Hansen Creative	marketing designs and layouts
Heath & Company CPA, LLC	Accountants
Home Health Coding Solutions	Medical records management
Independence Rehab	contract therapy services
Integra Telecom	Internet and phone
Kleenwell Biohazard Waste	Bio-waste management
Les Olson Company	Office equipment
McGee's Stamp & Trophy Co	name badges
McKesson Medical Surgical	Medical supplies
MedForms, Inc.	Medical forms
Medical Forms Management, Inc.	Medical forms
Oldham Technology	IT services
Optum Healthbank	health savings account
Payroll Experts	Payroll processing
Philadelphia Insurance	liability insurance
Quality Logo Products	Marketing
Roadrunner Print & Copy	Printing
Seagull Printing	printing services
Shred-IT USA	Document shredding
Smart Scrubs	nursing and aides scrubs/uniforms
Stericycle, Inc.	Sharps management & hazardous waste
Strategic Healthcare Programs, LLC	Clinical & financial benchmarking
T-Mobile	Mobile phones
The UPS Store	Document shipping
United Health Care	company health benefits
USPS	Document shipping
Verizon Wireless	cell phone service
Washington Labor & Industries department	workers compensation
Waste Management	Waste management & recycling

Appendix V	Copy of Envision Home Health of Washington license, DOH, WA

Appendix W	Accreditation standards for ACHC Palliative Care Distinction

ACHC ACCREDITATION STANDARDS

Customized for Palliative Care Hospice

Section 13: Distinction in Palliative Care

For an organization to earn accreditation with a Distinction in Palliative Care, the provider must have ACHC Home Health, Hospice or Private Duty Accreditation. This additional recognition focuses on patient and family centered care that optimizes quality of life throughout the continuum of illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. ACHC Palliative Care Standards are based on the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care.

Standard PC1-A: The provision of palliative care occurs in accordance with professional state and federal laws, regulations and current accepted standards of care. (Guideline 8.3)

Interpretation: The palliative care program is in compliance with federal and state statutes, regulations and laws regarding:

- Disclosure of medical records and health information
- Medical decision-making
- Advance care planning and directives
- The roles and responsibilities of surrogate decision-makers
- Appropriate prescribing of controlled substances
- Death pronouncement and certification processes
- Autopsy requests, organ and anatomical donation
- Health care documentation
- Palliative care program policies and procedures

Palliative care team members make efforts to understand how patient/family cultural beliefs, perceptions and practices may affect palliative care treatment options, services and the plan of care. The palliative care team is knowledgeable about legal and regulatory aspects of palliative care and has access to legal advice and counsel as needed.

Palliative care practice is modeled on and consistent with existing professional codes of ethics, scopes of practice and standards of care for all relevant disciplines.

Evidence: Patient Records
Evidence: Observation
Evidence: Personnel Files
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-A: Written policies and procedures are established and implemented in regard to the palliative care program coordinating care and collaborating with community resources to ensure continuity of care for the patient and family. (Guideline 1.8)

Interpretation: Written policies and procedures are established and implemented regarding:

- Coordination of care with community resources to ensure continuity of care
- Communication and collaboration with hospices and other community service providers involved in the patient’s care
- Referrals are only made with the patient or appropriate representative's consent
- Timely and effective sharing of information among healthcare teams while safeguarding privacy

The palliative care program supports and promotes continuity of care throughout the patient’s illness.

Non-hospice palliative care programs have relationships with one or more hospices and other community resources to ensure continuity of care. Non-hospice palliative care programs inform patients and families about hospice and other community resources.

The palliative care team informs the patient’s health care providers of the availability of hospice services and other community resources.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observation

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-B: Written policies and procedures are established and implemented in regard to palliative care services being provided to the patient and family to the extent that their preferences and needs can be met in their physical environment. (Guideline 1.9)

Interpretation: Written policies and procedures are established and implemented that describe the different environments of care available to the patient and family.

The palliative care team provides care in a setting preferred by the patient or family. When care is provided outside of the family's home, the interdisciplinary team (IDT) collaborates with other service providers to ensure the patient's safety and sense of control. When possible, the environment provides flexible visiting hours and space for a family visiting area, rest area, eating area, and privacy for the patient and family.

Unique care needs of pediatric/adolescent patients or family members/visitors will be addressed by the palliative care team.

Evidence: Written Policies and Procedures
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-C: Written policies and procedures are established and implemented in regard to the palliative care program providing care/service to patients and families of various belief systems. (Guideline 6.1)

Interpretation: Written policies and procedures describe the mechanisms the palliative care program uses to provide care for the patients/families of different cultural backgrounds, beliefs and religions.

Palliative care team members make efforts to understand how cultural beliefs, perceptions and practices may affect treatment options, services and the plan of care. Palliative care team members make efforts to understand and accommodate patient/family dietary and ritual practices.

Palliative care team members communicate in a language and manner the patient and family can understand.
Options may include:

- Language line
- Interpreters
- Written material in patient's preferred language

During the assessment process the interdisciplinary team (IDT) elicits and documents the patient/family cultural identification, strengths, concerns and/or needs.

Referrals to culture-specific or culturally based community resources are made as appropriate.

Evidence: Written Policies and Procedures
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-D: Written policies and procedures are established and implemented in regard to the palliative care program striving to enhance its cultural and linguistic competence. (Guideline 6.2)

Interpretation: The palliative care program has written policies and procedures that describe methods to enhance cultural and linguistic awareness and services.

The palliative care program supports a multicultural work environment. It is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation or national origin.

Palliative care staff identify differences in their own beliefs and the patient's beliefs and find ways to support the patient.

Ongoing education is provided to staff on cultural awareness and cultural competency.

The palliative care program regularly evaluates its services, policies and responsiveness to the multicultural population and makes changes as appropriate.

Evidence: Written Policies and Procedures
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-E: Written policies and procedures are established and implemented in regard to the palliative care program identifying and assessing complex ethical issues arising in the care of people with life-threatening illnesses. (Guideline 8.2)

Interpretation: Written policies and procedures describe mechanisms for identifying and addressing ethical issues in providing palliative care.

Existing or potential ethical issues are identified by the palliative care team. The palliative care team assesses for possible ethical issues such as withholding or withdrawing treatments, instituting a do not resuscitate (DNR) order, and the use of sedation in palliative care.

Ethical concerns are addressed with the patient or family and are documented in the clinical record.

Referrals are made to ethics consultants or the agency's ethics committee as appropriate. An ethics committee or consultant may be contacted for guidance on policy development, clinical care issues, conflict resolution and staff education.

Interdisciplinary team (IDT) members have education or training in ethical principles of palliative care.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observation
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC4-A: Written policies and procedures are established and implemented in regard to the palliative care program option to use volunteers to provide services to the patient and family. (Guideline 1.4)

Interpretation: Written policies and procedures describe the role and practices of volunteers in the palliative care program.

- Volunteers must comply with all personnel policies and procedures, including background checks and training.
- Volunteers are trained, coordinated and supervised by a palliative care team member.
- Services provided by volunteers will be included in the plan of care.

Evidence: Written Policies and Procedures
Evidence: Personnel Files
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC4-B: A written education plan is established and implemented that defines the content and frequency of evaluations as well as the amount of ongoing in-service training. (Guideline 1.5)

Interpretation: The palliative care program has a written education plan.

- The education plan includes training provided during orientation as well as ongoing in-service education. The palliative care program provides this training directly or arranges for personnel to attend sessions offered by outside sources.
- The ongoing education plan is a written document that outlines the education to be offered for personnel throughout the year. The plan is based on a reliable and valid assessment of needs relevant to individual job responsibilities.
- Education activities also include a variety of methods for providing personnel with current, relevant information to assist with their learning needs. These methods include provision of journals, reference materials, books, internet learning, in-house lectures and demonstrations.
- The palliative care program has an ongoing education plan that includes, but is not limited to:
    - The domains of palliative care
    - Pain and symptom management
    - Communication skills
    - Medical ethics
    - Grief and bereavement
    - Family and community resources
    - Hospice care and philosophy as well as eligibility
    - Advance care planning
    - Cultural considerations
    - Spiritual beliefs
- The program supports professional development through discipline-specific certifications, mentoring, preceptorships and supervision.
- There is written documentation confirming attendance at ongoing education programs.
- Personnel hired for specific positions within the palliative care program meet the minimum qualifications for those positions in accordance with applicable laws or regulations, licensure requirements, and the program's policies/ procedures and job

descriptions.

Evidence: Written Policies and Procedures
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC4-C: The palliative care program provides support services to its team members. (Guideline 1.7)

Interpretation: The palliative care program describes the mechanisms of support services available to staff.

- The palliative care program provides regular support meetings for staff and volunteers to encourage discussion of emotional stress/impact when caring for patients and families with serious or life-threatening illnesses.
- The palliative care program and interdisciplinary team (IDT) implements interventions to promote staff support and sustainability.
- Opportunities for additional counseling services are available.

Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-A: Written policies and procedures are established and implemented in regard to an initial evaluation of the patient and family being completed in a timely manner; this assessment forms the basis of the plan of care. (Guideline 1.1)

Interpretation: Written policies and procedures describe the palliative care program's mechanisms for completing an initial evaluation. Members of the interdisciplinary team (IDT) completes an initial evaluation and subsequent re-evaluations through patient and family interviews; review of medical and other available records; discussion with other providers; and physical exam and assessment. Initial contact occurs within two business days of palliative care referral.

The initial evaluation includes, but is not limited to:

- Assessments of the patient's current medical status, diagnosis and treatment options, a review of medical history and the patient's response to past treatments.
- Assessment includes documentation of the patient's diagnoses and prognosis, comorbid medical and psychiatric disorders, physical and psychological symptoms, functional status, social, cultural and spiritual needs, advance care planning concerns and patient/family goals for quality of life.
- Assessment of neonates, children and adolescents must be conducted with consideration of age and stage of neurocognitive development.
- Assessment of the patient/family perception and understanding of the life-limiting illness, including goals for quality of life and preferences for care.

Needs identified during the initial evaluation are referred to the appropriate IDT member for completion of a comprehensive assessment. Timeframes for completion of the comprehensive assessments are defined in agencies policies and procedures.

The palliative care program has policies in place for prioritizing and responding to referrals as well as responding timely to patient/family crises.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-B: Written policies and procedures are established and implemented in regard to patient and family participation in the formation of the plan of care. (Guideline 1.2)

Interpretation: The palliative care program ensures participation by the patient and family in the plan of care. The family is defined by the patient.

The plan of care is developed with professional guidance and support for patient/ family decision-making.

The care plan is based upon ongoing assessments and reflects goals set by the patient/family or surrogate in collaboration with the interdisciplinary team (IDT) and community providers (if applicable).

The care plan is updated as needed based on the evolving needs and presence of the patient and family.

Treatment options and alternatives are communicated to the patient and family to promote informed decision-making.

Complementary and alternative therapies may be included in the plan of care.

The plan of care includes values, goals, and needs that have been expressed by the patient/family.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-C: The interdisciplinary team (IDT) provides services to the patient and family in accordance with the plan of care. (Guideline 1.3)

Interpretation: The palliative care program has mechanisms in place for the IDT to provide services in accordance with the plan of care.

The IDT for the palliative care program consists of spiritual care professionals, nurses, physicians and social workers based on patient and family needs. It may also include other therapeutic disciplines as requested by the patient and family or when a need is identified by IDT members.

The IDT includes palliative care professionals with appropriate education, certifications or training in hospice and/or palliative care to meet the physical, psychological, social and spiritual needs of both the patient and family. If the palliative care program provides services for pediatric or adolescent patients or family members, the IDT members have specialized training in caring for children and or adolescents.

The palliative care program provides services 24 hours a day, seven days a week as necessary to meet patient needs. An on-call coverage system for care/services should be used to provide this coverage during evenings, nights weekends and holidays. If the palliative care program does not provide services 24/7, the IDT will ensure that the patient and family know how to contact the primary care physician for coverage after hours.

The palliative care program may provide respite services to the patient and family.

The IDT communicates frequently to discuss, review or update the patient's plan of care.

The IDT meets regularly to discuss care provided, staffing issues, policies, clinical practices and quality improvement activities.

Evidence: Patient Records
Evidence: Personnel Files
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-D: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) assessing and managing the patient's pain and/or other physical symptoms. (Guideline 2.1, 2.2)

Interpretation: Written policies and procedures are established for pain and symptom management. The palliative care program provides individualized care and disease-specific symptom management. Treatment plans for physical symptoms are individualized based on the disease, prognosis, patient functional limitations and patient-centered goals.

Patient/family understanding of the disease, treatment options, symptoms and side effects is assessed by the palliative care team and incorporated in the treatment plan. The goal of pain and symptom management is the safe and timely reduction of physical symptoms to a level acceptable to the patient.

A complete pain and symptom assessment is conducted initially and on an ongoing basis. The assessment includes, but is not limited to:

- Pain history and interventions
    - Pain severity
    - Use of a standardized pain tool
    - Use of an opioid analgesic risk assessment
- Shortness of breath
- Nausea
- Fatigue
- Anorexia
- Insomnia
- Restlessness
- Confusion
- Constipation

The palliative care program develops and uses symptom management tools, treatment policies, standards and guidelines appropriate to the care of patients. The palliative care team regularly documents ongoing assessments of pain and other physical symptoms and

functional capacity. Validated symptom assessment tools are used when available. The assessments are appropriate to the patient's age and diagnoses.

Treatment options for pain, symptom management and side effects include pharmacological, interventional, behavioral and complementary therapies. The program maintains documentation of symptom management in the patient's health record and communicates interventions and treatments with other health providers as appropriate.

Education regarding use of opioids and misconceptions are discussed with the patient and family members. The palliative care program uses an opioid analgesic risk assessment and management plan consistent with state and federal regulations for patients with chronic pain syndromes. Education regarding safe use of opioids, including driving or operating machinery, storage of medication, inventory and appropriate disposal, are discussed with the patient and family members.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-E: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) assessing the psychological and psychiatric aspects of the patient/family coping abilities and quality of life. (Guideline 3.1)

Interpretation: Written policies and procedures are established describing the mechanisms for assessing the psychological and psychiatric aspect of care.

The IDT includes professionals with specialized training in psychological and psychiatric issues such as depression, anxiety, delirium and cognitive impairment.

The IDT completes regular and ongoing assessments of patient/family reactions related to the illness including, but not limited to:

- Level of stress
- Coping strategies
- Anticipatory grieving
- Psychiatric conditions
- Age and developmentally appropriate assessments for pediatric patients and/or family members

Whenever possible and appropriate, a validated and context-specific assessment tool is used.

The IDT educates the patient and family on topics including:

- Disease or condition
- Symptoms
- Side effects
- Treatments
- Caregiver needs
- Decision-making capacity
- Coping strategies

Based on patient and family goals, interventions include assessing psychological needs, treating psychiatric diagnoses, and promoting adjustment to the physical condition or illness. Patient/family psychological stress and/or psychiatric syndromes are treated promptly with pharmacologic, non-pharmacologic and/or complementary therapies.

Patient and family members are informed of treatment options/alternatives. The IDT documents treatment options/alternatives discussed and the patient and/or family's decision.

Ongoing patient/family assessments regarding response to treatments and treatment efficacy are completed by the palliative care team and documented.

When necessary the IDT refers the patient and/or family members to appropriate healthcare professionals for ongoing psychological or psychiatric treatment.

The agency provides staff education and training in recognition and treatment of common psychological and psychiatric syndromes such as:

- Anxiety
- Depression
- Delirium
- Hopelessness
- Suicidal ideation

- Substance withdrawal symptoms
- Professional coping strategies to manage anticipatory grief and loss

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Personnel Files
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-F: The interdisciplinary team (IDT) assesses the social aspects of care to meet and promote patient/family needs and goals and to maximize patient/family strengths and well-being. (Guideline 4.1)

Interpretation: The IDT facilitates and enhances several social aspects of patient/family care, including:

- Patient/family understanding of and coping with illness and grief
- Support for patient/family decision-making
- Discussion of patient/family goals for care
- Emotional and social support
- Communication within the family, between patient/family and with the IDT

The IDT includes a social worker who has a bachelor's degree and/or graduate degree from an accredited school and experience in hospice and palliative care or a related health care field.

The IDT includes health professionals with expertise in the developmental needs and capacities of pediatric and adolescent patients and/or family members.

Evidence: Patient Records
Evidence: Observation
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-G: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) conducting a social assessment to identify the patient/family social strengths, needs and goals based on findings from the initial evaluation or subsequent evaluations. (Guideline 4.2)

Interpretation: Written policies and procedures are established and implemented that address the interdisciplinary team (IDT) completing a social assessment.

- The palliative care program completes a social assessment that includes:
    - Family structure and function
        - Roles
        - Communication
        - Decision-making patterns
    - Strengths and vulnerabilities
        - Resiliency
        - Social
        - Spiritual and cultural support
        - Effect of illness or injury on intimacy and sexual expression
        - Prior experiences with illness, disability and loss
        - Risk of abuse, neglect or exploitation
    - Changes in family members' activities
        - Schooling
        - Employment or vocational roles
        - Recreational activities
        - Economic security
    - Patient/family living environment and/or living arrangement
    - Patient/family perceptions about care giving needs, availability and capacity
    - Needs for adaptive equipment, home modifications or transportation
    - Access to medications and nutritional products
    - Access to community resources, financial support and respite care
    - Advance care planning and legal concerns

The IDT develops a social care plan that reflects patient/family culture, values, strengths, goals and preferences.

The IDT implements interventions such as education and family meetings to maximize social well-being and coping skills of both the patient and family.

The IDT refers the patient and family to appropriate resources and services as needed.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-H: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) conducting a spiritual assessment to identify religious or spiritual/existential background, preferences and related beliefs; rituals and practices of the patient and family; and symptoms such as spiritual distress and/or pain, guilt, resentment, despair and hopelessness based on needs identified during the initial evaluation or subsequent evaluations. (Guideline 5.1, 5.2)

Interpretation: Written policies and procedures are established and implemented in regard to the IDT conducting a spiritual assessment that includes spiritual and existential concerns recognizing spirituality as a fundamental aspect of compassionate patient and family-centered care.

The IDT documents spiritual themes including but not limited to:

- Life review
- Assessment of hopes, values and fears
- Meaning, purpose and beliefs about afterlife
- Spiritual or religious practices
- Cultural norms and beliefs
- Coping, guilt, forgiveness and life-completion tasks
- Whenever possible, a standard instrument is used

The patient's resources of spiritual strength are supported and documented. Spiritual/existential care needs, goals and concerns identified by patients, family members, IDT members or spiritual care professionals are documented and addressed in the IDT care plan.

The IDT re-evaluates spiritual/existential interventions and updates them as needed.

The IDT includes spiritual care professionals who have documented education and training in spirituality and existential issues, or other experience based on agency policies and/or job description.

All palliative care team members are respectful of patient/family religious and spiritual beliefs, rituals and practices.

The IDT refers the patient to appropriate community resources (pastoral counselor, spiritual director or spiritual care professional) when requested.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews
Evidence: Personnel Files
Evidence: Observation

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-I: Written policies and procedures are established and implemented in regard to the palliative care program facilitating religious, spiritual and/or cultural services as requested by the patient or family at and after the time of death. (Guideline 5.3)

Interpretation: Written policies and procedures are established and implemented by the palliative care program in regard to providing spiritual care services at and after the time of death.

The palliative care program provides spiritual counseling and services in accordance with patient/family acceptance of these services and with their beliefs and desires. This may include:

- Performing religious rituals
- Assisting with funerals and memorial services

The patient and family are supported in their desires to display and use their own religious, spiritual and/or cultural symbols.

The spiritual team facilitates communication with spiritual/religious communities or individuals as desired by the patient and/or family.

The palliative care team follows up post death with phone calls, home visits or attendance at the funeral or wake to offer support, identify

any additional needs/referrals and to assist the family with bereavement.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observations
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-J: Written policies and procedures are established and implemented in regard to a core component of the palliative care program being the provision of grief and bereavement services for patients and families, based on assessment of needs. (Guideline 3.2)

Interpretation: Written policies and procedures are established and implemented by the palliative care program for the provision of bereavement services.

Bereavement counseling services must be available to the patient and family to assist in minimizing the stress and problems that arise from living with a serious or life-threatening illness.

Bereavement services must be an organized program with services provided by qualified professionals who have experience and education in grief, loss and bereavement. Bereavement services may be provided by members of the interdisciplinary team (IDT) or through referrals to community resources.

An initial grief and bereavement assessment is completed upon admission to the palliative care program. The assessment shall include an evaluation of patient/family risks for complicated grief, bereavement and comorbid complications.

Information on loss, grief and the availability of bereavement services that are culturally appropriate and in a language the patient/family can understand is communicated to the family before and after death. Information on community services including support groups, counselors, collaborated partnerships with hospices and other community resources is also provided.

Patients/families who have been identified as at risk for complicated grief and bereavement shall receive intensive psychological support and prompt referrals to appropriate professionals.

Ongoing bereavement assessments and reassessments are completed by the palliative care team during the continuum of the patient's illness.

The IDT provides grief support and interventions appropriately determined by the cultural, spiritual and developmental needs and expectations of the patient and family.

Bereavement services and follow-up are recommended for the family for a minimum of 12 months after the death of the patient.

The palliative care program provides staff and volunteers with ongoing education, supervision and support in coping with their own grief as well as guidelines for effectively responding to patient/family grief.

Evidence: Written Policies and Procedures
Evidence: Patient and Bereavement Records
Evidence: Observation
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-K: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) providing a continuum of care for the patient and family through the transition of dying to the time of death and bereavement follow-up. (Guideline 7.1)

Interpretation: Written policies and procedures describe the types of services and mechanisms the palliative care program uses to provide care for the patient at the end of life to meet the physical, psychosocial, spiritual, social and cultural needs of patients and families.

The palliative care team identifies the needs of the patient and family during end-of-life care. The care of the patient is divided into three phases: pre-death, peri-death and post-death.

The palliative care team provides support and ongoing care of the patient and family during the end of life.
The IDT addresses:

- Concerns
- Hopes
- Fears and expectations about the dying process
- Symptom management and pain management

Care is provided with respect for the patient and family values, preferences, beliefs, culture and religion.

The IDT educates the family on signs and symptoms of imminent death and provides emotional support.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-L: Written policies and procedures are established and implemented in regard to the palliative care team presenting the patient and family with an end-of-life plan of care that addresses the dying process, treatments, symptom management, family preferences and other requests. (Guideline 7.2)

Interpretation: Written policies and procedures are established and implemented in regard to providing care at the time of death.

The palliative care team assesses the patient for symptoms and prepares family and other caregivers on the dying process and the management of symptoms. The plan of care during the dying process is discussed and updated as needed to meet the needs of the patient and family. Any discussion prior to the patient's death about an autopsy, organ or tissue donation, or other anatomical gifts is documented. Any inability to honor the patient/family expressed wishes for care during the dying process and at the time of death is documented in the clinical record.

The palliative care team will have an appropriately timed discussion with the patient/family regarding hospice services that adhere to patient/family preferences.

Evidence: Written Policies and Procedures
Evidence: Patient Records

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-M: Written policies and procedures are established and implemented in regard to the provision of post-death care based on care setting. (Guideline 7.3)

Interpretation: Written policies and procedures are established and implemented in regard to the palliative care program providing post-death care in a respectful manner that honors patient/family cultural and religious practices. The policies and procedures include, but are not limited to:

- Post-death care is provided in a respectful manner.
- Cultural and religious practices are honored in accordance with institutional practices, local laws and state regulations.
- Family has sufficient time with the patient after death.
- Preparation and disposition of the body in accordance with applicable law and regulations, taking into account patient/family wishes

Evidence: Written Policies and Procedures
Evidence: Patient Records

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-N: The palliative care program implements the bereavement plan post death. (Guideline 7.4)

Interpretation: Bereavement services for the patient's family are implemented post death by the interdisciplinary team (IDT). The bereavement plan is based on a social, cultural and spiritual grief assessment.

A palliative care team member is assigned to support the family and assist with religious practices, funeral arrangements, burial planning and emotional/grief support as appropriate.

Evidence: Patient Records
Evidence: Bereavement Records

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-O: Written policies and procedures are established and implemented in regard to the palliative care program respecting the patient's or surrogate's goals, preferences and choices for care within the limits of applicable state and federal laws, current accepted standards of medical care, and professional standards of practice. (Guideline 8.1)

Interpretation: Written policies and procedures are established and implemented in regard to ethical and legal principles in providing palliative care.

The interdisciplinary team (IDT) includes the patient's or surrogate's goals, preferences and choices in the development of the plan of care. The IDT discusses achievable goals for care in regard to the patient's or surrogate's desires and preferences and addresses advance directives. Patient and family members are encouraged to seek professional help with updating or completing legal and financial documents. A palliative care team member assists with completing advance directives as appropriate, communicates to other team members the patient's or surrogate's wishes, and documents the advance directives in the clinical record.

The IDT assesses the ability of the patient and family in the decision-making process. For care of pediatric patients, the child's views and preferences are documented and discussed with the patient and family as appropriate. The IDT advocates for the patient's wishes and preferences. In the absence of advance directives and if the patient is unable to communicate, the IDT will assess whether the patient previously expressed any wishes, values or preferences in regard to care. The IDT will support and assist the surrogate with decision-making concerns, questions, and legal or ethical issues in determining to honor the patient's preferences or wishes.

Failure to honor the patient's or surrogate's preferences is documented and addressed by the IDT.

The IDT includes professionals with knowledge and skill in ethical, legal and regulatory aspects of medical decision-making.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC6-A: The palliative care program develops, implements and maintains an effective, ongoing Quality Assessment and Performance Improvement (QAPI) program. The program measures, analyzes and tracks quality indicators and other aspects of performance that enable the program to assess processes of care, services and palliative care outcomes. (Guideline 1.6)

Interpretation: Written policies and procedures are established and implemented that describe the palliative care program's QAPI plan.

The palliative care program designates someone to coordinate and implement a QAPI program.

The QAPI program measures, analyzes and tracks quality indicators and other aspects of performance that enable the palliative care program to assess processes of care and operations.

Quality care follows the National Quality Strategy set forth by the U.S. Department of Health and Human Services described in the following provisions in the Affordable Care Act. These include, but are not limited to:

- Making care safer by reducing harm caused in the delivery of care
- Ensuring patients and families are engaged as partners in care
- Promoting effective communication and coordination of care
- Promoting the most effective treatment practices for the leading cause of mortality
- Making quality care more affordable

The QAPI program reviews all of the palliative care domains including organizational structure, education, team utilization and assessment. The review includes the effectiveness of physical, psychological, psychiatric, social, spiritual, cultural and ethical assessment and interventions to manage these aspects of care. CMS quality reporting requirements will be included in the review.

Quality improvement processes may include the development and testing of screening, history and assessment tools, protocols for diagnoses and interventions. Examples include:

- Structure and processes
- Physical aspects of care
- Psychological and psychiatric aspects of care
- Social aspects of care
- Spiritual, religious and existential aspects of care
- Cultural aspects of care
- Care of the patient at the end of life
- Ethical and legal aspects of care

Quality improvement activities for clinical services are collaborative, interdisciplinary, and focused on meeting patient/family goals.

The QAPI program must be ongoing and have a written plan of implementation. Ongoing means that there is a continuous and periodic collection and assessment of data. Opportunities to improve care should be applied on a program-wide basis, when appropriate. The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

From the QAPI process, the palliative care program establishes quality improvement policies and procedures.

The QAPI program includes evaluations of the palliative care program from patients, families, staff and the community.

Evidence: Written Policies and Procedures/QAPI Implementation Plan
Evidence: QAPI Reports and Documentation
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD