# Certificate of Need Application
## Hospice Agency

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

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

| Signature and Title of Responsible Officer | Date |
|---|---|
| Wenatchee Hospice Holdings LLC<br>By: Matt Ham, COO<br>Stride Health Care LLC, its Manager<br><br>Email Address<br>matt@advhh.com | 12/28/2022<br><br>Telephone Number<br>(480) 710-7323 |
| **Legal Name of Applicant**<br>Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee<br><br>**Address of Applicant**<br>285 Technology Center Way, Suite 108<br>Wenatchee, WA 98801 | Provide a brief project description<br>☐ New Agency<br>☑ Expansion of Existing Agency<br>☐ Other: _____<br><br>Estimated capital expenditure: $ 0 |

Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately.

Douglas County

**Wenatchee Hospice LLC, dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

**Proposing to Expand the approval of a Medicare Certified and Medicaid Eligible Hospice Agency in Chelan County into Douglas County**

**December 2022**

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## Introduction

Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee requests approval for expansion into Douglas County, of its certificate of need approval of Medicare Certified and Medicaid eligible hospice services in Chelan County.

An important consideration in this application is the fact that Chelan and Douglas Counties share the Wenatchee Valley as the largest population center for both counties. The valley is split in two by the Columbia River. On one side lies the city of Wenatchee in Chelan County, and on the other lies the city of East Wenatchee in Douglas County. This valley operates as one population center and in essence, one city. From the perspective of the residents, it is one city. From the perspective of the health care system and infrastructure, it is also one city. Outside of this population center of Wenatchee Valley, the remainder of both Chelan and Douglas Counties are very similar in that they have a rural landscape with mostly farmland and very small cities. Most of the health care infrastructure is located within Chelan County and most residents of Douglas County would be considered a part of this health care delivery system. This application will further discuss the many ways in which the two counties operate as one and therefore why Advanced Hospice[1] believes it is important to obtain approval for serving both Chelan AND Douglas Counties with its hospice services, in particular in regard to its Hispanic programming. The only Hospice provider in Douglas County is the same provider who currently serves Chelan County. An underserved population was identified in Chelan County and the application for Advanced Hospice was approved for Chelan County. The same dynamics are applicable for Douglas County.

Almost 34% of the population in Douglas County is Hispanic[2]. However, beyond basic translation services, there is no hospice cultural programming or outreach for the Hispanic population of Douglas County. Per claims data, there is no hospice utilization among the Hispanic population in Douglas County[3]. Just as in Chelan County, need exists for cultural outreach and programming to ensure access to hospice services to the Hispanic community of Douglas County. Increased utilization of hospice services leads to lesser symptoms, improved quality of life, and decreased overall healthcare spending[4].

Other specific indicators that point to the need for an additional provider in Douglas County should also be considered. Dual eligible hospice utilization in Douglas county is nearly 8% below national utilization levels[5]. Clinician time spent with patients on hospice in Douglas County is below national averages[6]. In addition, the speed in which patients are admitted to

[1] For simplicity and to shorten the application, "Advanced Hospice" will be used throughout this application in place of Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee.
[2] Washington State Department of Health, Community Health Assessment Tool, 2013-2017
[3] See Exhibit 7 Douglas County Hospice Utilization by Race 2021
[4] See Appendix 19 – Pyenson B, Connor S, Fitch K, Kinzbrunner B. Medicare cost in matched hospice and non-hospice cohorts. J Pain Symptom Manage. 2004 Sep;28(3):200-10. Doi: 10.1016/j.painsymman.2004.05.003.PMID: 15336332.
[5] See Exhibits 3 – Dual-Eligible Hospice Utilization Rates in Washington State Counties and 4 – Douglas County Dual-Eligible Hospice Admissions per 1,000 Deaths 2018-2021
[6] See Exhibits 5 – Visit Hours per Patient Day, Washington Hospice Programs and 6 – Visit Hours per Patient Day, Central Washington Hospice 2017-2021

hospice by the provider in Chelan and Douglas Counties ranks the lowest in the state – meaning that patients in Douglas County are admitted to hospice services less quickly after electing hospice than those in other counties. In fact, only 29% of admissions in Douglas County are admitted on the day of discharge from the hospital as compared to 80% nationally[7]. Slower speed to hospice admission will most significantly affect those who use hospice services for 7 days or less. Again, these facts all indicate the county could benefit from additional hospice services in the community, especially considering that the most vulnerable and least likely to access hospice services become the ones most impacted by these indicators. The Hispanic population unfortunately falls into this category.

In a market indicating some challenges in meeting the hospice needs of the community, and an identified underserved population, a second provider would not only add choice to the market, but also help improve the availability of services to other underserved population cohorts within the community. A solution has already been approved for Chelan County that could easily be expanded into Douglas County to meet this need.

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

[7] See Exhibits 1 – Speed of Admission Washington Hospice Programs and 2 – Central Washington Hospice Speed of Admission for Hospital Discharges 2017-2021

## I. Applicant Description

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

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

   Wenatchee Hospice LLC, dba Advanced Hospice Northwest of Wenatchee will be the licensee.
   285 Technology Center Way Suite 108
   Wenatchee WA, 98801

   It is wholly owned by Wenatchee Hospice Holdings, LLC (UBI 604-839-931) which is a subsidiary of Stride Health Care, LLC (Tax ID 85-1045067) who is the applicant.

   See Appendix 1 for Organizational Structure

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

   Wenatchee Hospice LLC is a Washington LLC with UBI 604 840 149.
   Stride Health Care is an Arizona LLC with Tax ID 85-1045067
   See Appendix 2 – Applicant Information

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

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

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

   Not Applicable

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

   See Appendix 1 – Organizational Structure

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

   See Appendix 3 – List of Owned Entities

## II. Project Description

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

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

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

   Advanced Hospice is in its startup phase in Chelan County. State Licensure has been granted and Wenatchee Hospice will soon admit its first patients in preparation for Medicare Certification survey and ACHC accreditation. This Douglas project will be operated in conjunction with the existing Chelan hospice. It will be operated in the same agency, out of the same same office, with same staff and under the same license.

   Advanced Home Health[8] already has established services in both Chelan and Douglas Counties and is well familiar with the geography and needs of both

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

Counties. Advanced Hospice will be well established within Chelan County upon approval of this project (Douglas) and it will therefore be seamless to simply expand the hospice services geographically from Chelan into Douglas County.

The existing office for Advanced Home Health and Advanced Hospice, is located just on the border of the two counties, in Wenatchee. It has worked well geographically for Advanced Home Health to meet the needs of both Chelan and Douglas Counties and will also allow Advanced Hospice to easily meet the needs in both Chelan and Douglas Counties without any modifications.

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

   N/A

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

   Advanced Hospice was approved for operation in Chelan County through last year's CN application cycle. Since then, Advanced Hospice has obtained its state license, will soon be admitting its first patients in order to work towards Medicare certification and ACHC accreditation, and will soon be certified to provide Medicare and Medicaid hospice services in Chelan County.

   This project will expand this existing hospice agency to also provide Medicare and Medicaid services to residents of Douglas County. The main focus will be to meet the underserved Hispanic population, but will also offer choice to the residents of Douglas County when deciding to utilize hospice services as there is currently only one provider.

   This project will be led by an administrator with two decades of hospice experience and will be comprised of a compassionate team of local health care providers focused on patient and family needs and experience. This will include physicians, nurses, social work, chaplain, volunteer services, therapy, DME, medical supplies, pharmacy services and bereavement support for family and friends of the patients. Services will include all necessary hospice services and supplies. Personalized plans of care will be developed based on each patients needs and wants in order to best meet their palliation needs and to best manage their terminal illness with dignity and respect.

   Advanced Hospice will support patients throughout the community and wherever they may live and will place special emphasis on outreach throughout the county. Outreach and education will be a significant focus of this project by Advanced Hospice and will be tailored to the particular unmet needs in the community with special emphasis on cultural programming and education for the Hispanic community.

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

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

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

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

Table 1 – Project Implementation Timeline

| Event | Anticipated Month/Year |
|---|---|
| CN Approval | August 2023 |
| Design Complete (if applicable) | N/A |
| Construction Commenced* (if applicable) | N/A |
| Construction Completed* (if applicable) | N/A |
| Agency Prepared for Survey | September 2023 |
| Agency Providing Medicare and Medicaid hospice services in the proposed county. | January 2024 |

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

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

Table 2 – Advanced Hospice Agency Services

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

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

   This application is proposing to expand upon the CN approval for Advanced Hospice to provide Medicare and Medicaid services in Chelan County. Medicare and Medicaid services are not being provided just yet as we are in the process of Medicare and Medicaid Certification. CMS has approved our application pending successful initial survey. We have our state department of health license and are working through delivering care to our first patients in preparation for our survey by ACHC which will provide Medicare Certification through deemed status by ACHC accreditation.

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

   The proposed services identified above are consistent with the existing services provided by the agency in other planning areas.

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

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

    Patients will have terminal conditions with a life expectancy of 6 months or less. The main causes of death in Douglas County are comprised of cardiovascular disease, cancer, Alzheimer's disease, chronic lower respiratory disease, diabetes and chronic liver disease[9]. Most services in Douglas County will be provided in patients homes, Group Homes, Assisted Living, and Independent Living facilities. Needs vary by the individual and this agency will work to meet the individual needs of each patient and their family while providing competent and compassionate care.

    Douglas County has an elderly population of 16.1% ages 65 and above which is higher than the state average of 14.5.[10] Douglas County also has a rapidly growing

[9] Washington State Department of Health, Community Health Assessment Tool, 2013-2017
[10] Washington State Department of Health, Community Health Assessment Tool, 2013-2017

Hispanic population that currently makes up 33.8% of the county population.[11] This population in particular will be the most significant focus for this project as will be outlined in the following section of this application.

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

    See Appendix 4 – Letter of Intent

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

    This agency will be licensed and certified by Medicare and Medicaid.

    IHS.FS. - 61323866

    Medicare #: - Pending

    Medicaid #: - Pending

[11] CY2020 estimates from Washington State Office of Financial Management. Small Area Demographic Estimates (SADE) by Age, Sex, Race and Hispanic Origin. Version: 20201210_R01.

## Certificate of Need Review Criteria

### A. Need (WAC 246-310-210)

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

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

   Although this application is to expand upon an existing agency, this question is not applicable as this agency was approved for CN last cycle and is in the process of standing up and as such has not yet had any historical utilization.

Table 3 – Not Applicable

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

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

   Advanced Hospice is close to being certified to provide Medicare and Medicaid hospice care in Chelan County and as such has no historical data. Presented in table 4a is the projections for Douglas County. Table 4b shows the approved projections for Chelan County for both the intervening year of 2023 and the three years of operation for this application for Douglas County. Table 4c shows the combined projections for Douglas and Chelan Counties. Assumptions are explained below the tables.

Table 4a – Advanced Hospice Utilization Projection–Douglas County

| **ADVANCED HOSPICE UTILIZATION PROJECTION** | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| Total number of admissions | | 15 | 15 | 15 |
| Total number of patient days | | 902 | 924 | 948 |
| Projected average daily census | | 2.5 | 2.5 | 2.6 |

Table 4b – Advanced Hospice Utilization Projection Approved for Chelan County

| **ADVANCED HOSPICE UTILIZATION PROJECTION** | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| Total number of admissions | 85 | 165 | 183 | 200 |
| Total number of patient days | 5,263 | 10,220 | 11,383 | 12,395 |
| Projected average daily census | 14.3 | 27.8 | 31 | 34 |

Table 4c – Advanced Hospice Utilization Projection–Combined Douglas and Chelan Counties

| **ADVANCED HOSPICE UTILIZATION PROJECTION** | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| Total number of admissions | 85 | 180 | 198 | 215 |
| Total number of patient days | 5,263 | 11,122 | 12,307 | 13,343 |
| Projected average daily census | 14.3 | 30.3 | 33.5 | 36.6 |

Assumptions used to make these projections:

Assumption 1:
Advanced Hospice plans to be in a position to begin offering hospice services to the residents of Douglas County in January 2024. State methodology calculated unmet need from 2022-2024. See appendix 5 for Department of Health 2022-2023 Hospice Numeric Need Methodology. In order to calculate unmet need in years 2025 and 2026, and to maintain consistency, Advanced Hospice used the same calculations from the Department of Health 2022-2023 Hospice Numeric Need Methodology, but expanded its application into 2025 and 2026 using population data provided in the state methodology to determine the projected average daily census for these years. Since population data was not projected into 2026, an average population growth rate was calculated using the population data from the state methodology ranging from 2019 through 2025. The highest and lowest values within those years were removed before calculating the average. This gave the most conservative population growth estimates for the year 2026.

Table 5a below shows the development of the unmet need that matches the state methodology but expands into 2025 and 2026. Steps 1-3 remained consistent. Step 4 applied the same calculated use rate to the state provided population projections for 2025 and the projected population for 2026 based on an average growth rate calculated from the provided population figures from 2019 through 2025. Steps 5-7 remained consistent. This calculation yielded the following results:

Table 5a – State Methodology Calculation

| | 0-64 | 65+ |
|---|---|---|
| Step 1: Calculate the Two Statewide Hospice Use Rates: | 23.16% | 58.07% |
| Step 2: Calculate the 3 Yr Death Rate by Age Cohort: | 50 | 201 |
| Step 3: Calculate Projected # of Patients | 12 | 117 |
| Step 4: Calculate Use Rate from Projected Patients | 0.000326 | 0.014005 |

| | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|
| Population | | | | | |
| 0-64 | 36,080 | 36,356 | 36633 | 36909 | 37193 |
| 65+ | 8974 | 9283 | 9591 | 9899 | 10245 |
| Expected Admissions | | | | | |
| 0-64 | 12 | 12 | 12 | 12 | 12 |
| 65+ | 126 | 130 | 134 | 139 | 143 |
| Total both Cohorts | 137 | 142 | 146 | 151 | 156 |
| | | | | | |
| Step 5: Subtract the Total Both Cohorts from the Actual Capacity of 195.33 | | | | | |
| 195.33 | (57.87) | (53.45) | (49.05) | (44.65) | (39.71) |
| Step 6: Multiply the unmet Admissions determined in step 5 by the state ALOS of 61.89 | | | | | |
| 61.89 | -3582 | -3308 | -3036 | -2763 | -2458 |
| Step 7: Divide the Daily Census by the number of days in the year to get Unmet ADC | | | | | |
| 365 | -10 | -9 | -8 | -8 | -7 |

Assumption 2:

For this project, Advanced Hospice is focused on meeting the need of the underserved Hispanic Population in Douglas County (this need among Hispanic population in Douglas County is further explained in points 3, 4, and 6 of this section). In order to determine the expected Hispanic population, the above calculation was adjusted to extrapolate the expected admissions, patient days, and average daily census for this population. There will likely be additional admissions based on other underserved population cohorts, but they will be very small numbers of admissions based on either choice, dual eligible, referrals from Advanced Home Health, etc. For purposes of this application, we will focus solely on the Hispanic population which will yield the most conservative projections.

Steps 1-4 remain the same in order to calculate the use rates for each age cohort. The remainder of step 4 was adjusted to calculate using the Hispanic population of each age cohort. According to Washington State's Office of Financial Management's Small Area

Demographic Estimates (SADE) for CY 2020, 39.9% of the 0-64 age cohort and 7.3% of the 65+ age cohort in Douglas County is Hispanic.[12]

Table 5b shows step 4 modified to show just the Hispanic population and expected admissions.

Table 5b – State Methodology Calculation Modified to Determine Hispanic Projections

| | 0-64 | 65+ |
|---|---|---|
| Step 1: Calculate the Two Statewide Hospice Use Rates: | 23.16% | 58.07% |
| Step 2: Calculate the 3 Yr Death Rate by Age Cohort: | 50 | 201 |
| Step 3: Calculate Projected # of Patients | 12 | 117 |
| Step 4: Calculate Use Rate from Projected Patients | 0.000326 | 0.014005 |

| | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|
| Population | | | | | |
| 0-64 | 14,396 | 14,506 | 14617 | 14727 | 14840 |
| 65+ | 655 | 678 | 700 | 723 | 748 |
| Expected Admissions | | | | | |
| 0-64 | 5 | 5 | 5 | 5 | 5 |
| 65+ | 9 | 9 | 10 | 10 | 10 |
| Total both Cohorts | 14 | 14 | 15 | 15 | 15 |
| Step 5: skip this step as it is not needed | | | | | |
| Step 6: Multiply expected Admissions determined in step 4 by the state ALOS of 61.89 | | | | | |
| 61.89 | 858 | 881 | 902 | 924 | 948 |
| Step 7: Divide the patient days by the number of days in the year to get Unmet ADC | | | | | |
| 365 | 2.4 | 2.4 | 2.5 | 2.5 | 2.6 |

Step 4 then provides the total expected admissions for both cohorts combined. Step 5 is skipped as it is not needed to determine the number of patient days and average daily census. Step 6 is used to calculate the number of patient days by multiplying the expected admissions for both cohorts by the average length of stay (ALOS). Step 7 is used to calculate the average daily census (ADC) by dividing the number of patient days calculated in step 6 by the number of days in the year to get the ADC. The results were used to complete table 4a above.

[12] CY2020 estimates from Washington State Office of Financial Management. Small Area Demographic Estimates (SADE) by Age, Sex, Race and Hispanic Origin. Version: 20201210_R01.

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

   In a 2019 study among residents of Douglas County, 24% of those surveyed expressed access to healthcare was a significant factor that could help improve quality of life.[13] The following factors could restrict patient access to hospice specific services in Douglas County:

   1. Lack of Hispanic programming and outreach. Of the total population in Douglas County, 33.8% is Hispanic as compared to 13.4% of the state's population.[14] In addition, 28.2% of the population of Douglas County speaks a language other than English in their home.[15] This number is important because it is made up of individuals who speak a language other than English at home and who do not speak English well. The inability to speak English well can create barriers such as healthcare access, provider communication and overall health literacy.[16] Racial and ethnic minorities utilize hospice less than that of the White population. A recent study validated this even when controlling for other socioeconomic factors such as income, area population, education, and age.[17] In Douglas County, this is also the case as there have been no claims submitted for hospice services for Hispanic beneficiaries.[18] The current hospice provider does not offer any Spanish Language or cultural programming beyond basic translation services to reach this population. According to the most recent Washington State Department of Health Community Health Assessment, the state's population is becoming more racially and ethnically diverse. One implication identified by the state is an increased demand for linguistically and culturally appropriate health services. Specifically it reads, "To be effective, service providers and organizations need to be reflective of the communities they serve. They also need to partner with communities to develop interventions, materials and services that are accessible and culturally appropriate."[19] Lack of Hispanic cultural programming and outreach in Douglas County restricts access to care among this population.

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[13] North Central Washington Community Health Needs Assessment 2019 – Appendix B, Community Voice Survey

[14] CY2020 estimates from Washington State Office of Financial Management. Small Area Demographic Estimates (SADE) by Age, Sex, Race and Hispanic Origin. Version: 20201210_R01.

[15] U.S. Census Bureau, QuickFacts Douglas County, Washington, available at https://www.census.gov/quickfacts/fact/table/douglascountywashington/POP815221#POP815221. Accessed Dec 10, 2022.

[16] North Central Washington Community Health Needs Assessment 2019

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

[18] See Exhibit 7 – Douglas County Hospice Utilization by Race 2021. It should be noted that demographic groups with less than 11 patients are suppressed in this data per CMS requirements.

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

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

3. Speed of admissions for Douglas county is also a factor that can affect access to Hospice services for a number of populations. Speed of admissions is significantly lower in Douglas County than state averages. Only 29% of admits to Douglas County Hospice services are admitted on the day of discharge from the hospital. Nationally, 80% of hospice patients are admitted on the day of discharge from the hospital.[20] This indicator speaks to the availability of the provider in meeting the community needs. Some simply are not able to access care timely. This has a most significant impact on patients who are on hospice for 7 days or less but can also have an impact on other patients accessing hospice services. Another hospice provider would give access to hospice services to those population groups that are limited due to choice or speed of admissions. At least two additional population cohorts in Douglas County will be impacted by choice and speed of admissions as outlined in the next 2 points.

    a. Dual eligible hospice utilization data for Douglas County indicates much lower utilization than national averages. Dual eligible patients in Douglas County are admitted at a rate of 413 per 1000 Medicare Deaths where the national average is 489 admissions per 1000 Medicare Deaths.[21] Choice and speed of admissions are significant barriers for this population.

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

4. Households that have no motor vehicle have a definite barrier to accessing healthcare. Douglas county reports 4% of households with no motor vehicle[22].

[20] See Exhibits 1 – Speed of Admission Washington Hospice Programs and 2 – Central Washington Hospice Speed of Admission for Hospital Discharges 2017-2021.
[21] See Exhibits 3 – Dual-Eligible Hospice Utilization Rates in Washington State Counties and 4 – Douglas County Dual-Eligible Hospice Admissions per 1,000 Deaths 2018-2021
[22] U.S. Census Bureau, American Community Survey, 2009-2013 and 2013-2017

Although hospice services are most often provided in the home, those with no motor vehicles are less likely to access even basic physician services, and are therefore less likely to even be aware of or have access to available home based services.

5. With almost 3,000 Veterans in Douglas County, this population is deserving of special attention to ensure needs are met.

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

Advanced Hospice believes this project to be necessary to meet the community needs for access to hospice care. Although the current hospice provider is well respected and is well connected into the healthcare delivery system for the county, the following indicators help demonstrate this project will not be an unnecessary duplication of services.

1. The lack of Hispanic cultural programming and outreach in the county where 33.8% of the population is Hispanic. There have been no claims for Hispanic hospice patients in Douglas County. See Exhibit 7
2. Dual Eligible utilization in Douglas County is nearly 8% less than the national average. See Exhibits 3 and 4.
3. Choice and speed of access are very real concerns in Douglas County. Only one provider of Hospice services operates in the county so there is no choice. Only 29% of hospital discharges to hospice are admitted on the day of discharge as compared to 80% nationally. See Exhibits 1 and 2.
4. Douglas County hospice data indicates average time spent with each hospice patient per day is .39 hours where national average is .53. This can be indicative of staffing challenges which can limit access to hospice services. See Exhibits 5 and 6.

Another important factor in this application, is that Geographically, the largest population center in both Chelan and Douglas Counties is the Wenatchee Valley. The Wenatchee Valley, as viewed from above, is a valley surrounded by mountains and split in the middle by the Columbia river. On one side of the river sits the city of Wenatchee (Chelan County) and on the other, the city of East Wenatchee (Douglas County). The Columbia River is the county line which divides Chelan from Douglas County. Although split in two different counties, the valley is truly one large population center. In most respects, the valley operates as one metropolitan area where everything from business to tourism to healthcare, etc., naturally operate and flow as it would through any metropolitan area, despite the fact that half is in one county and half in another. Organizations are structured in

a way to serve both counties as one. For example, instead of a Wenatchee Chamber of Commerce and an East Wenatchee Chamber of Commerce, there is only the Wenatchee Valley Chamber of Commerce serving businesses in the entire valley.

Another example is the Wenatchee Valley Visitors Bureau. Their website states the following; "The Wenatchee Valley is comprised of bustling communities on both sides of the river. The sister cities of Wenatchee and East Wenatchee are two cities and two counties divided by the mighty Columbia river but united as one community…"[23].

This sense of one community is real and alive, and doesn't end just with Wenatchee Valley but continues on between Douglas and Chelan Counties. Many non-government organizations have been combined or established in a way to support or service both counties due to the geographic dynamics and similarities between Douglas and Chelan Counties. Almost every organization supporting Douglas and Chelan Counties reside in Wenatchee Valley. Some examples of organizations in this category include Chelan Douglas Transportation Council[24], Chelan Douglas CASA[25], Chelan Douglas Land Trust[26], Chelan Douglas Community Action Council[27], and Chelan Douglas County Medical Society[28] to name just a few.

Even many local and state government organizations and departments have joined together, or consider the two counties as one. A few examples of this include the Chelan Douglas Health District, the Chelan Douglas Regional Port Authority, and the Washington State Employment Security Department.

The county health departments for Chelan and Douglas Counties operate as one unit. On its website, it states, "The Chelan-Douglas Health District is governed by a 12 member Board of Health consisting of local county and city elected officials and appointed community members. The Board sets county-wide policies and regulations to protect and promote the health of residents of Chelan and Douglas Counties."[29] Again, the county health department works as one entity for all of Chelan and Douglas Counties. Whether providing services in Chelan or Douglas counties, the required reporting by health care providers is to the same county health department.

Port Authority districts in Washington are focused on economic development specific to the county or area they serve. In 2019 the Port of Chelan County and the Port of Douglas County voted to combine the two ports into one entity creating

[23] Wenatchee Valley Visitors Bureau website accessible at https://wenatcheevalley.org
[24] Chelan Douglas Transportation Council website accessible at https://www.chelan-douglas.org
[25] Chelan Douglas CASA website accessible at https://www.cdcasa.org/who-we-are/
[26] Chelan Douglas Land Trust website accessible at https://www.cdlandtrust.org/who-we-are/history
[27] Chelan Douglas Community Action Council website accessible at https://cdcac.org/about-us/
[28] Chelan Douglas County Medical Society website accessible at http://www.cdcms.org
[29] Chelan Douglas Health District website accessible at https://www.cdhd.wa.gov/board-of-health

the Chelan Douglas Regional Port Authority[30]. This is the first and only instance in the state of Washington in which two separate Port Authorities consolidated organizations into one entity. This decision was unanimous and was made in large part because of the geographic dynamics of the counties and population centers as well as alignment of economic priorities between Douglas and Chelan Counties[31]. This wouldn't work in other areas but did here because of the oneness of Chelan and Douglas Counties.

The Washington State Employment Security Department[32] fills an important role in the state. One resource among many this department provides is labor market information for each county in the state as a resource to employers. All counties in the state are listed individually except Chelan and Douglas Counties. These are presented as one profile. Even the State Employment Security Department views these counties as one.

These examples could continue but the point is to simply show that Douglas and Chelan Counties are technically separate but because of the geographic makeup of the counties, and the similarities in economic drivers, and other factors, the counties are really viewed as similar, overlapping and in many cases one.

This is an important consideration for this project in that it is difficult for a provider of healthcare services to serve only one of these two counties. Advanced Hospice has identified an underserved population in Chelan County and based on the information presented in this application, argues that this underserved population also exists in Douglas County. It should be considered that there has been only one provider of hospice services for more than 10 years in Chelan and Douglas Counties. This provider has delivered services across both Chelan and Douglas Counties and if the Hispanic cultural programming was not in place in Chelan County, it is also not in place in Douglas County, as indicated by claims data[33].

Additionally, in order for Advanced Hospice to engage in community outreach and education within the healthcare infrastructure of Chelan County, it has become very clear that the messaging will be shared within a framework that supports both Chelan and Douglas Counties as one. The clinics, hospitals, nursing homes, etc. are largely located in Chelan County however they serve the communities of both counties, both in the Wenatchee Valley, and throughout the majority of Douglas County. If a patient from Douglas County is seen in a clinic or setting in Chelan County and hears of the Hispanic cultural programming of Advanced Hospice as many will, they will not be able to access this care, even though they in essence live in the same population center as their neighbors and friends. Advanced

[30] Chelan Douglas Regional Port Authority website accessible at https://www.washingtonports.org/economic-development
[31] Chelan Douglas Regional Port Authority History accessible at https://www.cdrpa.org/history
[32] Washington State Employment Security Department website accessible at https://esd.wa.gov/labormarketinfo/county-profiles/chelan-douglas
[33] See Exhibit 7 – Douglas County Hospice Utilization by Race 2021.

Hospice has become increasingly aware that they will have to screen patient referrals based on which side of the Wenatchee Valley the patients live on and will only be able to accept those who reside west of the Columbia River. Again, this river splits the main population center of Wenatchee Valley in two sides. This will in and of itself have the effect of creating fragmentation for the Hispanic population where some will have access to Advanced Hospices' Hispanic cultural programming and some will not.

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

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

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

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

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

   1. Through implementation of a Spanish language outreach and education program along with cultural programming for staff and volunteers. This will including written materials in Spanish along with staff and volunteers available to help promote and educate the Hispanic community regarding hospice services. One of the key recommendations to decreasing the gap between white and ethnic minorities hospice utilization is through outreach and education.[34] Through a culturally competent program, Advanced Hospice will enhance understanding and utilization of Hospice services among the Hispanic Population and provide care to this population utilizing staff and volunteers that have been trained and are able to provide culturally competent care.

      Advanced Hospice will work with the Hispanic Business Council and Chamber of Commerce as well as Columbia Valley Community Health clinics to identify opportunities for outreach and education. Just over 49% of Columbia Valley

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

Community Health Clinics patient population is Hispanic.[35] These patients reside in both Douglas and Chelan Counties. This project will engage resources and support from the Hispanic community in order to promote the program to help ensure maximum exposure to the targeted audience.

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

Benefits of serving this population are many including improved access to care, more appropriate cultural programming, improved understanding of objectives and benefits of hospice services, and decreased overall healthcare costs across the healthcare continuum. Nationally, Medicare spends close to 20% more on the last year of life for Hispanic People than White people due to underutilization of Hospice.[36]

This underserved population has already been identified and recognized in Chelan County. Given that the demographics of Chelan and Douglas County are so similar, and that the counties operate as one in the largest population center of Wenatchee Valley, and in many aspects, especially the delivery of Healthcare Services, operate as one county, Advanced Hospice believes that this application is a critical and necessary extension of the approved project for Chelan County and as shown in this application, will provide the same programming to the underserved populations of both Chelan and Douglas Counties in the most cost effective manner without duplication of services or fragmentation of care. All of the dynamics that existed in Chelan County also

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

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

exist in Douglas County and this project makes available the resources and services to best meet the underserved Hispanic needs of Douglas county.

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

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

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

**7. Provide a copy of the following policies:**

- **Admissions policy**
- **Charity care or financial assistance policy**
- **Patient Rights and Responsibilities policy**
- **Non-discrimination policy**

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

See Appendix 6 for Admissions Policy (Note, references to Clinical Supervisor are one in the same as references to Clinical Director)
See Appendix 7 for Charity Care Policy
See Appendix 8 for Patient Rights and Responsibilities Policy
See Appendix 9 for Non-Discrimination and Death With Dignity Policies
See Appendix 10 for Hiring / Orientation Policies
See Appendix 11 for QAPI Policy (Note, this policy has been in place at Advanced Home Health.)

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

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

Although the state methodology does not show a numeric need, this application and supporting documentation will show applicability under WAC 246-310-290(12) in that:

1. All applicable review criteria and standards with the exception of numeric need will been met;
2. Advanced Hospice does commit to serve Medicare and Medicaid patients; and
3. There is a specific population that is underserved. See questions 3, 4, and 6 above along with all the supporting documentation referenced therein. In particular, the Hispanic population comprises 33.8% of the total population of Douglas County. Medicare billing data shows no Hispanic Hospice utilization in Douglas County and Dual Eligible data also shows underutilization as compared to national averages. This population is not accessing hospice services and is by definition underserved. There is no cultural programming to ensure this population has access to hospice services. Hispanic cultural programming combined with outreach to both the Hispanic population as well as the additional identified underserved population cohorts will be the focus of this project. Although the numbers may be small for this underserved population in Douglas County, it is no less important that their needs be met in a culturally meaningful and appropriate way. This project will be the easiest and most cost effective way to meet the needs of this underserved population. Chelan and Douglas Counties operate very much as one and Advanced Hospice operating in both counties is no different. This project will simply extend what was already approved in Chelan County into Douglas County. The structure will already be in place, and as this application shows, Advanced Hospice will be able to simply expand its cultural programming into Douglas County with minimal cost and effort.

**B. Financial Feasibility (WAC 246-310-220)**
**Financial feasibility of a hospice project is based on the criteria in WAC 246-310-220.**

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

| Revenue | Expenses |
|---|---|
| Medicare, including Managed Care | Advertising |
| Medicaid, including Managed Care | Allocated Costs |
| Private Pay | B & O Taxes |
| Other, [TriCare, Veterans, LNI, etc.] detail what is included | Depreciation and Amortization |
| Non-operating revenue | Dues and Subscriptions |
| | Education and Training |
| | Employee Benefits |
| | Equipment Rental |
| | Information Technology/Computers |
| Deductions from Revenue: | Insurance |
| (Charity) | Interest |
| (Provision for Bad Debt) | Legal and Professional |
| (Contractual Allowances) | Licenses and Fees |
| | Medical Supplies |
| | Payroll Taxes |
| | Postage |
| | Purchased Services (utilities, other) |
| | Rental/Lease |
| | Repairs and Maintenance |
| | Salaries and Wages (DNS, RN, OT, clerical, etc.) |

**Supplies**
**Telephone**
**Travel (patient care, other)**
**Other, detail what is included**

Documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met are found in Appendix 12 - Projections and Pro Forma for Advanced Hospice in Douglas County, Chelan County, Combined for Douglas and Chelan Counties, and Stride.

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

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

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

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

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

   **If this is a new hospice agency at a new site, documentation of site control includes one of the following:**
   a. **An <u>executed</u> purchase agreement or deed for the site.**
   b. **A <u>draft</u> purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**

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

See Appendix 15 for documentation of site control.

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

Table 6 – Estimated Capital Expenditure

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

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

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

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

   There will be no startup costs. Advanced Hospice will already be certified and operational in Chelan County and will be able to simply expand into Douglas County with no additional startup costs. Existing staff will be able to meet the needs and are familiar with Douglas County. Again, the largest population center in both Douglas and Chelan Counties is the Wenatchee Valley. Advanced Home health is already covering both counties and Advanced Hospice is close to certification in Chelan County so expanding hospice services into Douglas will be very simple and will allow the underserved population cohorts in Douglas County to be served with minimal expense. This is truly the most cost effective option to meet these needs.

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

   There are no start-up costs for this project, however, Wenatchee Hospice Holdings LLC through Stride Health Care LLC, its manager, will be responsible for startup costs. See Appendix 16.

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

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

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

   Because Advanced Home Health is well established, and Advanced Hospice is already approved for Chelan County and will be fully operational prior to approval of this project, both startup costs and some fixed expenses will already have been invested and there will be no impact on the costs and charges for health services in Douglas County because of this project. Additionally, improved efficiencies will be promoted through this project in that some staff and ancillary expenses will be able to be shared across the two counties allowing for cost containment.

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

Table 7a – Douglas County Payer Mix Breakdown

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

Assumptions: Makeup of Douglas County is similar to Chelan County and is projected to be similar mix.

Table 7b – Chelan County Payer Mix Breakdown

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

Approved assumptions for Chelan County

Table 7c – Combined Counties Payer Mix Breakdown

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

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

The existing agency is in the process of standing up so there is no historical data. Below is the approved projections for the existing agency. Since the largest population center for both Douglas and Chelan Counties is the Wenatchee Valley, and the makeup of Douglas County is very similar to Chelan County, we anticipate this same mix in Douglas County.

Table 8 – Chelan County Payer Mix Breakdown

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

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

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

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

There is no financing needed for this project, however, should any financing be needed, Wenatchee Hospice Holdings LLC through Stride Health Care LLC, its manager, would finance the project. See Appendix 16.

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

    Not applicable.

15. **Provide the most recent audited financial statements for:**
    - **The applicant, and**
    - **Any parent entity responsible for financing the project.**

    No audited financials are available. See Appendix 17 for financial statements including most recent accountant reviewed financial statement.

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

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

Table 9a – FTE's Douglas County

| **Clinical Staff** | **2024** | **2025** | **2026** |
|---|---|---|---|
| Clinical Director (Also called Clinical Supervisor)* | 0.00 | 0.00 | 0.00 |
| RN Case Manager | 0.35 | 0.35 | 0.36 |
| CNA | 0.25 | 0.25 | 0.26 |
| QAPI Nurse* | 0.00 | 0.00 | 0.00 |
| Social Worker | 0.08 | 0.08 | 0.09 |
| Spiritual Care Coordinator | 0.08 | 0.08 | 0.09 |
| **Total** | **0.76** | **0.76** | **0.80** |
| | | | |
| **Administrative Staff** | **2024** | **2025** | **2026** |
| Administrator* | 0.00 | 0.00 | 0.00 |
| Outreach Coordinator^ | 0.00 | 0.00 | 0.00 |
| Volunteer Coordinator^ | 0.00 | 0.00 | 0.00 |
| Intake Coordinator / Clinical Support^ | 0.00 | 0.00 | 0.00 |
| Office Manager* | 0.00 | 0.00 | 0.00 |
| **Total** | **0.00** | **0.00** | **0.00** |
| | | | |
| **Total FTE's** | **0.76** | **0.76** | **0.80** |

*Staff with the asterisks are shared between Hospice and Home Health. They are not affected by this project and will be in place regardless of approval of this project. ^Staff with the caret symbol are, or will be, in place with Advanced Hospice in Chelan County regardless of approval of this project. This table reflects the staff not already in place that are additionally needed to care for the underserved population cohort needs in Douglas County.

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

Advanced Hospice is state licensed and in the process of becoming certified to provide Medicare and Medicaid hospice care in Chelan County and as such has no historical data. Presented in table 9a above is the projections for Douglas County. Table 9b shows the approved projections for Chelan County for both the intervening year of 2023 and the three following years of operation. Table 9c shows the combined FTE's for Douglas and Chelan Counties.

Table 9b – FTE's Chelan County

| **Clinical Staff** | 2023 | **2024** | **2025** | **2026** |
|---|---|---|---|---|
| Clinical Director (Also called Clinical Supervisor)* | 0.50 | 0.50 | 0.50 | 0.50 |
| RN Case Manager | 2.00 | 3.89 | 4.34 | 4.76 |
| CNA | 1.43 | 2.78 | 3.10 | 3.40 |
| QAPI Nurse* | 0.50 | 0.50 | 0.50 | 0.50 |
| Social Worker | 0.48 | 0.93 | 1.03 | 1.13 |
| Spiritual Care Coordinator | 0.48 | 0.93 | 1.03 | 1.13 |
| **Total** | **5.39** | **9.54** | **10.50** | **11.42** |
| **Administrative Staff** | 2023 | **2024** | **2025** | **2026** |
| Administrator* | 0.50 | 0.50 | 0.50 | 0.50 |
| Outreach Coordinator | 1.00 | 1.00 | 1.00 | 1.00 |
| Volunteer Coordinator | 1.00 | 1.00 | 1.00 | 1.00 |
| Intake Coordinator / Clinical Support | 1.00 | 1.00 | 1.00 | 1.00 |
| Office Manager* | 0.50 | 0.50 | 0.50 | 0.50 |
| **Total** | **4.00** | **4.00** | **4.00** | **4.00** |
| | | | | |
| **Total FTE's** | **9.39** | **13.54** | **14.50** | **15.42** |

Table 9c – FTE's Entire Agency (Douglas and Chelan Counties)

| **Clinical Staff** | 2023 | **2024** | **2025** | **2026** |
|---|---|---|---|---|
| Clinical Director (Also called Clinical Supervisor)* | 0.50 | 0.50 | 0.50 | 0.50 |
| RN Case Manager | 2.00 | 4.24 | 4.69 | 5.12 |
| CNA | 1.43 | 3.03 | 3.35 | 3.66 |
| QAPI Nurse* | 0.50 | 0.50 | 0.50 | 0.50 |
| Social Worker | 0.48 | 1.01 | 1.11 | 1.22 |
| Spiritual Care Coordinator | 0.48 | 1.01 | 1.11 | 1.22 |
| **Total** | **5.39** | **10.29** | **11.26** | **12.22** |
| **Administrative Staff** | 2023 | **2024** | **2025** | **2026** |
| Administrator* | 0.50 | 0.50 | 0.50 | 0.50 |
| Outreach Coordinator | 1.00 | 1.00 | 1.00 | 1.00 |
| Volunteer Coordinator | 1.00 | 1.00 | 1.00 | 1.00 |
| Intake Coordinator / Clinical Support | 1.00 | 1.00 | 1.00 | 1.00 |
| Office Manager* | 0.50 | 0.50 | 0.50 | 0.50 |
| **Total** | **4.00** | **4.00** | **4.00** | **4.00** |
| | | | | |
| **Total FTE's** | **9.39** | **14.29** | **15.26** | **16.22** |

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

Table 10 – FTE Assumptions

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

The number and types of FTE's is based off of an analysis that was conducted in order to validate the appropriateness of staffing for Advanced Hospice. This assessment showed that Advanced Hospice was in line with 4 other applicants approved over the past 3 years in Washington. These applicants were in rural counties, similar to Chelan County. This is applicable to this project in Douglas County as the requirements for Hospice providers related to delivery of care are all the same. Although there are variations in some other areas of staffing a hospice agency, this direct care staffing is fairly consistent among providers and was found to be in line with what Advanced Hospice determined its staffing requirements to be. This is also in line with what was approved by the department for Advanced Hospice for Chelan County.

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

Advanced Hospice is confident in the adequacy of planned staffing levels and verified through a review and comparison to a number of other entities that are currently in operation as well as a comparison to approved certificate of need applications in the 2018, 2019, and 2020 application cycles. In addition, the administrator with over 20 years of experience was consulted to verify accuracy of staffing projections.

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

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

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

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

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

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

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

   Joel Stephens
   Social Work Independent Clinical License – LW00007198
   Maria Jay
   Registered Nurse – RN00122257
   Carly Bozett
   Registered Nurse – RN61212618
   Katharine Broberg,
   Social Work Independent Clinical License – LW60998966
   Jose Mendez Rangel
   Nursing Assistant Certification – NC61292241
   Jonathan Kim
   Physician and Surgeon License – MD60204584

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

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

   Advanced Home Health has had a presence in the community for years and as such, is familiar with the challenges and opportunities of recruiting talent both

locally in Douglas County as well as outside of the county and state. Advanced Home Health has been able to recruit talent to meet its objectives in providing home health services in Douglas County. They offer competitive wages and benefits. Many of its current staff have interest and have begun working for Advanced Hospice to help stand up the hospice services through the certification process. This has helped improve access in the county by allowing available workforce that was not engaged in providing hospice services, to now be able to provide hospice services to help meet hospice needs in the community. Recruitment efforts will continue in the same manner for Advanced Hospice as has been employed and been shown to be effective for Advanced Home Health and Advanced Hospice, in order to meet staffing needs.

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

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

The most effective recruitment has been through word of mouth referrals from existing staff. Advanced Hospice also has access to typical recruiting platforms such as Indeed, Glassdoor, Linked In, etc. and will use those as needed to fill immediate and ongoing needs. For urgent or unexpected needs that arise, Advanced Hospice also has direct access to national recruiters and staffing agencies that have resources available to garner potential interest in open positions and to deal with any unexpected and urgent staffing challenges.

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

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

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

    Yes, Advanced Hospice currently uses an application called Fazzi to assess for customer satisfaction and identify quality improvement opportunities. Advanced Home Health has used a quality improvement process that has yielded positive results for the organization. Appendix 11 has the policy and procedure for this same program which is now also being used by Advanced Hospice.

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

    Wellsky Consolo (Kinnser) – EMR
    Forcura – Document Management and HIPAA compliant communication platform for clinicians
    Medbridge and Elsevier – Learning and resource platforms for clinicians
    Enclara Pharmacia – Pharmacy Vendor
    Medline – Supply Vendor
    Bellevue Healthcare Central Washington – DME Vendor
    Fazzi - Customer Satisfaction

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

    The existing ancillary and support agreements are not expected to change as a result of this project.

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

    Not Applicable

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

    Because the agency is in the process of standing up and admitting its first patients, contracts with SNF and Hospital partners are still being negotiated and there is not a documented working relationship as of yet. These will be in place shortly but are not as of yet.

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

These will not change. The main healthcare infrastructure (Hospitals, Skilled Nursing Facilities, clinics, etc.), reside mainly in Chelan County, mostly in the city of Wenatchee. Relationships are being established and built in this infrastructure and this will continue with the following which, although mainly located in Chelan County, serve the majority of residents in Douglas County. There are some additional entities that are specific to Douglas County but they are very small.

Hospitals: Central Washington Hospital, Wenatchee Valley Medical Center, Lake Chelan Community Hospital and Douglas County Hospital District in Waterville.

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

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

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

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

    Not Applicable

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

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

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

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

First, by not significantly changing the landscape of providers in the community. Currently, there are two providers of home health care in Douglas and Chelan Counties. Central Washington Hospital Home Health and Advanced Home Health. There are now two hospice providers in Chelan county – Central Washington Hospital Hospice and Advanced Hospice but only one provider of Hospice services in Douglas County – Central Washington Hospital Hospice. Central Washington Hospital Hospice is part of Confluence Health and is well known and respected for their services across all levels of care from physicians to hospitals and home health and hospice. They are an important and influential provider of health care in the community. However, what makes this project unique is that the largest population center in both Douglas and Chelan Counties is the Wenatchee Valley. As discussed previously in this application, the valley is divided in half with Wenatchee in Chelan County and East Wenatchee in Douglas County. Advanced Hospice is approved to provide Hospice Services in Chelan County but is not able to admit patients from half of the Wenatchee Valley, the largest population center for both counties, because it lies within Douglas County. This project will allow Advanced Hospice to expand its services to meet the needs of the Hispanic community within Douglas County. There is a need for culturally competent hospice service delivery to this underserved population within Douglas County – just as there was in Chelan County. This project will promote continuity and decrease fragmentation in the community and will not detract from, but will add to, what is already being done by Confluence Health.

One brief example of potential fragmentation that this project seeks to fix is the fact that Advanced Hospice is now beginning outreach and education in Chelan County which includes the city of Wenatchee and half of Wenatchee Valley. It is impossible to advertise and promote a service to half of a population center, especially when the health care delivery system resides mainly in Chelan County. Inevitably, a resident of Douglas County who enters Chelan County to receive healthcare services, will hear of and want to utilize Advanced Hospices services because of the Hispanic programming available. In fact, word is spreading and we have already had people who reside in Douglas County asking about our Hispanic programing. Advanced Hospice will have to screen referrals to see which side of the Wenatchee Valley the referral lives in. If they live in East Wenatchee (Douglas County) Advanced Hospice will have to deny the referral and send them to the other provider who does not have the cultural programming. This project will help allow the Hispanic programming to reach the residents of the entirety of the Wenatchee Valley as well as the rest of Douglas County. Advanced Hospice has become acutely aware of the fragmentation that will occur if the Hispanic programming is not available to the

residents of Douglas County. As discussed earlier in this application, there is adequate evidence of the Wenatchee Valley, and the Counties of Douglas and Chelan operating as one. This factor cannot be overstated as it relates to this project. It has become very clear that Advanced Hospice needs to be able to serve Douglas County as well as Chelan County.

Second, Advanced Home Health already has relationships in place within the health care community of Douglas County and Advanced Hospice is being established in Chelan County and will work to build on these relationships and partner with Skilled Nursing (all located in Chelan County) and Assisted Living Facilities (located in Chelan and Douglas Counties) that serve patients from Douglas County, in particular to identify needs among the patients who are most at risk and in need of hospice services. This project will work through outreach to help ensure hospice services that are needed in the Hispanic community are identified and accessed in order to help decrease overall healthcare costs and provide timely and appropriate palliative, comfort and supportive services to the patients and their families. This will add value and improve continuity in the delivery of healthcare in this market. It will not create unwarranted fragmentation but help decrease its likelihood.

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

To reiterate, having an additional provider of Hospice that already has a footprint in Home Health throughout the county will also allow for additional outreach and therefore improved utilization of hospice services for both providers as additional populations would be able to receive outreach, education, and access to hospice services. This increased utilization among the underserved Hispanic population in particular will ultimately lead to improved patient and family outcomes and satisfaction when dealing with death and dying. It will also lead to improved efficiency in use of the healthcare system as well as decreased overall healthcare costs.[37] Also, it is important to consider the unique geography and conditions that lead to the counties of Douglas and Chelan needing to be able to operate as one.

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

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

    Advanced Home Health has been serving the community of Douglas County for years and has already established appropriate relationships in the existing health care system. This proposed project will allow for a seamless transition into the existing health care system. Advanced Hospice will be able to build upon and expand the already existing appropriate relationships with health care partners in the community. Advanced Hospice will be able to utilize existing resources in an effective and efficient manner to add needed hospice services in the county without creating a burden to the existing healthcare system. Through utilizing existing admin and clinical staff from its existing hospice services, It will lead to a more effective use of resources to allow for additional staff and resources to help meet community needs.

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

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

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

    Not applicable.

**D. Cost Containment (WAC 246-310-240)**
**Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.**

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

   Alternatives considered prior to submission include:
   A. Do nothing or postpone the project
   B. Purchase an existing hospice
   C. Apply to expand Chelan CN approved license into Douglas County
   D. Apply for CN approval for new separate license for Douglas County only

   Please see discussion in Table 13 Below.

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

Table 11 - Alternative Analysis

| | A. Do Nothing | B. Purchase Existing Hospice | C. Apply to expand Chelan CN approved license into Douglas County | D. Apply for CN approval for new separate license for Douglas County only |
|---|---|---|---|---|
| Patient Access to Healthcare Services | This option would continue with the status quo in the community which has demonstrated underserved populations. These populations, in particular the Hispanic population would continue | This is not an option as there is not an available Hospice for sale. It would likely not allow for significant improvements in access to care in the immediate. It would take more time as time and | This option will allow for an efficient use of an already existing network to allow for quick set up and improved access to care for the identified underserved population cohorts. | This would also allow for an efficient use of a relationship with an already existing network to allow for quick set up and improved access to care for the identified underserved population cohorts. |

| | | | | |
|---|---|---|---|---|
| | to be underserved. | energy would be focused on a transition. | | |
| Capital Cost | This option would include no capital cost. | Depending on purchase price, this could have significant implications on immediate ability to expand and meet underserved population needs. | This project will expand upon already approved Advanced Hospice, therefore eliminating capital costs, and startup costs. In addition, the speed to project completion and improved access would be quickest. | This could also allow for expanding upon already approved Advanced Hospice, therefore eliminating capital costs and startup costs with exception of a new license vs expanding a license into another county. There would be some additional cost associated with this option |
| Legal Restrictions | There would be no real advantages. | A lengthy and costly process to evaluate purchase would be a disadvantage. There would be no real advantages. | Advanced Hospice staff that are already in place would be able to provide care to underserved population which improves access and quality of care and continuity. It does take time for CN approval which is a disadvantage. | There is a slight added complexity with a separate license for the same service line in different counties, ie maintaining renewal dates, etc. This would add, although very minimal, more complexity than expanding the existing CN and License for Hospice services. |
| Staffing Impacts | It would have no real impact on staffing in community. | It would have no real impact on staffing in community. | It will have an advantage of sharing key staff and allowing more | This could also have an advantage of sharing key staff and allowing |

| | | | | |
|---|---|---|---|---|
| | | | clinicians to meet community hospice needs. | more clinicians to meet community hospice needs. |
| Quality of Care | There would be no change to quality of Care in Douglas County. | It would have no real impact on quality of care in Chelan County. | This will allow for improved access to care by underserved Hispanic population. | This would also allow for improved access to care by underserved Hispanic population. |
| Cost/Operation Efficiency | There would be no real cost/operational efficiency change. | This option could potentially have a negative impact based on purchase price with no real improvement. | This option allows for a cost-effective method to leverage existing resources in an efficient way to meet the identified underserved population cohorts. Administrative, Lease, equipment and other fixed and variable costs could be minimized by sharing them between Home Health and Hospice. Start up costs would be non-existent and operational costs would be minimized as compared to other options. | This option would also allow for a cost-effective method to leverage existing resources in an efficient way to meet the identified underserved population cohorts. Administrative, lease, equipment and other fixed and variable costs could be minimized by sharing them between Home health and Hospice. Start up costs would be non-existent and operational costs would be minimized as compared to other options. This option would have a slight increase in cost for license renewals. There |

| | | | | |
|---|---|---|---|---|
| | | | | would be a slight operational inefficiency component with the separate license for the same service line. |
| Analysis and Rationale | This option does not improve access to identified underserved populations. | This option is not realistic in that a hospice is not for sale. It would also not likely improve access to underserved populations or | This option would improve access to identified underserved populations in a very cost effective and timely manner while improving continuity and minimizing any impact to the existing community healthcare services. | This option would improve access to identified underserved population cohorts in a cost effective and timely manner while improving continuity and minimizing any impact to the existing community healthcare services. It would have small inefficiencies and costs over the previous option |

3. **If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):**
   - **The costs, scope, and methods of construction and energy conservation are reasonable; and**
   - **The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.**

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

4. **Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health**

**services which foster cost containment and which promote quality assurance and cost effectiveness.**

This project will promote cost effectiveness and will meet the criteria of WAC 246-310-240. This project will have no capital or startup costs. Advanced Hospice is already being established as approved in Chelan County and will be well established by the time this project is approved. Advanced Home Health already has a presence in Douglas County. Entry into the market will come with no new expense. The time needed to connect and integrate into the existing healthcare network will be almost nonexistent as relationships already exist between current providers and Advanced Home Health and are currently being established with Hospice. In addition, time to setup and initiate services will be minimal as there will not be any hiring efforts needed to begin offering services. This project will lead most quickly and cost effectively to serving the identified underserved Hispanic population. All other options would have increased capital and startup costs as well as time to form connections in the healthcare system. There would also be a need to compete more with the existing provider. Because of the focus in this project on the underserved population in Douglas County, Advanced Hospice will be focused on the Hispanic population and will not need to compete with the current provider for any business. Because Advanced Hospice will have the infrastructure in place for Chelan County, this project can make sense financially and there will be no negative impact on the current provider of hospice services.

This project will also promote quality assurance from its inception as Advanced Home Health has been able to implement and learn from its newer QAPI programming. Advanced Hospice is now using this same programming in Chelan County and will be well established and productive upon approval of this project. This process has involved all staff and allows for systematic review of key performance metrics to assess and improve quality outcomes. The framework and structure is already in place and will require minimal efforts. See Appendix 11 for QAPI Policy. This project will allow for seamless integration into the community to offer the Hispanic Community continuity and access to quality care.

**Hospice Agency Superiority**

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

**Multiple Applications in One Year**

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

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

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

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

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

   Not applicable

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

   Not applicable

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

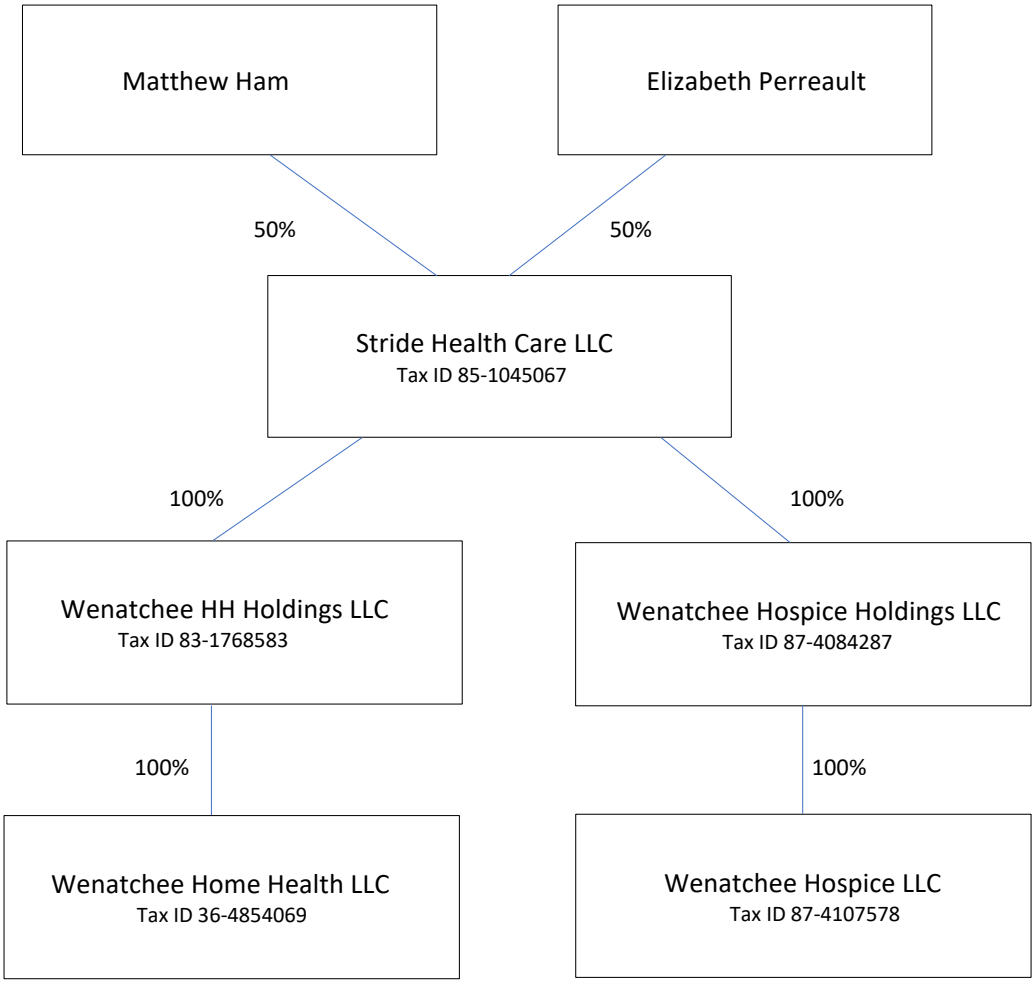
Not applicable

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 1

## Organizational Structure




Disclosure of Ownership

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 2

## Applicant Information

UNITED STATES OF AMERICA

# The State of Washington

## Secretary of State

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

**CERTIFICATE OF FORMATION**

to

**WENATCHEE HOSPICE LLC**

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

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

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

Steve R. Hobbs, Secretary of State

Date Issued: 12/01/2021

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 3

**List of Owned Entities**

| List of Owned Entities | |
|---|---|
| **Agency Name** | Wenatchee Home Health LLC dba Advanced Home Health Northwest of Wenatchee |
| **Agency Location** | 285 Technology Center Way Suite 107, Wenatchee, WA 98801 |
| **Agency License Number** | IHS.FS.60796898 |
| **Agency CMS Certification Number** | 50-7713 |
| **Agency Accreditation Status** | Not Accredited |
| **Type of Agency** | Home Health |
| | |
| **Agency Name** | Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee |
| **Agency Location** | 285 Technology Center Way Suite 108, Wenatchee, WA 98801 |
| **Agency License Number** | IHS.FS.61323866 |
| **Agency CMS Certification Number** | Pending |
| **Agency Accreditation Status** | Pending through ACHC |
| **Type of Agency** | Hospice |
| | |
| **Note: No Agencies have been sold by applicant** | |

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 4

**Letter of Intent**

WENATCHEE HOSPICE, LLC

**Via email to FSLCON@doh.wa.gov**

November 30, 2022

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

Dear Mr. Hernandez,

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

1. Description of proposed service: Wenatchee Hospice Holdings LLC, through Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee was approved 9/23/22 to provide hospice services to residents in Chelan County. This project requests approval for the certificate of need to expand its existing approval for Chelan County to also offer Hospice services in Douglas County.

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

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

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

Respectfully,
Wenatchee Hospice Holdings LLC

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

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

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 5

**Department of Health 2022-2023 Hospice Numeric Need Methodology**

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Distributed November 1, 2022*

**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 |
| 2019 | 3,712 |
| 2020 | 3,680 |
| 2021 | 3,893 |
| | average: 3,762 |

| Deaths ages 0-64 | |
|---|---|
| Year | Deaths |
| 2019 | 14,047 |
| 2020 | 16,663 |
| 2021 | 18015 |
| | average: 16,242 |

| Use Rates | |
|---|---|
| 0-64 | 23.16% |
| 65+ | 58.07% |

| Hospice admissions ages 65+ | |
|---|---|
| Year | Admissions |
| 2019 | 26,175 |
| 2020 | 27,957 |
| 2021 | 27,884 |
| | average: 27,339 |

| Deaths ages 65+ | |
|---|---|
| Year | Deaths |
| 2019 | 44,159 |
| 2020 | 46,367 |
| 2021 | 50,717 |
| | average: 47,081 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

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**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Distributed November 1, 2022*

**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 | 2019 | 2020 | 2021 | 2019-2021 Average Deaths |
| Adams | 35 | 20 | 23 | **26** |
| Asotin | 54 | 56 | 43 | **51** |
| Benton | 346 | 555 | 536 | **479** |
| Chelan | 137 | 224 | 256 | **206** |
| Clallam | 186 | 195 | 185 | **189** |
| Clark | 887 | 1,043 | 1,078 | **1,003** |
| Columbia | 7 | 7 | 11 | **8** |
| Cowlitz | 294 | 314 | 401 | **336** |
| Douglas | 63 | 42 | 45 | **50** |
| Ferry | 20 | 19 | 21 | **20** |
| Franklin | 123 | 100 | 110 | **111** |
| Garfield | 5 | 5 | 4 | **5** |
| Grant | 197 | 186 | 208 | **197** |
| Grays Harbor | 251 | 209 | 236 | **232** |
| Island | 167 | 110 | 116 | **131** |
| Jefferson | 72 | 68 | 54 | **65** |
| King | 3,275 | 4,456 | 4,892 | **4,208** |
| Kitsap | 557 | 454 | 489 | **500** |
| Kittitas | 90 | 78 | 88 | **85** |
| Klickitat | 46 | 42 | 50 | **46** |
| Lewis | 210 | 205 | 186 | **200** |
| Lincoln | 25 | 15 | 24 | **21** |
| Mason | 167 | 143 | 168 | **159** |
| Okanogan | 119 | 88 | 92 | **100** |
| Pacific | 66 | 55 | 59 | **60** |
| Pend Oreille | 31 | 41 | 55 | **42** |
| Pierce | 1,911 | 2,364 | 2,574 | **2,283** |
| San Juan | 20 | 18 | 24 | **21** |
| Skagit | 229 | 269 | 334 | **277** |
| Skamania | 19 | 26 | 25 | **23** |
| Snohomish | 1,533 | 1,587 | 1,563 | **1,561** |
| Spokane | 1,143 | 1,634 | 1,842 | **1,540** |
| Stevens | 112 | 86 | 114 | **104** |
| Thurston | 525 | 628 | 763 | **639** |
| Wahkiakum | 11 | 10 | 7 | **9** |
| Walla Walla | 118 | 150 | 138 | **135** |
| Whatcom | 394 | 457 | 443 | **431** |
| Whitman | 47 | 51 | 59 | **52** |
| Yakima | 555 | 653 | 699 | **636** |

| 65+ | | | | |
|---|---|---|---|---|
| County | 2019 | 2020 | 2021 | 2019-2021 Average Deaths |
| Adams | 93 | 59 | 92 | **81** |
| Asotin | 222 | 186 | 188 | **199** |
| Benton | 1,154 | 1,522 | 1,610 | **1,429** |
| Chelan | 626 | 785 | 870 | **760** |
| Clallam | 955 | 777 | 906 | **879** |
| Clark | 2,987 | 3,205 | 3,705 | **3,299** |
| Columbia | 52 | 43 | 43 | **46** |
| Cowlitz | 951 | 968 | 1,100 | **1,006** |
| Douglas | 270 | 160 | 174 | **201** |
| Ferry | 64 | 58 | 63 | **62** |
| Franklin | 313 | 263 | 261 | **279** |
| Garfield | 21 | 11 | 24 | **19** |
| Grant | 508 | 455 | 523 | **495** |
| Grays Harbor | 659 | 558 | 590 | **602** |
| Island | 642 | 505 | 504 | **550** |
| Jefferson | 338 | 273 | 295 | **302** |
| King | 10,213 | 11,186 | 11,896 | **11,098** |
| Kitsap | 1,811 | 1,714 | 1,832 | **1,786** |
| Kittitas | 266 | 241 | 241 | **249** |
| Klickitat | 160 | 113 | 164 | **146** |
| Lewis | 722 | 653 | 723 | **699** |
| Lincoln | 89 | 75 | 76 | **80** |
| Mason | 548 | 408 | 461 | **472** |
| Okanogan | 358 | 277 | 324 | **320** |
| Pacific | 265 | 177 | 239 | **227** |
| Pend Oreille | 125 | 101 | 119 | **115** |
| Pierce | 5,002 | 5,608 | 6,264 | **5,625** |
| San Juan | 127 | 94 | 91 | **104** |
| Skagit | 1,018 | 1,068 | 1,190 | **1,092** |
| Skamania | 87 | 47 | 56 | **63** |
| Snohomish | 4,081 | 4,278 | 4,478 | **4,279** |
| Spokane | 3,545 | 4,322 | 4,810 | **4,226** |
| Stevens | 345 | 248 | 304 | **299** |
| Thurston | 1,908 | 2,007 | 2,285 | **2,067** |
| Wahkiakum | 53 | 18 | 25 | **32** |
| Walla Walla | 450 | 522 | 595 | **522** |
| Whatcom | 1,461 | 1,481 | 1,674 | **1,539** |
| Whitman | 219 | 226 | 278 | **241** |
| Yakima | 1,451 | 1,675 | 1,644 | **1,590** |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

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**2022-2023 Hospice Numeric Need Methodology**
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**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 | 2019-2021 Average Deaths | Projected Patients: 23.16% of Deaths |
| Adams | 26 | 6 |
| Asotin | 51 | 12 |
| Benton | 479 | 111 |
| Chelan | 206 | 48 |
| Clallam | 189 | 44 |
| Clark | 1,003 | 232 |
| Columbia | 8 | 2 |
| Cowlitz | 336 | 78 |
| Douglas | 50 | 12 |
| Ferry | 20 | 5 |
| Franklin | 111 | 26 |
| Garfield | 5 | 1 |
| Grant | 197 | 46 |
| Grays Harbor | 232 | 54 |
| Island | 131 | 30 |
| Jefferson | 65 | 15 |
| King | 4,208 | 975 |
| Kitsap | 500 | 116 |
| Kittitas | 85 | 20 |
| Klickitat | 46 | 11 |
| Lewis | 200 | 46 |
| Lincoln | 21 | 5 |
| Mason | 159 | 37 |
| Okanogan | 100 | 23 |
| Pacific | 60 | 14 |
| Pend Oreille | 42 | 10 |
| Pierce | 2,283 | 529 |
| San Juan | 21 | 5 |
| Skagit | 277 | 64 |
| Skamania | 23 | 5 |
| Snohomish | 1,561 | 362 |
| Spokane | 1,540 | 357 |
| Stevens | 104 | 24 |
| Thurston | 639 | 148 |
| Wahkiakum | 9 | 2 |
| Walla Walla | 135 | 31 |
| Whatcom | 431 | 100 |
| Whitman | 52 | 12 |
| Yakima | 636 | 147 |

| 65+ | | |
|---|---|---|
| County | 2019-2021 Average Deaths | Projected Patients: 58.07% of Deaths |
| Adams | 81 | 47 |
| Asotin | 199 | 115 |
| Benton | 1,429 | 830 |
| Chelan | 760 | 442 |
| Clallam | 879 | 511 |
| Clark | 3,299 | 1,916 |
| Columbia | 46 | 27 |
| Cowlitz | 1,006 | 584 |
| Douglas | 201 | 117 |
| Ferry | 62 | 36 |
| Franklin | 279 | 162 |
| Garfield | 19 | 11 |
| Grant | 495 | 288 |
| Grays Harbor | 602 | 350 |
| Island | 550 | 320 |
| Jefferson | 302 | 175 |
| King | 11,098 | 6,445 |
| Kitsap | 1,786 | 1,037 |
| Kittitas | 249 | 145 |
| Klickitat | 146 | 85 |
| Lewis | 699 | 406 |
| Lincoln | 80 | 46 |
| Mason | 472 | 274 |
| Okanogan | 320 | 186 |
| Pacific | 227 | 132 |
| Pend Oreille | 115 | 67 |
| Pierce | 5,625 | 3,266 |
| San Juan | 104 | 60 |
| Skagit | 1,092 | 634 |
| Skamania | 63 | 37 |
| Snohomish | 4,279 | 2,485 |
| Spokane | 4,226 | 2,454 |
| Stevens | 299 | 174 |
| Thurston | 2,067 | 1,200 |
| Wahkiakum | 32 | 19 |
| Walla Walla | 522 | 303 |
| Whatcom | 1,539 | 893 |
| Whitman | 241 | 140 |
| Yakima | 1,590 | 923 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

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**Department of Health**
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**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**

| | | | 0-64 | | | | | |
|---|---|---|---|---|---|---|---|---|
| County | Projected Patients | 2019-2021 Average Population | 2022 projected population | 2023 projected population | 2024 projected population | 2022 potential volume | 2023 potential volume | 2024 potential volume |
| Adams | 6 | 18,303 | 18,622 | 18,787 | 18,953 | 6 | 6 | 6 |
| Asotin | 12 | 16,655 | 16,540 | 16,485 | 16,429 | 12 | 12 | 12 |
| Benton | 111 | 169,475 | 172,638 | 174,249 | 175,861 | 113 | 114 | 115 |
| Chelan | 48 | 62,401 | 62,562 | 62,611 | 62,661 | 48 | 48 | 48 |
| Clallam | 44 | 52,389 | 52,027 | 51,821 | 51,615 | 43 | 43 | 43 |
| Clark | 232 | 416,817 | 426,529 | 431,158 | 435,786 | 238 | 240 | 243 |
| Columbia | 2 | 2,782 | 2,710 | 2,675 | 2,640 | 2 | 2 | 2 |
| Cowlitz | 78 | 85,859 | 85,769 | 85,695 | 85,621 | 78 | 78 | 78 |
| Douglas | 12 | 35,487 | 36,080 | 36,356 | 36,633 | 12 | 12 | 12 |
| Ferry | 5 | 5,582 | 5,506 | 5,470 | 5,435 | 5 | 5 | 5 |
| Franklin | 26 | 90,186 | 94,784 | 97,124 | 99,465 | 27 | 28 | 28 |
| Garfield | 1 | 1,561 | 1,522 | 1,502 | 1,483 | 1 | 1 | 1 |
| Grant | 46 | 87,144 | 89,322 | 90,403 | 91,485 | 47 | 47 | 48 |
| Grays Harbor | 54 | 57,008 | 56,401 | 56,122 | 55,844 | 53 | 53 | 53 |
| Island | 30 | 63,219 | 63,296 | 63,312 | 63,328 | 30 | 30 | 30 |
| Jefferson | 15 | 20,688 | 20,550 | 20,463 | 20,377 | 15 | 15 | 15 |
| King | 975 | 1,903,445 | 1,930,192 | 1,941,913 | 1,953,635 | 988 | 994 | 1000 |
| Kitsap | 116 | 219,729 | 221,192 | 221,771 | 222,349 | 117 | 117 | 117 |
| Kittitas | 20 | 38,918 | 39,556 | 39,827 | 40,097 | 20 | 20 | 20 |
| Klickitat | 11 | 15,572 | 15,304 | 15,168 | 15,033 | 10 | 10 | 10 |
| Lewis | 46 | 62,955 | 63,327 | 63,491 | 63,654 | 47 | 47 | 47 |
| Lincoln | 5 | 7,807 | 7,698 | 7,644 | 7,591 | 5 | 5 | 5 |
| Mason | 37 | 51,050 | 51,672 | 51,946 | 52,221 | 37 | 38 | 38 |
| Okanogan | 23 | 32,211 | 31,991 | 31,896 | 31,800 | 23 | 23 | 23 |
| Pacific | 14 | 14,424 | 14,242 | 14,161 | 14,081 | 14 | 14 | 14 |
| Pend Oreille | 10 | 9,813 | 9,727 | 9,684 | 9,642 | 10 | 10 | 10 |
| Pierce | 529 | 763,798 | 774,696 | 779,475 | 784,253 | 536 | 540 | 543 |
| San Juan | 5 | 10,782 | 10,707 | 10,684 | 10,661 | 5 | 5 | 5 |
| Skagit | 64 | 101,410 | 102,236 | 102,586 | 102,935 | 65 | 65 | 65 |
| Skamania | 5 | 9,238 | 9,205 | 9,186 | 9,168 | 5 | 5 | 5 |
| Snohomish | 362 | 714,698 | 726,273 | 731,019 | 735,765 | 367 | 370 | 372 |
| Spokane | 357 | 425,148 | 428,033 | 429,326 | 430,619 | 359 | 360 | 361 |
| Stevens | 24 | 34,006 | 33,841 | 33,766 | 33,690 | 24 | 24 | 24 |
| Thurston | 148 | 241,186 | 246,235 | 248,602 | 250,970 | 151 | 152 | 154 |
| Wahkiakum | 2 | 2,448 | 2,368 | 2,332 | 2,295 | 2 | 2 | 2 |
| Walla Walla | 31 | 50,924 | 51,075 | 51,121 | 51,168 | 31 | 31 | 31 |
| Whatcom | 100 | 187,499 | 190,722 | 192,178 | 193,633 | 102 | 102 | 103 |
| Whitman | 12 | 43,282 | 43,322 | 43,330 | 43,337 | 12 | 12 | 12 |
| Yakima | 147 | 224,364 | 227,147 | 228,473 | 229,798 | 149 | 150 | 151 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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**2022-2023 Hospice Numeric Need Methodology**
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**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 | 2019-2021 Average Population | 2022 projected population | 2023 projected population | 2024 projected population | 2022 potential volume | 2023 potential volume | 2024 potential volume |
| Adams | 47 | 2,317 | 2,424 | 2,466 | 2,507 | 49 | 50 | 51 |
| Asotin | 115 | 5,997 | 6,344 | 6,514 | 6,683 | 122 | 125 | 129 |
| Benton | 830 | 32,170 | 34,597 | 35,820 | 37,044 | 892 | 924 | 955 |
| Chelan | 442 | 16,445 | 17,695 | 18,339 | 18,982 | 475 | 492 | 510 |
| Clallam | 511 | 22,323 | 23,535 | 24,168 | 24,802 | 538 | 553 | 567 |
| Clark | 1,916 | 82,139 | 89,247 | 92,807 | 96,368 | 2,081 | 2,164 | 2,248 |
| Columbia | 27 | 1,264 | 1,304 | 1,322 | 1,339 | 28 | 28 | 28 |
| Cowlitz | 584 | 22,945 | 24,470 | 25,220 | 25,971 | 623 | 642 | 661 |
| Douglas | 117 | 8,334 | 8,974 | 9,283 | 9,591 | 126 | 130 | 135 |
| Ferry | 36 | 2,233 | 2,337 | 2,386 | 2,434 | 37 | 38 | 39 |
| Franklin | 162 | 9,627 | 10,557 | 11,030 | 11,504 | 178 | 186 | 194 |
| Garfield | 11 | 658 | 680 | 692 | 703 | 11 | 11 | 12 |
| Grant | 288 | 15,469 | 16,665 | 17,258 | 17,852 | 310 | 321 | 332 |
| Grays Harbor | 350 | 16,636 | 17,612 | 18,092 | 18,571 | 370 | 380 | 390 |
| Island | 320 | 20,809 | 22,047 | 22,682 | 23,317 | 339 | 348 | 358 |
| Jefferson | 175 | 11,945 | 12,722 | 13,121 | 13,520 | 187 | 193 | 198 |
| King | 6,445 | 324,334 | 350,881 | 363,992 | 377,102 | 6,972 | 7,232 | 7,493 |
| Kitsap | 1,037 | 55,965 | 60,492 | 62,800 | 65,107 | 1,121 | 1,164 | 1,206 |
| Kittitas | 145 | 7,952 | 8,589 | 8,911 | 9,234 | 156 | 162 | 168 |
| Klickitat | 85 | 6,062 | 6,448 | 6,627 | 6,807 | 90 | 92 | 95 |
| Lewis | 406 | 17,241 | 18,175 | 18,652 | 19,130 | 428 | 439 | 451 |
| Lincoln | 46 | 2,963 | 3,119 | 3,200 | 3,280 | 49 | 50 | 51 |
| Mason | 274 | 16,524 | 17,836 | 18,504 | 19,173 | 296 | 307 | 318 |
| Okanogan | 186 | 10,862 | 11,519 | 11,827 | 12,136 | 197 | 202 | 207 |
| Pacific | 132 | 6,897 | 7,159 | 7,284 | 7,408 | 137 | 139 | 142 |
| Pend Oreille | 67 | 4,090 | 4,371 | 4,504 | 4,636 | 71 | 74 | 76 |
| Pierce | 3,266 | 136,408 | 148,729 | 155,037 | 161,344 | 3,561 | 3,712 | 3,863 |
| San Juan | 60 | 5,978 | 6,357 | 6,541 | 6,724 | 64 | 66 | 68 |
| Skagit | 634 | 29,121 | 31,460 | 32,607 | 33,753 | 685 | 710 | 735 |
| Skamania | 37 | 2,797 | 3,048 | 3,172 | 3,297 | 40 | 42 | 43 |
| Snohomish | 2,485 | 125,510 | 138,737 | 145,495 | 152,254 | 2,747 | 2,880 | 3,014 |
| Spokane | 2,454 | 91,294 | 97,979 | 101,288 | 104,597 | 2,633 | 2,722 | 2,811 |
| Stevens | 174 | 11,804 | 12,591 | 12,969 | 13,346 | 185 | 191 | 196 |
| Thurston | 1,200 | 52,830 | 56,967 | 59,035 | 61,102 | 1,294 | 1,341 | 1,388 |
| Wahkiakum | 19 | 1,549 | 1,595 | 1,611 | 1,626 | 19 | 19 | 19 |
| Walla Walla | 303 | 11,141 | 11,632 | 11,915 | 12,197 | 317 | 324 | 332 |
| Whatcom | 893 | 42,586 | 45,794 | 47,372 | 48,949 | 961 | 994 | 1,027 |
| Whitman | 140 | 5,783 | 6,201 | 6,395 | 6,588 | 150 | 155 | 159 |
| Yakima | 923 | 38,465 | 40,559 | 41,643 | 42,727 | 974 | 1,000 | 1,026 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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**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 | 2022 potential volume | 2023 potential volume | 2024 potential volume | Current Supply of Hospice Providers | 2022 Unmet Need Admissions* | 2023 Unmet Need Admissions* | 2024 Unmet Need Admissions* |
|---|---|---|---|---|---|---|---|
| Adams | 56 | 56 | 57 | **51.33** | 4 | 5 | 6 |
| Asotin | 134 | 137 | 140 | **96.33** | 37 | 41 | 44 |
| Benton | 1,005 | 1,038 | 1,070 | **994.00** | 11 | 44 | 76 |
| Chelan | 523 | 540 | 557 | **741.41** | (219) | (201) | (184) |
| Clallam | 582 | 596 | 610 | **492.75** | 89 | 103 | 118 |
| Clark | 2,319 | 2,405 | 2,490 | **2,751.75** | (433) | (347) | (261) |
| Columbia | 29 | 30 | 30 | **38.33** | (9) | (9) | (8) |
| Cowlitz | 701 | 720 | 739 | **855.33** | (154) | (135) | (116) |
| Douglas | 138 | 142 | 147 | **195.33** | (58) | (53) | (49) |
| Ferry | 42 | 43 | 44 | **33.00** | 9 | 10 | 11 |
| Franklin | 205 | 213 | 222 | **190.33** | 14 | 23 | 32 |
| Garfield | 12 | 12 | 13 | **7.00** | 5 | 5 | 6 |
| Grant | 357 | 368 | 380 | **277.33** | 79 | 91 | 102 |
| Grays Harbor | 423 | 433 | 443 | **363.08** | 60 | 70 | 80 |
| Island | 369 | 379 | 388 | **443.67** | (75) | (65) | (55) |
| Jefferson | 202 | 207 | 213 | **201.33** | 0 | 6 | 12 |
| King | 7,960 | 8,227 | 8,493 | **8,727.96** | (768) | (501) | (235) |
| Kitsap | 1,237 | 1,280 | 1,323 | **1,305.08** | (68) | (25) | 18 |
| Kittitas | 176 | 182 | 188 | **161.33** | 15 | 21 | 27 |
| Klickitat | 100 | 103 | 105 | **158.80** | (58) | (56) | (54) |
| Lewis | 475 | 486 | 497 | **439.67** | 35 | 46 | 58 |
| Lincoln | 54 | 55 | 56 | **23.33** | 30 | 32 | 33 |
| Mason | 333 | 345 | 356 | **512.08** | (179) | (167) | (156) |
| Okanogan | 220 | 225 | 230 | **199.33** | 20 | 26 | 31 |
| Pacific | 151 | 153 | 155 | **66.00** | 85 | 87 | 89 |
| Pend Oreille | 81 | 83 | 85 | **67.33** | 14 | 16 | 18 |
| Pierce | 4,097 | 4,252 | 4,406 | **4,156.74** | (59) | 95 | 249 |
| San Juan | 69 | 71 | 73 | **92.00** | (23) | (21) | (19) |
| Skagit | 750 | 775 | 800 | **764.67** | (15) | 10 | 35 |
| Skamania | 45 | 47 | 49 | **38.67** | 7 | 8 | 10 |
| Snohomish | 3,114 | 3,250 | 3,386 | **4,288.02** | (1,174) | (1,038) | (902) |
| Spokane | 2,992 | 3,082 | 3,172 | **3,120.75** | (128) | (38) | 52 |
| Stevens | 209 | 215 | 220 | **145.67** | 64 | 69 | 74 |
| Thurston | 1,445 | 1,493 | 1,542 | **1,829.19** | (384) | (336) | (287) |
| Wahkiakum | 21 | 21 | 22 | **13.67** | 8 | 8 | 8 |
| Walla Walla | 348 | 356 | 364 | **283.00** | 65 | 73 | 81 |
| Whatcom | 1,062 | 1,096 | 1,130 | **1,317.08** | (255) | (221) | (187) |
| Whitman | 162 | 167 | 172 | **139.67** | 23 | 27 | 32 |
| Yakima | 1,123 | 1,149 | 1,176 | **1,214.67** | (92) | (65) | (38) |

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

Sources:
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Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

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**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** | **2022 Unmet Need Admissions*** | **2023 Unmet Need Admissions*** | **2024 Unmet Need Admissions*** | **Statewide ALOS** | **2022 Unmet Need Patient Days*** | **2023 Unmet Need Patient Days*** | **2024 Unmet Need Patient Days*** |
| **Adams** | 4 | 5 | 6 | **61.89** | 260 | 316 | 372 |
| **Asotin** | 37 | 41 | 44 | **61.89** | 2,317 | 2,516 | 2,716 |
| **Benton** | 11 | 44 | 76 | **61.89** | 692 | 2,710 | 4,728 |
| **Chelan** | (219) | (201) | (184) | **61.89** | (13,529) | (12,457) | (11,385) |
| **Clallam** | 89 | 103 | 118 | **61.89** | 5,506 | 6,393 | 7,280 |
| **Clark** | (433) | (347) | (261) | **61.89** | (26,780) | (21,480) | (16,181) |
| **Columbia** | (9) | (9) | (8) | **61.89** | (550) | (528) | (507) |
| **Cowlitz** | (154) | (135) | (116) | **61.89** | (9,552) | (8,374) | (7,195) |
| **Douglas** | (58) | (53) | (49) | **61.89** | (3,569) | (3,295) | (3,022) |
| **Ferry** | 9 | 10 | 11 | **61.89** | 560 | 606 | 652 |
| **Franklin** | 14 | 23 | 32 | **61.89** | 887 | 1,422 | 1,956 |
| **Garfield** | 5 | 5 | 6 | **61.89** | 326 | 337 | 347 |
| **Grant** | 79 | 91 | 102 | **61.89** | 4,907 | 5,625 | 6,343 |
| **Grays Harbor** | 60 | 70 | 80 | **61.89** | 3,735 | 4,343 | 4,951 |
| **Island** | (75) | (65) | (55) | **61.89** | (4,624) | (4,020) | (3,416) |
| **Jefferson** | 0 | 6 | 12 | **61.89** | 19 | 378 | 737 |
| **King** | (768) | (501) | (235) | **61.89** | (47,516) | (31,022) | (14,528) |
| **Kitsap** | (68) | (25) | 18 | **61.89** | (4,193) | (1,528) | 1,136 |
| **Kittitas** | 15 | 21 | 27 | **61.89** | 936 | 1,308 | 1,681 |
| **Klickitat** | (58) | (56) | (54) | **61.89** | (3,612) | (3,463) | (3,313) |
| **Lewis** | 35 | 46 | 58 | **61.89** | 2,170 | 2,874 | 3,578 |
| **Lincoln** | 30 | 32 | 33 | **61.89** | 1,884 | 1,960 | 2,036 |
| **Mason** | (179) | (167) | (156) | **61.89** | (11,059) | (10,360) | (9,661) |
| **Okanogan** | 20 | 26 | 31 | **61.89** | 1,265 | 1,587 | 1,909 |
| **Pacific** | 85 | 87 | 89 | **61.89** | 5,232 | 5,375 | 5,517 |
| **Pend Oreille** | 14 | 16 | 18 | **61.89** | 851 | 982 | 1,113 |
| **Pierce** | (59) | 95 | 249 | **61.89** | (3,672) | 5,880 | 15,432 |
| **San Juan** | (23) | (21) | (19) | **61.89** | (1,425) | (1,311) | (1,197) |
| **Skagit** | (15) | 10 | 35 | **61.89** | (921) | 637 | 2,196 |
| **Skamania** | 7 | 8 | 10 | **61.89** | 420 | 521 | 622 |
| **Snohomish** | (1,174) | (1,038) | (902) | **61.89** | (72,664) | (64,234) | (55,804) |
| **Spokane** | (128) | (38) | 52 | **61.89** | (7,943) | (2,371) | 3,200 |
| **Stevens** | 64 | 69 | 74 | **61.89** | 3,931 | 4,271 | 4,611 |
| **Thurston** | (384) | (336) | (287) | **61.89** | (23,774) | (20,777) | (17,780) |
| **Wahkiakum** | 8 | 8 | 8 | **61.89** | 468 | 477 | 486 |
| **Walla Walla** | 65 | 73 | 81 | **61.89** | 4,030 | 4,507 | 4,984 |
| **Whatcom** | (255) | (221) | (187) | **61.89** | (15,763) | (13,667) | (11,571) |
| **Whitman** | 23 | 27 | 32 | **61.89** | 1,394 | 1,684 | 1,973 |
| **Yakima** | (92) | (65) | (38) | **61.89** | (5,700) | (4,036) | (2,372) |

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

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Distributed November 1, 2022*

**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** | **2022 Unmet Need Patient Days*** | **2023 Unmet Need Patient Days*** | **2024 Unmet Need Patient Days*** | **2022 Unmet Need ADC*** | **2023 Unmet Need ADC*** | **2024 Unmet Need ADC*†** |
| **Adams** | 260 | 316 | 372 | 1 | 1 | 1 |
| **Asotin** | 2,317 | 2,516 | 2,716 | 6 | 7 | 7 |
| **Benton** | 692 | 2,710 | 4,728 | 2 | 7 | 13 |
| **Chelan** | (13,529) | (12,457) | (11,385) | (37) | (34) | (31) |
| **Clallam** | 5,506 | 6,393 | 7,280 | 15 | 18 | 20 |
| **Clark** | (26,780) | (21,480) | (16,181) | (73) | (59) | (44) |
| **Columbia** | (550) | (528) | (507) | (2) | (1) | (1) |
| **Cowlitz** | (9,552) | (8,374) | (7,195) | (26) | (23) | (20) |
| **Douglas** | (3,569) | (3,295) | (3,022) | (10) | (9) | (8) |
| **Ferry** | 560 | 606 | 652 | 2 | 2 | 2 |
| **Franklin** | 887 | 1,422 | 1,956 | 2 | 4 | 5 |
| **Garfield** | 326 | 337 | 347 | 1 | 1 | 1 |
| **Grant** | 4,907 | 5,625 | 6,343 | 13 | 15 | 17 |
| **Grays Harbor** | 3,735 | 4,343 | 4,951 | 10 | 12 | 14 |
| **Island** | (4,624) | (4,020) | (3,416) | (13) | (11) | (9) |
| **Jefferson** | 19 | 378 | 737 | 0 | 1 | 2 |
| **King** | (47,516) | (31,022) | (14,528) | (130) | (85) | (40) |
| **Kitsap** | (4,193) | (1,528) | 1,136 | (11) | (4) | 3 |
| **Kittitas** | 936 | 1,308 | 1,681 | 3 | 4 | 5 |
| **Klickitat** | (3,612) | (3,463) | (3,313) | (10) | (9) | (9) |
| **Lewis** | 2,170 | 2,874 | 3,578 | 6 | 8 | 10 |
| **Lincoln** | 1,884 | 1,960 | 2,036 | 5 | 5 | 6 |
| **Mason** | (11,059) | (10,360) | (9,661) | (30) | (28) | (26) |
| **Okanogan** | 1,265 | 1,587 | 1,909 | 3 | 4 | 5 |
| **Pacific** | 5,232 | 5,375 | 5,517 | 14 | 15 | 15 |
| **Pend Oreille** | 851 | 982 | 1,113 | 2 | 3 | 3 |
| **Pierce** | (3,672) | 5,880 | 15,432 | (10) | 16 | 42 |
| **San Juan** | (1,425) | (1,311) | (1,197) | (4) | (4) | (3) |
| **Skagit** | (921) | 637 | 2,196 | (3) | 2 | 6 |
| **Skamania** | 420 | 521 | 622 | 1 | 1 | 2 |
| **Snohomish** | (72,664) | (64,234) | (55,804) | (199) | (176) | (152) |
| **Spokane** | (7,943) | (2,371) | 3,200 | (22) | (6) | 9 |
| **Stevens** | 3,931 | 4,271 | 4,611 | 11 | 12 | 13 |
| **Thurston** | (23,774) | (20,777) | (17,780) | (65) | (57) | (49) |
| **Wahkiakum** | 468 | 477 | 486 | 1 | 1 | 1 |
| **Walla Walla** | 4,030 | 4,507 | 4,984 | 11 | 12 | 14 |
| **Whatcom** | (15,763) | (13,667) | (11,571) | (43) | (37) | (32) |
| **Whitman** | 1,394 | 1,684 | 1,973 | 4 | 5 | 5 |
| **Yakima** | (5,700) | (4,036) | (2,372) | (16) | (11) | (6) |

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

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Distributed November 1, 2022*

**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 | 2022 Unmet Need ADC* | 2023 Unmet Need ADC* | 2024 Unmet Need ADC*† | Numeric Need? | Number of New Agencies Needed?** |
| Adams | 1 | 1 | 1 | FALSE | FALSE |
| Asotin | 6 | 7 | 7 | FALSE | FALSE |
| Benton | 2 | 7 | 13 | FALSE | FALSE |
| Chelan | (37) | (34) | (31) | FALSE | FALSE |
| Clallam | 15 | 18 | 20 | FALSE | FALSE |
| Clark | (73) | (59) | (44) | FALSE | FALSE |
| Columbia | (2) | (1) | (1) | FALSE | FALSE |
| Cowlitz | (26) | (23) | (20) | FALSE | FALSE |
| Douglas | (10) | (9) | (8) | FALSE | FALSE |
| Ferry | 2 | 2 | 2 | FALSE | FALSE |
| Franklin | 2 | 4 | 5 | FALSE | FALSE |
| Garfield | 1 | 1 | 1 | FALSE | FALSE |
| Grant | 13 | 15 | 17 | FALSE | FALSE |
| Grays Harbor | 10 | 12 | 14 | FALSE | FALSE |
| Island | (13) | (11) | (9) | FALSE | FALSE |
| Jefferson | 0 | 1 | 2 | FALSE | FALSE |
| King | (130) | (85) | (40) | FALSE | FALSE |
| Kitsap | (11) | (4) | 3 | FALSE | FALSE |
| Kittitas | 3 | 4 | 5 | FALSE | FALSE |
| Klickitat | (10) | (9) | (9) | FALSE | FALSE |
| Lewis | 6 | 8 | 10 | FALSE | FALSE |
| Lincoln | 5 | 5 | 6 | FALSE | FALSE |
| Mason | (30) | (28) | (26) | FALSE | FALSE |
| Okanogan | 3 | 4 | 5 | FALSE | FALSE |
| Pacific | 14 | 15 | 15 | FALSE | FALSE |
| Pend Oreille | 2 | 3 | 3 | FALSE | FALSE |
| Pierce | (10) | 16 | 42 | *TRUE* | *1* |
| San Juan | (4) | (4) | (3) | FALSE | FALSE |
| Skagit | (3) | 2 | 6 | FALSE | FALSE |
| Skamania | 1 | 1 | 2 | FALSE | FALSE |
| Snohomish | (199) | (176) | (152) | FALSE | FALSE |
| Spokane | (22) | (6) | 9 | FALSE | FALSE |
| Stevens | 11 | 12 | 13 | FALSE | FALSE |
| Thurston | (65) | (57) | (49) | FALSE | FALSE |
| Wahkiakum | 1 | 1 | 1 | FALSE | FALSE |
| Walla Walla | 11 | 12 | 14 | FALSE | FALSE |
| Whatcom | (43) | (37) | (32) | FALSE | FALSE |
| Whitman | 4 | 5 | 5 | FALSE | FALSE |
| Yakima | (16) | (11) | (6) | FALSE | FALSE |

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

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

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*290(7)(b) Agencies*

| | |
|---|---|
| Release Year | 2022 |
| Supply year 1 | 2019 |
| Supply year 3 | 2021 |
| Statewide ALOS | 61.89 |
| Default Admits = 35 ADC | 206.4 |

| | | | Supply Years | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2019 | | 2020 | | 2021 | | |
| Provider | County | Certificate Year | Survey | # Used | Survey | # Used | Survey | # Used | Notes |
| Wesley Homes Hospice | King | 2017 | 91 | 206.4 | | | | | Third year 2019 |
| Heart of Hospice | Klickitat | 2017 | 26 | 206.4 | | | | | Third year 2019 |
| Envision Hospice | Thurston | 2018 | 24 | 206.4 | 25 | 206.4 | | | Third year 2020 |
| Olympic Medical Center | Clallam | 2019 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2021 |
| Providence Health & Services | Clark | 2019 | none | 206.4 | none | 206.4 | 18 | 206.4 | Third year 2021 |
| Envision Hospice | King | 2019 | none | 206.4 | 77 | 206.4 | 74 | 206.4 | Third year 2021 |
| Continuum Care of Snohomish | Snohomish | 2019 | none | 206.4 | 143 | 206.4 | 342 | 342.0 | Third year 2021 |
| Envision Hospice | Snohomish | 2019 | none | 206.4 | none | 206.4 | 1 | 206.4 | Third year 2021 |
| Glacier Peak Healthcare (Alpha) | Snohomish | 2019 | none | 206.4 | 31 | 206.4 | 117 | 206.4 | Third year 2021 |
| Heart of Hospice | Snohomish | 2019 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2021 |
| Symbol Healthcare (Puget Sound Hospice) | Thurston | 2019 | none | 206.4 | 6 | 206.4 | 19 | 206.4 | Third year 2021 |
| Continuum Care of King | King | 2020 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2022 |
| Envision Hospice | Kitsap | 2020 | none | 206.4 | none | 206.4 | 61 | 206.4 | Third year 2022 |
| EmpRes Healthcare Group | Whatcom | 2020 | none | 206.4 | none | 206.4 | 26 | 206.4 | Third year 2022 |
| The Pennant Group (Puget Sound Hospice) | Grays Harbor | 2021 | none | 206.4 | none | 206.4 | 6 | 206.4 | Third year 2023 |
| EmpRes Healthcare Group | King | 2021 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2023 |
| Seasons | King | 2021 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2023 |
| The Pennant Group (Puget Sound Hospice) | Mason | 2021 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2023 |
| Providence Health & Services | Pierce | 2021 | none | 206.4 | none | 206.4 | 2 | 206.4 | Third year 2023 |
| Envision Hospice | Pierce | 2021 | none | 206.4 | none | 206.4 | 121 | 206.4 | Third year 2023 |
| EmpRes Healthcare Group | Snohomish | 2021 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2023 |
| Seasons | Snohomish | 2021 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2023 |
| MultiCare Health | Thurston | 2021 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2023 |
| Bristol Hospice | Thurston | 2021 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2023 |
| Stride Health Care | Chelan | 2022 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2024 |
| The Pennant Group | King | 2022 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2024 |
| Y.B.G. Healthcare | King | 2022 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2024 |
| Continuum Care of Snohomish | Pierce | 2022 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2024 |
| The Pennant Group | Pierce | 2022 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2024 |
| Seasons | Pierce | 2022 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2024 |
| Seasons | Spokane | 2022 | none | 206.4 | none | 206.4 | none | 206.4 | Third year 2024 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Hospice Capacity Admission Calculations*

**0-64 Total Admissions by County**

| Sum of 0-6 | Column Labels | | |
|---|---|---|---|
| Row Labels | 2019 | 2020 | 2021 |
| Adams | 8 | 4 | 4 |
| Asotin | 9 | 24 | 9 |
| Benton | 103 | 132 | 107 |
| Chelan | 28 | 32 | 53 |
| Clallam | 23 | 24 | 24 |
| Clark | 287 | 297 | 308 |
| Columbia | 3 | 3 | 3 |
| Cowlitz | 121 | 94 | 116 |
| Douglas | 19 | 17 | 23 |
| Ferry | 5 | 3 | 6 |
| Franklin | 26 | 34 | 17 |
| Garfield | 1 | 3 | 0 |
| Grant | 45 | 40 | 27 |
| Grays Harb | 41 | 27 | 2 |
| Island | 43 | 54 | 68 |
| Jefferson | 26 | 17 | 15 |
| King | 765 | 889 | 812 |
| Kitsap | 173 | 96 | 389 |
| Kittitas | 16 | 12 | 15 |
| Klickitat | 12 | 12 | 13 |
| Lewis | 50 | 47 | 38 |
| Lincoln | 3 | 6 | 5 |
| Mason | 34 | 43 | 37 |
| Okanogan | 27 | 31 | 19 |
| Pacific | 15 | 12 | 2 |
| Pend Oreill | 4 | 17 | 12 |
| Pierce | 556 | 425 | 322 |
| San Juan | 6 | 8 | 5 |
| Skagit | 77 | 70 | 85 |
| Skamania | 1 | 3 | 4 |
| Snohomish | 342 | 361 | 514 |
| Spokane | 342 | 362 | 368 |
| Stevens | 20 | 21 | 31 |
| Thurston | 115 | 129 | 107 |
| Wahkiakur | 0 | 3 | 3 |
| Walla Wall | 41 | 41 | 41 |
| Whatcom | 138 | 80 | 113 |
| Whitman | 12 | 12 | 15 |
| Yakima | 175 | 195 | 161 |

**65+ Total Admissions by County**

| Sum of 65+ | Column Labels | | |
|---|---|---|---|
| Row Labels | 2019 | 2020 | 2021 |
| Adams | 54 | 48 | 36 |
| Asotin | 71 | 84 | 92 |
| Benton | 837 | 973 | 830 |
| Chelan | 385 | 421 | 686 |
| Clallam | 234 | 283 | 271 |
| Clark | 2060 | 2238 | 2464 |
| Columbia | 25 | 50 | 31 |
| Cowlitz | 735 | 707 | 793 |
| Douglas | 130 | 170 | 227 |
| Ferry | 25 | 28 | 32 |
| Franklin | 166 | 194 | 134 |
| Garfield | 4 | 7 | 6 |
| Grant | 236 | 254 | 230 |
| Grays Harb | 212 | 186 | 8 |
| Island | 341 | 375 | 450 |
| Jefferson | 181 | 194 | 171 |
| King | 6315 | 7131 | 6592 |
| Kitsap | 1074 | 921 | 704 |
| Kittitas | 169 | 157 | 115 |
| Klickitat | 90 | 87 | 82 |
| Lewis | 362 | 401 | 421 |
| Lincoln | 22 | 22 | 12 |
| Mason | 193 | 263 | 347 |
| Okanogan | 171 | 167 | 183 |
| Pacific | 98 | 69 | 2 |
| Pend Oreill | 65 | 49 | 55 |
| Pierce | 3170 | 2714 | 2310 |
| San Juan | 73 | 89 | 95 |
| Skagit | 705 | 607 | 750 |
| Skamania | 33 | 37 | 38 |
| Snohomish | 2214 | 2636 | 3580 |
| Spokane | 2333 | 2648 | 2690 |
| Stevens | 126 | 128 | 111 |
| Thurston | 947 | 1070 | 923 |
| Wahkiakur | 7 | 11 | 17 |
| Walla Wall | 242 | 242 | 242 |
| Whatcom | 995 | 978 | 1054 |
| Whitman | 77 | 128 | 175 |
| Yakima | 998 | 1190 | 925 |

**Actual Survey Admits**
Not Adjusted For Newly Approved
All Agencies

| County | 2019 | 2020 | 2021 |
|---|---|---|---|
| Adams | 62 | 52 | 40 |
| Asotin | 80 | 108 | 101 |
| Benton | 940 | 1,105 | 937 |
| Chelan | 413 | 453 | 739 |
| Clallam | 257 | 307 | 295 |
| Clark | 2,347 | 2,535 | 2,772 |
| Columbia | 28 | 53 | 34 |
| Cowlitz | 856 | 801 | 909 |
| Douglas | 149 | 187 | 250 |
| Ferry | 30 | 31 | 38 |
| Franklin | 192 | 228 | 151 |
| Garfield | 5 | 10 | 6 |
| Grant | 281 | 294 | 257 |
| Grays Harbor | 253 | 213 | 10 |
| Island | 384 | 429 | 518 |
| Jefferson | 207 | 211 | 186 |
| King | 7,080 | 8,020 | 7,404 |
| Kitsap | 1,247 | 1,017 | 1,093 |
| Kittitas | 185 | 169 | 130 |
| Klickitat | 102 | 99 | 95 |
| Lewis | 412 | 448 | 459 |
| Lincoln | 25 | 28 | 17 |
| Mason | 227 | 306 | 384 |
| Okanogan | 198 | 198 | 202 |
| Pacific | 113 | 81 | 4 |
| Pend Oreille | 69 | 66 | 67 |
| Pierce | 3,726 | 3,139 | 2,632 |
| San Juan | 79 | 97 | 100 |
| Skagit | 782 | 677 | 835 |
| Skamania | 34 | 40 | 42 |
| Snohomish | 2,556 | 2,997 | 4,094 |
| Spokane | 2,675 | 3,010 | 3,058 |
| Stevens | 146 | 149 | 142 |
| Thurston | 1,062 | 1,199 | 1,030 |
| Wahkiakum | 7 | 14 | 20 |
| Walla Walla | 283 | 283 | 283 |
| Whatcom | 1,133 | 1,058 | 1,167 |
| Whitman | 89 | 140 | 190 |
| Yakima | 1,173 | 1,385 | 1,086 |

**Actual Survey Admits**
Only Under Default 290(7)(b)
Newly Approved Only

| County | 2019 | 2020 | 2021 |
|---|---|---|---|
| Adams | | | |
| Asotin | | | |
| Benton | | | |
| Chelan | | | |
| Clallam | 0 | 0 | 0 |
| Clark | 0 | 0 | 18 |
| Columbia | | | |
| Cowlitz | | | |
| Douglas | | | |
| Ferry | | | |
| Franklin | | | |
| Garfield | | | |
| Grant | | | |
| Grays Harbor | | | 6 |
| Island | | | |
| Jefferson | | | |
| King | 91 | 77 | 74 |
| Kitsap | | 0 | 61 |
| Kittitas | | | |
| Klickitat | 26 | | |
| Lewis | | | |
| Lincoln | | | |
| Mason | | | 0 |
| Okanogan | | | |
| Pacific | | | |
| Pend Oreille | | | |
| Pierce | | | 123 |
| San Juan | | | |
| Skagit | | | |
| Skamania | | | |
| Snohomish | 0 | 174 | 118 |
| Spokane | | | |
| Stevens | | | |
| Thurston | 24 | 31 | 19 |
| Wahkiakum | | | |
| Walla Walla | | | |
| Whatcom | | 0 | 26 |
| Whitman | | | |
| Yakima | | | |

**Count of Newly Approved Agencies**
Only Under Default 290(7)(b)
Newly Approved Only

| County | 2019 | 2020 | 2021 |
|---|---|---|---|
| Adams | | | |
| Asotin | | | |
| Benton | | | |
| Chelan | 1 | 1 | 1 |
| Clallam | 1 | 1 | 1 |
| Clark | 1 | 1 | 1 |
| Columbia | | | |
| Cowlitz | | | |
| Douglas | | | |
| Ferry | | | |
| Franklin | | | |
| Garfield | | | |
| Grant | | | |
| Grays Harbor | 1 | 1 | 1 |
| Island | | | |
| Jefferson | | | |
| King | 7 | 6 | 6 |
| Kitsap | 1 | 1 | 1 |
| Kittitas | | | |
| Klickitat | 1 | | |
| Lewis | | | |
| Lincoln | | | |
| Mason | 1 | 1 | 1 |
| Okanogan | | | |
| Pacific | | | |
| Pend Oreille | | | |
| Pierce | 5 | 5 | 5 |
| San Juan | | | |
| Skagit | | | |
| Skamania | | | |
| Snohomish | 6 | 6 | 5 |
| Spokane | 1 | 1 | 1 |
| Stevens | | | |
| Thurston | 4 | 4 | 3 |
| Wahkiakum | | | |
| Walla Walla | | | |
| Whatcom | 1 | 1 | 1 |
| Whitman | | | |
| Yakima | | | |

**Default Adjustments**
Only Under Default 290(7)(b)
Newly Approved Only

| County | 2019 | 2020 | 2021 |
|---|---|---|---|
| Adams | - | - | - |
| Asotin | - | - | - |
| Benton | - | - | - |
| Chelan | 206.4 | 206.4 | 206.4 |
| Clallam | 206.4 | 206.4 | 206.4 |
| Clark | 206.4 | 206.4 | 206.4 |
| Columbia | - | - | - |
| Cowlitz | - | - | - |
| Douglas | - | - | - |
| Ferry | - | - | - |
| Franklin | - | - | - |
| Garfield | - | - | - |
| Grant | - | - | - |
| Grays Harbor | 206.4 | 206.4 | 206.4 |
| Island | - | - | - |
| Jefferson | - | - | - |
| King | 1,444.9 | 1,238.5 | 1,238.5 |
| Kitsap | 206.4 | 206.4 | 206.4 |
| Kittitas | - | - | - |
| Klickitat | 206.4 | - | - |
| Lewis | - | - | - |
| Lincoln | - | - | - |
| Mason | 206.4 | 206.4 | 206.4 |
| Okanogan | - | - | - |
| Pacific | - | - | - |
| Pend Oreille | - | - | - |
| Pierce | 1,032.1 | 1,032.1 | 1,032.1 |
| San Juan | - | - | - |
| Skagit | - | - | - |
| Skamania | - | - | - |
| Snohomish | 1,238.5 | 1,238.5 | 1,032.1 |
| Spokane | 206.4 | 206.4 | 206.4 |
| Stevens | - | - | - |
| Thurston | 825.7 | 825.7 | 619.2 |
| Wahkiakum | - | - | - |
| Walla Walla | - | - | - |
| Whatcom | 206.4 | 206.4 | 206.4 |
| Whitman | - | - | - |
| Yakima | - | - | - |

**Adjusted Admits**
Includes Adjustment for 290(7)(b) Agencies
All Agencies

| County | 2019 | 2020 | 2021 | Average |
|---|---|---|---|---|
| Adams | 62.00 | 52.00 | 40.00 | **51.33** |
| Asotin | 80.00 | 108.00 | 101.00 | **96.33** |
| Benton | 940.00 | 1,105.00 | 937.00 | **994.00** |
| Chelan | 619.41 | 659.41 | 945.41 | **741.41** |
| Clallam | 463.41 | 513.41 | 501.41 | **492.75** |
| Clark | 2,553.41 | 2,741.41 | 2,960.41 | **2751.75** |
| Columbia | 28.00 | 53.00 | 34.00 | **38.33** |
| Cowlitz | 856.00 | 801.00 | 909.00 | **855.33** |
| Douglas | 149.00 | 187.00 | 250.00 | **195.33** |
| Ferry | 30.00 | 31.00 | 38.00 | **33.00** |
| Franklin | 192.00 | 228.00 | 151.00 | **190.33** |
| Garfield | 5.00 | 10.00 | 6.00 | **7.00** |
| Grant | 281.00 | 294.00 | 257.00 | **277.33** |
| Grays Harbor | 459.41 | 419.41 | 210.41 | **363.08** |
| Island | 384.00 | 429.00 | 518.00 | **443.67** |
| Jefferson | 207.00 | 211.00 | 186.00 | **201.33** |
| King | 8,433.90 | 9,181.49 | 8,568.49 | **8727.96** |
| Kitsap | 1,453.41 | 1,223.41 | 1,238.41 | **1305.08** |
| Kittitas | 185.00 | 169.00 | 130.00 | **161.33** |
| Klickitat | 282.41 | 99.00 | 95.00 | **158.80** |
| Lewis | 412.00 | 448.00 | 459.00 | **439.67** |
| Lincoln | 25.00 | 28.00 | 17.00 | **23.33** |
| Mason | 433.41 | 512.41 | 590.41 | **512.08** |
| Okanogan | 198.00 | 198.00 | 202.00 | **199.33** |
| Pacific | 113.00 | 81.00 | 4.00 | **66.00** |
| Pend Oreille | 69.00 | 66.00 | 67.00 | **67.33** |
| Pierce | 4,758.07 | 4,171.07 | 3,541.07 | **4156.74** |
| San Juan | 79.00 | 97.00 | 100.00 | **92.00** |
| Skagit | 782.00 | 677.00 | 835.00 | **764.67** |
| Skamania | 34.00 | 40.00 | 42.00 | **38.67** |
| Snohomish | 3,794.49 | 4,061.49 | 5,008.07 | **4288.02** |
| Spokane | 2,881.41 | 3,216.41 | 3,264.41 | **3120.75** |
| Stevens | 146.00 | 149.00 | 142.00 | **145.67** |
| Thurston | 1,863.66 | 1,993.66 | 1,630.24 | **1829.19** |
| Wahkiakum | 7.00 | 14.00 | 20.00 | **13.67** |
| Walla Walla | 283.00 | 283.00 | 283.00 | **283.00** |
| Whatcom | 1,339.41 | 1,264.41 | 1,347.41 | **1317.08** |
| Whitman | 89.00 | 140.00 | 190.00 | **139.67** |
| Yakima | 1,173.00 | 1,385.00 | 1,086.00 | **1214.67** |

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/61.89 ALOS = 206.4 default admissions
206.4 Default
For affected counties, the actual volumes from these recently approved agencies will be subtracted, and default values will be added.

Includes one or more proxies for new agencies, survey year predates approval.

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Survey Data*

| Agency Name | License Number | County | Year | 0-64 | 65+ |
|---|---|---|---|---|---|
| Alpha Home Health | IHS.FS.61032013 | Snohomish | 2019 | 0 | 0 |
| Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice | IHS.FS.60384078 | Garfield | 2019 | 1 | 4 |
| Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice | IHS.FS.60384078 | Asotin | 2019 | 9 | 71 |
| Central Washington Homecare Services | IHS.FS.00000250 | Douglas | 2019 | 19 | 125 |
| Central Washington Homecare Services | IHS.FS.00000250 | Chelan | 2019 | 28 | 385 |
| Chaplaincy Health Care 2018 | IHS.FS.00000456 | Franklin | 2019 | 26 | 164 |
| Chaplaincy Health Care 2018 | IHS.FS.00000456 | Benton | 2019 | 96 | 700 |
| Community Home Health/Hospice | IHS.FS.00000262 | Wahkiakum | 2019 | 0 | 7 |
| Community Home Health/Hospice | IHS.FS.00000262 | Clark | 2019 | 60 | 453 |
| Community Home Health/Hospice | IHS.FS.00000262 | Cowlitz | 2019 | 98 | 636 |
| Continuum Care of King LLC | IHS.FS.61058934 | King | 2019 | 0 | 0 |
| Continuum Care of Snohomish LLC | IHS.FS.61010090 | Snohomish | 2019 | 0 | 0 |
| Envision Hospice of Washington | IHS.FS.60952486 | Thurston | 2019 | 2 | 22 |
| EvergreenHealth | IHS.FS.00000278 | Island | 2019 | 1 | 11 |
| EvergreenHealth | IHS.FS.00000278 | Snohomish | 2019 | 53 | 471 |
| EvergreenHealth | IHS.FS.00000278 | King | 2019 | 225 | 2025 |
| Franciscan Hospice | IHS.FS.00000287 | King | 2019 | 92 | 921 |
| Franciscan Hospice | IHS.FS.00000287 | Kitsap | 2019 | 118 | 757 |
| Franciscan Hospice | IHS.FS.00000287 | Pierce | 2019 | 364 | 2236 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Douglas | 2019 | 0 | 5 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Grant | 2019 | 4 | 8 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Okanogan | 2019 | 27 | 171 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Pacific | 2019 | 15 | 98 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Grays Harbor | 2019 | 41 | 212 |
| Heartlinks | IHS.FS.00000369 | Franklin | 2019 | 0 | 2 |
| Heartlinks | IHS.FS.00000369 | Benton | 2019 | 7 | 137 |
| Heartlinks | IHS.FS.00000369 | Yakima | 2019 | 21 | 180 |
| Horizon Hospice | IHS.FS.00000332 | Spokane | 2019 | 30 | 393 |
| Hospice of Jefferson County, Jefferson Healthcare | IHI.FS.00000349 | Jefferson | 2019 | 26 | 172 |
| Hospice of Spokane | IHS.FS.00000337 | Pend Oreille | 2019 | 4 | 65 |
| Hospice of Spokane | IHS.FS.00000337 | Ferry | 2019 | 5 | 25 |
| Hospice of Spokane | IHS.FS.00000337 | Stevens | 2019 | 20 | 126 |
| Hospice of Spokane | IHS.FS.00000337 | Spokane | 2019 | 289 | 1692 |
| Hospice of the Northwest | IHS.FS.00000437 | Snohomish | 2019 | 5 | 58 |
| Hospice of the Northwest | IHS.FS.00000437 | San Juan | 2019 | 6 | 73 |
| Hospice of the Northwest | IHS.FS.00000437 | Island | 2019 | 14 | 56 |
| Hospice of the Northwest | IHS.FS.00000437 | Skagit | 2019 | 77 | 705 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Skamania | 2019 | 0 | 17 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Clark | 2019 | 0 | 3 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Snohomish | 2019 | 0 | 0 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Klickitat | 2019 | 2 | 24 |
| Kaiser Continuing Care Services Hospice | IHS.FS.00000353 | Clark | 2019 | 43 | 387 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | Snohomish | 2019 | 7 | 62 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | Kitsap | 2019 | 18 | 123 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | Pierce | 2019 | 25 | 176 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | King | 2019 | 37 | 489 |
| Kindred Hospice | IHS.FS.60330209 | King | 2019 | 6 | 217 |
| Kindred Hospice | IHS.FS.60308060 | Spokane | 2019 | 23 | 248 |
| Kindred Hospice | IHS.FS.60308060 | Whitman | 2019 | 12 | 77 |
| Kittitas Valley Healthcare Home Health and Hospice | IHS.FS.00000320 | Kittitas | 2019 | 16 | 169 |
| Klickitat Valley Hospice | IHS.FS.00000361 | Klickitat | 2019 | 1 | 44 |
| Kline Galland Community Based Services | IHS.FS.60103742 | King | 2019 | 35 | 345 |
| Memorial Home Care Services | IHS.FS.00000376 | Yakima | 2019 | 148 | 730 |
| MultiCare Hospice | IHS.FS.60639376 | King | 2019 | 27 | 149 |
| MultiCare Hospice | IHS.FS.60639376 | Kitsap | 2019 | 37 | 194 |
| MultiCare Hospice | IHS.FS.60639376 | Pierce | 2019 | 167 | 758 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Jefferson | 2019 | 0 | 9 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Mason | 2019 | 6 | 45 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Lewis | 2019 | 17 | 244 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Thurston | 2019 | 22 | 240 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Clallam | 2019 | 23 | 234 |
| Olympic Medical Hospice | IHS.FS.00000393 | Clallam | 2019 | 0 | 0 |
| PeaceHealth Hospice | IHS.FS.60331226 | Skamania | 2019 | 0 | 1 |
| PeaceHealth Hospice | IHS.FS.60331226 | Cowlitz | 2019 | 23 | 99 |
| PeaceHealth Hospice | IHS.FS.60331226 | Clark | 2019 | 184 | 1217 |
| PeaceHealth Whatcom | IHS.FS.00000471 | Whatcom | 2019 | 138 | 995 |
| Providence Hospice | IHS.FS.60201476 | Clark | 2019 | 0 | 0 |
| Providence Hospice | IHS.FS.60201476 | Skamania | 2019 | 1 | 15 |
| Providence Hospice | IHS.FS.60201476 | Klickitat | 2019 | 9 | 22 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Island | 2019 | 1 | 29 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Snohomish | 2019 | 272 | 1613 |
| Providence Hospice of Seattle | IHS.FS.00000336 | Snohomish | 2019 | 5 | 10 |
| Providence Hospice of Seattle | IHS.FS.00000336 | King | 2019 | 338 | 2083 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Mason | 2019 | 28 | 148 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Survey Data*

| Agency Name | License Number | County | Year | 0-64 | 65+ |
|---|---|---|---|---|---|
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Lewis | 2019 | 33 | 118 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Thurston | 2019 | 91 | 685 |
| Puget Sound Hopsice | IHS.FS.61032138 | Thurston | 2019 | 0 | 0 |
| Walla Walla Community Hospice | IHS.FS.60480441 | Columbia | 2019 | 3 | 25 |
| Walla Walla Community Hospice | IHS.FS.60480441 | Walla Walla | 2019 | 41 | 242 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Lincoln | 2019 | 3 | 22 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Adams | 2019 | 8 | 54 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Grant | 2019 | 41 | 228 |
| Wesley Homes | IHS.FS.60276500 | King | 2019 | 5 | 86 |
| WhidbeyHealth Home Health, Hospice | IHS.FS.00000323 | Island | 2019 | 27 | 245 |
| Yakima HMA Home Health, LLC | IHS.FS.60097245 | Yakima | 2019 | 6 | 88 |
| Alpha Hospice | IHS.FS.61032013 | Snohomish | 2020 | 1 | 30 |
| Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice | IHS.FS.60384078 | Garfield | 2020 | 3 | 7 |
| Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice | IHS.FS.60384078 | Asotin | 2020 | 24 | 84 |
| Astria Hospice | IHS.FS.60097245 | Yakima | 2020 | 0 | 56 |
| Central Washington Home Care Service | IHS.FS.00000250 | Douglas | 2020 | 13 | 159 |
| Central Washington Home Care Service | IHS.FS.00000250 | Chelan | 2020 | 32 | 421 |
| Chaplaincy Health Care | IHS.FS.00000456 | Franklin | 2020 | 30 | 192 |
| Chaplaincy Health Care | IHS.FS.00000456 | Benton | 2020 | 118 | 821 |
| Community Home Health/Hospice | IHS.FS.00000262 | Pacific | 2020 | 1 | 3 |
| Community Home Health/Hospice | IHS.FS.00000262 | Wahkiakum | 2020 | 3 | 11 |
| Community Home Health/Hospice | IHS.FS.60547198 | Clark | 2020 | 61 | 430 |
| Community Home Health/Hospice | IHS.FS.00000262 | Cowlitz | 2020 | 78 | 616 |
| Continuum Care of King LLC | IHS.FS.61058934 | King | 2020 | 0 | 0 |
| Continuum Care of Snohomish | IHS.FS.61010090 | King | 2020 | 2 | 40 |
| Continuum Care of Snohomish | IHS.FS.61010090 | Snohomish | 2020 | 12 | 131 |
| Eden Hospice at Whatcom County, LLC | IHS.FS.61117985 | Whatcom | 2020 | 0 | 0 |
| Envision Hospice of Washington LLC | IHS.FS.60952486 | Kitsap | 2020 | 0 | 0 |
| Envision Hospice of Washington LLC | IHS.FS.60952486 | Snohomish | 2020 | 0 | 0 |
| Envision Hospice of Washington LLC | IHS.FS.60952486 | King | 2020 | 1 | 76 |
| Envision Hospice of Washington LLC | IHS.FS.60952486 | Pierce | 2020 | 1 | 20 |
| Envision Hospice of Washington LLC | IHS.FS.60952486 | Thurston | 2020 | 1 | 24 |
| EvergreenHealth | IHS.FS.00000278 | Island | 2020 | 0 | 6 |
| EvergreenHealth | IHS.FS.00000278 | Snohomish | 2020 | 70 | 672 |
| EvergreenHealth | IHS.FS.00000278 | King | 2020 | 316 | 2451 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Grant | 2020 | 0 | 3 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Douglas | 2020 | 4 | 11 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Okanogan | 2020 | 30 | 167 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Pacific | 2020 | 11 | 66 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Grays Harbor | 2020 | 27 | 186 |
| HEART OF HOSPICE | IHS.FS.60741443 | Clark | 2020 | 0 | 3 |
| HEART OF HOSPICE | IHS.FS.60741443 | Snohomish | 2020 | 0 | 0 |
| HEART OF HOSPICE | IHS.FS.60741443 | Klickitat | 2020 | 2 | 21 |
| HEART OF HOSPICE | IHS.FS.60741443 | Skamania | 2020 | 2 | 18 |
| Heartlinks | IHS.FS.00000369 | Franklin | 2020 | 4 | 2 |
| Heartlinks | IHS.FS.00000369 | Benton | 2020 | 14 | 152 |
| Heartlinks | IHS.FS.00000369 | Yakima | 2020 | 20 | 181 |
| Horizon Hospice & Palliative Care | IHS.FS.00000332 | Spokane | 2020 | 28 | 456 |
| Hospice of Jefferson County | IHS.FS.00000349 | Jefferson | 2020 | 17 | 178 |
| Hospice of Spokane | IHS.FS.00000337 | Whitman | 2020 | 0 | 1 |
| Hospice of Spokane | IHS.FS.00000337 | Lincoln | 2020 | 1 | 1 |
| Hospice of Spokane | IHS.FS.00000337 | Okanogan | 2020 | 1 | 0 |
| Hospice of Spokane | IHS.FS.00000337 | Ferry | 2020 | 3 | 28 |
| Hospice of Spokane | IHS.FS.00000337 | Pend Oreille | 2020 | 17 | 49 |
| Hospice of Spokane | IHS.FS.00000337 | Stevens | 2020 | 21 | 128 |
| Hospice of Spokane | IHS.FS.00000337 | Spokane | 2020 | 302 | 1895 |
| Kaiser Permanente Continuing Care Services | IHS.FS.00000353 | Clark | 2020 | 42 | 433 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | Snohomish | 2020 | 3 | 84 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | Kitsap | 2020 | 13 | 114 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | Pierce | 2020 | 30 | 181 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | King | 2020 | 49 | 446 |
| Kindred Hospice | IHS.FS.60330209 | King | 2020 | 9 | 200 |
| Kindred Hospice | IHS.FS.60308060 | Whitman | 2020 | 12 | 127 |
| Kindred Hospice | IHS.FS.60308060 | Spokane | 2020 | 32 | 297 |
| Kittitas Valley Home Health and Hospice | IHS.FS.00000320 | Kittitas | 2020 | 12 | 157 |
| Klickitat Valley Health Home Health & Hospice | IHS.FS.00000361 | Klickitat | 2020 | 4 | 38 |
| Kline Galland Hospice | IHS.FS.60103742 | King | 2020 | 83 | 896 |
| Memorial Home Care Services | IHS.FS.00000376 | Yakima | 2020 | 175 | 953 |
| Multicare Home Health, Hospice | IHS.FS.60639376 | Kitsap | 2020 | 12 | 126 |
| Multicare Home Health, Hospice | IHS.FS.60639376 | King | 2020 | 36 | 137 |
| Multicare Home Health, Hospice | IHS.FS.60639376 | Pierce | 2020 | 161 | 866 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Jefferson | 2020 | 0 | 16 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Pierce | 2020 | 0 | 1 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Mason | 2020 | 8 | 70 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Lewis | 2020 | 15 | 226 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Survey Data*

| Agency Name | License Number | County | Year | 0-64 | 65+ |
|---|---|---|---|---|---|
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Thurston | 2020 | 22 | 268 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Clallam | 2020 | 24 | 283 |
| Olympic Medical Hospice | IHS.FS.00000393 | Clallam | 2020 | 0 | 0 |
| PeaceHealth Hospice Southwest | IHS.FS.60331226 | Skamania | 2020 | 0 | 3 |
| PeaceHealth Hospice Southwest | IHS.FS.60331226 | Cowlitz | 2020 | 16 | 91 |
| PeaceHealth Hospice Southwest | IHS.FS.60331226 | Clark | 2020 | 194 | 1372 |
| Providence Hospice | IHS.FS.60201476 | Clark | 2020 | 0 | 0 |
| Providence Hospice | IHS.FS.60201476 | Skamania | 2020 | 1 | 16 |
| Providence Hospice | IHS.FS.60201476 | Klickitat | 2020 | 6 | 28 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Island | 2020 | 5 | 36 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Snohomish | 2020 | 267 | 1645 |
| Providence Hospice of Seattle | IHS.FS.00000336 | Snohomish | 2020 | 0 | 0 |
| Providence Hospice of Seattle | IHS.FS.00000336 | King | 2020 | 338 | 2059 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Lewis | 2020 | 32 | 175 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Mason | 2020 | 35 | 193 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Thurston | 2020 | 106 | 772 |
| Puget Sound Hospice | IHS.FS.61032138 | Thurston | 2020 | 0 | 6 |
| Skagit Hospice Services dba Hospice of the Northwest | IHS.FS.00000437 | San Juan | 2020 | 8 | 89 |
| Skagit Hospice Services dba Hospice of the Northwest | IHS.FS.00000437 | Snohomish | 2020 | 8 | 74 |
| Skagit Hospice Services dba Hospice of the Northwest | IHS.FS.00000437 | Island | 2020 | 20 | 81 |
| Skagit Hospice Services dba Hospice of the Northwest | IHS.FS.00000437 | Skagit | 2020 | 70 | 607 |
| Virginia Mason Franciscan Hospice & Palliative Care | IHS.FS.00000287 | King | 2020 | 52 | 716 |
| Virginia Mason Franciscan Hospice & Palliative Care | IHS.FS.00000287 | Kitsap | 2020 | 71 | 681 |
| Virginia Mason Franciscan Hospice & Palliative Care | IHS.FS.00000287 | Pierce | 2020 | 232 | 1630 |
| Walla Walla Community Hospice | IHS.FS.60480441 | Columbia | 2020 | 3 | 50 |
| Walla Walla Community Hospice | IHS.FS.60480441 | Walla Walla | 2020 | 41 | 242 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Adams | 2020 | 4 | 48 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Lincoln | 2020 | 5 | 21 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Grant | 2020 | 40 | 251 |
| Wesley Homes Hospice, LLC | IHS.FS.60276500 | Pierce | 2020 | 1 | 16 |
| Wesley Homes Hospice, LLC | IHS.FS.60276500 | King | 2020 | 3 | 110 |
| Whatcom Hospice | IHS.FS.00000471 | Whatcom | 2020 | 80 | 978 |
| WhidbeyHealth Hospice | IHS.FS.00000323 | Island | 2020 | 29 | 252 |
| Alpha Hospice | IHS.FS.61032013 | Snohomish | 2021 | 6 | 111 |
| Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice | IHS.FS.60384078 | Asotin | 2021 | 9 | 92 |
| Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice | IHS.FS.60384078 | Garfield | 2021 | 0 | 6 |
| Astria Hospice | IHS.FS.60097245 | Yakima | 2021 | 3 | 52 |
| Bristol Hospice - Thurston, LLC | IHS.FS.61211200 | Thurston | 2021 | 0 | 0 |
| Central Washington Home Care Services | IHS.FS.00000250 | Chelan | 2021 | 53 | 686 |
| Central Washington Home Care Services | IHS.FS.00000250 | Douglas | 2021 | 19 | 209 |
| Community Home Health/Hospice | IHS.FS.00000262 | Cowlitz | 2021 | 73 | 558 |
| Community Home Health/Hospice | IHS.FS.00000262 | Wahkiakum | 2021 | 1 | 14 |
| Community Home Health/Hospice | IHS.FS.60547198 | Clark | 2021 | 57 | 425 |
| Continuum Care of King LLC | IHS.FS.61058934 | King | 2021 | 0 | 0 |
| Continuum Care of Snohomish, LLC | IHS.FS.61010090 | Snohomish | 2021 | 36 | 306 |
| Continuum Care of Snohomish, LLC | IHS.FS.61010090 | King | 2021 | 9 | 309 |
| Eden Hospice at Whatcom County | IHS.FS.61117985 | Whatcom | 2021 | 2 | 24 |
| Eden Hospice at Whatcom County | IHS.FS.61117985 | Skagit | 2021 | 0 | 1 |
| Enhabit Hospice | IHS.FS.61165576 | Douglas | 2021 | 4 | 18 |
| Enhabit Hospice | IHS.FS.61165576 | Grant | 2021 | 2 | 5 |
| Enhabit Hospice | IHS.FS.61165576 | Okanogan | 2021 | 19 | 183 |
| Enhabit Hospice | IHS.FS.61165576 | Lincoln | 2021 | 0 | 0 |
| Enhabit Hospice | IHS.FS.61165576 | Ferry | 2021 | 0 | 0 |
| Enhabit Hospice | IHS.FS.61165576 | Chelan | 2021 | 0 | 0 |
| Envision Hospice of Washington LLC | IHS.FS.60952486 | Snohomish | 2021 | 0 | 1 |
| Envision Hospice of Washington, LLC | IHS.FS.60952486 | King | 2021 | 1 | 73 |
| Envision Hospice of Washington, LLC | IHS.FS.60952486 | Kitsap | 2021 | 6 | 55 |
| Envision Hospice of Washington, LLC | IHS.FS.60952486 | Pierce | 2021 | 8 | 113 |
| Envision Hospice of Washington, LLC | IHS.FS.60952486 | Thurston | 2021 | 1 | 22 |
| EvergreenHealth | IHS.FS.00000278 | King | 2021 | 259 | 2082 |
| EvergreenHealth | IHS.FS.00000278 | Snohomish | 2021 | 67 | 627 |
| EvergreenHealth | IHS.FS.00000278 | Island | 2021 | 0 | 4 |
| Franciscan Hospice and Palliative Care | IHS.FS.00000287 | Kitsap | 2021 | 356 | 371 |
| Franciscan Hospice and Palliative Care | IHS.FS.00000287 | Pierce | 2021 | 141 | 1081 |
| Franciscan Hospice and Palliative Care | IHS.FS.00000287 | King | 2021 | 31 | 387 |
| Harbors Home Health & Hospice | IHS.FS.00000306 | Grays Harbor | 2021 | 2 | 2 |
| Harbors Home Health & Hospice | IHS.FS.00000306 | Pacific | 2021 | 2 | 2 |
| HEART OF HOSPICE | IHS.FS.60741443 | Clark | 2021 | 0 | 0 |
| HEART OF HOSPICE | IHS.FS.60741443 | Klickitat | 2021 | 3 | 20 |
| HEART OF HOSPICE | IHS.FS.60741443 | Skamania | 2021 | 2 | 22 |
| HEART OF HOSPICE | IHS.FS.60741443 | Snohomish | 2021 | 0 | 0 |
| Heartlinks | IHS.FS.00000369 | Benton | 2021 | 17 | 205 |
| Heartlinks | IHS.FS.00000369 | Yakima | 2021 | 15 | 224 |
| Heartlinks | IHS.FS.00000369 | Franklin | 2021 | 1 | 9 |
| Horizon Hospice | IHS.FS.00000332 | Spokane | 2021 | 36 | 520 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Survey Data*

| Agency Name | License Number | County | Year | 0-64 | 65+ |
|---|---|---|---|---|---|
| Hospice of Jefferson County | IHS.FS.00000349 | Jefferson | 2021 | 14 | 162 |
| Hospice of Spokane | IHS.FS.00000337 | Spokane | 2021 | 317 | 1899 |
| Hospice of Spokane | IHS.FS.00000337 | Stevens | 2021 | 31 | 111 |
| Hospice of Spokane | IHS.FS.00000337 | Ferry | 2021 | 6 | 32 |
| Hospice of Spokane | IHS.FS.00000337 | Pend Oreille | 2021 | 12 | 55 |
| Hospice of Spokane | IHS.FS.00000337 | Lincoln | 2021 | 1 | 2 |
| Kaiser Permanente | IHS.FS.00000353 | Clark | 2021 | 37 | 408 |
| Kaiser Permanente | IHS.FS.00000353 | Cowlitz | 2021 | 4 | 7 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | King | 2021 | 42 | 281 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | Kitsap | 2021 | 11 | 138 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | Pierce | 2021 | 21 | 156 |
| Kaiser Permanente Home Health & Hospice | IHS.FS.00000305 | Snohomish | 2021 | 5 | 63 |
| Kittitas Valley Healthcare Hospice | IHS.FS.00000320 | Kittitas | 2021 | 15 | 115 |
| Klickitat Valley Health - Hospice | IHS.FS.00000361 | Klickitat | 2021 | 3 | 28 |
| Kline Galland Hospice | IHS.FS.60103742 | King | 2021 | 42 | 410 |
| Memorial Home Care Services | IHS.FS.00000376 | Yakima | 2021 | 143 | 649 |
| Multicare Hospice | IHS.FS.60639376 | King | 2021 | 21 | 141 |
| Multicare Hospice | IHS.FS.60639376 | Pierce | 2021 | 145 | 914 |
| Multicare Hospice | IHS.FS.60639376 | Kitsap | 2021 | 16 | 140 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Clallam | 2021 | 24 | 271 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Jefferson | 2021 | 1 | 9 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Lewis | 2021 | 19 | 221 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Mason | 2021 | 12 | 47 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Pierce | 2021 | 0 | 1 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Thurston | 2021 | 31 | 282 |
| Odyssey HealthCare Operating B, LP | IHS.FS.60308060 | Spokane | 2021 | 15 | 271 |
| Odyssey HealthCare Operating B, LP | IHS.FS.60308060 | Whitman | 2021 | 15 | 175 |
| Odyssey HealthCare Operating B, LP | IHS.FS.60330209 | King | 2021 | 1 | 116 |
| Olympic Medical Hospice | IHS.FS.00000393 | Clallam | 2021 | 0 | 0 |
| PeaceHealth Southwest Hospice | IHS.FS.60331226 | Clark | 2021 | 213 | 1614 |
| PeaceHealth Southwest Hospice | IHS.FS.60331226 | Cowlitz | 2021 | 39 | 228 |
| PeaceHealth Southwest Hospice | IHS.FS.60331226 | Skamania | 2021 | 0 | 1 |
| PeaceHealth Southwest Hospice | IHS.FS.60331226 | Wahkiakum | 2021 | 2 | 3 |
| Providence Hospice | IHS.FS.60201476 | Klickitat | 2021 | 7 | 34 |
| Providence Hospice | IHS.FS.60201476 | Skamania | 2021 | 2 | 15 |
| Providence Hospice | IHS.FS.60201476 | Clark | 2021 | 1 | 17 |
| Providence Hospice of Seattle | IHS.FS.00000336 | King | 2021 | 402 | 2664 |
| Providence Hospice of Seattle | IHS.FS.00000336 | Pierce | 2021 | 1 | 1 |
| Providence Hospice Snohomish | IHS.FS.00000418 | Island | 2021 | 7 | 36 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Preliminary Death Data Updated October 3, 2022**

| | 0-64 | | | 65+ | | |
|---|---|---|---|---|---|---|
| County | 2019 | 2020 | 2021 | 2019 | 2020 | 2021 |
| ADAMS | 35 | 20 | 23 | 93 | 59 | 92 |
| ASOTIN | 54 | 56 | 43 | 222 | 186 | 188 |
| BENTON | 346 | 555 | 536 | 1154 | 1522 | 1610 |
| CHELAN | 137 | 224 | 256 | 626 | 785 | 870 |
| CLALLAM | 186 | 195 | 185 | 955 | 777 | 906 |
| CLARK | 887 | 1043 | 1078 | 2987 | 3205 | 3705 |
| COLUMBIA | 7 | 7 | 11 | 52 | 43 | 43 |
| COWLITZ | 294 | 314 | 401 | 951 | 968 | 1100 |
| DOUGLAS | 63 | 42 | 45 | 270 | 160 | 174 |
| FERRY | 20 | 19 | 21 | 64 | 58 | 63 |
| FRANKLIN | 123 | 100 | 110 | 313 | 263 | 261 |
| GARFIELD | 5 | 5 | 4 | 21 | 11 | 24 |
| GRANT | 197 | 186 | 208 | 508 | 455 | 523 |
| GRAYS HARBOR | 251 | 209 | 236 | 659 | 558 | 590 |
| ISLAND | 167 | 110 | 116 | 642 | 505 | 504 |
| JEFFERSON | 72 | 68 | 54 | 338 | 273 | 295 |
| KING | 3,275 | 4456 | 4892 | 10213 | 11186 | 11896 |
| KITSAP | 557 | 454 | 489 | 1811 | 1714 | 1832 |
| KITTITAS | 90 | 78 | 88 | 266 | 241 | 241 |
| KLICKITAT | 46 | 42 | 50 | 160 | 113 | 164 |
| LEWIS | 210 | 205 | 186 | 722 | 653 | 723 |
| LINCOLN | 25 | 15 | 24 | 89 | 75 | 76 |
| MASON | 167 | 143 | 168 | 548 | 408 | 461 |
| OKANOGAN | 119 | 88 | 92 | 358 | 277 | 324 |
| PACIFIC | 66 | 55 | 59 | 265 | 177 | 239 |
| PEND OREILLE | 31 | 41 | 55 | 125 | 101 | 119 |
| PIERCE | 1,911 | 2364 | 2574 | 5002 | 5608 | 6264 |
| SAN JUAN | 20 | 18 | 24 | 127 | 94 | 91 |
| SKAGIT | 229 | 269 | 334 | 1018 | 1068 | 1190 |
| SKAMANIA | 19 | 26 | 25 | 87 | 47 | 56 |
| SNOHOMISH | 1,533 | 1587 | 1563 | 4081 | 4278 | 4478 |
| SPOKANE | 1,143 | 1634 | 1842 | 3545 | 4322 | 4810 |
| STEVENS | 112 | 86 | 114 | 345 | 248 | 304 |
| THURSTON | 525 | 628 | 763 | 1908 | 2007 | 2285 |
| WAHKIAKUM | 11 | 10 | 7 | 53 | 18 | 25 |
| WALLA WALLA | 118 | 150 | 138 | 450 | 522 | 595 |
| WHATCOM | 394 | 457 | 443 | 1461 | 1481 | 1674 |
| WHITMAN | 47 | 51 | 59 | 219 | 226 | 278 |
| YAKIMA | 555 | 653 | 699 | 1451 | 1675 | 1644 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*0-64 Population Projection*

| County | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2019-2021 Average Population |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adams | 17,637 | 17,768 | 17,899 | 18,029 | 18,160 | 18,291 | 18,456 | 18,622 | 18,787 | 18,953 | 19,118 | 18,303 |
| Asotin | 16,969 | 16,906 | 16,842 | 16,779 | 16,715 | 16,652 | 16,596 | 16,540 | 16,485 | 16,429 | 16,373 | 16,655 |
| Benton | 162,262 | 163,693 | 165,123 | 166,554 | 167,984 | 169,415 | 171,026 | 172,638 | 174,249 | 175,861 | 177,472 | 169,475 |
| Chelan | 61,284 | 61,520 | 61,755 | 61,991 | 62,227 | 62,463 | 62,512 | 62,562 | 62,611 | 62,661 | 62,710 | 62,401 |
| Clallam | 52,716 | 52,661 | 52,605 | 52,550 | 52,494 | 52,439 | 52,233 | 52,027 | 51,821 | 51,615 | 51,409 | 52,389 |
| Clark | 387,296 | 393,291 | 399,287 | 405,282 | 411,278 | 417,273 | 421,901 | 426,529 | 431,158 | 435,786 | 440,414 | 416,817 |
| Columbia | 2,988 | 2,947 | 2,905 | 2,863 | 2,822 | 2,780 | 2,745 | 2,710 | 2,675 | 2,640 | 2,605 | 2,782 |
| Cowlitz | 85,417 | 85,517 | 85,617 | 85,717 | 85,817 | 85,917 | 85,843 | 85,769 | 85,695 | 85,621 | 85,547 | 85,859 |
| Douglas | 33,540 | 33,938 | 34,335 | 34,732 | 35,130 | 35,527 | 35,803 | 36,080 | 36,356 | 36,633 | 36,909 | 35,487 |
| Ferry | 5,834 | 5,782 | 5,731 | 5,680 | 5,628 | 5,577 | 5,541 | 5,506 | 5,470 | 5,435 | 5,399 | 5,582 |
| Franklin | 79,651 | 81,742 | 83,832 | 85,922 | 88,012 | 90,102 | 92,443 | 94,784 | 97,124 | 99,465 | 101,806 | 90,186 |
| Garfield | 1,665 | 1,644 | 1,623 | 1,602 | 1,581 | 1,560 | 1,541 | 1,522 | 1,502 | 1,483 | 1,464 | 1,561 |
| Grant | 81,535 | 82,660 | 83,784 | 84,909 | 86,033 | 87,158 | 88,240 | 89,322 | 90,403 | 91,485 | 92,567 | 87,144 |
| Grays Harb | 59,105 | 58,675 | 58,246 | 57,817 | 57,387 | 56,958 | 56,679 | 56,401 | 56,122 | 55,844 | 55,565 | 57,008 |
| Island | 62,514 | 62,664 | 62,814 | 62,964 | 63,114 | 63,264 | 63,280 | 63,296 | 63,312 | 63,328 | 63,344 | 63,219 |
| Jefferson | 20,636 | 20,653 | 20,670 | 20,688 | 20,705 | 20,722 | 20,636 | 20,550 | 20,463 | 20,377 | 20,291 | 20,688 |
| 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 | 1,903,445 |
| Kitsap | 212,548 | 214,045 | 215,543 | 217,040 | 218,538 | 220,035 | 220,614 | 221,192 | 221,771 | 222,349 | 222,928 | 219,729 |
| Kittitas | 36,206 | 36,768 | 37,330 | 37,892 | 38,453 | 39,015 | 39,286 | 39,556 | 39,827 | 40,097 | 40,368 | 38,918 |
| Klickitat | 16,208 | 16,082 | 15,955 | 15,828 | 15,702 | 15,575 | 15,439 | 15,304 | 15,168 | 15,033 | 14,897 | 15,572 |
| Lewis | 61,494 | 61,796 | 62,097 | 62,398 | 62,700 | 63,001 | 63,164 | 63,327 | 63,491 | 63,654 | 63,817 | 62,955 |
| Lincoln | 8,101 | 8,042 | 7,982 | 7,923 | 7,864 | 7,805 | 7,751 | 7,698 | 7,644 | 7,591 | 7,537 | 7,807 |
| Mason | 48,672 | 49,162 | 49,652 | 50,142 | 50,632 | 51,122 | 51,397 | 51,672 | 51,946 | 52,221 | 52,496 | 51,050 |
| Okanogan | 33,087 | 32,906 | 32,726 | 32,545 | 32,364 | 32,183 | 32,087 | 31,991 | 31,896 | 31,800 | 31,704 | 32,211 |
| Pacific | 15,115 | 14,972 | 14,830 | 14,688 | 14,545 | 14,403 | 14,322 | 14,242 | 14,161 | 14,081 | 14,000 | 14,424 |
| Pend Oreill | 10,045 | 9,998 | 9,952 | 9,905 | 9,859 | 9,812 | 9,769 | 9,727 | 9,684 | 9,642 | 9,599 | 9,813 |
| Pierce | 721,137 | 729,937 | 738,738 | 747,538 | 756,339 | 765,139 | 769,918 | 774,696 | 779,475 | 784,253 | 789,032 | 763,798 |
| San Juan | 11,305 | 11,194 | 11,084 | 10,974 | 10,863 | 10,753 | 10,730 | 10,707 | 10,684 | 10,661 | 10,638 | 10,782 |
| Skagit | 97,885 | 98,616 | 99,346 | 100,076 | 100,807 | 101,537 | 101,887 | 102,236 | 102,586 | 102,935 | 103,285 | 101,410 |
| Skamania | 9,272 | 9,266 | 9,260 | 9,254 | 9,248 | 9,242 | 9,223 | 9,205 | 9,186 | 9,168 | 9,149 | 9,238 |
| Snohomish | 661,812 | 672,806 | 683,800 | 694,793 | 705,787 | 716,781 | 721,527 | 726,273 | 731,019 | 735,765 | 740,511 | 714,698 |
| Spokane | 414,493 | 416,684 | 418,875 | 421,066 | 423,256 | 425,447 | 426,740 | 428,033 | 429,326 | 430,619 | 431,912 | 425,148 |
| Stevens | 34,576 | 34,459 | 34,343 | 34,226 | 34,109 | 33,992 | 33,917 | 33,841 | 33,766 | 33,690 | 33,615 | 34,006 |
| Thurston | 224,951 | 228,261 | 231,571 | 234,880 | 238,190 | 241,500 | 243,867 | 246,235 | 248,602 | 250,970 | 253,337 | 241,186 |
| Wahkiakur | 2,726 | 2,669 | 2,612 | 2,555 | 2,498 | 2,441 | 2,405 | 2,368 | 2,332 | 2,295 | 2,259 | 2,448 |
| Walla Wall | 49,893 | 50,111 | 50,328 | 50,546 | 50,763 | 50,981 | 51,028 | 51,075 | 51,121 | 51,168 | 51,215 | 50,924 |
| Whatcom | 175,840 | 178,234 | 180,629 | 183,023 | 185,418 | 187,812 | 189,267 | 190,722 | 192,178 | 193,633 | 195,088 | 187,499 |
| Whitman | 42,880 | 42,965 | 43,051 | 43,137 | 43,222 | 43,308 | 43,315 | 43,322 | 43,330 | 43,337 | 43,344 | 43,282 |
| Yakima | 215,882 | 217,605 | 219,328 | 221,051 | 222,774 | 224,497 | 225,822 | 227,147 | 228,473 | 229,798 | 231,123 | 224,364 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*65+ Population Projection*

| County | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2019-2021 Average Population |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adams | 1,773 | 1,887 | 2,000 | 2,114 | 2,227 | 2,341 | 2,383 | 2,424 | 2,466 | 2,507 | 2,549 | 2,317 |
| Asotin | 5,041 | 5,233 | 5,426 | 5,619 | 5,812 | 6,005 | 6,175 | 6,344 | 6,514 | 6,683 | 6,853 | 5,997 |
| Benton | 26,328 | 27,492 | 28,657 | 29,821 | 30,986 | 32,150 | 33,373 | 34,597 | 35,820 | 37,044 | 38,267 | 32,170 |
| Chelan | 13,746 | 14,279 | 14,811 | 15,343 | 15,876 | 16,408 | 17,052 | 17,695 | 18,339 | 18,982 | 19,626 | 16,445 |
| Clallam | 19,934 | 20,401 | 20,867 | 21,334 | 21,800 | 22,267 | 22,901 | 23,535 | 24,168 | 24,802 | 25,436 | 22,323 |
| Clark | 64,524 | 68,044 | 71,564 | 75,085 | 78,605 | 82,125 | 85,686 | 89,247 | 92,807 | 96,368 | 99,929 | 82,139 |
| Columbia | 1,102 | 1,135 | 1,169 | 1,202 | 1,236 | 1,269 | 1,287 | 1,304 | 1,322 | 1,339 | 1,357 | 1,264 |
| Cowlitz | 18,863 | 19,684 | 20,505 | 21,326 | 22,148 | 22,969 | 23,719 | 24,470 | 25,220 | 25,971 | 26,721 | 22,945 |
| Douglas | 6,450 | 6,831 | 7,213 | 7,595 | 7,976 | 8,358 | 8,666 | 8,974 | 9,283 | 9,591 | 9,899 | 8,334 |
| Ferry | 1,876 | 1,949 | 2,022 | 2,095 | 2,168 | 2,241 | 2,289 | 2,337 | 2,386 | 2,434 | 2,482 | 2,233 |
| Franklin | 7,499 | 7,921 | 8,343 | 8,765 | 9,188 | 9,610 | 10,083 | 10,557 | 11,030 | 11,504 | 11,977 | 9,627 |
| Garfield | 595 | 607 | 620 | 633 | 645 | 658 | 669 | 680 | 692 | 703 | 714 | 658 |
| Grant | 12,395 | 13,011 | 13,628 | 14,244 | 14,861 | 15,477 | 16,071 | 16,665 | 17,258 | 17,852 | 18,446 | 15,469 |
| Grays Harb | 14,005 | 14,535 | 15,064 | 15,594 | 16,123 | 16,653 | 17,133 | 17,612 | 18,092 | 18,571 | 19,051 | 16,636 |
| Island | 18,086 | 18,625 | 19,163 | 19,701 | 20,239 | 20,777 | 21,412 | 22,047 | 22,682 | 23,317 | 23,952 | 20,809 |
| Jefferson | 10,244 | 10,580 | 10,916 | 11,252 | 11,588 | 11,924 | 12,323 | 12,722 | 13,121 | 13,520 | 13,919 | 11,945 |
| King | 254,219 | 268,307 | 282,395 | 296,484 | 310,572 | 324,660 | 337,771 | 350,881 | 363,992 | 377,102 | 390,213 | 324,334 |
| Kitsap | 45,652 | 47,697 | 49,743 | 51,788 | 53,833 | 55,878 | 58,185 | 60,492 | 62,800 | 65,107 | 67,414 | 55,965 |
| Kittitas | 6,464 | 6,760 | 7,055 | 7,351 | 7,647 | 7,943 | 8,266 | 8,589 | 8,911 | 9,234 | 9,557 | 7,952 |
| Klickitat | 4,792 | 5,051 | 5,310 | 5,570 | 5,829 | 6,088 | 6,268 | 6,448 | 6,627 | 6,807 | 6,987 | 6,062 |
| Lewis | 15,166 | 15,576 | 15,987 | 16,398 | 16,808 | 17,219 | 17,697 | 18,175 | 18,652 | 19,130 | 19,608 | 17,241 |
| Lincoln | 2,619 | 2,687 | 2,755 | 2,823 | 2,891 | 2,959 | 3,039 | 3,119 | 3,200 | 3,280 | 3,360 | 2,963 |
| Mason | 13,528 | 14,123 | 14,717 | 15,311 | 15,905 | 16,499 | 17,167 | 17,836 | 18,504 | 19,173 | 19,841 | 16,524 |
| Okanogan | 8,773 | 9,198 | 9,624 | 10,050 | 10,475 | 10,901 | 11,210 | 11,519 | 11,827 | 12,136 | 12,445 | 10,862 |
| Pacific | 6,095 | 6,258 | 6,421 | 6,584 | 6,747 | 6,910 | 7,035 | 7,159 | 7,284 | 7,408 | 7,533 | 6,897 |
| Pend Oreill | 3,195 | 3,378 | 3,560 | 3,742 | 3,925 | 4,107 | 4,239 | 4,371 | 4,504 | 4,636 | 4,768 | 4,090 |
| Pierce | 108,983 | 114,409 | 119,836 | 125,262 | 130,688 | 136,114 | 142,422 | 148,729 | 155,037 | 161,344 | 167,652 | 136,408 |
| San Juan | 4,876 | 5,099 | 5,322 | 5,545 | 5,768 | 5,991 | 6,174 | 6,357 | 6,541 | 6,724 | 6,907 | 5,978 |
| Skagit | 22,735 | 24,021 | 25,308 | 26,595 | 27,881 | 29,168 | 30,314 | 31,460 | 32,607 | 33,753 | 34,899 | 29,121 |
| Skamania | 2,158 | 2,286 | 2,414 | 2,542 | 2,670 | 2,798 | 2,923 | 3,048 | 3,172 | 3,297 | 3,422 | 2,797 |
| Snohomish | 95,788 | 101,674 | 107,560 | 113,447 | 119,333 | 125,219 | 131,978 | 138,737 | 145,495 | 152,254 | 159,013 | 125,510 |
| Spokane | 73,817 | 77,325 | 80,834 | 84,343 | 87,852 | 91,361 | 94,670 | 97,979 | 101,288 | 104,597 | 107,906 | 91,294 |
| Stevens | 9,454 | 9,930 | 10,407 | 10,884 | 11,360 | 11,837 | 12,214 | 12,591 | 12,969 | 13,346 | 13,723 | 11,804 |
| Thurston | 42,459 | 44,534 | 46,608 | 48,683 | 50,757 | 52,832 | 54,900 | 56,967 | 59,035 | 61,102 | 63,170 | 52,830 |
| Wahkiakur | 1,254 | 1,316 | 1,379 | 1,441 | 1,503 | 1,565 | 1,580 | 1,595 | 1,611 | 1,626 | 1,641 | 1,549 |
| Walla Wall | 10,757 | 10,819 | 10,881 | 10,944 | 11,006 | 11,068 | 11,350 | 11,632 | 11,915 | 12,197 | 12,479 | 11,141 |
| Whatcom | 33,950 | 35,688 | 37,426 | 39,164 | 40,902 | 42,640 | 44,217 | 45,794 | 47,372 | 48,949 | 50,526 | 42,586 |
| Whitman | 4,370 | 4,659 | 4,948 | 5,237 | 5,526 | 5,815 | 6,008 | 6,201 | 6,395 | 6,588 | 6,781 | 5,783 |
| Yakima | 34,088 | 34,949 | 35,809 | 36,670 | 37,530 | 38,391 | 39,475 | 40,559 | 41,643 | 42,727 | 43,811 | 38,465 |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Department of Health**
**2022-2023 Hospice Numeric Need Methodology**
*Methodology By County*

**COUNTY:** **Douglas** **Select from drop down menu*

**Douglas County Only**

Population information (OFM)

| Ages | County | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2019-2021 Avgerage |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 - 64 | Douglas | 33,540 | 33,938 | 34,335 | 34,732 | 35,130 | 35,527 | 35,803 | 36,080 | 36,356 | 36,633 | 36,909 | 35,487 |
| | | | | | | | | | | | | | |
| Ages | County | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2019-2021 Avgerage |
| 65 + | Douglas | 6,450 | 6,831 | 7,213 | 7,595 | 7,976 | 8,358 | 8,666 | 8,974 | 9,283 | 9,591 | 9,899 | 8,334 |

**WAC 246-310-290(8)(a) Step 1:**

| | | 2019 | 2020 | 2021 | Average | Use Rate |
|---|---|---|---|---|---|---|
| Ages 0 - 64 | Hospice unduplicated admissions | 3,712 | 3,680 | 3,893 | **3,762** | **23.16%** |
| | Total deaths | 14,047 | 16,663 | 18015 | **16,242** | |

| | | 2019 | 2020 | 2021 | Average | Use Rate |
|---|---|---|---|---|---|---|
| Ages 65 + | Hospice unduplicated admissions | 26,175 | 27,957 | 27,884 | **27,339** | **58.07%** |
| | Total deaths | 44,159 | 46,367 | 50,717 | **47,081** | |

**WAC 246-310-290(8)(a) Steps 2-8:**

| Ages 0-64 | Step | Result | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | |
|---|---|---|---|---|---|---|---|---|---|
| Planning area historical resident deaths (OFM) | 2 | | 63 | 42 | 45 | | | | Ages 0 - 64 |
| Average deaths (2019-2021) | 2 | 50 | | | | | | | |
| Projected patient deaths: 23.16% | 3 | 12 | | | | | | | |
| Average population (OFM) | 4 | 35,487 | | | | | | | |
| Projected population | N/A | | 35,130 | 35,527 | 35,803 | 36,080 | 36,356 | 36,633 | Steps 2-4 |
| Potential volume | N/A | | 11 | 12 | 12 | 12 | 12 | 12 | |

| Ages 65+ | Step | Result | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | |
|---|---|---|---|---|---|---|---|---|---|
| PA historical resident deaths (OFM) | 2 | | 270 | 160 | 174 | | | | Ages 65+ |
| Average deaths (2019-2021) | 2 | 201 | | | | | | | |
| Projected patient deaths: 58.07% | 3 | 117 | | | | | | | |
| Average population (OFM) | 4 | 8,334 | | | | | | | |
| Projected population | N/A | | 7,976 | 8,358 | 8,666 | 8,974 | 9,283 | 9,591 | Steps 2-4 |
| Potential volume | N/A | | 112 | 117 | 122 | 126 | 130 | 135 | |

| All Ages | Step | Result | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | |
|---|---|---|---|---|---|---|---|---|---|
| Combined age cohorts | 5 | | 123 | 129 | 133 | 138 | 142 | 147 | All Ages |
| Current capacity (DOH survey) | N/A | 195 | | | | | | | |
| Unmet need | 5 | | **(72)** | **(66)** | **(62)** | **(58)** | **(53)** | **(49)** | |
| Unmet need patient days (statewide ALOS) | 6 | 61.89 | (4,454) | (4,115) | (3,842) | (3,569) | (3,295) | (3,022) | |
| Unmet Average Daily Census (ADC) | 7 | | (12) | (11) | (11) | (10) | (9) | (8) | Steps 5-8 |
| Agency needed (ADC > 35) | 8 | 35 | **FALSE** | **FALSE** | **FALSE** | **FALSE** | **FALSE** | **FALSE** | |

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

DOH 260-028 November 2022

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 6

**Admissions Policy**

## ADMISSION CRITERIA AND PROCESS

**Policy No. 4-021.1**

## PURPOSE

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

## POLICY

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

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

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

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

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

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

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

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

***Admission Criteria***

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

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

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

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

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

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

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

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

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

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

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

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

## PROCEDURE

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

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

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

   A. Patient's geographical location

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

   C. Hospice personnel's education and experience

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

   E. Urgency of identified need for assessment

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

   A. Such notification and approval will be documented.

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

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

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

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

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

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

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

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

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

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

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

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

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Source of payment

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

   A. Nature and goals of care and/or service

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

   C. Access to care after hours

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

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

   F. Safety information

   G. Infection control information

   H. Emergency preparedness plans

   I. Available community resources

   J. Complaint/grievance process

K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    A. Patient

    B. Physician

    C. Referral source (if not physician)

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

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

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

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

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 7

**Charity Care Policy**

# CHARITY CARE
**Policy No. 3-007.1**

## PURPOSE

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

## POLICY

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

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

The organization will consistently apply the charity care policy.

## PROCEDURE

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

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

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

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

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

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

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

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

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

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

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# APPENDIX 8

**Patient Rights and Responsibilities Policy**

**PATIENT BILL OF RIGHTS**
**Policy No. 2-002.1**

## PURPOSE

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

## POLICY

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

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

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

## PROCEDURE

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

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

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

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

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

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

 

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

U. Be informed of the patient's responsibilities.

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

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

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

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

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

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

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

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

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

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

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

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# APPENDIX 9

**Non Discrimination and Death With Dignity Policies**

# NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS

**Policy No. 2-037.1**

## PURPOSE

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

## POLICY

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

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

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

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

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

## PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**DEATH WITH DIGNITY POLICY**
**Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee**

## PURPOSE

In accordance with the Washington Death with Dignity Act (RCW 70.245), Advanced Hospice Northwest of Wenatchee recognizes the patient's right to request a prescription for a life-ending dose of medication to end his or her life. The Death with Dignity Act allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. The act relates to this agency in that it involves the self-administration of medication in the person's home environment

Definitions related to the Death with Dignity Act and this policy:

1. Adult means an individual who is 18 years of age or older.

2. Competent means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

3. Self-Administer means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.

4. Qualified patient means a competent adult who is a resident of Washington state and has satisfied the requirements under the Washington Death with Dignity Act in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

5. Terminal disease means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

6. Washington Death with Dignity Act medication means any medication that is prescribed under Washington Death with Dignity Act for the purpose of ending the patient's life.

## POLICY

This policy is designed to provide guidelines for staff caring for a patient who expresses interest in proceeding with The Washington Death with Dignity Act, RCW 70.245.

Giving patients general information about their available options under the Washington Death with Dignity law is to be distinguished from activities directly related to the delivery, ingestion, or direct facilitation of life-ending activities under the act.

It is the policy of Advanced Hospice Northwest of Wenatchee that it respects the right of both employees and patients to determine whether they wish to participate in actions defined in this policy about the Death with Dignity Act.

## PROCEDURE

1. Hospice will continue to provide care and support to patients who qualify for Hospice services regardless of their stated interest or intent of pursuing Washington Death with Dignity.
2. The Hospice RN/MSW will provide information to the patient and family about Washington Death with Dignity Act. This may include information from End of Life Washington.
3. Upon request, the Hospice RN/MSW may make a referral to End of Life Washington regarding patient interest in Washington Death with Dignity.
4. Hospice Staff will not provide, deliver, or assist with medications intended for Washington Death with Dignity.
5. Hospice staff may not be present in the home when a patient ingests Washington Death with Dignity medication.
6. Should a staff member arrive at the home of a patient in the course of a regularly scheduled visit and finds one of the two scenarios, (1) the patient has taken the medication but is not dead, or (2) the patient has taken the medication and died, the staff member provides appropriate quality hospice care.
7. If a staff member requests not to work with a patient pursuing Washington Death with Dignity, another staff will be assigned to the patient to offer hospice care. If no other staff member is available to provide the needed care, the staff member currently caring for the patient will provide the necessary care until alternative staffing can be arranged.
8. A staff member's beliefs and choice of as it relates to the Washington Death with Dignity Act or choosing not to participate in a patient's care based on this belief system will not be part of his/her performance evaluation.
9. Advanced Hospice Northwest of Wenatchee will not provide any funds/resources related to the facilitation of Washington Death with Dignity or paying for any medication that will be used to end a patient life.

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

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# APPENDIX 10

**Selection/Hiring of Personnel Policy**

**Orientation Policy**

**Personnel Orientation Checklist**

## SELECTION/HIRING OF PERSONNEL
**Policy No. 1-006.1**

## PURPOSE

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

## POLICY

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

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

## PROCEDURE

***Selection and Screening***

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

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

    A. Valid state license or certification, as applicable

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

***Hiring***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Verification of the above will be documented.

***Promotion***

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

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

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

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

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

**ORIENTATION**
**Policy No. 1-022.1**

## PURPOSE

To provide guidelines for the orientation process.

## POLICY

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

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

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

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

## PROCEDURE

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

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

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

   C. Hours of work

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

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

   F. Baseline skills assessments as applicable to job classification

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

   H. Performance standards

   I. Confidentiality of organization and patient information/HIPAA regulations

J. Documentation requirements (record keeping and requirements)

K. OSHA compliance

L. Handling of hazardous medications and other materials

M. Medical Device Reporting/Incident Reporting

N. Equal Employment Opportunity Act

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

P. Sexual Harassment Act

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

R. Unemployment and workers' compensation

S. Malpractice coverage, as applicable

T. Collective bargaining information, as applicable

U. Drug testing

V. Drug diversion

W. Family/State Medical Leave Act

X. Cultural Diversity and communication barriers

Y. Hispanic programing resources and expectations including volunteer program

Z. Client/Patient Rights including Advance Directives

AA. Standards of Conduct and Ethical Issues

BB. QAPI and activities

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

DD. Pain and symptom management

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

FF. Compliance Plan and employee compliance responsibilities

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

HH. Handling of patient complaints/grievances

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

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

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

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

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

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

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

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

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

   B. Personnel responsibilities

   C. Specific care and services to be provided

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

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

   A. Lines of authority and responsibility

   B. Hours of work

   C. Job responsibilities

D. Skills assessment as applicable to the specific job classification

E. Documentation responsibilities

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

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

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

## PERSONNEL ORIENTATION CHECKLIST

Name: _____ Date:_____

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

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

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 11

**QAPI Policy**

# IMPROVING ORGANIZATIONAL PERFORMANCE

**Policy No. 5-001.1**

## PURPOSE

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

## POLICY

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

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

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

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

## PROCEDURE

1. Senior management will:

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

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

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

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

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

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

D. Identify and participate in benchmarking activities that utilize:

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

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

E. Allocate resources for QAPI activities by:

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

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

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

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

3. All other organization personnel will:

   A. Be involved in QAPI teams and activities.

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

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

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

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

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

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

# Sample Quality Assessment and Performance Improvement (QAPI) Plan

## MISSION

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

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

To carry out this mission, The Hospice provides:

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

## PURPOSE

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

## OBJECTIVES

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

## METHODOLOGY

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

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

## ASSIGNMENT OF RESPONSIBILITY

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

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

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

## RESPONSIBILITIES OF QAPI COORDINATOR

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

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

## RESPONSIBILITIES OF QAPI COMMITTEE

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

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

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

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

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

## EVALUATION OF THE QAPI PLAN

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

## CONFIDENTIALITY

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

• • •

## THE QAPI PLAN – DISCUSSION

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

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

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

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

## ROUTINE MEASUREMENT OF INDICATORS

### SAMPLE SCHEDULE

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

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

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

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

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 12

**Projections and Pro Forma**

| **ADVANCED HOSPICE UTILIZATION PROJECTION – Douglas County** | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| Total number of admissions | | 15 | 15 | 15 |
| Total number of patient days | | 902 | 924 | 948 |
| Projected average daily census | | 2.5 | 2.5 | 2.6 |

| **ADVANCED HOSPICE UTILIZATION PROJECTION – Chelan County** | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| Total number of admissions | 85 | 165 | 183 | 200 |
| Total number of patient days | 5,263 | 10,220 | 11,383 | 12,395 |
| Projected average daily census | 14.3 | 27.8 | 31 | 34 |

| **ADVANCED HOSPICE UTILIZATION PROJECTION – Combined Chelan and Douglas Counties** | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| Total number of admissions | 85 | 180 | 198 | 215 |
| Total number of patient days | 5,263 | 11,122 | 12,307 | 13,343 |
| Projected average daily census | 14.3 | 30.3 | 33.5 | 36.6 |

## Advanced Hospice Rates

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

**Advanced Hospice - Douglas County**
**3 Year Projected Income**

| | 2024 | 2025 | 2026 | |
|---|---|---|---|---|
| Census | | | | |
| Medicare | 2.2 | 2.2 | 2.3 | Assumptions based on census growth estimates and projected need |
| Medicaid | 0.2 | 0.2 | 0.2 | |
| Commercial | 0.1 | 0.1 | 0.1 | |
| **Census** | **2.5** | **2.5** | **2.6** | |
| | | | | |
| Medicare | | | | |
| Routine 1 - 60 | 151,184 | 151,184 | 157,536 | Assumptions based on census estimates, mix projections, and rates. |
| Routine 61 + | 3,994 | 3,994 | 4,162 | ALOS based on DOH 2022 Methodology average of 61.89 days |
| Respite | 4,215 | 4,215 | 4,392 | Routine, respite and GIP utilization based on reviewing data from hospice |
| GIP | 4,177 | 4,177 | 4,352 | providers, NHPCO facts and figures 2021 edition, and review with |
| Continuous | - | - | - | |
| Medicare Total | 163,570 | 163,570 | 170,442 | |
| | | | | |
| Medicaid | | | | |
| Routine 1 - 60 | 11,797 | 11,797 | 11,797 | |
| Routine 61 + | - | - | - | |
| Respite | - | - | - | |
| GIP | - | - | - | |
| Continuous | - | - | - | |
| Medicaid Total | 11,797 | 11,797 | 11,797 | |
| | | | | |
| Commercial | | | | |
| Routine 1 - 60 | 8,494 | 8,494 | 8,494 | |
| Routine 61 + | - | - | - | |
| Respite | - | - | - | |
| GIP | - | - | - | |
| Continuous | - | - | - | |
| Commercial Total | 8,494 | 8,494 | 8,494 | |
| | | | | |
| **Gross Revenue** | **183,861** | **183,861** | **190,733** | |
| Charity Care | (3,677) | (3,677) | (3,815) | 2% based on averages from hospice providers |
| Bad Debt | (1,839) | (1,839) | (1,907) | 1% based on averages from hospice providers |
| | | | | |
| **Net Revenue** | **178,345** | **178,345** | **185,011** | |
| | | | | |
| Operating Expenses | | | | |
| Clinical Labor Expense | | | | |
| Clinical Director | - | - | - | |
| RN Case Manager | 26,263 | 26,263 | 27,014 | Salary of 75,038 * .35 for years 2024 and 2025 and .36 for 2026 |
| CNA | 9,901 | 9,901 | 10,297 | Salary of 39,603 * .25 for years 2024 and 2025 and .26 for 2026 |
| QAPI Nurse | - | - | - | |
| Social Worker | 5,836 | 5,836 | 6,566 | Salary of 72,953 * .08 for years 2024 and 2025 and .09 for 2026 |
| Spiritual Care Coordinator | 4,669 | 4,669 | 5,253 | Salary of 58,363 * .08 for 2024 and 2025 and .09 for 2026 |
| Payroll Taxes | 4,947 | 4,947 | 5,208 | 10.6% of wages based on home health experience |
| Workers Compensation | 574 | 574 | 604 | 1.23% of wages based on home health experience |
| | | | | |
| Direct Wages | 52,190 | 52,190 | 54,942 | |
| | | | | |
| Ancillary Expense | | | | |
| Ambulance/Transportation | 310 | 310 | 323 | .34 PPD |
| Medical Director | 6,240 | 6,240 | 6,490 | $200/hour contract and assumption of 1.04 hours per ADC |
| Equipment Rental / DME | 4,015 | 4,015 | 4,176 | 4.40 PPD |
| GIP | 2,856 | 2,856 | 2,940 | 700 per GIP day |
| Inpatient Respite | 1,848 | 1,848 | 1,920 | 200 per Respite day |
| Contract Rehabilitation | 450 | 450 | 468 | 3 hours per 10 ADC at avg rate of 49.96 |
| Medical Supplies | 1,734 | 1,734 | 1,803 | 1.90 PPD |
| Pharmacy / Lab / Xray | 6,543 | 6,543 | 6,804 | 7.17 PPD |
| Total Ancillary Expense | 23,996 | 23,996 | 24,924 | |
| | | | | |
| **Total Direct Care Expenses** | **76,186** | **76,186** | **79,866** | |

| | | | | |
|---|---|---|---|---|
| Overhead Expenses | | | | |
| Administration Labor | | | | |
| Administrator | - | - | - | |
| Volunteer Coordinator | - | - | - | |
| Office Manager | - | - | - | |
| Outreach Coordinator | - | - | - | |
| Intake Coordinator / Clinical Support | - | - | - | |
| Payroll Taxes - Admin | - | - | - | |
| Workers Compensation - Admin | - | - | - | |
| Total Administration Labor | - | - | - | |
| | | | | |
| Administration Other Expenses | | | | |
| Employee Benefits | 1,764 | 1,764 | 1,857 | 3.78% of employee wages based on home health experience |
| Mileage | 1,082 | 1,082 | 1,126 | Per patient average cost of $432.92 from home health experience |
| Advertising | 9,000 | 9,000 | 9,000 | $750/ Month to account for cities in douglas county outside of Wenatchee |
| Liability Insurance | - | - | - | |
| Licenses and Fees | - | - | - | |
| Software | - | - | - | |
| Payroll Services | - | - | - | |
| Management Fees | - | - | - | |
| B & O Taxes | 3,218 | 3,218 | 3,338 | 1.75% of gross revenues |
| Dues & Education | - | - | - | |
| Legal & Professional | - | - | - | |
| Office Supplies and Postage | - | - | - | |
| Telephone/Internet | - | - | - | |
| Repairs and Maintenance | - | - | - | |
| Recruitment | - | - | - | |
| Allocated Costs | - | - | - | |
| Total Administration Other Expenses | 15,064 | 15,064 | 15,321 | |
| | | | | |
| **Total Administration Expenses** | **15,064** | **15,064** | **15,321** | |
| | | | | |
| Non Operating Expenses | | | | |
| Depreciation and Amortization | - | - | - | |
| Interest | - | - | - | |
| Lease Expense (Incl Utilities) | - | - | - | |
| Total Non Operating Expenses | - | - | - | |
| | | | | |
| **Total Expenses** | **91,250** | **91,250** | **95,187** | |
| | | | | |
| **Profit (Loss)** | **87,095** | **87,095** | **89,824** | |

**Advanced Hospice - Douglas**
**3 Year Projected Balance Sheet**

| | 2024 | 2025 | 2026 |
|---|---|---|---|
| **Assets** | | | |
| Current Assets | | | |
| Cash | $ 85,531 | $ 172,626 | $ 262,450 |
| Accounts Receivable | $ 7,661 | $ 7,661 | $ 7,661 |
| Prepaid | | | |
| Total Current Assets | $ 93,192 | $ 180,287 | $ 270,111 |
| | | | |
| **Intangible Assets** | | | |
| Intangible Assets | | | |
| Accumulated Amortization | | | |
| | | | |
| **Other Assets** | | | |
| Deposits | | | |
| **Total Assets** | $ 93,192 | $ 180,287 | $ 270,111 |
| | | | |
| **Liabilities** | | | |
| Current Liabilities | | | |
| Accounts Payable | $ 5,157 | $ 5,157 | $ 5,157 |
| Accrued Payroll and Taxes | $ 940 | $ 940 | $ 940 |
| Demand Note - Member | | | |
| Accrued Interest | | | |
| Total Current Liabilties | $ 6,097 | $ 6,097 | $ 6,097 |
| | | | |
| **Member's Equity** | | | |
| Contributions | $ - | $ - | $ - |
| Member's Equity | $ - | $ 87,095 | $ 174,190 |
| Net Income | $ 87,095 | $ 87,095 | $ 89,824 |
| Member's Equity | $ 87,095 | $ 174,190 | $ 264,014 |
| **Liabilities & Member's Equity** | $ 93,192 | $ 180,287 | $ 270,111 |

**Advanced Hospice Chelan County**
**3 year Projected Income Statement (with intervening year)**

| | 2023 | 2024 | 2025 | 2026 | |
|---|---|---|---|---|---|
| Census | | | | | |
| Medicare | 12.6 | 24.5 | 27.3 | 29.9 | Assumptions based on census growth estimates and projected need |
| Medicaid | 1.0 | 1.9 | 2.2 | 2.4 | |
| Commercial | 0.7 | 1.4 | 1.5 | 1.7 | |
| **Census** | **14.3** | **27.8** | **31.0** | **34.0** | |
| | | | | | |
| Medicare | | | | | |
| Routine 1 - 60 | 866,885 | 1,683,187 | 1,874,687 | 2,005,866 | Assumptions based on census estimates, mix projections, and rates. |
| Routine 61 + | 22,898 | 44,465 | 49,524 | 54,317 | ALOS based on DOH 2021 Methodology average of 62 days |
| Respite | 24,166 | 46,928 | 52,267 | 57,325 | Routine, respite and GIP utilization based on reviewing data from hospice |
| GIP | 23,946 | 46,500 | 51,790 | 56,802 | providers, NHPCO facts and figures 2021 edition, and review with |
| Continuous | - | - | - | | the administrator of over 20 years operational experience. |
| Medicare Total | 937,895 | 1,821,079 | 2,028,268 | 2,174,310 | |
| | | | | | |
| Medicaid | | | | | |
| Routine 1 - 60 | 67,637 | 131,342 | 146,285 | 160,442 | |
| Routine 61 + | 1,709 | 3,729 | 3,729 | 3,729 | |
| Respite | 3,673 | 7,347 | 11,020 | 11,020 | |
| GIP | - | - | - | | |
| Continuous | - | - | - | | |
| Medicaid Total | 73,020 | 142,418 | 161,034 | 175,191 | |
| | | | | | |
| Commercial | | | | | |
| Routine 1 - 60 | 43,709 | 84,940 | 93,434 | 104,051 | |
| Routine 61 + | 1,119 | 1,678 | 3,356 | 3,356 | |
| Respite | 2,479 | 4,959 | 4,959 | 4,959 | |
| GIP | - | - | - | | |
| Continuous | - | - | - | | |
| Commercial Total | 47,307 | 91,577 | 101,749 | 112,366 | |
| | | | | | |
| **Gross Revenue** | **1,058,222** | **2,055,074** | **2,291,051** | **2,461,867** | |
| Charity Care | (21,164) | (41,101) | (45,821) | (50,242) | 2% based on averages from hospice providers |
| Bad Debt | (10,582) | (20,551) | (22,911) | (25,121) | 1% based on averages from hospice providers |
| | | | | | |
| **Net Revenue** | **1,026,476** | **1,993,422** | **2,222,319** | **2,386,504** | |
| | | | | | |
| Operating Expenses | | | | | |
| Clinical Labor Expense | | | | | |
| Clinical Director | 52,109 | 52,109 | 52,109 | 52,109 | |
| RN Case Manager | 150,076 | 291,898 | 325,665 | 357,181 | |
| CNA | 56,632 | 110,096 | 122,769 | 134,650 | |
| QAPI Nurse | 40,645 | 40,645 | 40,645 | 40,645 | |
| Social Worker | 35,017 | 67,846 | 75,142 | 82,437 | |
| Spiritual Care Coordinator | 28,014 | 54,278 | 60,114 | 65,950 | |
| Payroll Taxes | 38,424 | 65,388 | 71,703 | 77,695 | 10.6% of employee wages based on home health experience |
| Workers Compensation | 4,459 | 7,588 | 8,320 | 9,016 | 1.23% based on home health experience |
| | | | | | |
| Direct Wages | 405,376 | 689,848 | 756,468 | 819,683 | |
| | | | | | |
| Ancillary Expense | | | | | (Based on averages from hospice providers) |
| Ambulance/Transportation | 1,775 | 3,450 | 3,847 | 4,219 | .34 PPD |
| Medical Director | 35,693 | 69,389 | 77,376 | 84,864 | $200/hour contract and assumption of 1.04 hours per ADC |
| Equipment Rental / DME | 22,966 | 44,647 | 49,786 | 54,604 | 4.40 PPD |
| GIP | 16,212 | 31,479 | 35,063 | 38,178 | 700 per GIP day |
| Inpatient Respite | 13,326 | 26,040 | 29,966 | 32,160 | 200 per Respite day |
| Contract Rehabilitation | 2,572 | 5,000 | 5,576 | 6,115 | 3 hours per 10 ADC at avg rate of 49.96 |
| Medical Supplies | 9,917 | 19,279 | 21,499 | 23,579 | 1.90 PPD |
| Pharmacy / Lab / Xray | 37,424 | 72,754 | 81,129 | 88,980 | 7.17 PPD |
| Total Ancillary Expense | 139,884 | 272,038 | 304,241 | 332,699 | |
| | | | | | |
| **Total Direct Care Expenses** | **545,261** | **961,886** | **1,060,708** | **1,152,382** | |

| | | | | | |
|---|---|---|---|---|---|
| Overhead Expenses | | | | | |
| Administration Labor | | | | | |
| Administrator | 57,623 | 57,623 | 57,623 | 57,623 | |
| Volunteer Coordinator | 50,025 | 50,025 | 50,025 | 50,025 | |
| Office Manager | 31,266 | 31,266 | 31,266 | 31,266 | |
| Outreach Coordinator | 56,278 | 56,278 | 56,278 | 56,278 | |
| Intake Coordinator / Clinical Support | 37,519 | 37,519 | 37,519 | 37,519 | |
| Payroll Taxes - Admin | 24,667 | 24,667 | 24,667 | 24,667 | 10.6% of employee wages based on home health experience |
| Workers Compensation - Admin | 2,862 | 2,862 | 2,862 | 2,862 | 1.23% of employee wages based on home health experience |
| Total Administration Labor | 260,241 | 260,241 | 260,241 | 260,241 | |
| | | | | | |
| Administration Other Expenses | | | | | |
| Employee Benefits | 22,499 | 32,114 | 34,366 | 36,503 | 3.78% of employee wages based on home health experience |
| Mileage | 6,191 | 12,035 | 13,420 | 14,719 | Per patient average cost of $432.92 from home health experience |
| Advertising | 14,400 | 14,400 | 14,400 | 14,400 | $1,200 / month based on advertising pricing |
| Liability Insurance | 7,800 | 7,800 | 7,800 | 7,800 | Estimate from Broker |
| Licenses and Fees | 6,000 | 6,000 | 6,000 | 6,000 | Acreditation and state licenses |
| Software | 24,000 | 24,000 | 24,000 | 24,000 | $2,000/month based on rates quoted by vendors |
| Payroll Services | 6,000 | 6,000 | 6,000 | 6,000 | $500/month based on home health experience |
| Management Fees | 120,000 | 120,000 | 120,000 | 120,000 | $10,000/month for operational support |
| B & O Taxes | 18,519 | 35,964 | 40,093 | 43,083 | 1.75% of gross revenues |
| Dues & Education | 15,000 | 15,000 | 15,000 | 15,000 | $1,000/month for cultural education and 3,000/year in dues |
| Legal & Professional | 1,200 | 1,200 | 1,200 | 1,200 | $100/month |
| Office Supplies and Postage | 5,400 | 5,400 | 5,400 | 5,400 | $450/month |
| Telephone/Internet | 9,825 | 13,848 | 14,597 | 15,720 | 93.57 per actual employee per month based on home health experience |
| Repairs and Maintenance | 1,200 | 1,200 | 1,200 | 1,200 | $100/month |
| Recruitment | 5,000 | 5,000 | 5,000 | 5,000 | $5,000 annual based on home health experience |
| Allocated Costs | - | - | - | | |
| Total Administration Other Expenses | 263,033 | 299,962 | 308,477 | 316,025 | |
| | | | | | |
| **Total Administration Expenses** | **523,274** | **560,202** | **568,718** | **576,265** | |
| | | | | | |
| Non Operating Expenses | | | | | |
| Depreciation and Amortization | - | - | - | | |
| Interest | - | - | - | | |
| Lease Expense (Incl Utilities) | 6,000 | 6,000 | 6,000 | 6,000 | $500/month |
| Total Non Operating Expenses | 6,000 | 6,000 | 6,000 | 6,000 | |
| | | | | | |
| **Total Expenses** | **1,074,534** | **1,528,088** | **1,635,426** | **1,734,647** | |
| | | | | | |
| **Profit (Loss)** | **48,058** | **465,334** | **586,893** | **651,857** | |

**Advanced Hospice - Chelan**
**4 Year Projected Balance Sheet**

| | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| **Assets** | | | | |
| Current Assets | | | | |
| Cash | $ 74,378 | $ 330,512 | $ 680,186 | $ 1,457,678 |
| Accounts Receivable | $ 153,971 | $ 452,985 | $ 786,333 | $ 802,060 |
| Prepaid | | | | |
| Total Current Assets | $ 228,349 | $ 783,497 | $ 1,466,519 | $ 2,259,738 |
| | | | | |
| **Intangible Assets** | | | | |
| Intangible Assets | | | | |
| Accumulated Amortization | | | | |
| | | | | |
| **Other Assets** | | | | |
| Deposits | | | | |
| **Total Assets** | $ 228,349 | $ 783,497 | $ 1,466,519 | $ 2,259,738 |
| | | | | |
| **Liabilities** | | | | |
| Current Liabilities | | | | |
| Accounts Payable | $ 102,229 | $ 150,396 | $ 201,956 | $ 270,621 |
| Accrued Payroll and Taxes | $ 29,178 | $ 70,825 | $ 115,394 | $ 188,092 |
| Demand Note - Member | | | | |
| Accrued Interest | | | | |
| Total Current Liabilties | $ 131,407 | $ 221,221 | $ 317,350 | $ 458,713 |
| | | | | |
| **Member's Equity** | | | | |
| Contributions | $ 145,000 | $ 145,000 | $ 145,000 | $ 145,000 |
| Member's Equity | $ - | $ (48,058) | $ 417,276 | $ 1,004,168 |
| Net Income | $ (48,058) | $ 465,334 | $ 586,893 | $ 651,857 |
| Member's Equity | $ 96,942 | $ 562,276 | $ 1,149,169 | $ 1,801,025 |
| **Liabilities & Member's Equity** | $ 228,349 | $ 783,497 | $ 1,466,519 | $ 2,259,738 |

**Advanced Hospice Douglas and Chelan Counties Combined**
**3 year Projected Income Statement (with intervening year)**

| | 2023 | 2024 | 2025 | 2026 | |
|---|---|---|---|---|---|
| Census | | | | | |
| Medicare | 12.6 | 26.7 | 29.5 | 32.2 | Assumptions based on census growth estimates and projected need |
| Medicaid | 1.0 | 2.1 | 2.3 | 2.6 | |
| Commercial | 0.7 | 1.5 | 1.7 | 1.8 | |
| **Census** | **14.3** | **30.3** | **33.5** | **36.6** | |
| | | | | | |
| Medicare | | | | | |
| Routine 1 - 60 | 866,885 | 1,834,371 | 2,025,871 | 2,163,402 | Assumptions based on census estimates, mix projections, and rates. |
| Routine 61 + | 22,898 | 48,459 | 53,518 | 58,479 | ALOS based on DOH 2021 Methodology average of 62 days |
| Respite | 24,166 | 51,143 | 56,482 | 61,717 | Routine, respite and GIP utilization based on reviewing data from hospice |
| GIP | 23,946 | 50,676 | 55,967 | 61,154 | providers, NHPCO facts and figures 2021 edition, and review with |
| Continuous | - | - | - | | the administrator of over 20 years operational experience. |
| Medicare Total | 937,895 | 1,984,649 | 2,191,838 | 2,344,752 | |
| | | | | | |
| Medicaid | | | | | |
| Routine 1 - 60 | 67,637 | 143,139 | 158,082 | 172,239 | |
| Routine 61 + | 1,709 | 3,729 | 3,729 | 3,729 | |
| Respite | 3,673 | 7,347 | 11,020 | 11,020 | |
| GIP | - | - | - | | |
| Continuous | - | - | - | | |
| Medicaid Total | 73,020 | 154,215 | 172,831 | 186,988 | |
| | | | | | |
| Commercial | | | | | |
| Routine 1 - 60 | 43,709 | 93,434 | 101,928 | 112,545 | |
| Routine 61 + | 1,119 | 1,678 | 3,356 | 3,356 | |
| Respite | 2,479 | 4,959 | 4,959 | 4,959 | |
| GIP | - | 0 | 0 | 0 | |
| Continuous | - | 0 | 0 | 0 | |
| Commercial Total | 47,307 | 100,071 | 110,243 | 120,860 | |
| | | | | | |
| **Gross Revenue** | **1,058,222** | **2,238,935** | **2,474,913** | **2,652,600** | |
| Charity Care | (21,164) | (44,778) | (49,498) | (54,057) | 2% based on averages from hospice providers |
| Bad Debt | (10,582) | (22,390) | (24,750) | (27,028) | 1% based on averages from hospice providers |
| | | | | | |
| **Net Revenue** | **1,026,476** | **2,171,767** | **2,400,665** | **2,571,515** | |
| | | | | | |
| Operating Expenses | | | | | |
| Clinical Labor Expense | | | | | |
| Clinical Director | 52,109 | 52,109 | 52,109 | 52,109 | |
| RN Case Manager | 150,076 | 318,161 | 351,928 | 384,195 | |
| CNA | 56,632 | 119,997 | 132,670 | 144,947 | |
| QAPI Nurse | 40,645 | 40,645 | 40,645 | 40,645 | |
| Social Worker | 35,017 | 73,682 | 80,978 | 89,003 | |
| Spiritual Care Coordinator | 28,014 | 58,947 | 64,783 | 71,203 | |
| Payroll Taxes | 38,424 | 70,335 | 76,650 | 82,903 | 10.6% of employee wages based on home health experience |
| Workers Compensation | 4,459 | 8,162 | 8,894 | 9,620 | 1.23% based on home health experience |
| Direct Wages | 405,376 | 742,038 | 808,658 | 874,625 | |
| | | | | | |
| Ambulance/Transportation | 1,775 | 3,760 | 4,157 | 4,542 | .34 PPD |
| Medical Director | 35,693 | 75,629 | 83,616 | 91,354 | $200/hour contract and assumption of 1.04 hours per ADC |
| Equipment Rental / DME | 22,966 | 48,662 | 53,801 | 58,780 | 4.40 PPD |
| GIP | 16,212 | 34,335 | 37,919 | 41,118 | 700 per GIP day |
| Inpatient Respite | 13,326 | 27,888 | 31,814 | 34,080 | 200 per Respite day |
| Contract Rehabilitation | 2,572 | 5,450 | 6,025 | 6,583 | 3 hours per 10 ADC at avg rate of 49.96 |
| Medical Supplies | 9,917 | 21,013 | 23,233 | 25,382 | 1.90 PPD |
| Pharmacy / Lab / Xray | 37,424 | 79,297 | 87,672 | 95,784 | 7.17 PPD |
| Total Ancillary Expense | 139,884 | 296,034 | 328,236 | 357,623 | |
| | | | | | |
| **Total Direct Care Expenses** | **545,261** | **1,038,072** | **1,136,894** | **1,232,248** | |

| | | | | | |
|---|---|---|---|---|---|
| Overhead Expenses | | | | | |
| Administrator | 57,623 | 57,623 | 57,623 | 57,623 | |
| Volunteer Coordinator | 50,025 | 50,025 | 50,025 | 50,025 | |
| Office Manager | 31,266 | 31,266 | 31,266 | 31,266 | |
| Outreach Coordinator | 56,278 | 56,278 | 56,278 | 56,278 | |
| Intake Coordinator / Clinical Support | 37,519 | 37,519 | 37,519 | 37,519 | |
| Payroll Taxes - Admin | 24,667 | 24,667 | 24,667 | 24,667 | 10.6% of employee wages based on home health experience |
| Workers Compensation - Admin | 2,862 | 2,862 | 2,862 | 2,862 | 1.23% of employee wages based on home health experience |
| Total Administration Labor | 260,241 | 260,241 | 260,241 | 260,241 | |
| | | | | | |
| Administration Other Expenses | | | | | |
| Employee Benefits | 22,499 | 33,878 | 36,130 | 38,360 | 3.78% of employee wages based on home health experience |
| Mileage | 6,191 | 13,117 | 14,503 | 15,845 | Per patient average cost of $432.92 from home health experience |
| Advertising | 14,400 | 23,400 | 23,400 | 23,400 | $1,200 / month based on advertising pricing |
| Liability Insurance | 7,800 | 7,800 | 7,800 | 7,800 | Estimate from Broker |
| Licenses and Fees | 6,000 | 6,000 | 6,000 | 6,000 | Acreditation and state licenses |
| Software | 24,000 | 24,000 | 24,000 | 24,000 | $2,000/month based on rates quoted by vendors |
| Payroll Services | 6,000 | 6,000 | 6,000 | 6,000 | $500/month based on home health experience |
| Management Fees | 120,000 | 120,000 | 120,000 | 120,000 | $10,000/month for operational support |
| B & O Taxes | 18,519 | 39,182 | 43,311 | 46,421 | 1.75% of gross revenues |
| Dues & Education | 15,000 | 15,000 | 15,000 | 15,000 | $1,000/month for cultural education and 3,000/year in dues |
| Legal & Professional | 1,200 | 1,200 | 1,200 | 1,200 | $100/month |
| Office Supplies and Postage | 5,400 | 5,400 | 5,400 | 5,400 | $450/month |
| Telephone/Internet | 9,825 | 13,848 | 14,597 | 15,720 | 93.57 per actual employee per month based on home health experience |
| Repairs and Maintenance | 1,200 | 1,200 | 1,200 | 1,200 | $100/month |
| Recruitment | 5,000 | 5,000 | 5,000 | 5,000 | $5,000 annual based on home health experience |
| Allocated Costs | - | - | - | | |
| Total Administration Other Expenses | 263,033 | 315,026 | 323,541 | 331,346 | |
| | | | | | |
| **Total Administration Expenses** | **523,274** | **575,267** | **583,782** | **591,587** | |
| | | | | | |
| Non Operating Expenses | | | | | |
| Depreciation and Amortization | - | - | - | - | |
| Interest | - | - | - | - | |
| Lease Expense (Incl Utilities) | 6,000 | 6,000 | 6,000 | 6,000 | $500/month |
| Total Non Operating Expenses | 6,000 | 6,000 | 6,000 | 6,000 | |
| | | | | | |
| **Total Expenses** | **1,074,534** | **1,619,338** | **1,726,676** | **1,829,835** | |
| | | | | | |
| **Profit (Loss)** | **(48,058)** | **552,429** | **673,989** | **741,681** | |

**Advanced Hospice - Chelan & Douglas**
**4 Year Projected Balance Sheet**

| | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| **Assets** | | | | |
| Current Assets | | | | |
| Cash | $ 74,378 | $ 416,043 | $ 852,812 | $ 1,720,128 |
| Accounts Receivable | $ 153,971 | $ 460,646 | $ 793,994 | $ 809,721 |
| Prepaid | | | | |
| Total Current Assets | $ 228,349 | $ 876,689 | $ 1,646,806 | $ 2,529,849 |
| | | | | |
| **Intangible Assets** | | | | |
| Intangible Assets | | | | |
| Accumulated Amortization | | | | |
| | | | | |
| **Other Assets** | | | | |
| Deposits | | | | |
| **Total Assets** | $ 228,349 | $ 876,689 | $ 1,646,806 | $ 2,529,849 |
| | | | | |
| **Liabilities** | | | | |
| Current Liabilities | | | | |
| Accounts Payable | $ 102,229 | $ 155,553 | $ 207,113 | $ 275,778 |
| Accrued Payroll and Taxes | $ 29,178 | $ 71,765 | $ 116,334 | $ 189,032 |
| Demand Note - Member | | | | |
| Accrued Interest | | | | |
| Total Current Liabilties | $ 131,407 | $ 227,318 | $ 323,447 | $ 464,811 |
| | | | | |
| **Member's Equity** | | | | |
| Contributions | $ 145,000 | $ 145,000 | $ 145,000 | $ 145,000 |
| Member's Equity | $ - | $ (48,058) | $ 504,369 | $ 1,178,358 |
| Net Income | $ (48,058) | $ 552,429 | $ 673,989 | $ 741,681 |
| Member's Equity | $ 96,942 | $ 649,371 | $ 1,323,358 | $ 2,065,039 |
| **Liabilities & Member's Equity** | $ 228,349 | $ 876,689 | $ 1,646,805 | $ 2,529,850 |

**Stride Health Care, LLC**
**3 year Projected Income Statement (with intervening year)**

| **Revenue** | 2023 | **2024** | **2025** | **2026** |
|---|---|---|---|---|
| Gross Revenue | 2,955,813 | 4,136,527 | 4,372,504 | 4,550,191 |
| Contractual Adjustment | - | - | - | - |
| Charity Care | (21,164) | (44,778) | (49,498) | (54,057) |
| Bad Debt | (29,558) | (41,366) | (43,725) | (46,004) |
| **Net Revenue** | **2,905,091** | **4,050,382** | **4,279,280** | **4,450,130** |
| **Operating Expenses** | | | | |
| Salaries & Wages | 1,754,115 | 2,055,163 | 2,114,735 | 2,173,723 |
| Payroll Taxes | 185,936 | 217,847 | 224,162 | 230,415 |
| Employee Benefits | 66,306 | 77,685 | 79,937 | 82,167 |
| Workers Compensation | 21,567 | 25,270 | 26,003 | 26,729 |
| Medical Supplies & Pharmacy | 60,623 | 113,593 | 124,187 | 134,448 |
| Equipment Rent | 26,787 | 52,483 | 57,622 | 62,601 |
| Transportation | 1,775 | 3,760 | 4,157 | 4,542 |
| Telephone/Internet | 33,246 | 37,270 | 38,018 | 39,141 |
| Mileage | 45,052 | 51,979 | 53,364 | 54,707 |
| Professional Services/Software/Payroll Services | 166,091 | 241,589 | 257,662 | 271,423 |
| Dues | 52,228 | 52,228 | 52,228 | 52,228 |
| Legal & Accounting | 14,242 | 14,242 | 14,242 | 14,242 |
| Liability Insurance | 9,981 | 9,981 | 9,981 | 9,981 |
| Marketing/Recruitment | 29,246 | 38,246 | 38,246 | 38,246 |
| Taxes/Licenses | 59,404 | 80,067 | 84,197 | 87,306 |
| Management Fees | 120,000 | 120,000 | 120,000 | 120,000 |
| Interest Expense | 9,866 | 9,866 | 9,866 | 9,866 |
| Repairs & Maintenance | 1,536 | 1,536 | 1,536 | 1,536 |
| Office Supplies | 13,908 | 13,908 | 13,908 | 13,908 |
| **Total Operating Expenses** | **2,671,908** | **3,216,712** | **3,324,050** | **3,427,208** |
| **Non Operating Expenses** | | | | |
| Property Taxes | - | - | - | - |
| Amortization | 3,333 | 3,333 | 3,333 | 3,333 |
| Property Rent | 37,852 | 37,852 | 37,852 | 37,852 |
| Property Insurance | 2,427 | 2,427 | 2,427 | 2,427 |
| **Total Non Operating Expenses** | **43,613** | **43,613** | **43,613** | **43,613** |
| **Profit (Loss)** | **189,569** | **790,057** | **911,618** | **979,310** |

**Stride Health Care LLC**
**4 Year Consolidated Balance Sheet**

| | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| **Assets** | | | | |
| Current Assets | | | | |
| Cash | $ 350,938 | $ 856,681 | $ 1,457,526 | $ 2,488,917 |
| Accounts Receivable | $ 843,316 | $ 1,337,853 | $ 1,859,062 | $ 2,062,651 |
| Prepaid | $ 5,462 | $ 5,462 | $ 5,462 | $ 5,462 |
| Total Current Assets | $ 1,199,716 | $ 2,199,996 | $ 3,322,050 | $ 4,557,030 |
| **Intangible Assets** | | | | |
| Intangible Assets | $ 50,000 | $ 50,000 | $ 50,000 | $ 50,000 |
| Accumulated Amortization | $ (5,000) | $ (5,000) | $ (5,000) | $ (5,000) |
| **Other Assets** | | | | |
| Deposits | $ 2,416 | $ 2,416 | $ 2,416 | $ 2,416 |
| **Total Assets** | $ 1,247,132 | $ 2,247,412 | $ 3,369,466 | $ 4,604,446 |
| **Liabilities** | | | | |
| Current Liabilities | | | | |
| Accounts Payable | $ 216,695 | $ 327,518 | $ 436,576 | $ 562,738 |
| Accrued Payroll and Taxes | $ 144,680 | $ 244,078 | $ 345,458 | $ 474,967 |
| Demand Note - Member | $ 113,307 | $ 113,307 | $ 113,307 | $ 113,307 |
| Accrued Interest | $ 9,165 | $ 9,165 | $ 9,165 | $ 9,165 |
| Total Current Liabilties | $ 483,847 | $ 694,068 | $ 904,506 | $ 1,160,178 |
| **Member's Equity** | | | | |
| Contributions | $ 145,000 | $ 145,000 | $ 145,000 | $ 145,000 |
| Member's Equity | $ 428,716 | $ 618,286 | $ 1,408,343 | $ 2,319,961 |
| Net Income | $ 189,569 | $ 790,057 | $ 911,618 | $ 979,310 |
| Member's Equity | $ 763,285 | $ 1,553,343 | $ 2,464,961 | $ 3,444,271 |
| **Liabilities & Member's Equity** | $ 1,247,132 | $ 2,247,411 | $ 3,369,467 | $ 4,604,448 |

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 13

**Management Agreement**

## MANAGEMENT SERVICES AGREEMENT

THIS MANAGEMENT SERVICES AGREEMENT (this "**Agreement**") is made and entered into as of the date the final party has executed this agreement, but shall only become effective as of the date the Company's certificate of need is approved (the "**Effective Date**"), by and between Stride Health Care, an Arizona limited liability company (the "**Service Provider**"), and Wenatchee Hospice LLC, a Washington limited liability company (the "**Company**"). Service Provider and the Company are sometimes referred to herein individually as a "**Party**" and collectively as the "**Parties**."

## RECITALS

WHEREAS, the Company desires to retain Service Provider to provide certain management and administrative services to the Company, and Service Provider is willing to provide such management and administrative services to the Company, upon the terms and conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the foregoing, the terms and conditions hereinafter set forth, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto hereby agree as follows:

1. **Retention of Service Provider; Services**. The Company hereby retains Service Provider, and Service Provider hereby agrees, to provide to the Company certain management and administrative support services (the "**Services**") which include, without limitation, the following: (i) regulatory support, (ii) human resources (iii) financial forecasting, report generation, and payroll, and insurance consulting, (iii) external contract management, (iv) operational reviews and consultations, (v) quality assurance and performance improvement. The Parties agree that the Service Provider's employees, contractors, and agents shall provide the services (the "**Employees**"), or third-party providers hired by Service Provider.

2. **Relationship of the Parties**. At no time shall the Employees, any independent contractors engaged by Service Provider and/or the employees of any such independent contractors be considered employees of the Company. Service Provider shall be responsible for complying with all federal, state and local labor and tax laws and regulations with respect to Employees. This Agreement is not one of agency between Service Provider and the Company, but one in which Service Provider is engaged to provide management oversight and administration support services as an independent contractor. All employment arrangements are therefore solely Service Provider's concern, and the Company shall not have any liability with respect thereto except as otherwise expressly set forth herein.

3. **Duties of Service Provider**.

**3.1** Service Provider will perform, or cause to be performed, the Services hereunder with not less than the degree of care, skill and diligence with which it performs or would perform similar services for itself consistent with past practices (including, without limitation, with respect to the type, quantity, quality and timeliness of such services). If the Service Provider is required to engage third parties to perform one or more of the Services required hereunder, Service Provider shall use all commercially reasonable efforts to cause such third parties to deliver such Services in a competent and timely fashion.

**3.2** Service Provider shall maintain books, records, documents and other written evidence, consistent with its normal accounting procedures and practices, sufficient to accurately, completely and properly reflect the performance of the Services hereunder and the amounts due in accordance with any provision of this Agreement (collectively, the "**Services Evidence**").

4. **Term**.

**4.1** The term of this Agreement shall commence as of the Effective Date and shall continue in effect for four years (the "**Initial Term**"), and thereafter shall be automatically renewed upon the same terms and conditions set forth herein for subsequent one year terms (each, a "**Renewal Term**") unless Service Provider or the Company gives notice in writing within 90 days before the expiration of the Initial Term or any Renewal Term of its desire to terminate this Agreement; *provided, however,* that either the Company or Service Provider will have the right to terminate this Agreement following a breach of a material term of this Agreement by the other party hereto and a failure to cure such breach within 30 days following written notice thereof. The Initial Term and any Renewal Terms are referred to herein collectively as the "**Term**".

**4.2** Notwithstanding Section 4.1, the Parties agree that this Agreement will terminate upon (i) the liquidation or

dissolution of the Company, (ii) the sale of all or substantially all of the assets of the Company to a third party or (iii) the sale of control the Company, whether by sale of membership interests, merger, reorganization, consolidation or otherwise, to a third party.

**5. Compensation.**

**5.1 Amount.** As consideration for the performance of the Services, the Company shall pay Service Provider Ten Thousand Dollars per month ($10,000) (the "**Fee**").

**5.2 Payment**. Service Provider will deliver a monthly invoice (the "**Invoice**") to the Company as soon as practicable following the end of each month for the Fee payable to Service Provider under Section 5.1 hereof for the month or the period last ended or, in the case of expiration or termination the final Fee. The Company shall pay the Invoice within five days of receipt of such Invoice. Interest at the rate of 12% per annum, compounded monthly, will accrue and will be payable with respect to any amounts due and not paid by the Company until such amounts, and any interest thereon, have been paid.

**5.3 Form of Payment**. Payments pursuant to this Agreement will be paid by check or wire transfer of immediately available federal funds to such account as Service Provider may specify to the Company in writing prior to such payment.

**6. Confidentiality**. Service Provider shall, and shall cause its officers, directors, managers, principals, members, employees (including the Employees), agents and representatives (collectively, "**Representatives**") to, comply with the confidentiality provisions of the Company must observe under Washington patient privacy laws and federal patient privacy laws, including but not limited to HIPPA.

**7. Exculpation and Indemnification.**

**7.1 LLC Agreement.** Service Provider and its Representatives shall be entitled to the same rights with respect to exculpation and indemnification as a "**Covered Person**" would be entitled under the Company's limited liability company Agreement, or as otherwise afforded under Washington statute.

**7.2 Rights of Indemnification; Survival**. The rights of indemnification provided in this Section 7 shall be in addition to any rights to which a party entitled to indemnification under Section 7.1 may otherwise be entitled by contract or as a matter of law, and shall extend to each of such party's heirs, successors and assigns. The provisions of this Section 7 shall survive the termination of this Agreement.

**8. Assignment.** Neither Party may assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other Party.

**9. Choice of Law.** Except as set forth below, this Agreement shall be construed and interpreted, and the rights of the Parties shall be governed by, the internal laws of the State of Washington, without giving effect to conflicts of laws rules and principles that require the application of the laws of any other jurisdiction.

**10. Entire Agreement; Amendments and Waivers.** This Agreement, together with all Schedules hereto, constitute the entire agreement between the Parties pertaining to the subject matter hereof and supersede all prior and contemporaneous agreements, understandings, negotiations and discussions, whether oral or written, of the Parties, and there are no other warranties, representations or other agreements between the parties in connection with the subject matter hereof. No amendment, supplement, modification or waiver of this Agreement shall be binding unless executed in writing by all Parties hereto. No waiver of any of the provisions of this Agreement shall be deemed to constitute a waiver of any other provision hereof (whether or not similar), nor shall such waiver constitute a continuing waiver unless expressly agreed to in writing by the affected Party.

**12. Counterparts.** This Agreement may be executed in one or more counterparts, including by facsimile and portable document format (.pdf) delivery, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument. The Parties agree and acknowledge that delivery of a signature by facsimile or in .pdf form shall constitute execution by such signatory.

**13. Invalidity.** In the event that any one or more of the provisions contained in this Agreement or in any other instrument referred to herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement or any other such instrument, and such invalid, illegal or unenforceable provision shall be interpreted so as to give the maximum effect of such provision allowable by law.

**14. Notices.** Unless otherwise provided herein, any notice, request, consent, instruction or other document to be given hereunder by any Party hereto to another Party hereto shall be in writing and will be deemed given: (a) when received, if delivered personally or by courier; or (b) on the date receipt is acknowledged, if delivered by certified mail, postage prepaid, return receipt requested; or (c) one day after transmission, if sent by facsimile or electronic mail transmission with confirmation of transmission, as follows:

| **To the Company:** | **To the Service Provider:** |
|---|---|
| Wenatchee Hospice LLC<br>285 Technology Center Way, Ste 108<br>Wenatchee, WA 98801 | Stride Health Care LLC<br>4240 S. St. Claire<br>Mesa, AZ 85212 |

**15. Additional Documents.** Each of the Parties hereto agree to execute any document or documents that may be requested from time to time by the other Party to implement or complete such Party's obligations pursuant to this Agreement and to otherwise cooperate fully with such other Party in connection with the performance of such Party's obligations under this Agreement.

**16. Successors and Assigns.** Except as herein otherwise specifically provided, this Agreement shall be binding and inure to the benefit of the Parties and their successors and permitted assigns.

**17. No Third-Party Beneficiaries.** This Agreement is solely for the benefit of the Parties hereto and their successors and assigns permitted under this Agreement, and no provisions of this Agreement shall be deemed to confer upon any other persons any remedy, claim, liability, reimbursement, cause of action or other right except as expressly provided herein.

**18. No Presumption Against Any Party.** Neither this Agreement nor any uncertainty or ambiguity herein shall be construed or resolved against any Party, whether under any rule of construction or otherwise. On the contrary, this Agreement has been reviewed by each of the Parties and their counsel and shall be construed and interpreted according to the ordinary meaning of the words used so as to fairly accomplish the purposes and intentions of all Parties hereto.

**19. Specific Performance.** The Parties acknowledge and agree that any Party would be damaged irreparably in the event any of the provisions of this Agreement are not performed in accordance with their specific terms or otherwise are breached. Accordingly, the Parties agree that any Party shall be entitled to an injunction or injunctions to prevent breaches of the provisions of this Agreement and to enforce specifically this Agreement and the terms and provisions hereof as set forth in Section 20.

| **COMPANY:**<br>**WENATCHEE HOSPICE LLC** | **SERVICE PROVIDER:**<br>**STRIDE HEALTH CARE, LLC** |
|---|---|
| By: Wenatchee Hospice Holdings, LLC<br>Its: Manager | By: Matt Ham<br>Its: Chief Operating Officer |
| 5/6/22<br>Date | 5/6/22<br>Date |

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 14

**Medical Director Agreement**

## PROFESSIONAL SERVICES AGREEMENT MEDICAL DIRECTOR

This Agreement is made this 16th day of December, 2022, (effective as of the date Advanced Hospice Northwest of Wenatchee is licensed as a state certified hospice agency), by and between Advanced Hospice Northwest of Wenatchee ("ORGANIZATION") and Jonathan Kim, a physician ("MEDICAL DIRECTOR").

### 1. PURPOSE

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

### 2. OBLIGATIONS OF MEDICAL DIRECTOR

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

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

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

2.2 Duties and Responsibilities of MEDICAL DIRECTOR.

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

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

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

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

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

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

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

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

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

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

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

2.4 Compliance with Standards. MEDICAL DIRECTOR will perform all services and duties under this Agreement in strict accordance with all laws, rules, regulations, ordinances, and judicial and administrative interpretations thereof, of the United States, the State of Washington, the County of Chelan, the City of Wenatchee, and all political subdivisions, agencies, and instrumentality's of any of them, as well as with the bylaws, rules, regulations, guidelines, policies, and procedures of Advanced Hospice Northwest of Wenatchee, as all of the foregoing may from time to time be in effect. Particularly, and not by way of limitation, MEDICAL DIRECTOR will comply with the Washington State Medical Practice Act or Osteopathic Practice Act and all rules and regulations of the Washington State Board of Medical Examiners or State Board of Osteopathic Physicians and will do everything necessary to maintain in effect his license as a doctor of medicine or osteopathy within the State of Washington.

2.5 Insurance. The MEDICAL DIRECTOR will at all times throughout the term of this Agreement maintain professional liability insurance in an amount no less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

The MEDICAL DIRECTOR will deliver to Advanced Hospice Northwest of Wenatchee at least annually in advance a certificate of insurance evidencing the required coverage, both during the term of this Agreement and thereafter.

Organization shall obtain and maintain in full force and effect, its own general and professional liability insurance in amounts not less than $1,000,000 per occurrence and $3,000,000, in the aggregate, either through a commercial carrier or through an adequate self-insurance program, covering its operations of the Organization. Organization represents and warrants that such insurance is in effect on the date of execution of this Agreement and shall remain in effect during the term of this agreement.

2.6 Time. MEDICAL DIRECTOR will devote such time and attention as is necessary to fulfill his or her duties and responsibilities. MEDICAL DIRECTOR will be available from 8:00 – 4:30, Monday – Friday, for on-call consultation, assistance and decisions regarding patient care. MEDICAL DIRECTOR will be responsible for arranging for coverage when he is unavailable; however, prior approval of any physician providing coverage for MEDICAL DIRECTOR must be obtained from the Administrator/Executive Director of Advanced Hospice Northwest of Wenatchee

2.7 Disclosure of Information. MEDICAL DIRECTOR recognizes and acknowledges that he will have access to certain confidential information of the ORGANIZATION and that such information constitutes valuable, special and unique property of the ORGANIZATION. MEDICAL DIRECTOR will not, during or after the term of this Agreement, without the consent of the ORGANIZATION disclose any such confidential information to any other person, firm, corporation, association, or other entity for any reason or purpose whatsoever except as may be ordered by a court or governmental agency or as may otherwise be required by law. In the event of a breach or a threatened breach by MEDICAL DIRECTOR of the provisions of this paragraph, the ORGANIZATION will be entitled to an injunction restraining MEDICAL DIRECTOR from disclosing in whole or in part any confidential information. Nothing herein will be construed as prohibiting the ORGANIZATION from pursuing any other remedies available to it for such breach or threatened breach, including the recovery of damages from MEDICAL DIRECTOR.

2.8 Financial Obligation. MEDICAL DIRECTOR will incur no financial obligation on behalf of the ORGANIZATION or for which the ORGANIZATION will be responsible without prior approval of the Administrator/Executive Director.

2.9 Billing. The MEDICAL DIRECTOR will not charge patients for services rendered as MEDICAL DIRECTOR of the ORGANIZATION. The professional fees charged to patients will be for professional services rendered to individual patients only. Such fees will be separate from ORGANIZATION fees to the patient for ORGANIZATION services, including services performed by any physician as MEDICAL DIRECTOR.

2.10 Services. MEDICAL DIRECTOR will perform all obligations of MEDICAL DIRECTOR under this Agreement at the ORGANIZATION's principal place of business, Advanced Hospice Northwest of Wenatchee's street address. All communications to ORGANIZATION will be directed to the Administrator/Executive Director at such address and the ORGANIZATION's Administrator/Executive Director will have full authority to communicate to MEDICAL DIRECTOR on behalf of ORGANIZATION.

## 3. OBLIGATIONS OF ORGANIZATION

3.1 Compensation. For all services provided by MEDICAL DIRECTOR pursuant to this Agreement, ORGANIZATION will pay MEDICAL DIRECTOR $200.00 per hour for consultation time payable following the month of service, commencing on the effective date of this agreement. MEDICAL DIRECTOR shall submit an invoice outlining services rendered and the time expended to provide said services.

## 4. INDEPENDENT CONTRACTOR

In the performance of all services pursuant to this Agreement, MEDICAL DIRECTOR is at all times acting as an independent contractor engaged in the profession and practice of medicine or osteopathy. MEDICAL DIRECTOR will employ his own means and methods and exercise his own professional judgment in the performance of such services, and ORGANIZATION will have no right of control or direction with respect to such means, methods, or judgments, or with respect to the details of such services. The only concern of ORGANIZATION under this Agreement or otherwise is that, irrespective of the means selected, such services will be provided in a competent, efficient, and satisfactory manner. It is expressly agreed that MEDICAL DIRECTOR will not for any purpose be deemed to be an employee, agent, partner, joint venture, ostensible or apparent agent, servant, or borrowed servant of ORGANIZATION. MEDICAL DIRECTOR, and all physicians and other individuals providing services pursuant to this Agreement, will not have any claim against ORGANIZATION for vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits, or employee benefits of any kind.

## 5. DURATION AND TERMINATION

5.1 Term. This Agreement will commence on the date the ORGANIZATION is licensed as a state certified hospice agency and will continue in effect for a term of one (1) calendar year from the effective date with automatic one-year renewals unless terminated sooner as hereinafter set forth.

5.2 Termination. Either party at any time may terminate the Agreement, with or without cause, by giving written notice of such termination to the other party at least 60 days prior to the date on which the termination is to be effective, such date to be specified in the notice. Notwithstanding the above, if MEDICAL DIRECTOR fails to comply with any or all of the requirements set forth in Section 2, of this Agreement at any time during this Agreement, ORGANIZATION will be entitled to terminate this Agreement effective immediately.

5.3 Modification or Renewal. The payment provisions of this Agreement may not be altered or modified during any 12-month term. Moreover, following termination without cause, the parties will not enter into the same or a similar contract with each other unless the new contract does not have the effect of altering or modifying the previous Agreement's payment provisions within a 12-month period. The intent of this provision is to prohibit the parties from terminating this Agreement without cause and then entering into a new contract in order to alter or modify the payment provisions within a period of less than one (1) year.

## 6. MISCELLANEOUS

6.1 Governing Law. This Agreement will be subject to and governed by the laws of the State of Washington.

6.2 Remedies. All rights, powers and remedies granted to either party by any particular term of this Agreement are in addition to, and not in limitation of, any rights, powers or remedies which it has under any other term of this Agreement, at common law, in equity, by statute, or otherwise. All such rights, powers and remedies may be exercised separately or concurrently, in such order and as often as may be deemed expedient by either party. No delay or omission by either party to exercise any right, power or remedy will impair such right, power or remedy or be construed to be a waiver of or an acquiescence to any breach or default. A waiver by either party of any breach or default hereunder will not constitute a waiver of any subsequent breach or default.

6.3 Amendment. No amendment or variation of the terms of this Agreement will be valid unless in writing and signed by both parties in the manner provided in Section 6.11 of this Agreement.

6.4 Assignment. Neither this Agreement nor any rights, powers or duties hereunder may be assigned by either party without the express written consent of the other party, and any such unauthorized assignment will be void. If any such unauthorized assignment is attempted by either party, the other party will have the power, at its election, to terminate this Agreement effective immediately. Further, MEDICAL DIRECTOR may not subcontract or otherwise arrange for another individual or entity to perform his duties under this Agreement, with the exception of the limited coverage provisions set out in Section 2.5, of this Agreement.

6.5 Captions. The captions for each Paragraph of this Agreement are included for convenience of reference only and are not to be considered a part hereof, and will not be deemed to modify, restrict or enlarge any of the terms of provisions of this Agreement.

6.6 Notice. Any notice required or permitted to be given under this Agreement will be sufficient if in writing and hand delivered or sent by certified or registered mail, return receipt requested, addressed as follows:

**Advanced Hospice Northwest of Wenatchee**

**Joel Stephens**
Administrator/Executive Director
285 Technology Center Way, Suite 108
Wenatchee, WA 98801

**Medical Director**

Jonathan Kim,
M.D.
Street Address: 207 Woodring St
City, State Zip: Cashmere, WA 98815

or to any other address as may be given by either party to the other by notice in writing pursuant to the provisions of this Section.

6.7 Severability. In the event that any provision of the Agreement is held to be unenforceable for any reason, the unenforceability of that provision will not affect the remainder of this Agreement, which will remain in full force and effect in accordance with its terms.

6.8 Fraud and Abuse. The parties enter into this Agreement with the intent of conducting their relationship in full compliance with applicable state, local, and federal law including the Medicare/Medicaid Anti fraud and Abuse Amendments. Notwithstanding any unanticipated effect of any of the provisions herein, neither party will intentionally conduct itself under the terms of this Agreement in a manner to constitute a violation of the Medicare and Medicaid fraud and abuse provisions. Further, if legislation is passed, the effect of which would be to hinder ORGANIZATION's ability to obtain reimbursement from Medicare/Medicaid due to the existence of this Agreement, or if this Agreement becomes illegal under any subsequent law or regulation, then this Agreement will terminate immediately.

6.9 Access to Books and Records of Subcontractor. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the MEDICAL DIRECTOR will make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection will be available up to four (4) years after

the rendering of such services. If the MEDICAL DIRECTOR carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a 12-month period with a related individual or ORGANIZATION, the MEDICAL DIRECTOR agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Public Law 96-+99, Sec. 952 (Sec. 1861(v)(1) of the Social Security Act) and the regulations promulgated thereunder. No attorney-client, accountant-client or other legal privilege will be deemed to have been waived by the ORGANIZATION or the MEDICAL DIRECTOR by virtue of this Agreement.

6.10 Policy. *Nothing contained in this Agreement will require MEDICAL DIRECTOR or any physician to admit or refer any patients to Advanced Hospice Northwest of Wenatchee as a precondition to receiving the benefits set forth herein except insofar as the Advanced Hospice Northwest of Wenatchee's bylaws may now or in the future establish minimum requirements for eligibility for active staff privileges.*

6.11 Entire Agreement. This Agreement constitutes the entire Agreement between the parties with respect to the subject matter hereof, and supersedes any and all other agreements, understandings, negotiations, or representations, oral or written, between them.

6.12 Execution in Counterparts. This Agreement and any amendments hereto will be executed in multiple counterparts by MEDICAL DIRECTOR and by the Administrator/Executive Director of Advanced Hospice Northwest of Wenatchee for and on behalf of ORGANIZATION. Each counterpart will be deemed an original but all counterparts together will constitute one and the same instrument.

6.13 Authorization for Agreement. The execution and performance of this Agreement by ORGANIZATION and MEDICAL DIRECTOR have been duly authorized by all necessary laws, resolutions, and corporate action, and this Agreement constitutes the valid and enforceable obligations of MEDICAL DIRECTOR and ORGANIZATION in accordance with its terms.

In WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and year first above written.

MD
Medical Director Signature

Name: Jonathan Kim, MD

Date: 12/21/22

Agency Signature

Name: Joel D. Stephens

Date: 12/23/2022

## Exhibit A

## Medical Director Responsibilities

The hospice Medical Director will have overall responsibility for the medical component of the hospice program.

The hospice Medical Director will provide oversight of physician services by complementing attending physician care, acting as a medical resource to the interdisciplinary group, assuring continuity of hospice medical services, and assuring appropriate measures to control patient symptoms. The Medical director will serve as a hospice champion – promoting and representing the program to physicians, physician groups, discharge planners, other referral sources, community health organizations, and potential donors, as appropriate.

The responsibilities of the Medical Director will include, but not be limited to the following:

1. Devoting his/her best ability to the proper management of the program

2. Providing overall medical direction to the program

3. Assuring that the established policies, bylaws, rules, and regulations of the organization are followed in the program

4. Adhering to requirements, terms, and conditions required by Medicare Conditions of Participation, accrediting body, and federal and state statutes governing the provision of services

5. Establishing and continually reviewing policies and procedures related to patient care, medical education, and emergency procedures

6. Developing and continually reviewing, in cooperation with the CEO/Executive Director/Administrator and/or Chief Clinical Officer/Clinical Director, criteria to monitor the quality of the education programs provided to physicians, personnel, and volunteers

7. Evaluating quality assessment performance improvement (QAPI) plans and monitoring to identify medical education needs in cooperation with the CEO/Executive Director/Administrator and/or Chief Clinical Officer/Clinical Director. Participates in QAPI teams and activities, as needed

8. Proposing organizational programs to address the needs identified (with the assistance and input of consultants of the specialties where medical education needs were identified)

9. Working with the CEO/Executive Director/Administrator and/or CCO/Clinical Director, after implementation of the programs, to determine the impact of said programs on the quality of care

10. Serving as a hospice champion in the community

11. Acting as a liaison to community physicians by providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care

12. Acting as medical liaison with other physicians at Advanced Hospice Northwest of Wenatchee

13. Providing training regarding the medical aspects of caring for terminally ill patients to physicians, personnel, and volunteers

14. Reviewing patients' medical eligibility for hospice services, in accordance with hospice program policies and procedures, and establishing the plan of care in conjunctions with attending physician and interdisciplinary group prior to providing care written certification of terminal illness

15. Providing written certification of the terminal illness for all subsequent benefit periods

16. Perform face-to-face encounters within thirty (30) days of the third and subsequent hospice benefit certification periods and attest to the encounter. (NP may complete the encounter and report findings to the hospice physician.)

17. Consulting with attending physicians regarding pain and symptoms management for hospice patients

18. Managing oversight of the patient's medications and treatments

19. Acting as medical resource to the hospice interdisciplinary group

20. Attending interdisciplinary group meetings and working in a team approach with the group

21. In conjunction with the attending physician and interdisciplinary group, reviewing and updating the plan of care at least every 15 days, or more frequently as needed.

22. Documenting care provided in the patient's clinical record, providing evidence of progression of the end-stage disease process

23. Acting as primary physician for patients whose referring/attending physicians desire to relinquish that care and/or if the referring/attending physicians are not available for further contact

24. Maintaining current knowledge of the latest research and trends in hospice care and pain/symptom management

25. Reviewing and developing protocols for treatment, and proposing the most current options for interventions

26. Develop and implement procedures and protocols in regard to OSHA standards, including the handling of hazardous medications.

27. Demonstrating knowledge in communications, and counseling patients and family/caregivers dealing with end-of-life issues

28. Participating in resolution of interpersonal conflict and issues of clinical and ethical concern

29. Ensuring that competent physician services are routinely available on a 24-hour basis to meet the general medical needs of the hospice patient to the extent the needs are not met by the attending physician

30. Assisting with evaluation of protocols and procedures with respect to quality and cost outcome

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 15

**Lease Agreement**

# SUBLEASE AGREEMENT

This SUBLEASE AGREEMENT (hereinafter referred to as this "Agreement"), dated November 1, 2022 (the "Effective Date"), by and between Wenatchee Home Health, LLC dba Advanced Home Health Northwest of Wenatchee whose address is 285 Technology Center Way Ste 107, Wenatchee, Washington 98801 (hereinafter referred to as the "Sublessor") and Wenatchee Hospice LLC dba Advanced Hospice Northwest Of Wenatchee (hereinafter referred to as the "Sublessee"). A copy of the original lease (the "Lease") is attached to this Agreement and is incorporated herein. The Sublessee agrees to comply with all the terms and conditions of the Lease.

**1. PREMISES**

***WHEREAS,*** the Landlord is the owner or manager of the real property located at the Confluence Technology Center (the "CTC"). Address of 285 Technology Center Way, Wenatchee WA 98801 (hereinafter referred to as the "Premises"); and

***WHEREAS,*** the Sublessor has the consent of the Landlord and wishes to sublease Office 108 of the above-mentioned Premises to the Sublessee upon the terms and conditions contained in this Agreement; and

***WHEREAS,*** the Sublessee wishes to sublease Office 108 of the above- mentioned Premises from Sublessor upon the terms and conditions contained herein;

***NOW, THEREFORE,*** in consideration of all of the mutual promises and covenants set forth herein, the Sublessor, Sublessor and Sublessee agree as follows:

**2. TERM**

2.1 The term of this Agreement shall commence on the "effective date" and shall continue for a period of one year ("Initial Term") with the option of 3 additional 1-year terms.

**3. MONTHLY LEASE AMOUNT**

3.1 The Sublessee shall pay to the Sublessor a monthly rental amount of $500.00 on the First day of each month for the duration of the lease term. Upon the signing of this Agreement, the Sublessee shall pay to the Sublessor the first month's rent.

3.2 All future monthly payments shall be hand delivered or mailed to the Sublessor at the address set forth in the preamble or to such other person or place as the Sublessor may designate in writing.

3.3 The monthly rental amount shall be negotiated by the parties prior to the beginning of any renewal term but will remain unchanged for the first 4 years from effective date.

**4. USE OF LEASED PREMISES**

4.1 The Leased Premises shall be used by Sublessee for general office purposes, and for no other purpose unless agreed to in advance by Sublessor. Further, the Sublessee agrees that:

4.2 Sublessee shall not allow the use of the Leased Premises in a manner which would increase Sublessor's insurance premiums unless Sublessee agrees to reimburse Sublessor for such increase, or for any illegal purpose.

4.3 Sublessee shall comply with all laws and shall observe all applicable rules and regulations related to the use of the Leased Premises, including (a) the Building Operating Policies and Procedures for the Confluence Technology Center, and any amendments thereto; a copy of which has been received and reviewed by Sublessee and which Building Operating Policies and Procedures is incorporated herein by this reference, (b) present and future rules and regulations of the Sublessor regarding the use of Leased space in the CTC, and (c) the present and future rules and regulations of the Confluence Technology Center including security access limitations and security badging requirements required by the CTC, acting by and through the CTC Manager. Landlord shall not be responsible to Sublessee for the non-performance by any other Tenant or occupant of the Confluence Technology Center of the Building Operating Policies and Procedures or any rules and regulations adopted by the CTC. Sublessee understands and agrees that Landlord may amend the Building Operating Policies and Procedures, and that such amendments shall be binding upon Sublessee.

**5. ALTERATIONS AND IMPROVEMENTS.**

5.1 Sublessee shall make no changes, improvements, or alterations, to the Leased Premises without the Sublessor's prior written consent, which Sublessor is not required to give.

**6. REPAIR AND MAINTENANCE.**

6.1 Unless otherwise agreed, Sublessee shall, at its own expense, maintain the Leased Premises in the condition that existed at the commencement of this Lease. Such maintenance (including repairs and replacements necessary to maintain the Leased Premises as set forth herein) shall be made promptly as and when necessary. All repairs and replacements shall be approved in advance by Sublessor and must be of quality and class at least equal to the original work as reasonably determined by Sublessor.

6.2 In the event Sublessee fails to maintain the Leased Premises as required above, the Sublessor may, but shall not be required to, conduct such work and make such repairs and replacements for the Sublessee's account, and the expense thereof shall constitute and be collectible as additional rent.

6.3 Sublessor shall not be obligated to repair or replace any fixtures or equipment installed by Sublessee and Sublessor shall not be obligated to make any repair or replacement occasioned by any act or omission of Sublessee, its employees, agents, invitees or licensees.

**7. RIGHT OF ENTRY.**

7 . 1 Landlord may enter the Leased Premises at all times for emergencies, and at reasonable times during or after business hours, for the purpose of inspecting, cleaning, repairing, altering, improving or exhibiting the Leased Premises, but nothing in this Lease shall be construed as imposing any obligation on the Landlord to perform any repair or improvement to the Leased Premises.

**8. DAMAGE OR DESTRUCTION.**

8.1 All damage or injury done to the Leased Premises of the Leased Premises by Sublessee or by any persons who may be in or upon the Leased Premises or in or upon the Leased Premises at the invitation of Sublessee shall be paid for by Sublessee.

8.2 If the Property is destroyed or damaged by fire or any other casualty (except as set forth in Section 11.1) to the extent the cost of repairing the damage to the Property or Leased Premises exceeds $10,000, either Sublessor or Tenant may terminate this Lease by notice in writing to the other within thirty (30) days after the destruction or damage, unless Sublessor agrees in writing within 30 days after the destruction to pay the cost of repair, in which case the Lease shall not terminate. In the meantime, the monthly rent shall be abated in the same proportion as the untenantable portion of the Leased Premises bears to the whole of the Leased Premises.

8.3 Notwithstanding the foregoing, Sublessor shall have no obligation to repair, reconstruct, or restore the Leased Premises.

8.4 Sublessor's liability shall be limited to its contractual obligation in this Lease.

**9. INDEMNITY.**

9.1 The Sublessee shall indemnify the Sublessor from and against any and all claims, demands, cause of actions, suits or judgments (including fees, costs and expenses [including attorney fees] incurred in connection therewith and in enforcing the indemnity) for deaths or injuries to persons or for loss of or damage to property arising out of or in connection with the condition, use or occupancy of the Leased Premises or any improvements thereon; or by Sublessee's non-observance or non- performance of any law, ordinance or regulation applicable to the Leased Premises; or incurred in obtaining possession of the Leased Premises after a default by the Sublessee, or after the Sublessee 's default in surrendering possession upon expiration or earlier termination of the term of the Lease, or enforcing any of the Sublessee 's covenants in this Lease. This includes, without limitation, any liability or injury to the person or property of Sublessee, its agents, officers, employees, or invitees. **The Sublessee specifically waives any immunity provided by Washington's Industrial Insurance Act. This indemnification covers claims by Sublessee's own employees.**

9.2 In the event of any such claims made or suits filed, Sublessor shall give Sublessee prompt written notice thereof and Sublessee shall have the right to defend or settle the same to the extent of its interests thereunder.

9.3 Sublessee, as a material part of the consideration to be rendered to Sublessor, waives all claims against Sublessor for damages to goods, wares, merchandise and loss of business in, upon or about the Leased Premises and for injury to Sublessee, its agents, employees, invitees or their persons in or about the Leased Premises from any cause arising at any time; except for Sublessor's negligence or wrongful conduct.

**10. INSURANCE.**

10.1 Sublessee shall be solely responsible for insuring its own personal property.

10.2 From and after the effective date of the term of this Lease, Sublessee shall

provide general commercial liability insurance at its sole cost and expense, against claim for bodily injury and property damage under a policy of general liability insurance, with limits of

$500,000.00 single limit or its equivalent for bodily injury, and $500,000.00 for property damage for matters occurring at the Leased Premises or the CTC as a result of Sublessee's occupancy or use. Such policy shall name Landlord and Sublessee as insureds. Before taking possession of the Leased Premises, the Sublessee shall furnish the Sublessor with a certificate evidencing the aforesaid insurance coverage.

10.3 The aforementioned minimum limits of policies shall in no event limit the liability of Tenant hereunder. No policy of Sublessee 's insurance shall be cancelable or subject to reduction of coverage or other modification except after thirty (30) days prior written notice to Sublessor by the insurer. Sublessee shall, at least thirty (30) days prior to the expiration of the policies, furnish Sublessor with renewals or binders.

10.4 The insurance shall be issued by carriers acceptable to the Sublessor, and Sublessor's approval shall not be unreasonably withheld.

10.5 Sublessee agrees that if Sublessee does not take out and maintain such insurance, Sublessor may (but shall not be required to) procure such insurance on Sublessee 's behalf and charge Sublessee the premiums together with a twenty-five percent (25%) handling charge, payable upon demand.

**11. RELEASE.**

11.1 In addition to, and not by way of limitation of, the Sublessee 's obligation to indemnify Sublessor, Sublessee waives its right of recovery against the Sublessor for any loss insured by fire, extended coverage, and other property insurance policies existing for the benefit of the Leased Premises. The Sublessee shall obtain any special endorsements, if required, by its insurer to evidence compliance with the waiver.

11.2 Each insurance policy obtained by the Sublessee shall provide that the insurance company waives all rights of recovery by way of subrogation against the Sublessor in connection with any damage covered by the policy. The Sublessor shall not be liable to the Sublessee for any damage caused by fire or any other risk insured against under any property insurance policy carried under the terms of this Lease.

**12. ASSIGNMENT AND SUBLETTING.**

12.1 The Sublessee may not assign, transfer, mortgage, pledge, hypothecate or encumber this Lease or any interest therein, and may not sublet the Leased Premises or any part thereof.

12.2 An assignment or sublet includes the following: (1) any action which causes a change in control of the Sublessee corporation at any time during the Term; (2) if all or substantially all of the assets of Sublessee shall be sold, assigned or transferred with or without a specific assignment of the Lease; or (3) if Sublessee shall merge or consolidate with any firm or corporation.

12.3 Sublessor, at its option, may, by giving fifteen (15) days' prior written notice to Sublessee after discovery of the action, declare such change to be an assignment or subletting in violation of this Lease, subject to the remedies provided for in event of breach of this Lease.

**1 3 . QUIET ENJOYMENT.**

1 3 . 1 Sublessor covenants that Sublessee, upon performance of all Sublessee 's obligations under this Lease, shall lawfully and quietly hold, occupy and enjoy the Leased Premises during the term of this

Lease without disturbance by the Sublessor or from any person claiming through the Sublessor, except as expressly set forth in this Lease.

**14. SIGNS**.

14.1 All signs must comply with sign ordinances, be placed in accordance with the required permits and the Condominium Declaration, and require the advance written approval of the CTC Manager, which approval the CTC Manager is not required to give.

14.2 The Sublessor may demand the removal of any signs which do not receive its prior written approval. Sublessee 's failure to comply with Sublessor's demand to remove within forty- eight (48) hours of such demand shall constitute a breach of this paragraph and shall entitle Sublessor to cause the sign to be removed and the building repaired at the Sublessee 's sole expense.

14.3 At the termination of this Lease, Sublessee shall remove all signs placed by it upon the Leased Premises, and shall repair any damage caused by such removal.

**15. VACATING UPON TERMINATION.**

15.1 Sublessee covenants and agrees that upon the expiration of the Lease or renewal term, or upon the termination of the Lease for any cause, Sublessee shall at once peacefully surrender and deliver the whole of the above-described Leased Premises together with all improvements thereon to the Sublessor, or Sublessor's agents or assigns unless Sublessee shall have expressly acquired the right to remain through another written extension of this Lease. Sublessee shall make all reasonable and necessary repairs to return the Lease Premises to the same or better condition as at the initial time of occupancy.

**16. PRESENCE AND USE OF HAZARDOUS SUBSTANCES.**

1 6 . 1 Sublessee shall not, without Sublessor 's prior written consent, keep on or around the Leased Premises, for use, disposal, treatment, generation, storage or sale, any substances designated as, or containing designated as hazardous, dangerous, toxic or harmful (collectively referred to as "Hazardous Substances"), and/or which are subject to regulation by any federal, state or local law, regulation, statute or ordinance.

16.2 With respect to any Hazardous Substance, Sublessee shall:

16.3 Comply promptly, timely, and completely with all governmental requirements for reporting, keeping and submitting manifests, and obtaining and keeping current identification numbers;

16.4 Submit to Sublessor true and correct copies of all reports, manifests and identification numbers at the same time as they are required to be submitted to the appropriate governmental authorities;

16.5 Within five (5) days of Sublessor 's request, submit written reports to Sublessor regarding Sublessee's use, storage, treatment, transportation, generation, disposal or sale of Hazardous Substances and provide evidence satisfactory to Sublessor of Sublessee 's compliance with the applicable governmental regulation;

16.6 Allow Landlord or Landlord's agents or representatives to come on the Leased Premises at all times, after reasonable notice, to check Sublessee 's compliance with all applicable governmental regulations regarding Hazardous Substances;

16.7 Comply with minimum levels, standards or other performance standards or requirements which may be set forth or established for certain Hazardous Substances (if minimum standards or levels are applicable to Hazardous Substances present on the Leased Premises, these levels or standards shall be established by an on-site inspection by the appropriate governmental authorities and shall be set forth in an addendum to this Lease);

16.8 Comply with all governmental rules, regulations and requirements regarding the proper and lawful use, sale, transportation, generation, treatment and disposal of Hazardous Substances; and

16.9 Landlord shall have the right, at reasonable times and upon reasonable notice to Sublessee, to inspect the Leased Premises to monitor Sublessee 's compliance with this section. Landlord shall pay and be responsible for the costs of its own inspection. Notwithstanding the foregoing, if an inspection reveals the use or presence of Hazardous Substances requiring clean-up or other action, then Sublessee shall pay, as part of the clean-up cost incorporated in Paragraph 16.10 below, Landlord's actual costs, including reasonable attorney's fees and costs, incurred in making or providing for such inspection and any follow-up inspections.

16.10 Sublessee shall be fully and completely liable to Landlord for any and all clean-up costs and any and all charges, fees, penalties (civil and criminal) imposed by any governmental authority with respect to Sublessee 's use, disposal, transportation, generation and/or sale of Hazardous Substances, in or about the Leased Premises.

16.11 Sublessee shall indemnify, defend and hold Sublessor and Landlord harmless from any and all costs, fees, penalties and charges assessed against or imposed upon Landlord including Landlord's reasonable attorneys' fees and costs as a result of Sublessee 's use, disposal, transportation, generation and/or sale of Hazardous Substances.

16.11 Upon Sublessee's default under this article, in addition to the rights and remedies set forth elsewhere in this Lease, Sublessor shall be entitled to the following rights and remedies.

16.12 At Sublessor's option, to terminate this Lease immediately; and

16.13 To recover any and all damage associated with the default, including, but not limited to clean-up costs and charges, civil and criminal penalties and fees, loss of business and sales by Sublessor and any and all damages and claims asserted by third parties together with reasonable attorneys' fees and costs.

**17. LICENSES AND PERMITS.**

17.1 Sublessee, at its sole expense, shall obtain all licenses or permits which may be required for conducting its business within the terms of this Lease.

**18. DEFAULT AND RE-ENTRY.**

18.1 If Sublessee defaults in any rent payment due under the terms of this Lease, and

such default is not cured within three (3) calendar days after written notice from Sublessor or if the default is other than the payment of rent and the default is not cured within fifteen (15) calendar days after written notice from Sublessor, Sublessor may terminate this Lease and re-enter the Leased Premises.

18.2 Each of the following events is a default by Sublessor and a breach of this Lease:

18.2.1 Any failure by Sublessee to make any payment required to be made by Sublessor on or before the time the payment is due.

18.2.2 The abandonment or vacation of the Leased Premises by the Sublessee.

18.2.3 A failure by Sublessee to observe and perform any provision of this Lease or any other lease or agreement between Sublessee or any subsidiaries of Sublessee and Sublessor which is to be observed or performed by the Sublessee or any subsidiary of Sublessee.

18.2.4 The appointment of a receiver to take possession of all or substantially all the assets of the Sublessee.

18.2.5 A general assignment by Sublessee for the benefit of creditors.

18.2.6 Any action taken or suffered by Sublessee under any insolvency or bankruptcy act. If Sublessee becomes insolvent, bankrupt, or if a receiver, assignee, or other liquidating officer is appointed for the Sublessee 's business, Sublessor may cancel this Lease, subject to Section 365 of Bankruptcy Code, 11 U.S.C. 365.

18.2.7 A default under this Lease may, at Sublessor's discretion, be declared to be a default under any other lease or agreement between Sublessee and Sublessor, or between any subsidiary of Sublessee and Sublessor.

**19. NON-WAIVER OF COVENANTS.**

1 9 . 1 The Sublessor's failure to insist upon the strict performance of any provision of this Lease shall not be construed as depriving the Sublessor of the right to insist on strict performance of such provision in the future. The subsequent acceptance of rent, whether full or partial payment, by the Sublessor shall not be deemed a waiver of any preceding breach by the Sublessee of any term, covenant, or condition of this Lease, other than the failure of the Sublessee to pay the particular part of the rent accepted, regardless of the Sublessor 's knowledge of the preceding breach at the time of the acceptance of that part of the rent.

**20 AS-IS. NO WARRANTY**.

26.1 TENANT ACKNOWLEDGES IT IS FAMILIAR WITH THE LEASED PREMISES AND THE CTC, HAS INVESTIGATED SAME, AND HAS BEEN PROVIDED WITH ADDITIONAL OPPORTUNITIES TO INVESTIGATE THE LEASED PREMISES AND THE CTC PRIOR TO SIGNING THIS LEASE. SUBLESSEE ACKNOWLEDGES AND AGREES THAT IT IS RELYING SOLELY ON ITS INSPECTION AND INVESTIGATION OF

THE LEASED PREMISES AND THE CTC, AND ACCEPTS THE LEASED PREMISES "AS IS, WHERE IS" IN ITS PRESENT CONDITION WITH NO WARRANTIES OF ANY KIND, EXPRESS OR IMPLIED, EITHER ORAL OR WRITTEN, MADE BY SUBLESSOR OR ANY EMPLOYEE, AGENT OR REPRESENTATIVE OF SUBLESSOR WITH RESPECT TO THE PHYSICAL CONDITION OF THE LEASED PREMISES. SUBLESSEE SHALL HAVE DETERMINED TO ITS SATISFACTION PRIOR TO SIGNING THIS LEASE, THAT THE LEASED PREMISES CAN BE USED FOR THE PURPOSES SUBLESSEE INTENDS. SUBLESSEE ACKNOWLEDGES AND AGREES THAT NEITHER SUBLESSOR NOR SUBLESSOR'S AGENTS OR EMPLOYEES HAVE MADE, AND DO NOT MAKE, ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, WITH RESPECT TO THE SUITABILITY FOR COMMERCIAL OR BUSINESS PURPOSES, MERCHANTABILITY, POTENTIAL USE OF THE LEASED PREMISES, OR FITNESS FOR A PARTICULAR PURPOSE OF THE LEASED PREMISES, ALL OF WHICH WARRANTIES SUBLESSOR HEREBY EXPRESSLY DISCLAIMS.

**21. COST AND ATTORNEYS' FEES.**

2 1 . 1 In the event it is necessary for either party to utilize the services of an attorney to enforce any of the terms of this agreement, such enforcing party shall be entitled to compensation for its reasonable attorneys' fees and costs. In the event of litigation regarding any of the terms of this agreement, the substantially prevailing party shall be entitled, in addition to other relief, to such reasonable attorneys' fees and costs as determined by the court.

**22. CAPTIONS AND CONSTRUCTION.**

2 2 . 1 The titles to sections of the Lease are not a part of this Lease and shall have no effect upon the construction and interpretation of any part of the Lease.

**23. TIME.**

23.1 TIME IS OF THE ESSENCE IN THIS LEASE.

**24. BINDING ON HEIRS, SUCCESSORS AND ASSIGNS.**

2 4 . 1 All the covenants, agreement terms and conditions contained in this Lease shall apply to and be binding upon Sublessor and Sublessee and their respective heirs, executors, administrators, successors and assigns, except as may be provided to the contrary in other sections of this Lease.

**25. SAVINGS CLAUSE.** Nothing in this Lease shall be construed so as to require the commission of any act contrary to law, and wherever there is any conflict between any provisions of this Lease and any statute, law, public regulation or ordinance, the latter shall prevail, but in such event, the provisions of this Lease affected shall be curtailed and limited only to the extent necessary to bring it within legal requirements.

**26. INCORPORATION.** This agreement represents the entire agreement of the parties. Unless set forth herein in writing, neither party shall be bound by any statements or representations made, and each agrees that there are no such statements or representations being relied upon in making this Lease. No alterations, changes, or amendments to this Lease will be binding upon either party unless

such party has executed a written statement acknowledging such alteration, change or amendment.

**27. GOVERNING LAW.** This Lease shall be governed by the laws of the State of Washington and venue for any action arising from this Lease shall be in Chelan County, Washington.

**28. REMEDIES CUMULATIVE.** The specified remedies to which the Sublessor and Sublessee may resort under the terms of this Lease are cumulative and are not intended to be exclusive of any other remedies or means of redress to which the Sublessor and Sublessee may be lawfully entitled in case of any breach or threatened breach by Sublessee or Sublessor, as the case may be, of any provision of this Lease. In addition to the other remedies provided in this Lease, Sublessor and Sublessee shall be entitled to the restraint by injunction of the violation, or attempted or threatened violation, of any of the covenants, conditions, or provisions of this Lease. The Sublessor 's or Sublessee 's selection of one or more remedies shall not constitute an election of remedies to the exclusion of any other remedies.

**29. STATUS OF TENANT.** If applicable, each individual executing this Lease on behalf of Sublessee, if Sublessee is a corporation or limited liability company, represents and warrants that he/she is duly authorized to execute and deliver this Lease on behalf of said corporation or limited liability company in accordance with a duly adopted resolution of the Board of Directors or the Members, as the case may be, and that this Lease is binding upon said corporation or the limited liability company in accordance with its terms.

**IN WITNESS WHEREOF**, the parties hereby execute this Agreement:

(Sublessor Signature) 10/28/2022 (Dated)

Wenatchee Home Health, LLC dba Advanced Home Health Northwest of Wenatchee

(Sublessee Signature) 10/28/22 (Dated)

Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee

**ADDENDUM NO. 1 TO SUBLEASE AGREEMENT 2022**
**("Addendum No. 1")**

This addendum No. 1 is entered into this date by and between Wenatchee Home Health, LLC dba Advanced Home Health Northwest of Wenatchee, hereafter referred to as sublessor and Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee, hereafter referred to as sublessee sometimes collectively referred to as the "Parties" or individually a "Party".

**RECITALS**

A. The parties entered into a Sublease Agreement commencing November 1, 2022 (the "sublease"), whereby sublessee subleased suite 108 of 285 Technology center way from sublessor.
B. The current sublease is set for one term of one year with the option of 3 additional renewal terms of one year each and as such is due to expire October 31, 2026. The parties desire to add the option of a 10-month renewal, which will extend the sublease through August 31, 2027 to align with the expiration of the original lease between Chelan Douglas Regional Port authority, (Landlord) and Wenatchee Home Health, LLC (Tenant) and thereby align renewal periods for Wenatchee Home Health, LLC and Wenatchee Hospice, LLC with this original Lease Agreement.

Now therefore, in light of the foregoing Recitals, which are incorporated herein by this reference, and the mutual terms and conditions set forth herein, the parties agree as follows:

**AGREEMENT**

1. **RATIFICATION OF SUBLEASE**. Except as modified herein, the Sublease is hereby ratified by the Parties and shall remain in full force and effect.

IN WITNESS WHEREOF, the undersigned set their hands and state that they are authorized to execute this Addendum No. 1.

SUBLESSOR

Wenatchee Home Health, LLC

By: _____
Joel Stephens

Date: 12/16/2022

TENANT

Wenatchee Hospice, LLC

By: _____
Matthew Ham

Date: 12/16/2022

**ADDENDUM NO. 1 TO LEASE AGREEMENT 2020**
**("Addendum No. 1")**

This Addendum No. 1 is entered into this date by and between the CHELAN DOUGLAS REGIONAL PORT AUTHORITY, a Washington municipal corporation, hereafter referred to as "Landlord," and ADVANCED HOME HEALTH, a Washington Corporation, hereafter referred to as "Tenant," sometimes collectively referred to as the "Parties" or individually a "Party."

**RECITALS**

A. The Parties entered into a Lease Agreement commencing September 1, 2020 (the "Lease"), whereby Tenant leased from Landlord a portion of the building commonly known as the Confluence Technology Center (the "CTC") consisting of five (5) offices in the northeast side of Unit 102 of the CTC (the "Leased Premises"), all as more fully described and depicted in the Lease.

B. The current Advanced Home Health lease is due to expire August 31, 2022, with the option of two additional one-year terms.
The Parties desire to add three (3) additional one-year option to renew at the end of the current renewal terms.

C. The Tenant, Advanced Home Health, will designate one of their 5 offices for Wenatchee Hospice, LLC. Advanced Home Health will continue to be the responsible party for the timely payments of rent per Section 3.1 of the Lease.

Now therefore, in light of the foregoing Recitals, which are incorporated herein by this reference, and the mutual terms and conditions set forth herein, the Parties agree as follows:

**AGREEMENT**

1. **RATIFICATION OF LEASE.** Except as modified herein, the Lease is hereby ratified by the Parties and shall remain in full force and effect.

IN WITNESS WHEREOF, the undersigned set their hands and state that they are authorized to execute this Addendum No. 1.

| LANDLORD | TENANT |
|---|---|
| Chelan Douglas Regional Port Authority | Advanced Home Health |
| By: _____ | By: _____ |
| JAMES KUNTZ, CEO | JOEL STEVENS, Administrator |
| Date: 12-14-2021 | Date: 12/14/2021 |

**LEASE AGREEMENT**
**2020**

THIS LEASE AGREEMENT ("Lease") is entered into this date, between CHELAN DOUGLAS REGIONAL PORT AUTHORITY, a Washington municipal corporation ("Landlord"), and Advanced Home Health - Wenatchee, an Washington Corporation ("Tenant"), sometimes collectively referred to as the "Parties" or individually as a "Party."

1. **PREMISES.**

1.1 Landlord hereby leases to Tenant, and Tenant leases from Landlord, upon the terms and conditions included in this Lease, located in the building commonly known as the Confluence Technology Center (the "CTC"). The portion of the CTC being leased by the Tenant are 5 offices, unfurnished, located in Unit 102 of the CTC (the "Leased Premises") indicated on attached **Exhibit "A"** which is incorporated herein by this reference.

1.2 The Tenant shall share a common access corridor to the Leased Premises, as depicted in **Exhibit "A"** with other tenants and owners of the CTC. Tenant shall have use of the common restrooms located on the first floor of the CTC.

1.3 Landlord shall have the right to relocate the Tenant to a comparable space within the CTC upon thirty (30) days advance written notice to the Tenant.

2. **TERM OF LEASE.** This Lease shall be on a Two Year Lease commencing on the 1st day of September, 2020, with an option to renew.

2.1 Tenant shall have the option to renew this Lease for two (2) additional one-year terms (each a "Renewal Term"), considering the Tenant has been in full compliance of the Lease terms. Each Renewal Term will commence immediately upon expiration of the preceding Lease term, unless Landlord is notified in writing no less than thirty (30) days prior to the expiration of the then-current Lease term. A Renewal Term shall be on the same terms and conditions applicable to the original Lease term, except for Base Rent which shall be adjusted as follows:

3. **RENT.**

3.1 During the initial term of the lease, Tenant shall pay Landlord monthly rent ("Base Rent") in the amount of Two thousand four hundred fifteen and 84/100 Dollars ($2,415.84) per month payable in lawful money of the United States. Rent shall be paid in advance on the first day of each month of the Lease term and any renewal thereof.

3.2 Effective September 1, 2021 and on an annual basis thereafter, for the remainder of the Term, the Base Rent shall be adjusted in accordance with the Consumer Price Index to the amount determined as hereafter set out.

3.2.1 The Base Rent shall be adjusted to an amount equal to the product obtained by multiplying the Base Rent set forth in Section 3.1 by a fraction, the denominator of which is the data for August 2020 from the "Consumer Price Indexes Pacific Cities and U.S. City Average" for "All Items Indexes" for "All Urban Consumers (1982-84 = 100, unless otherwise noted)", published by the Bureau of Labor Statistics of the United States Department of Labor, as

adjusted for the "West-B/C" area ("CPI_U), and the numerator of which is the CPI-U for August 2021: provided however, that in the event the period designated above shall not be listed in the Index, the closest period, or month if reporting data is monthly, preceding December will be used; and provided that rent shall not decrease as a result of a calculation set forth in this paragraph.

3.2.2 The monthly rent commencing September 1, 2021, shall be calculated as follows:

| | | | | |
|---|---|---|---|---|
| **CPI-U for August 2021 for West-B/C** | | | | |
| _____ | **X** | **$2415.84** | = | **Monthly rent beginning September 1, 2021** |
| **CPI-U for August 2020 for West-B/C** | | | | |

3.2.3 If the US Department of Labor, Bureau of Labor Statistics, shall discontinue publication of the Consumer Price Index, then other index generally recognized as authoritative shall be substituted by agreement, and if the Parties should not agree, such substituted index shall be selected by the then presiding Judge of Chelan County Superior Court upon the application of either party.

3.3 In addition to Base Rent, Tenant shall pay to the Landlord such sums as may be required by law for payment of leasehold or other tenant tax as required by the State of Washington or other tax entity, as such laws now exists or as they hereafter be amended (such leasehold tax currently being 12.84%) . If leasehold tax is increased or decreased, the total amount payable for rent plus leasehold tax shall increase or decrease, but the amount of Base Rent shall not be changed as a result of any change in the leasehold tax rate.

3.4 In the event the lease term commences or terminates on a date that is not the first or last day of the month, respectively, Tenant shall pay a pro-rated monthly installment, in advance, on the first day of the lease term or the first day of the last month of the lease term, respectively, at the then current rate, based on the number of days of actual occupancy during the first or last calendar month of the lease term.

3.5 Tenant shall pay, before the same become delinquent, all taxes assessed against Tenant's personal property, furniture, equipment, inventory and other property on the Leased Premises.

3.6 Prior to taking possession of the Leased Premises, Tenant shall deposit with Landlord a security deposit in an amount equal to one (1) months' rent ($2,415.84) to be held by Landlord as security for the full and faithful performance by Tenant of each and every term, covenant and condition of the Lease. If Tenant breaches any of the lease terms, including the

obligation to pay Rent, Landlord may, at Landlord's option, make demand upon such security and apply the proceeds thereof to the breach.

3.7 In the event any rental amount called for herein, including the leasehold tax, is not paid within ten (10) days from the date it is due Tenant shall pay to Landlord a late charge of five percent (5%) of the rental amount per month for each unpaid Lease payment until such payment is paid. The late charge is due immediately and is in addition to all of Landlord's other rights in this Lease. In the event Landlord gives written notice of Tenant's default, delinquency or other Lease violations, Tenant agrees to pay Landlord's actual costs and attorneys' fees reasonably incurred in providing such notice, in addition to the late charge and all other payments and obligations called for herein.

4. **POSSESSION.**

4.1 Possession of the Leased Premises pursuant to this Lease shall commence on September 1, 2020.

5. **ACCEPTANCE OF FACILITIES.**

5.1 Tenant hereby accepts the Leased Premises and the CTC in their present condition.

5.2 No representation, statement or warranty, expressed or implied, is or shall be made by or on behalf of the Landlord as to the Leased Premises' condition, or as to the use that may be made of the CTC or Leased Premises unless specifically set forth in writing. Tenant releases Landlord from any responsibility for any representation that may have been made to the Tenant about the Leased Premises or the CTC that is not specifically set out in this Lease Agreement.

6. **USE OF LEASED PREMISES.** The Leased Premises shall be used by Tenant for general office purposes, and for no other purpose unless agreed to in advance by Landlord. Further, the Tenant agrees that:

6.1 Tenant shall not allow the use of the Leased Premises in a manner which would increase Landlord's insurance premiums unless Tenant agrees to reimburse Landlord for such increase, or for any illegal purpose.

6.2 Tenant shall comply with all laws and shall observe all applicable rules and regulations related to the use of the Leased Premises, including (a) the Building Operating Policies and Procedures for the Confluence Technology Center, and any amendments thereto; a copy of which has been received and reviewed by Tenant and which Building Operating Policies and Procedures is incorporated herein by this reference, (b) present and future rules and regulations of the Landlord regarding the use of Leased space in the CTC, and (c) the present and future rules and regulations of the Confluence Technology Center including security access limitations and security badging requirements required by the CTC, acting by and through the CTC Manager. Landlord shall not be responsible to Tenant for the non-performance by any other Tenant or occupant of the Confluence Technology Center of the Building Operating Policies and Procedures or any rules and regulations adopted by the CTC. Tenant understands

and agrees that Landlord may amend the Building Operating Policies and Procedures, and that such amendments shall be binding upon Tenant.

7. **SERVICES AND UTILITIES**.

7.1 In addition to Rent, the Tenant shall make all arrangements for and pay all phone, internet, fiber and other telecommunications costs and expenses, of any kind or nature.

7.2 As part of the Rent, Landlord shall provide the following basic utilities and services to the Leased Premises: electricity, water, sewer, janitorial service, and garbage collection.

7.3 Landlord does not warrant that any utilities and services mentioned above will be free from interruption. The Landlord shall not be liable to Tenant for any loss or damage caused by or resulting from any variation, interruption, or failure of heat or any utility or service due to any cause, other than Landlord's negligent or willful acts. No temporary interruption or failure of services due to the making of repairs, alterations, or improvements, or due to accident, strike or conditions or events beyond Landlord's control shall be deemed an eviction of Tenant or relieve Tenant from any of Tenant's obligations under this Lease.

8. **ALTERATIONS AND IMPROVEMENTS.** Tenant shall make no changes, improvements or alterations, to the Leased Premises without the Landlord's prior written consent, which Landlord is not required to give.

9. **REPAIR AND MAINTENANCE.**

9.1 Unless otherwise agreed, Tenant shall, at its own expense, maintain the Leased Premises in the condition that existed at the commencement of this Lease. Such maintenance (including repairs and replacements necessary to maintain the Leased Premises as set forth herein) shall be made promptly as and when necessary. All repairs and replacements shall be approved in advance by Landlord and must be of quality and class at least equal to the original work as reasonably determined by Landlord. Notwithstanding the foregoing, the Landlord shall be responsible for maintaining, repairing, and replacing the roof, heating, air conditioning, fire protection system and plumbing systems; provided said maintenance, repair, or replacement is not caused by the negligence or other wrongful conduct of the Tenant.

9.2 In the event Tenant fails to maintain the Leased Premises as required above, the Landlord may, but shall not be required to, conduct such work and make such repairs and replacements for the Tenant's account, and the expense thereof shall constitute and be collectible as additional rent.

9.3 Landlord shall not be obligated to repair or replace any fixtures or equipment installed by Tenant and Landlord shall not be obligated to make any repair or replacement occasioned by any act or omission of Tenant, its employees, agents, invitees or licensees.

10. **RIGHT OF ENTRY.** Landlord may enter the Leased Premises, including the Leased Premises, at all times for emergencies, and at reasonable times during or after business hours, for the purpose of inspecting, cleaning, repairing, altering, improving or exhibiting the Leased

Premises, but nothing in this Lease shall be construed as imposing any obligation on the Landlord to perform any repair or improvement to the Leased Premises.

11. **DAMAGE OR DESTRUCTION.**

11.1 All damage or injury done to the Leased Premises of the Leased Premises by Tenant or by any persons who may be in or upon the Leased Premises or in or upon the Leased Premises at the invitation of Tenant shall be paid for by Tenant.

11.2 If the Property is destroyed or damaged by fire or any other casualty (except as set forth in Section 11.1) to the extent the cost of repairing the damage to the Property or Leased Premises exceeds $10,000, either Landlord or Tenant may terminate this Lease by notice in writing to the other within thirty (30) days after the destruction or damage, unless Landlord agrees in writing within 30 days after the destruction to pay the cost of repair, in which case the Lease shall not terminate. In the meantime, the monthly rent shall be abated in the same proportion as the untenantable portion of the Leased Premises bears to the whole of the Leased Premises.

11.3 Notwithstanding the foregoing, Landlord shall have no obligation to repair, reconstruct, or restore the Leased Premises.

11.4 Landlord's liability shall be limited to its contractual obligation in this Lease.

12. **INDEMNITY.**

12.1 The Tenant shall indemnify the Landlord from and against any and all claims, demands, cause of actions, suits or judgments (including fees, costs and expenses [including attorney fees] incurred in connection therewith and in enforcing the indemnity) for deaths or injuries to persons or for loss of or damage to property arising out of or in connection with the condition, use or occupancy of the Leased Premises or any improvements thereon; or by Tenant's non-observance or non-performance of any law, ordinance or regulation applicable to the Leased Premises; or incurred in obtaining possession of the Leased Premises after a default by the Tenant, or after the Tenant's default in surrendering possession upon expiration or earlier termination of the term of the Lease, or enforcing any of the Tenant's covenants in this Lease. This includes, without limitation, any liability or injury to the person or property of Tenant, its agents, officers, employees, or invitees. **The tenant specifically waives any immunity provided by Washington's Industrial Insurance Act. This indemnification covers claims by Tenant's own employees.**

12.2 In the event of any such claims made or suits filed, Landlord shall give Tenant prompt written notice thereof and Tenant shall have the right to defend or settle the same to the extent of its interests thereunder.

12.3 Tenant, as a material part of the consideration to be rendered to Landlord, waives all claims against Landlord for damages to goods, wares, merchandise and loss of business in, upon or about the Leased Premises and for injury to Tenant, its agents, employees, invitees or their persons in or about the Leased Premises from any cause arising at any time; except for Landlord's negligence or wrongful conduct.

13. **INSURANCE.**

13.1 Tenant shall be solely responsible for insuring its own personal property.

13.2 From and after the commencement date of the term of this Lease, Tenant shall provide general commercial liability insurance at its sole cost and expense, against claim for bodily injury and property damage under a policy of general liability insurance, with limits of $500,000.00 single limit or its equivalent for bodily injury, and $500,000.00 for property damage for matters occurring at the Leased Premises or the CTC as a result of Tenant's occupancy or use. Such policy shall name Landlord and Tenant as insureds. Before taking possession of the Leased Premises, the Tenant shall furnish the Landlord with a certificate evidencing the aforesaid insurance coverage.

13.3 The aforementioned minimum limits of policies shall in no event limit the liability of Tenant hereunder. No policy of Tenant's insurance shall be cancelable or subject to reduction of coverage or other modification except after thirty (30) days prior written notice to Landlord by the insurer. Tenant shall, at least thirty (30) days prior to the expiration of the policies, furnish Landlord with renewals or binders.

13.4 The insurance shall be issued by carriers acceptable to the Landlord, and Landlord's approval shall not be unreasonably withheld.

13.5 Tenant agrees that if Tenant does not take out and maintain such insurance, Landlord may (but shall not be required to) procure such insurance on Tenant's behalf and charge Tenant the premiums together with a twenty-five percent (25%) handling charge, payable upon demand.

14. **RELEASE.**

14.1 In addition to, and not by way of limitation of, the Tenant's obligation to indemnify Landlord, Tenant waives its right of recovery against the Landlord for any loss insured by fire, extended coverage, and other property insurance policies existing for the benefit of the Leased Premises. The Tenant shall obtain any special endorsements, if required, by its insurer to evidence compliance with the waiver.

14.2 Each insurance policy obtained by the Tenant shall provide that the insurance company waives all rights of recovery by way of subrogation against the Landlord in connection with any damage covered by the policy. The Landlord shall not be liable to the Tenant for any damage caused by fire or any other risk insured against under any property insurance policy carried under the terms of this Lease.

15. **ASSIGNMENT AND SUBLETTING.**

15.1 The Tenant may not assign, transfer, mortgage, pledge, hypothecate or encumber this Lease or any interest therein, and may not sublet the Leased Premises or any part thereof without Landlord's prior written consent which Landlord is not required to give. Any attempt to assign or sublet without such consent shall be null and void and shall constitute a breach of this

Lease. If the Landlord does give written consent to an assignment or sublet, Tenant shall still be liable for full performance of all the Tenant's obligations in this Lease.

15.2 An assignment or sublet includes the following: (1) any action which causes a change in control of the Tenant corporation at any time during the Term; (2) if all or substantially all of the assets of Tenant shall be sold, assigned or transferred with or without a specific assignment of the Lease; or (3) if Tenant shall merge or consolidate with any firm or corporation.

15.3 Landlord, at its option, may, by giving fifteen (15) days' prior written notice to Tenant after discovery of the action, declare such change to be an assignment or subletting in violation of this Lease, subject to the remedies provided for in event of breach of this Lease.

16. **QUIET ENJOYMENT.** Landlord covenants that Tenant, upon performance of all Tenant's obligations under this Lease, shall lawfully and quietly hold, occupy and enjoy the Leased Premises during the term of this Lease without disturbance by the Landlord or from any person claiming through the Landlord, except as expressly set forth in this Lease.

17. **SIGNS.**

17.1 All signs must comply with sign ordinances, be placed in accordance with the required permits and the Condominium Declaration, and require the advance written approval of the CTC Manager, which approval the CTC Manager is not required to give.

17.2 The Landlord may demand the removal of any signs which do not receive its prior written approval. Tenant's failure to comply with Landlord's demand to remove within forty-eight (48) hours of such demand shall constitute a breach of this paragraph and shall entitle Landlord to cause the sign to be removed and the building repaired at the Tenant's sole expense.

17.3 At the termination of this Lease, Tenant shall remove all signs placed by it upon the Leased Premises, and shall repair any damage caused by such removal.

18. **VACATING UPON TERMINATION.** Tenant covenants and agrees that upon the expiration of the Lease or renewal term, or upon the termination of the Lease for any cause, Tenant shall at once peacefully surrender and deliver the whole of the above-described Leased Premises together with all improvements thereon to the Landlord, or Landlord's agents or assigns unless Tenant shall have expressly acquired the right to remain through another written extension of this Lease. Tenant shall make all reasonable and necessary repairs to return the Lease Premises to the same or better condition as at the initial time of occupancy.

19. **PRESENCE AND USE OF HAZARDOUS SUBSTANCES.** Tenant shall not, without Landlord's prior written consent, keep on or around the Leased Premises, for use, disposal, treatment, generation, storage or sale, any substances designated as, or containing designated as hazardous, dangerous, toxic or harmful (collectively referred to as "Hazardous Substances"), and/or which are subject to regulation by any federal, state or local law, regulation, statute or ordinance.

19.1 With respect to any Hazardous Substance, Tenant shall:

19.1.1 Comply promptly, timely, and completely with all governmental requirements for reporting, keeping and submitting manifests, and obtaining and keeping current identification numbers;

19.1.2 Submit to Landlord true and correct copies of all reports, manifests and identification numbers at the same time as they are required to be submitted to the appropriate governmental authorities;

19.1.3 Within five (5) days of Landlord's request, submit written reports to Landlord regarding Tenant's use, storage, treatment, transportation, generation, disposal or sale of Hazardous Substances and provide evidence satisfactory to Landlord of Tenant's compliance with the applicable governmental regulation;

19.1.4 Allow Landlord or Landlord's agents or representatives to come on the Leased Premises at all times, after reasonable notice, to check Tenant's compliance with all applicable governmental regulations regarding Hazardous Substances;

19.1.5 Comply with minimum levels, standards or other performance standards or requirements which may be set forth or established for certain Hazardous Substances (if minimum standards or levels are applicable to Hazardous Substances present on the Leased Premises, these levels or standards shall be established by an on-site inspection by the appropriate governmental authorities and shall be set forth in an addendum to this Lease);

19.1.6 Comply with all governmental rules, regulations and requirements regarding the proper and lawful use, sale, transportation, generation, treatment and disposal of Hazardous Substances; and

19.1.7 Landlord shall have the right, at reasonable times and upon reasonable notice to Tenant, to inspect the Leased Premises to monitor Tenant's compliance with this section. Landlord shall pay and be responsible for the costs of its own inspection. Notwithstanding the foregoing, if an inspection reveals the use or presence of Hazardous Substances requiring clean-up or other action, then Tenant shall pay, as part of the clean-up cost incorporated in Paragraph 19.1.8 below, Landlord's actual costs, including reasonable attorney's fees and costs, incurred in making or providing for such inspection and any follow-up inspections.

19.1.8 Tenant shall be fully and completely liable to Landlord for any and all clean-up costs and any and all charges, fees, penalties (civil and criminal) imposed by any governmental authority with respect to Tenant's use, disposal, transportation, generation and/or sale of Hazardous Substances, in or about the Leased Premises.

19.1.9 Tenant shall indemnify, defend and hold Landlord harmless from any and all costs, fees, penalties and charges assessed against or imposed upon Landlord including Landlord's reasonable attorneys' fees and costs as a result of Tenant's use, disposal, transportation, generation and/or sale of Hazardous Substances.

19.1.10 Upon Tenant's default under this article, in addition to the rights and remedies set forth elsewhere in this Lease, Landlord shall be entitled to the following rights and remedies.

19.1.10.1 At Landlord's option, to terminate this Lease immediately; and

19.1.10.2 To recover any and all damage associated with the default, including, but not limited to clean-up costs and charges, civil and criminal penalties and fees, loss of business and sales by Landlord and any and all damages and claims asserted by third parties together with reasonable attorneys' fees and costs.

20. **LICENSES AND PERMITS.** Tenant, at its sole expense, shall obtain all licenses or permits which may be required for conducting its business within the terms of this Lease.

21. **DEFAULT AND RE-ENTRY.**

21.1 If Tenant defaults in any rent payment due under the terms of this Lease, and such default is not cured within three (3) calendar days after written notice from Landlord or if the default is other than the payment of rent and the default is not cured within fifteen (15) calendar days after written notice from Landlord, Landlord may terminate this Lease and re-enter the Leased Premises; or Landlord may, without terminating this Lease, re-enter said Leased Premises, and relet the whole or any part upon as favorable terms and conditions as the market will allow for the balance of the lease term.

21.2 Notwithstanding any re-entry, the liability of the Tenant for the full amounts payable by the Tenant under this Lease shall not be extinguished for the balance of the Lease or renewal term. Tenant shall make good to Landlord any deficiency arising from a reletting of the Leased Premises at a lesser rental or on different economic terms plus the reasonable costs and expenses of re-letting the Leased Premises including, but not limited, to commissions, advertising, attorneys' fees, and the costs of renovating or altering the Leased Premises.

21.3 Each of the following events is a default by Tenant and a breach of this Lease:

21.3.1 Any failure by Tenant to make any payment required to be made by Tenant on or before the time the payment is due.

21.3.2 The abandonment or vacation of the Leased Premises by the Tenant.

21.3.3 A failure by Tenant to observe and perform any provision of this Lease or any other lease or agreement between Tenant or any subsidiaries of Tenant and Landlord which is to be observed or performed by the Tenant or any subsidiary of Tenant.

21.3.4 The appointment of a receiver to take possession of all or substantially all the assets of the Tenant.

21.3.5 A general assignment by Tenant for the benefit of creditors.

21.3.6 Any action taken or suffered by Tenant under any insolvency or bankruptcy act. If Tenant becomes insolvent, bankrupt, or if a receiver, assignee, or other liquidating officer is appointed for the Tenant's business, Landlord may cancel this Lease, subject to Section 365 of Bankruptcy Code, 11 U.S.C. 365.

21.3.7 A default under this Lease may, at Landlord's discretion, be declared to be a default under any other lease or agreement between Tenant and Landlord, or between any subsidiary of Tenant and Landlord.

22. **LANDLORD'S EXPENSES ON TENANT'S DEFAULT.** Except as otherwise provided, if either party to this Lease fails (the "Defaulting Party") to make any payment or perform any obligations under this Lease, the non-defaulting party, with reasonable notice to or demand upon the Defaulting Party and without waiving or releasing the Defaulting Party from any obligations under this Lease, may make any payment or perform any other obligation of the Defaulting Party, in such manner and to such extent as the non-defaulting party deems desirable. All costs and expenses paid by the non-defaulting party in connection with the performance of any such obligations, together with interest at the rate of 12% per annum, compounded annually, from the date of making such expenditure by the non-defaulting party, shall be payable to the non-defaulting party upon demand.

23. **REMOVAL OF PROPERTY.**

23.1 If the Landlord, after Tenant's default, lawfully re-enters the Leased Premises, Landlord shall have the right, but not the obligation, to remove all property located therein and to place such property in storage at the Tenant's expense and risk. If the Tenant does not pay the storage cost, after it has been stored for a period of thirty (30) calendar days or more and after giving Tenant ten (10) days' written notice of sale, Landlord may, at its sole discretion, sell, or permit to be sold, any or all of the property at public or private sale.

23.2 Landlord, at its sole discretion, may retain any trade fixtures and other items of Tenant's property, which are not removed by the Tenant at the expiration of the lease term or any renewal period or at such earlier time as Tenant's rights under this Lease may be terminated for default. At Landlord's option, title to the fixtures and other property shall be vested in the Landlord without any duty to account or pay to Tenant for the value of the property or for any other matter in connection for the Landlord's acquisition of the fixtures and attached property.

24. **HOLDOVER.**

24.1 If Tenant, with the implied or expressed consent of the Landlord, shall holdover after the expiration of the term of this Lease, Tenant, shall remain bound by all this Lease's covenants and agreements, except that the tenancy shall be from month to month, and the monthly rent shall be the rent amount due the last month of the immediately preceding term plus twenty-five percent (25%).

24.2 If Tenant should holdover beyond the expiration of this lease term, or the renewal thereof, without consent of the Landlord, Tenant shall pay as liquidated damages a sum equal to treble the rent amount due the last month of the immediately preceding term. This paragraph

shall not affect any of the Landlord's rights to terminate this Lease and declare a forfeiture or to otherwise take possession of the Leased Premises.

25. **NON-WAIVER OF COVENANTS.** The Landlord's failure to insist upon the strict performance of any provision of this Lease shall not be construed as depriving the Landlord of the right to insist on strict performance of such provision in the future. The subsequent acceptance of rent, whether full or partial payment, by the Landlord shall not be deemed a waiver of any preceding breach by the Tenant of any term, covenant, or condition of this Lease, other than the failure of the Tenant to pay the particular part of the rent accepted, regardless of the Landlord's knowledge of the preceding breach at the time of the acceptance of that part of the rent.

26. AS-IS. NO WARRANTY. TENANT ACKNOWLEDGES IT IS FAMILIAR WITH THE LEASED PREMISES AND THE CTC, HAS INVESTIGATED SAME, AND HAS BEEN PROVIDED WITH ADDITIONAL OPPORTUNITIES TO INVESTIGATE THE LEASED PREMISES AND THE CTC PRIOR TO SIGNING THIS LEASE. TENANT ACKNOWLEDGES AND AGREES THAT IT IS RELYING SOLELY ON ITS INSPECTION AND INVESTIGATION OF THE LEASED PREMISES AND THE CTC, AND ACCEPTS THE LEASED PREMISES "AS IS, WHERE IS" IN ITS PRESENT CONDITION WITH NO WARRANTIES OF ANY KIND, EXPRESS OR IMPLIED, EITHER ORAL OR WRITTEN, MADE BY LANDLORD OR ANY EMPLOYEE, AGENT OR REPRESENTATIVE OF LANDLORD WITH RESPECT TO THE PHYSICAL CONDITION OF THE LEASED PREMISES. TENANT SHALL HAVE DETERMINED TO ITS SATISFACTION PRIOR TO SIGNING THIS LEASE, THAT THE LEASED PREMISES CAN BE USED FOR THE PURPOSES TENANT INTENDS. TENANT ACKNOWLEDGES AND AGREES THAT NEITHER LANDLORD NOR LANDLORD'S AGENTS OR EMPLOYEES HAVE MADE, AND DO NOT MAKE, ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, WITH RESPECT TO THE SUITABILITY FOR COMMERCIAL OR BUSINESS PURPOSES, MERCHANTABILITY, POTENTIAL USE OF THE LEASED PREMISES, OR FITNESS FOR A PARTICULAR PURPOSE OF THE LEASED PREMISES, ALL OF WHICH WARRANTIES LANDLORD HEREBY EXPRESSLY DISCLAIMS.

27. **COST AND ATTORNEYS' FEES.** In the event it is necessary for either party to utilize the services of an attorney to enforce any of the terms of this agreement, such enforcing party shall be entitled to compensation for its reasonable attorneys' fees and costs. In the event of litigation regarding any of the terms of this agreement, the substantially prevailing party shall be entitled, in addition to other relief, to such reasonable attorneys' fees and costs as determined by the court.

28. **CAPTIONS AND CONSTRUCTION.** The titles to sections of the Lease are not a part of this Lease and shall have no effect upon the construction and interpretation of any part of the Lease.

29. **TIME.** TIME IS OF THE ESSENCE IN THIS LEASE.

30. **BINDING ON HEIRS, SUCCESSORS AND ASSIGNS.** All the covenants, agreement terms and conditions contained in this Lease shall apply to and be binding upon Landlord and

Tenant and their respective heirs, executors, administrators, successors and assigns, except as may be provided to the contrary in other sections of this Lease.

31. **SAVINGS CLAUSE.** Nothing in this Lease shall be construed so as to require the commission of any act contrary to law, and wherever there is any conflict between any provisions of this Lease and any statute, law, public regulation or ordinance, the latter shall prevail, but in such event, the provisions of this Lease affected shall be curtailed and limited only to the extent necessary to bring it within legal requirements.

32. **INCORPORATION.** This agreement represents the entire agreement of the parties. Unless set forth herein in writing, neither party shall be bound by any statements or representations made, and each agrees that there are no such statements or representations being relied upon in making this Lease. No alterations, changes, or amendments to this Lease will be binding upon either party unless such party has executed a written statement acknowledging such alteration, change or amendment.

33. **GOVERNING LAW.** This Lease shall be governed by the laws of the State of Washington and venue for any action arising from this Lease shall be in Chelan County, Washington.

34. **REMEDIES CUMULATIVE.** The specified remedies to which the Landlord and Tenant may resort under the terms of this Lease are cumulative and are not intended to be exclusive of any other remedies or means of redress to which the Landlord and Tenant may be lawfully entitled in case of any breach or threatened breach by Tenant or Landlord, as the case may be, of any provision of this Lease. In addition to the other remedies provided in this Lease, Landlord and Tenant shall be entitled to the restraint by injunction of the violation, or attempted or threatened violation, of any of the covenants, conditions, or provisions of this Lease. The Landlord's or Tenant's selection of one or more remedies shall not constitute an election of remedies to the exclusion of any other remedies.

35. **STATUS OF TENANT.** If applicable, each individual executing this Lease on behalf of Tenant, if Tenant is a corporation or limited liability company, represents and warrants that he/she is duly authorized to execute and deliver this Lease on behalf of said corporation or limited liability company in accordance with a duly adopted resolution of the Board of Directors or the Members, as the case may be, and that this Lease is binding upon said corporation or the limited liability company in accordance with its terms.

36. **NOTICES.**

36.1 Any notices shall be effective if personally served upon the other party or if mailed by registered or certified mail, return receipt requested, to the following addresses:

Landlord: Chelan Douglas Regional Port Authority
1 Campbell Parkway, Suite A
East Wenatchee, Washington 98802

Tenant: Advanced Home Health
285 Technology Center Way, Suite 104

Wenatchee, WA 98801

36.2 Upon possession by Tenant of the Leased Premises, notices shall be sent to new address of Tenant in the Leased Premises.

36.3 Notices mailed shall be deemed given on the date of mailing. Landlord and Tenant shall notify each other of any change of address.

37. **INTERPRETATION.**

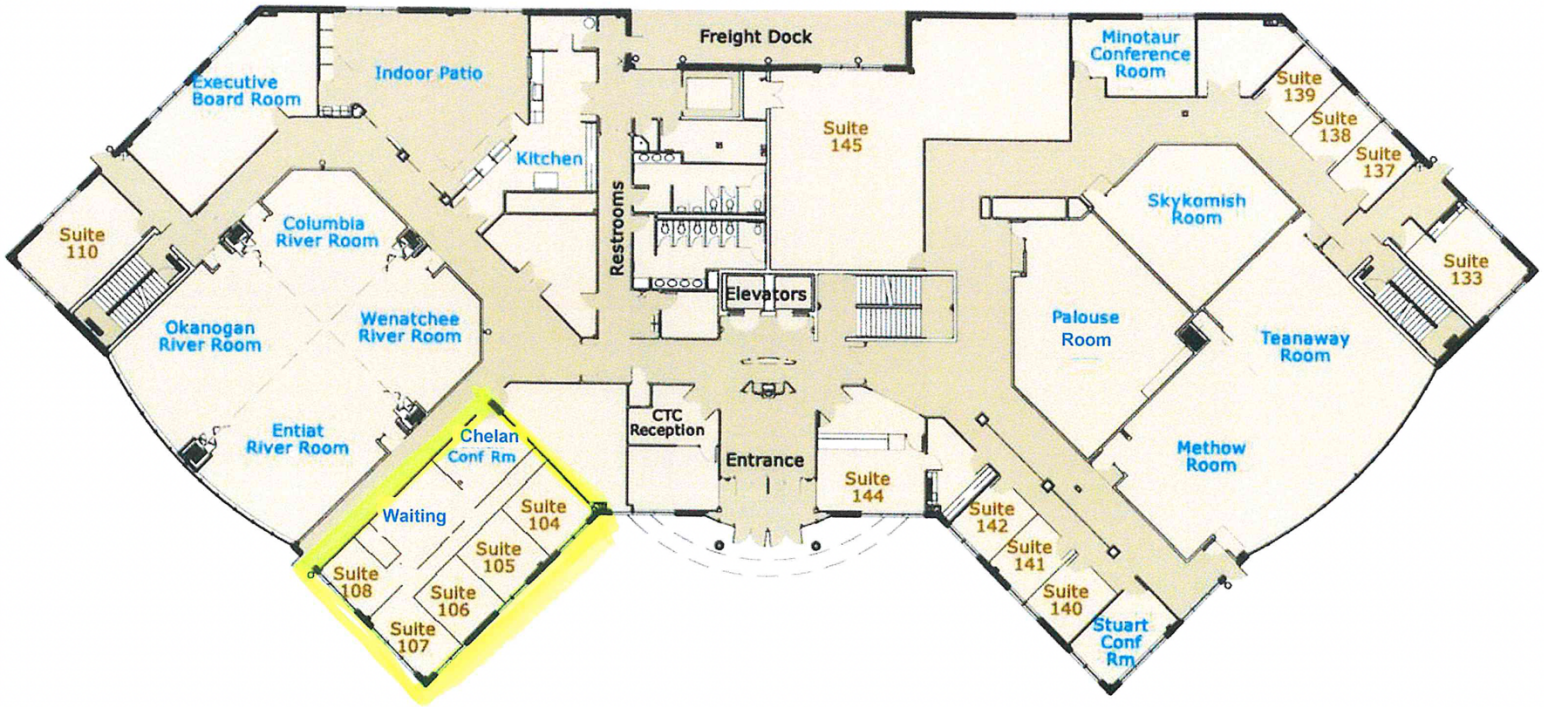
37.1 This Lease has been submitted to the scrutiny of all parties and their counsel, if desired, and it shall be given a fair and reasonable interpretation in accordance with its words, without consideration to or weight given to its being drafted by any party or its counsel.

37.2 All words used in the singular shall include the plural; the present tense shall include the future tense; and the masculine gender shall include the feminine and neuter genders.

IN WITNESS WHEREOF, the parties state that they are authorized to execute this Lease and agree that the effective date of this Lease shall be the date of the last signature set forth below.

| LANDLORD | TENANT |
|---|---|
| CHELAN DOUGLAS REGIONAL PORT AUTHORITY | ADVACED HOME HEALTH WENATCHEE |
| JAMES M. KUNTZ, CEO 9-5-2020 | PAETON BANGART, Executive Director |

Exhibit A




**Confluence Technology Center - First Floor Map**

# APPENDIX 16

## Letter of Financial Commitment

STRIDE

HEALTH CARE, LLC

December 27, 2022

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

Dear Mr. Hernandez,

This letter of financial commitment is submitted to the Washington Certificate of Need Program on behalf of Wenatchee Hospice, LLC dba Advanced Hospice Northwest of Wenatchee.

I am Stride's chief operating officer, and as such, have intimate knowledge regarding Stride's financial affairs. Stride Health Care, LLC ("Stride"), by and through its Members, had agreed to provide the necessary working capital to finance Wenatchee Hospice, LLC's previously approved project for Chelan County. Accordingly, on behalf of Stride and its members, I submit this letter confirming Stride's commitment to provide Wenatchee Hospice, LLC with funding for this proposed project for Douglas County.

Although this project does not require any start up or financing costs as all start up and financing costs will be incurred establishing Wenatchee Hospice, LLC in Chelan County, Stride is committed to ensuring all funds required to complete this Douglas project, should any ever be needed, will be available.

Please do not hesitate to contact me if you have any questions or need additional information.

Sincerely,

Matt Ham
COO
Stride Health Care, LLC

4240 S ST. CLAIRE MESA AZ 85212 480-710-7323

**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 17

**Financial Status Information**

**Stride Health Care, LLC**
**Historical Income Statement**

| **Revenue** | **2020** | **2021** | **2022** |
|---|---|---|---|
| Gross Revenue | 690,186 | 1,777,828 | 2,044,823 |
| Contractual Adjustment | - | - | - |
| Charity Care | - | - | - |
| Bad Debt | - | (22,149) | - |
| **Net Revenue** | **690,186** | **1,755,679** | **2,044,823** |
| **Operating Expenses** | | | |
| Salaries & Wages | 601,598 | 1,197,007 | 1,029,500 |
| Payroll Taxes | 70,705 | 118,567 | 96,383 |
| Employee Benefits | - | 65,846 | 33,717 |
| Workers Compensation | 8,896 | 14,246 | 13,581 |
| Medical Supplies & Pharmacy | 5,355 | 16,394 | 28,763 |
| Equipment Rent | 1,327 | 3,785 | 70 |
| Transportation | - | - | - |
| Telephone/Internet | 10,133 | 23,421 | 26,145 |
| Mileage | 3,423 | 765 | 111 |
| Professional Services/Software/Payroll Services | 17,192 | 73,438 | 182,252 |
| Dues | 4,449 | 37,228 | 83,268 |
| Legal & Accounting | 29,176 | 17,911 | 15,035 |
| Liability Insurance | - | 2,181 | 4,342 |
| Marketing/Recruitment | 10,012 | 9,846 | 7,074 |
| Taxes/Licenses | 21,818 | 34,885 | 62,553 |
| Management Fees | - | - | - |
| Interest Expense | 3,423 | 10,976 | 8,806 |
| Repairs & Maintenance | 541 | 336 | - |
| Office Supplies | 4,921 | 8,432 | 12,292 |
| **Total Operating Expenses** | **792,969** | **1,635,264** | **1,603,891** |
| **Non Operating Expenses** | | | |
| Property Taxes | 2,174 | - | - |
| Amortization | 1,944 | 3,333 | 3,056 |
| Property Rent | 13,719 | 31,852 | 32,598 |
| Property Insurance | 4,012 | 2,427 | 3,031 |
| Forgiveness of Debt | - | (405,737) | - |
| **Total Non Operating Expenses** | **21,848** | **(368,124)** | **38,685** |
| **Profit (Loss)** | **(124,631)** | **488,539** | **402,247** |

**Note: 2020 is a partial year, May-Dec and 2022 is a partial year, Jan-Nov**

**Stride Health Care, LLC**
**Balance Sheet Summary**
**As of November 30, 2022**

| | | Total |
|---|---|---|
| **ASSETS** | | |
| **Current Assets** | | |
| **Cash** | | 144,019.14 |
| **Accounts Receivable** | | 523,294.52 |
| **Other Current Assets** | | -22,437.80 |
| **Total Current Assets** | **$** | **644,875.86** |
| **Other Assets** | | 74,800.90 |
| **TOTAL ASSETS** | **$** | **719,676.76** |
| **LIABILITIES AND EQUITY** | | |
| **Liabilities** | | |
| **Current Liabilities** | | |
| **Accounts Payable** | | 67,838.03 |
| **Credit Cards** | | 14,630.90 |
| **Other Current Liabilities** | | 254,039.08 |
| **Total Current Liabilities** | **$** | **336,508.01** |
| **Total Liabilities** | **$** | **336,508.01** |
| **Equity** | | 383,168.75 |
| **TOTAL LIABILITIES AND EQUITY** | **$** | **719,676.76** |

# APPENDIX 18

## Closing the Gap in Hospice Utilization for the Minority Medicare Population Study

Gerontology & Geriatric Medicine
Volume 5: 1–8

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SAGE

# Closing the Gap in Hospice Utilization for the Minority Medicare Population

**M. Courtney Hughes, PhD, MS[1,2] and Erin Vernon, PhD, MA[3]**

**Abstract**

**Background:** Medicare spends about 20% more on the last year of life for Black and Hispanic people than White people. With lower hospice utilization rates, racial/ethnic minorities receive fewer hospice-related benefits such as lesser symptoms, lower costs, and improved quality of life. For-profit hospices have higher dropout rates than nonprofit hospices, yet target racial/ethnic minority communities more through community outreach. This analysis examined the relationship between hospice utilization and for-profit hospice status and conducted an economic analysis of racial/ethnic minority utilization. **Method**: Cross-sectional analysis of 2014 Centers for Medicare & Medicaid Services (CMS), U.S. Census, and Hospice Analytics data. Measures included Medicare racial/ethnic minority hospice utilization, for-profit hospice status, estimated cost savings, and several demographic and socioeconomic variables. **Results**: The prevalence of for-profit hospices was associated with significantly increased hospice utilization among racial/ethnic minorities. With savings of about $2,105 per Medicare hospice enrollee, closing the gap between the White and racial/ethnic minority populations would result in nearly $270 million in annual cost savings. **Discussion**: Significant disparities in hospice use related to hospice for-profit status exist among the racial/ethnic minority Medicare population. CMS and state policymakers should consider lower racial/ethnic minority hospice utilization and foster better community outreach at all hospices to decrease patient costs and improve quality of life.

**Keywords**

hospice, Medicaid/Medicare, health care disparity, race/ethnicity

**Manuscript received:** June 29, 2018; **final revision received:** March 10, 2019; **accepted:** April 4, 2019.

## Introduction

On average, one quarter of individual Medicare expenditures take place during the patient's last year of life (Riley & Lubitz, 2010), with end-of-life Medicare costs for Black people exceeding those for White people by 20% (Byhoff, Harris, Langa, & Iwashyna, 2016). Several studies have examined why such racial disparities in spending exist, pointing some of the causes to geographic, sociodemographic, and morbidity differences (Baicker, Chandra, Skinner, & Wennberg, 2004; Hanchate, Kronman, Young-Xu, Ash, & Emanuel, 2009; Kelley et al., 2011). Through patient interviews, Martin et al. (2011) found racial/ethnic minorities were more likely than White people to expend their financial resources to extend life. Medicare expenditure data showed Black and Hispanic people were significantly more likely than White people to be admitted to the intensive care unit. Black people were also more likely to receive more intensive procedures such as resuscitation and cardiac conversion, mechanical ventilation, and gastrostomy for artificial nutrition (Hanchate et al., 2009).

An alternative to pursuing costly, life-sustaining strategies for terminally ill patients is enrolling in hospice. Hospice care uses a team-oriented medical approach and emphasizes pain management and emotional support for the patient with a life expectancy of 6 months or less. Most hospice care takes place in the patient's home (56% of hospice care) or a nursing facility (42% of hospice care) (National Hospice and Palliative Care Organization, 2018) and provides support to the patient's family. Benefits from such care include lower costs, lesser symptoms, and a higher quality of life (Institute of Medicine, 1997; Kelley, Deb, Du, Aldridge Carlson, & Morrison, 2013; Steinhauser et al., 2000). Two surveys conducted by Gallup 4 years apart both showed 9 out of 10 terminally ill patients with less

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Email: courtneyhughes@niu.edu

than 6 months to live would prefer to be cared for at home (Institute of Medicine, 1997). American Hospice Foundation (n.d., para. 2) cites two common reasons patients choose hospice care: (a) to stay at home and (b) avoid curative treatments that are painful or require hospitalization.

A recent analysis of Medicare's new payment structure that began in January 2016 showed hospice enrollment would still provide the potential for cost savings. Medicare's new payment structure, designed to align payments with service costs and ensure quality care in the last days of life, consists of a two-tiered per diem structure with payments increasing through Days 1 to 60 then decreasing for Days 61 and beyond. The last 7 days of life may have add-on payments retrospectively (Taylor et al., 2018).

Racial/ethnic minority hospice utilization has been found to be lower than that of the White population (Haines et al., 2018; Hardy et al., 2011; Ramey & Chin, 2012) when controlling for other socioeconomic factors such as income, area population, education, and age. Pan, Abraham, Giron, LeMarie, and Pollack (2015) showed Asian and Hispanic people were less familiar than White people with hospice services. In that study, most of the Asian and Hispanic respondents were open to receiving information about hospice in the future and reported they would tell friends and family members about hospice (Pan et al., 2015). One variable that relates to a greater number of racial/ethnic minorities receiving information about hospice is hospice ownership status. For-profit hospices tend to engage in greater community outreach to low-income and racial/ethnic minority communities than nonprofit hospices (Aldridge et al., 2014; Stevenson, Grabowski, Keating, & Huskamp, 2016). Stevenson et al. (2016) found this relationship persisted despite its chain status. With the growth in the proportion of hospices having for-profit ownership from 5% in 1990 to over 60% in 2014, it is important to compare measures such as utilization between hospices with different ownership status.

This study compares hospice utilization by racial/ethnic minorities between for-profit and nonprofit hospices, examining whether there is an association between the proportion of Medicare racial/ethnic minority patients enrolling in hospice per state and the proportion of for-profit hospices in that state. Also included are estimated projected cost savings if racial/ethnic minority Medicare hospice utilization levels were to increase to that of the White Medicare hospice utilization levels.

## Method

### *Data Sources*

The 2014 hospice utilization data were obtained from the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Data Warehouse (CCW; 2018), a database that has 100% of Medicare enrollment and fee-for-service claims data. CCW was launched to aid researchers in analyzing CMS data to help improve quality of care, decrease health care costs, and curb medical utilization for chronically ill Medicare beneficiaries. CCW contains 17 years' worth of data and includes enrollment/eligibility, assessment data, and fee-for-service institutional and noninstitutional claims. The U.S. Census Medicare beneficiary data (U.S. Census Bureau, 2015) are obtained from the March 2015 Current Population Survey Annual Social and Economic Supplement based on 2014 data.

Data for the percentage of individuals identifying as religious in 2014 were obtained from the Pew Research Center (Smith et al., 2015), whereas the measures for the 2014 per capita state income levels and 2010 education levels were accessed from the Bureau of Economic Analysis (2018) and the American Community Survey (U.S. Census Bureau, n.d.), respectively. Data on 2014 hospice by owner type and state-level racial/ethnicity measures were obtained from Hospice Analytics (2018) and the Kaiser Family Foundation (n.d.), respectively. The authors used Taylor et al.'s (2018) estimated cost savings per hospice enrollee based on the updated 2016 Medicare hospice payment structure. Taylor et al.'s study derived its findings from 2009 to 2010 Medicare claims data from North Carolina Medicare beneficiaries ($N$ = 36,035).

### *Measures*

The independent variable of for-profit hospice prevalence was calculated by the total amount of for-profit hospices per 10,000 Medicare beneficiaries for each state. The same calculation was used for nonprofit hospice prevalence for each state. Medicare beneficiaries include Medicare Advantage and fee-for-service beneficiaries. The percentage of individuals identifying as religious, the percentage of adults with at least a high school education, per capita income, and the percentage of racial/ethnic minorities within a state were included as covariates in the statistical model to control for state-level socioeconomic factors. The racial/ethnic minority hospice utilization disparity measure was calculated by dividing the percentage of racial/ethnic minorities using hospice by the percentage of racial/ethnic minorities enrolled in Medicare for each state. States were assigned a "1" if they possessed less of a disparity between racial/ethnic minority hospice Medicare patients and overall racial/ethnic minority Medicare enrollees compared with the median of all states (states with a value above 0.70) and a "0" otherwise.

For the projected cost savings from closing the gap between White and racial/ethnic minority Medicare hospice utilization, the breakdown by ethnicity followed the Kaiser Family Foundation Medicare beneficiary categories of Black, White, Hispanic, and Other. The Other category included Asians, Native Hawaiians and Pacific Islanders, American Indians, Aleutians, Eskimos, and

**Table 1.** Descriptive Statistics of Independent Variables.

| Variable | Definition | *M* (*SD*) |
|---|---|---|
| Prevalence of for-profit hospices | Ratio of for-profit hospices per 10,000 Medicare beneficiaries | 0.59 (0.67) |
| Prevalence of nonprofit hospices | Ratio of nonprofit hospices per 10,000 Medicare beneficiaries | 0.65 (0.63) |
| Per capita income | Average per capita income per state (in thousands) | $45.65 (7.72) |
| Percentage religious | Percentage state population stating they are religious | 0.77 (0.06) |
| Percentage racial/ethnic minority | Percentage of state population identified as non-White | 0.31 (0.16) |
| High school education or higher | Percentage with high school degree or higher | 0.87 (0.03) |

*Note.* Calculations were performed by state.

people of two or more races (Kaiser Family Foundation, 2017). To calculate the Medicare hospice participation rate by ethnicity, Medicare hospice beneficiaries within each racial group (CCW, 2018) were divided by the total number of Medicare beneficiaries within the same year (Kaiser Family Foundation, 2017). Then, the number of additional hospice enrollees necessary to match the higher White hospice utilization rate was calculated. Next, the projected mean cost savings of $2,105 per hospice enrollee (Taylor et al., 2018) was applied to estimate the potential cost savings from closing the racial/ethnic minority hospice utilization gap.

### *Analysis*

Multivariate logistic regression was performed with the dependent variable being a dichotomous measure of whether or not a state had a relatively large racial/ethnic minority hospice usage gap. The independent variables of the study included the prevalence of for-profit and nonprofit hospices within a state as well as state-level socioeconomic measures of religiosity, racial/ethnic diversity, income, and education. All 50 U.S. states and Washington, D.C., were included in the analysis. StataSE version 15 (StataCorp LP, College Station, TX, USA) was utilized for statistical analyses.

## Results

### *State Variable Summary Statistics*

Table 1 displays the descriptive statistics of the study independent variables across the 50 states plus Washington, D.C. States tended to have more nonprofit hospices (0.65 per 10,000 state Medicare beneficiaries) versus for-profit hospices (0.59 per 10,000 state Medicare beneficiaries). In 2014, states on average had per capita incomes of $45,650 with 77% of the population stating they were religious, and 31% of the population representing non-White racial/ethnic categories as defined by the Kaiser Family Foundation (n.d.). In addition, 87% of the population earned a high school education or higher. The hospice utilization disparity was the dependent variable of focus. Nineteen states were assigned a "1" indicating that their minority hospice utilization disparity was below the national median.

**Table 2.** Multivariate Logistic Regression Results ($N = 51$).

| | Coefficient | *SE* | *p*-value |
|---|---|---|---|
| Constant | −0.30 | 13.50 | .98 |
| Prevalence of for-profit hospices* | 1.93 | 0.72 | .01 |
| Prevalence of nonprofit hospices | −0.69 | 0.77 | .37 |
| Per capita income | −0.03 | 0.06 | .65 |
| Percentage religious | −1.20 | 6.22 | .85 |
| Non-White population | 2.78 | 2.63 | .29 |
| Education—high school graduate | 0.27 | 15.55 | .99 |

*Note.* Calculations were performed by state. $\chi^2$ (6, $N = 51$) = 17.76, $p = .007$.
*Significant at the 5% level.

*Statistical Results.* Based on the logistic regression analysis displayed in Table 2, the prevalence of for-profit hospices was positively associated with racial/ethnic minority Medicare beneficiary hospice utilization, $\chi^2$ (6, $N = 51$) = 17.76, $p = .007$. As the prevalence of for-profit hospices per Medicare beneficiary increases within a state, the probability increases that a state would have a lower than average hospice utilization gap between racial/ethnic minorities and the White population. No other coefficients were found to be significant.

The economic analysis found if racial/ethnic minority Medicare hospice utilization were to equal that of the current White Medicare hospice utilization, it would result in an estimated savings of nearly $270 million per year (Table 3).

## Discussion

This study indicates a positive association exists between racial/ethnic minority Medicare hospice utilization and the prevalence of for-profit hospices. An estimated nationally representative annual savings of nearly $270 million in projected annual savings would result from closing the Medicare hospice utilization gap between racial/ethnic minority and White Medicare beneficiaries.

The finding of the positive relationship between the prevalence of for-profit hospices and racial/ethnic minority Medicare utilization is not surprising given previous research showed for-profit hospices engage in greater community outreach to racial/ethnic minorities and low-income communities than nonprofit hospices

**Table 3.** Estimated Cost Savings From Closing Medicare Hospice Utilization Gap.

| | White | Black | Hispanic | Other[a] | Total |
|---|---|---|---|---|---|
| Medicare beneficiaries[b] | 38,505,300 | 5,160,600 | 4,137,400 | 2,742,900 | 50,546,200 |
| Hospice beneficiaries[c] | 1,112,625 | 107,461 | 68,776 | 43,499 | 1,332,361 |
| Hospice beneficiaries/Medicare beneficiaries | 2.89% | 2.08% | 1.66% | 1.59% | 2.64% |
| Racial/ethnic minority enrollment that closes disparity | | 41,656 | 50,776 | 35,758 | |
| Estimated cost savings from closing disparity[d] | | $87,686,851 | $106,882,881 | $75,270,839 | $269,840,571 |

[a]Other includes Asians, Native Hawaiians and Pacific Islanders, American Indians, Aleutians, Eskimos, and people of two or more races.
[b]*Source*. Kaiser Family Foundation (2017).
[c]*Source*. Chronic Conditions Data Warehouse (CCW; 2018).
[d]*Source*. Utilizes Taylor et al.'s (2018) cost savings estimate of $2,105 per beneficiary.

(Aldridge et al., 2014; Stevenson et al., 2016). Prior research showed that both lower income and lower education were associated with lower rates of hospice care enrollment and at-home hospice death when holding other covariates constant (Barclay, Kuchibhatla, Tulsky, & Johnson, 2013; Jenkins et al., 2011; Silveira, Connor, Goold, McMahon, & Feudtner, 2011). The current study did not find significant relationships between state-level education and income measures and the minority hospice utilization gap. That said, the correlations in the individual-level studies between lower socioeconomic status and lower hospice utilization are not surprising given the significant role social determinants of health plays in end-of-life care decisions (Koroukian et al., 2017). A potential strategy for increasing hospice enrollment among groups across socioeconomic levels is to include offering short bouts of increased emotional and physical support for the patient and/or caregiver(s) during times of crisis in end-of-life care (Barclay et al., 2013). In addition, given informational materials hospices provide are not written at a level understood by most Americans (Kehl & McCarty, 2012), hospices should also focus on developing materials that comply with the Clear Communication initiative established by the National Institutes of Health. Clear Communication involves incorporating plain language and new technologies with accessible formats and content, all grounded in cultural respect (National Institutes of Health, n.d., para. 1).

Although policies targeting increased hospice enrollment levels for low-income populations with no specific focus on racial/ethnic minority populations would contribute to the economic savings discussed in this article, prior research has indicated that they would not eliminate the racial disparities within hospice enrollment. Brown et al. (2018) showed the effects of race/ethnicity on the intensity of end-of-life care are only partly mediated by other social determinants of health. Another study showed removing racial and ethnic disparities is complex and sometimes well-intended reform initiatives might inadvertently reinforce racial/ethnic disparities (Alegria, Alvarez, Ishikawa, DiMarzio, & McPeck, 2016). Strategies hospices could use for specifically addressing racial disparities in hospice utilization may include offering materials in languages spoken by the targeted racial/ethnic minorities (Kehl & McCarty, 2012; Young, 2014) and employing bilingual and bicultural clinicians or trained staff who act as interpreters and provide cultural context for the clients' beliefs and behaviors (Jackson & Gracia, 2014; Substance Abuse and Mental Health Services Administration, 2016).

This study estimated a projected savings of around $270 million annually from increasing the Medicare racial/ethnic minority hospice usage rate to that of the White population. Several studies have estimated the higher end-of-life expenditures among racial/ethnic minority groups (Baicker et al., 2004; Byhoff et al., 2016; Hanchate et al., 2009; Kelley et al., 2011) and savings from hospice utilization, in general (Kelley et al., 2013; Taylor et al., 2018; Taylor, Ostermann, Van Houtven, Tulsky, & Steinhauser, 2007). However, to the authors' knowledge, no other study has estimated the cost savings that could result from closing the hospice utilization gap. In addition to achieving cost savings, increasing Medicare racial/ethnic minority hospice use could potentially improve patient quality of care (Meier, 2011). As Livne (2014) states, "Limiting spending means helping people face their imminent death and avoiding prolonged aggressive treatment; in the context of hospice, it becomes a way of caring" (p. 906).

For terminally ill Medicare patients, hospice often provides a lower cost care option emphasizing quality of life that meets patients' preconceived wishes for end-of-life care (e.g., dying at home and being comfortable/without pain) (Kelley et al., 2013; Taylor et al., 2018; Teno et al., 2004; Wright et al., 2010; Zuckerman, Stearns, & Sheingold, 2016). Why racial/ethnic minority populations utilize this option less is subject to much discussion and debate (Elliott, Alexander, Mescher, Mohan, & Barnato, 2016; Pan et al., 2015). A systematic review of hospice use of Black people cited multiple factors contributing to relatively lower hospice utilization levels, including lack of hospice awareness, monetary concerns, mistrust of the health care system, a conflict in value with hospice care, and expected lack of racial/ethnic minority staff within hospice care (Washington, Bickel-Swenson, & Stephens, 2008). Alternately, Koss and Baker (2017) reported findings that question the common assertion that mistrust of the

health system by Black older adults contributes to lower rates of advance care planning (a practice associated with receiving hospice care earlier and longer) (Bischoff, Sudore, Miao, Boscardin, & Smith, 2013; Teno, Gruneir, Schwartz, Nanda, & Wetle, 2007). Adams, Horn, and Bader (2007) emphasized the lack of access to health services prior to hospice admission for the U.S. Hispanic population as a significant reason for lower hospice use by that group.

Simply closing the gap on hospice enrollment will not eliminate racial disparities observed within hospice care. Research finds once in hospice care, Black people experience higher levels of disenrollment, often to pursue costly, more invasive end-of-life treatment (Aldridge, Canavan, Cherlin, & Bradley, 2015; Johnson, Kuchibhatla, & Tulsky, 2008). Research in this area is ongoing with one study finding, on average, Black and Hispanic people tended to enroll in hospices that provided a lower quality of care. However, within a particular hospice, Black and Hispanic people receive care that is similar to that of White people (Price, Parast, Haas, Teno, & Elliott, 2017). In contrast, another study found disparities existed between the quality of care for Black and White people within the same hospice setting (Rizzuto & Aldridge, 2018). Barclay et al. (2013) found Black people enrolled in hospice were also less likely to die at home compared with White people even when accounting for other socioeconomic factors such as income, location, and education. The explanation for the lower rate of at-home deaths for Black hospice patients is inconclusive, with some studies suggesting potential differences in culture, caretaker support, and hospice care communication may be contributors (Barclay et al., 2013).

This article discusses potential advantages (e.g., quality of life, lesser symptoms, and cost savings) from closing the current gap between racial/ethnic minority and White Medicare hospice utilization (Institute of Medicine, 1997; Kelley et al., 2013; Steinhauser et al., 2000). Recent research based on national survey data shows the disparities in health care access between Black and Hispanic people and White people have significantly narrowed from 2013 to 2015 after the passage of the Affordable Care Act (ACA). In addition to reducing racial and ethnic disparities, the ACA was associated with increased access for all three groups examined—Black, Hispanic, and White people, partly through Medicaid expansion (Hayes, Riley, Radley, & McCarthy, 2017). The racial and ethnic disparity within hospice is slightly different given that all citizens over 65 years of age, at least in theory, have access to hospice via their automatic Medicare enrollment. The disparities seen in hospice go beyond insurance accessibility or income (Harris et al., 2017; Ornstein et al., 2016). The hospice community outreach efforts discussed above (e.g., access improvements, materials at a lower reading level) would likely improve participation among people of all racial and ethnic backgrounds, including White people. Such increased enrollment across all racial and ethnic Medicare groups has the potential for even greater improvements in health and cost outcomes than addressed in this analysis.

This research has some limitations. First, due to a lack of variation estimates in the existing literature, it was assumed a similar proportion of Medicare beneficiaries would be eligible for hospice care across all racial groups. There is also the possibility the racial/ethnic minority Medicare beneficiaries, who would comprise the additional hospice enrollees, would have a different average length of stay, disease prevalence estimates, and disenrollment rates. The authors chose not to project these statistics because of the uncertainty as to the types of patients (e.g., diagnoses) greater hospice community outreach to racial/ethnic minorities would most attract. Second, this research is limited to state-level data. Future research is recommended examining the relationship between racial/ethnic minority Medicare hospice utilization and the prevalence of for-profit hospices that include additional variables of hospice utilizers such as metropolitan status (e.g., rural vs. urban), gender, and income.

Another limitation is for-profit hospices have been shown to have higher levels of dementia patients compared with nonprofit hospices (Wachterman, Marcantonio, Davis, & McCarthy, 2011). Studies suggest dementia hospice patients have higher costs compared with nonhospice counterparts on account of relatively longer hospice stays and fewer invasive end-of-life treatments for this type of disease regardless of a patient's hospice status (Taylor et al., 2018; Zuckerman et al., 2016). Another risk is enrolling patients in hospice too early, increasing chances of live discharge which research has shown is positively associated with both hospice profit margins and the proportion of patients from racial/ethnic minority groups (Dolin et al., 2017; Stevenson et al., 2016). If for-profit hospices improve racial/ethnic minority hospice enrollment by focusing solely on dementia patients and/or engage in too early enrollment practices—both of which are practices more associated with for-profit hospices than nonprofit hospices (Dolin et al., 2017; Stevenson et al., 2016)—and nonprofit hospices do not improve their racial/ethnic minority recruiting efforts across all primary diagnosis levels, the estimated cost savings discussed in this article could be overstated. Policymakers should be aware of this potential issue and ensure racial/ethnic minority hospice recruitment programs encourage hospice use across all eligible diseases. In addition, mechanisms should be in place to monitor both for-profit and nonprofit hospices to ensure quality of care remains paramount in decisions about recruiting and care.

## Conclusion

With average per capita end-of-life medical spending in the last year of life at $80,000 in the United

States—comprising a larger fraction of its gross domestic product than that for all eight other countries examined in a 2017 study (French et al., 2017), implementing strategies to increase the inclusiveness of all racial/ethnic groups to hospice may be one way Medicare can simultaneously lessen its financial burden and improve the quality of life for its beneficiaries. This research finds a positive association between the prevalence of for-profit hospices and racial/ethnic minority Medicare hospice utilization, highlighting a potential business ownership model to further examine when developing strategies for racial/ethnic minority Medicare enrollees' inclusion in hospice care. With the potential to provide nearly $270 million in annual cost savings while also improving health outcomes, further research on specific programs that successfully reduce the racial/ethnic minority hospice enrollment gap is paramount. In addition, collaboration between hospices, health systems, and community organizations is needed to reduce the disparities between racial/ethnic minority and White Medicare beneficiary hospice utilization.

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## Declaration of Conflicting Interests

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## ORCID iD

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**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# APPENDIX 19

**Medicare Cost in Matched Hospice and Non-Hospice Cohorts Study**

NHPCO *Original Article*

# Medicare Cost in Matched Hospice and Non-Hospice Cohorts

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***Abstract***
*Hospice care is perceived as enhancing life quality for patients with advanced, incurable illness, but cost comparisons to non-hospice patients are difficult to make. The very large Medicare expenditures for care given during the end of life, combined with the pressure on Medicare spending, make this information important. We sought to identify cost differences between patients who do and do not elect to receive Medicare-paid hospice benefits. We introduce an innovative prospective/retrospective case-control method that we used to study 8,700 patients from a sample of 5% of the entire Medicare beneficiary population for 1999–2000 associated with 16 narrowly defined indicative markers. For the majority of cohorts, mean and median Medicare costs were lower for patients enrolled in hospice care. The lower costs were not associated with shorter duration until death. For important terminal medical conditions, including non-cancers, costs are lower for patients receiving hospice care. The lower cost is not associated with shorter time until death, and appears to be associated with longer mean time until death.* J Pain Symptom Manage 2004;28:200–210. © *2004 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

***Key Words***
*Medicare, costs, hospice, duration until death*

## *Introduction*

The Medicare Hospice Benefit, enacted in 1982, was intended to provide compassionate and cost-effective care for Medicare beneficiaries with incurable advanced illnesses. Medicare's very large expenditures on dying beneficiaries,[1] combined with federal funding pressures, have given new prominence to end-of-life care. Since Medicare began its hospice benefit, it has been thought to be unethical to conduct randomized hospice/non-hospice studies, as a right to hospice care is presumed. Therefore, investigations have been limited to studies that can very closely match populations and overcome selection bias.

The Medicare hospice benefit is potentially available to all Medicare beneficiaries after a physician certifies that the beneficiary is expected to live fewer than 180 days. Hospice services are provided by the patient's choice of the

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Medicare-certified hospice agencies available in the patient's locale. Under the program, the vast majority of services are provided in the patient's place of residence. Approximately 95% of the days of hospice care delivered in the US are at the routine home care level.[2] The hospice provides all needed services, including prescription drugs and palliative care and receives a flat payment amount for each day the patient is enrolled in hospice. The amount varies somewhat by locale. The patient can elect to stop receiving hospice care and return to traditional Medicare coverage at any time.

The cost analysis of patients enrolled in the Medicare Hospice Benefit has been debated since the benefit began in 1982. Changes in hospice care such as the growth of palliative treatments (e.g., chemotherapy, radiation and pain management therapies) and increased enrollment of non-cancer beneficiaries (e.g., end-stage chronic obstructive pulmonary disease [COPD], congestive heart failure [CHF], Alzheimer's disease) have created a new context for the debate. Early studies of hospice care[3,4] implied Medicare savings with increased home care and reduced hospitalization, futile treatment and diagnostics. These studies were criticized for lack of rigorous matching criteria and the effects of selection bias.[5] More recent studies find mixed results. Hospice use is associated with decreased cost in oncology populations but may not be for some other diagnoses.[6–8]

The costs for patients enrolled in the Medicare Hospice Benefit vary depending on where services are rendered (home, nursing home or hospital) and duration of hospice enrollment, among other factors. Substituting hospice for conventional care is more likely to show hospice most favorably if patients are on hospice just long enough to avoid unnecessary services. Hospice services provided to patients just before death can be an additional expense, as can hospice care provided for many months or years. A period of at least 2–3 months of hospice care may be optimal from both a cost and clinical standpoint.[9,10]

In addition to cost analysis, the effect of hospice care on length of life has been raised in connection with the quality of care. Anecdotal evidence suggests that some patients live longer after receiving hospice care.[11–14] Patients with chronic organ failure may benefit from attention to psychosocial concerns and personal care from hospice programs. Terminally ill oncology patients who forego aggressive cure-directed therapies and who receive greater psychosocial support may have greater survival.[15] No definitive survival data has been previously presented to support these findings and reports of increased survival of breast cancer patients in support groups have been questioned.[16]

Effectively matching populations for cost and longevity comparisons requires identifying a similar point in patients' terminal decline.[17] Attempts to develop accurate tools to predict the timing of death have generally been unsuccessful.[18] SUPPORT investigators used a computer-generated algorithm to model the probability of death.[19] This method found that estimating probabilities of death was not clinically useful. The National Hospice and Palliative Care Organization (NHPCO) published expert opinion guidelines for determining 6-month prognosis for selected non-cancer terminal illnesses.[20] These guidelines were modified by Centers for Medicare and Medicaid Services (CMS) fiscal intermediaries for use as local medical review policies that define payment criteria. However, the NHPCO guidelines and subsequent payment policies have also been found to have weak predictive validity.[21] "Look-back studies," which compare costs for hospice and non-hospice patients for a set period before death, have been criticized because of inadequate control for potential selection bias and failure to account for survival differences. The use of algorithms applied to administrative data to predict future costs has likewise had limited success[22] and we have avoided such approaches. For these reasons, we conceived the methodology of the present study to examine cost for subsets of patients that most clinicians would recognize as suitable for hospice care.

## *Methods*

In this study, we used established actuarial methods and administrative data to measure both costs and time until death starting from dates narrowly defined by claims data. We established cohorts of patients with diagnoses and, in most cases, paired treatments that indicated advanced illness. For each patient, unique dates for specific clinical events were used to measure the beginning point for time until death and cost through death.

The goal of our methodology was to identify patients who might, within days or months, reasonably choose hospice care. For each disease cohort, we sought to identify patients and, for each patient, a similar point in time from which we could begin to measure costs and length of life. Such a methodology avoids the biases of an approach of tabulating costs backwards from the date of death for a specified preceding time period, where the treatments received could bias the time until survival.

The use of administrative data allowed us to identify relatively large numbers of patients, even for very narrowly defined cohorts. The Medicare 5% sample database contains demographic and medical claim details for almost 2 million Medicare beneficiaries, of which about 100,000 die each year. While these data contain details of dates of service, diagnostic (ICD-9) and procedural (CPT or HCPCS) information, the data do not contain typical clinical information (such as laboratory values or stage of disease).

Physician advice is often an important element in a patient's decision to join a hospice, and we assembled a group of physicians active in hospice care who worked with medical coding and data experts. The group was charged with identifying patient characteristics, recognizable through the Medicare data that would strongly suggest the patient would soon be eligible for hospice care. While the majority of patients who choose the Medicare hospice benefit are dying of cancer, we did not limit the study to cancer patients. The advisory group ultimately developed subsets of 16 diagnoses (Table 1) where some combination of medical claims would define an unambiguous starting point for tabulating cost and time until death and where the patient could soon face a decision about enrolling in the Medicare Hospice Benefit. Within each diagnosis, we selected *an indicative marker* in the end-stage of these incurable, advanced diseases on the basis of specific diagnosis, treatments and response to treatments. These *indicative markers* represented unambiguous (from a data standpoint) points in the end stage of these 16 diagnoses. The criteria for creating indicative markers were:

- the defining event had to appear as medical claims. In practice, this generally meant some combination of a hospital admission or physician intervention, and
- the defining event would generally occur near the end of life but before an individual would have made a choice to enroll in the Medicare hospice benefit.

For most diagnoses, a minority of patients was selected for inclusion in the analysis, because most did not receive the pre-defined medical interventions. Within a given diagnostic cohort, we compared cost and time until death for patients choosing or not choosing hospice care—starting with the date of the indicative marker. We restricted the cohorts to patients who died within the calendar year of the indicative marker or the next calendar year.

The diagnostic definitions both described relatively narrow cohorts and allowed identification of a unique date for each individual. Our indicative marker methodology produced cohorts that, for most diseases, represent small subsets of patients who died of the disease. We believe that the complicated set of circumstances we used to define the cohorts provides a very significant degree of homogeneity within the cohorts. This complexity for identifying patients in effect lessens the need for risk adjustment, which is fortunate because the standard risk adjustment methodologies are not designed for use with dying patients.

*Indicative Markers*

We used the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the Current Procedural Terminology, Fourth Edition (CPT), and the Health Care Financing Administration Common Procedure Coding System (HCPCS) to create "indicative markers" for 17 diagnoses by an expert panel of oncologists, hospice medical directors, actuaries and Medicare insurance coding specialists. The indicative marker consisted of either an ICD-9-CM code alone or an ICD-9-CM code combined with CPT and/or HCPCS codes.

The panel was instructed to identify the circumstances, which could be identified with the available Medicare claims data, under which a patient could shortly thereafter be advised to consider obtaining hospice care. The majority of suggested circumstances proved impractical because they depended upon data that were

*Table 1*
**Definitions of Indicative Conditions and Markers**

| Condition | Administrative Claims Data Indicative Marker for Study Inclusion |
|---|---|
| Malignant neoplasm of esophagus | Beneficiaries with ICD-9-CM (ICD-9) for cancer of the esophagus except those with CPT for radical esophagectomy with interpositioning. The exception was made because that procedure may be performed with the expectation of cure or long-term survival |
| Malignant neoplasm of stomach | Beneficiaries with ICD-9 for stomach cancer except those with CPT for partial or subtotal gastrectomy and have claims for chemotherapy (chemo) starting within 1st quarter of surgery |
| Malignant neoplasm of colon | Beneficiaries with ICD-9 for colon cancer and have claims for chemo and either:<br>– no previous colon resection<br>– colon resection >1 quarter before start of chemotherapy |
| Malignant neoplasm of rectum | Beneficiaries with ICD-9 for cancer of the rectum and have claims for chemotherapy and/or radiation therapy (RT) and either:<br>– no previous rectal resection<br>– rectal resection >1 quarter prior to chemo and/or RT |
| Malignant neoplasm of liver and intra-hepatic bile ducts | Beneficiaries with ICD-9 for liver and intra-hepatic bile duct cancer |
| Malignant neoplasm of gallbladder and extra-hepatic bile ducts | Beneficiaries with ICD-9 for gallbladder and extra-hepatic bile duct cancer |
| Malignant neoplasm of pancreas | Beneficiaries with ICD-9 for pancreatic cancer except cases with islet cell cancer |
| Malignant neoplasm of trachea, bronchus and lung | Beneficiaries with ICD-9 for lung cancer and have claims for chemotherapy, which indicate a switch to another combination of chemotherapy drugs within 1–2 quarters of the initial chemotherapy |
| Malignant neoplasm of female breast | Beneficiaries with ICD-9 for breast cancer and have claims for chemotherapy, which indicate a switch to another combination of chemotherapy drugs within 1–2 quarters of the initial chemotherapy |
| Malignant neoplasm of ovary and other uterine adnexa | Beneficiaries with ICD-9 for ovarian and uterine cancer and claims indicate treatment course (at minimum) of primary abdominal surgery followed by chemotherapy |
| Malignant neoplasm of prostate | Beneficiaries with ICD-9 for prostate cancer and HCPCs J codes for all chemotherapies except leuprolide (includes cases receiving strontium 89) |
| Malignant neoplasm of brain | Beneficiaries with ICD-9 for brain cancer and claims indicate a diagnostic/treatment sequence of brain biopsy or debulking or craniotomy, followed by RT |
| Congestive heart failure (CHF) | Beneficiaries with ICD-9 for CHF and have claims indicating 1 or >hospitalizations involving:<br>– invasive monitoring<br>– intubation and ventilatory management<br>Exclusions: cases with CPT for CABG within 1 quarter prior to hospitalization and cases in which hospitalization for invasive monitoring or intubation indicate primary diagnosis of acute MI |
| Chronic obstructive pulmonary disease (COPD) | Beneficiaries with ICD-9 for COPD and have claims indicating 1 or more hospitalizations requiring intubation and ventilatory management |
| Alzheimer's disease | Beneficiaries claims indicating 1 or more admissions with primary diagnosis of sepsis and/or aspiration pneumonia along with a secondary diagnosis of Alzheimer's disease |
| Stroke | Beneficiaries with 1 or more admissions with primary diagnosis of sepsis and/or aspiration pneumonia along with a secondary diagnosis of stroke |

not available in the Medicare 5% sample. For example, any cohort definitions that depended upon laboratory values, stage of a disease or other clinical measure were rejected.

We selected these markers based on the practicality of obtaining the required information from administrative data and perceived relevance to hospice (judged to have a life expectancy of less than one year but not facing imminent death). We established the indicative markers prior to conducting the data analysis. Data extraction for one of the 17 diagnoses resulted in fewer than 20 individuals; therefore, we report the results for 16 out of the 17 diagnoses.

For cancer of the liver, gallbladder and pancreas, the first hospital claim or the first of at least two physician outpatient claims, appearing with ICD-9-CM codes for these "indicative diagnoses," was used as the starting point to tabulate costs and longevity. Because the prognosis is typically poor for these conditions, the first appearance of the diagnosis is an effective starting point for which costs and longevity could be tabulated. For cancer of the esophagus and stomach, we excluded beneficiaries who

appeared to be receiving curative therapy as defined by particular surgical interventions, because certain types of esophagus and stomach cancer are considered curable through surgery.

For the remainder of the diagnoses, an "indicative event" that signaled the terminal phase of an incurable, advanced disease was chosen as the marker. The indicative event consisted of specific treatments (chemotherapy, radiation therapy and surgery as detailed in Table 1) or a hospitalization with specific interventions or diagnoses. The treatments identified for the cancer diagnoses suggested either failure of curative therapy or evidence for palliative therapy. The hospital treatments used to define indicative events for the non-cancer diagnoses suggested a serious decline in health status.

The vast majority of dying patients would not meet the criteria of the indicative diagnoses – whether or not they elected to receive the Medicare Hospice Benefit. The challenge of using the available data to identify a patient at the cusp of being faced with a decision about choosing hospice care severely limited the possible number of cohorts. Hospice physicians, including those who advised us, do not identify patients through medical claims coding, and rarely if ever treat patients before they decide to obtain hospice benefits. Because of these constraints, the authors feel that there was no deliberate bias in our methodology.

*Data Source*

Our analysis used Medicare health insurance claims and enrollment data from the 5% Sample Beneficiary Standard Analytic Files[23] for the years 1998, 1999, and 2000. The 5% sample, which is created by and available from the Centers for Medicare and Medicaid Services (CMS), was created from the 100% Medicare Standard Analytical Files. The 5% sample is created by CMS as a statistically representative, longitudinal dataset.

The 5% Medicare Sample contains claims for about two million enrollees. Members have unique identifiers that allow patient tracking from year to year. The claims sample comprises seven distinct databases, each containing claims from a particular provider type: Physician Supplier Part B, Outpatient Hospital, Inpatient Hospital, Home Health Agency (HHA), Hospice, Skilled Nursing Facility (SNF), and Durable Medical Equipment (DME). We extracted data from all patients who met our criteria.

*Sample Selection*

Our data selection criteria were chosen primarily to avoid biasing time until death or cost according to whether an individual chose hospice. Consequently, we caution the reader that the costs and time until death time shown should not be used as a guide for individual patient time until death or cost.

In our algorithm, assignment into one of the 16 diagnostic categories required two physician claims or one inpatient hospital claim with the relevant ICD-9-CM code. We used a disease hierarchy to set the category for a beneficiary who could fall into more than one category. Before applying narrowing criteria, these diagnoses accounted for approximately 55% of all Medicare beneficiaries' deaths in the 5% Medicare sample. Beneficiaries were designated as hospice users if they had one or more hospice claims.

The final sample size did not change significantly from the base sample for beneficiaries diagnosed with esophageal, stomach, liver, gallbladder and pancreatic cancer, as the date of the first appearance of the diagnostic ICD-9-CM code itself was used as the marker for each affected individual. For other diagnoses, the final sample was significantly smaller than the base sample, as specific treatments, "indicative events," were required. The percentage of individuals utilizing hospice services was similar for patients with or without the indicative event.

Because cost comparison analysis was the primary focus of this study, and because the last few days of life can be very expensive, especially if the patient is hospitalized, we included only patients whose death could be observed in the data. Costs (Medicare payments) were tabulated starting with the time of the "indicative diagnosis" or "indicative event" to the time of death. For years prior to 2000, Medicare Part B claims indicate a date of service, which was used as the marker date for cost and longevity comparison. Medicare Part A claims show only the quarter and year of service; Part A claims were attributed to the patient if the claim fell in the quarter of the indicative event or later. Medicare payments are the amounts that

Medicare pays—net of beneficiary coinsurance and deductibles.

We removed certain patients and their claims from the analysis as required by inherent data limitations or in order to avoid bias in favor of patients who chose or did not choose hospice care. In particular, we removed patients who incurred less than $4,000 in claims (approximating the low end cost of one Medicare-paid hospitalization) or greater than $115,000 in claims from the indicative event through death. This reduced the population by about 5% and total cost by about 20%. The removal of these patients reduces the possibility that the results reflect the influence of very large or very small claims. We also removed patients who died within 15 days after the indicative event. This removes from the analysis people who die very quickly, and, as a result, may incur very low costs, and may not have a chance to consider entering hospice. For congestive heart failure, COPD and stroke, the short-stay trim removed a significantly higher portion of patients. This is not surprising, because the indicative marker for each of these cohorts is an acute hospital stay with significant intervention, and those patients who die within 15 days of admission might not have the opportunity to consider hospice care. We note that hospice data show many patients enter hospice with only a few days to live, and hospice executives complain about the quality and cost impact this has.[24] We note that hospice practitioners inform us that many patients do choose hospice care under such circumstances.

We followed individuals identified in 1999 with indicative events through the year 2000. For esophageal, stomach, liver, gallbladder and pancreatic cancers, where we used the first appearance of the ICD-9-CM code in the data as the indicative marker, we examined 1998 data for earlier appearances of these diagnoses among the claims. For the other diseases, we identified each individual's first indicative event in 1999. Individuals with a first indicative event in 2000 were eliminated from our study, to avoid biasing the sample toward short survivors. It is possible, but for most conditions clinically unlikely, that some individuals may have had a first indicative event in 1998 and a second in 1999. We did not examine the data from 1998 to identify any such patients. As a result of this approach, we considered only patients who were age 66 and older if the indicative event occurred in 1999.

We eliminated any individuals who were not observed to die. While the data from such individuals would be useful for a survival study, costs are generally believed to be higher toward the end of life. Because of our focus on cost, we wanted to capture only people with observed deaths. As mentioned above, because the primary purpose of this study was to evaluate cost, we analyzed only patients who died. This limits the usefulness of the data for survival analysis purposes. Nonetheless, we report the mean and median time until death for the cohorts.

*Statistical Analysis*

We used the *t*-test to evaluate differences in means, which is the goal of this study, to measure the Type I comparison wise error rate. We did not attempt to develop predictive parameters for time until death or cost. We tested for the significance of the following variables: age, sex, Medicaid-eligibility, and use or nonuse of hospice cost. The significance of these variables was tested through a generalized linear model. The *P* values shown in Table 2 are based on unadjusted means tests using cost as the only independent variable. The significance of other variables was determined using multiple regression on hospice use, age, sex and dual eligibility for Medicare and Medicaid. Table 3 shows that the hospice group is slightly more female and slightly younger than the non-hospice group.

We did not perform any analysis to attempt to identify the impact of co-morbidities on cost or time until death. The patient cohorts were very narrowly chosen from approximately 200,000 Medicare deaths, and the hierarchy we used in assigning indicative markers does provide some control over co-morbidities. More fundamentally, the predictive models in commercial use have weak predictive power and all were designed to forecast future costs for general populations, not those with short-term terminal illness.[22] Similarly, the Charlson approach also seems inappropriate given the terminally ill characteristic of the population and the narrow population definitions.[25] The geographic distribution by state of the hospice and non-hospice groups was very similar, with a 93% correlation coefficient, 94% for dual-eligibles and 92% for non-dual-eligibles. Of the cancer cohorts, 53%

*Table 2*
**Medicare Cost Per Patient for Studied Diseases**

| Disease Cohort | Choice[a]/Patient Count | Mean Cost/SD per Patient (US$) | Median Cost per Patient (US$) | Mean Time Until Death in Days/SD | Median Time Until Death in Days |
|---|---|---|---|---|---|
| Alzheimer's disease | H/29 | 29,828/16,986 | 29,309 | 221/177 | 166 |
| | NH/122 | 30,925/21,268 | 24,034 | 175/155 | 117 |
| Brain cancer | H/284 | 35,768/20,743 | 32,706 | 203/146 | 170 |
| | NH/166 | 38,300/24,729 | 31,260 | 159/139 | 108 |
| Breast cancer | H/144 | 37,968/22,426 | 34,428 | 353/172 | 362 |
| | NH/111 | 41,269/24,641 | 38,349 | 306/184 | 293 |
| Congestive heart failure[b] | H/174 | 46,793/24,469 | 41,136 | 185/163 | 136 |
| | NH/1141 | 53,528/26,705 | 50,015 | 135/145 | 65 |
| Colon cancer | H/327 | 31,819/20,727 | 41,136 | 310/168 | 292 |
| | NH/199 | 33,979/22,283 | 50,015 | 266/182 | 226 |
| Chronic obstructive pulmonary disease | H/33 | 43,744/22,830 | 37,495 | 136/143 | 96 |
| | NH/292 | 51,831/26,991 | 45,458 | 132/151 | 57 |
| Esophageal cancer | H/232 | 33,489/22,749 | 28,289 | 252/168 | 210 |
| | NH/300 | 36,133/22,833 | 31,816 | 209/173 | 149 |
| Gallbladder cancer | H/70 | 30,454/17,895 | 25,725 | 211/163 | 159 |
| | NH/58 | 33,026/22,676 | 27,596 | 186/163 | 139 |
| Liver cancer[b] | H/496 | 27,364/19,544 | 22,909 | 183/158 | 133 |
| | NH/388 | 30,402/23,331 | 21,974 | 170/167 | 100 |
| Ovarian cancer | H/24 | 45,296/22,272 | 35,946 | 296/141 | 303 |
| | NH/17 | 54,231/30,387 | 43,197 | 248/133 | 246 |
| Pancreatic cancer[b] | H/663 | 29,621/20,786 | 23,617 | 198/160 | 151 |
| | NH/459 | 34,784/24,232 | 27,834 | 183/164 | 128 |
| Prostate cancer | H/270 | 30,573/19,761 | 25,763 | 404/180 | 392 |
| | NH/459 | 30,382/21,257 | 25,182 | 366/177 | 370 |
| Rectal cancer | H/191 | 34,478/21,698 | 31,168 | 289/174 | 263 |
| | NH/193 | 37,917/25,152 | 32,283 | 233/179 | 200 |
| Stomach cancer | H/252 | 32,004/22,687 | 25,314 | 228/175 | 190 |
| | NH/264 | 35,658/25,151 | 29,951 | 194/171 | 133 |
| Stroke[b] | H/22 | 46,910/30,767 | 40,900 | 177/127 | 156 |
| | NH/125 | 34,579/24,148 | 28,230 | 165/168 | 101 |
| Trachea, bronchial & lung cancer | H/648 | 36,209/20,136 | 32,886 | 262/157 | 229 |
| | NH/547 | 37,845/20,808 | 34,855 | 225/152 | 201 |

[a]H = patients choosing hospice; NH = patients not choosing hospice.
[b]$P < 0.05$ for mean cost differences.

of the patients were in the hospice cohorts, compared to 60% of all Medicare decedents in 2000, while for cancer plus non-cancer cohorts, 44% of patients were in the hospice cohorts compared to 23% for all Medicare decedents in 2000.[24]

SAS™ (SAS Institute Inc, Cary, NC) and Excel™ were used for all analyses. We conducted statistical tests on each disease separately and did not attempt cross-disease analysis to determine whether hospice use, age, sex or dual eligible status had significant impacts.

## *Results*

For the diseases studied, we compared Medicare patients enrolled in the Medicare hospice benefit with those not enrolled in the Medicare hospice benefit for Medicare cost. Table 2

*Table 3*
**Age–Sex Demographics of Cohorts**

| Age | Female | Male | Total |
|---|---|---|---|
| Patients Receiving Hospice Care | | | |
| 64–69 | 412 | 476 | 888 |
| 70–74 | 462 | 578 | 1,040 |
| 75–79 | 449 | 481 | 930 |
| 80–84 | 299 | 297 | 596 |
| >85 | 221 | 184 | 405 |
| Total | 1,843 | 2,016 | 3,859 |
| Patients Not Receiving Hospice Care | | | |
| 64–69 | 437 | 532 | 969 |
| 70–74 | 497 | 643 | 1,140 |
| 75–79 | 464 | 648 | 1,112 |
| 80–84 | 400 | 458 | 858 |
| >85 | 401 | 361 | 762 |
| Total | 2,199 | 2,642 | 4,841 |
| Grand Total | 4,042 | 4,658 | 8,700 |

shows summaries of these measures for the narrowly defined patient populations shown in Table 1.

For all diseases except prostate cancer and stroke, mean cost was lower for patients who chose hospice but was significant ($P < 0.05$) only for CHF, liver cancer and pancreatic cancer. Patients choosing hospice had higher cost at this significance for stroke (Table 2). Median costs generally followed the same pattern. Mean and median costs for untrimmed data followed the same pattern as for trimmed data with few exceptions.

Because cost was the focus of this study, we included only patients who died during the study period. Consequently, the data are of limited value for a survival study. Nevertheless, the pattern of lower costs for patients who choose hospice does not appear to be associated with shorter survival. Patients who choose hospice showed longer mean and median time until death than their matched non-hospice cohorts—by days to months for all of the diagnoses studied.

We caution the reader that the time until death times shown in Table 2 are means for the cohorts studied. Because the criteria use administrative, not clinical data, clinicians may find it hard to know whether an individual patient meets the detailed criteria we used to select patients, and the results should not be used to predict time until death times for individual patients.

A multiple regression was used to evaluate the effect of the available variables (i.e., hospice/non-hospice, age, sex, and Medicaid dual eligibility status) on time until death, cost, and cost/day by disease category. For each condition, we show whether hospice status, age, sex or Medicaid dual eligibility were significant for cost. Table 3 presents age and sex demographics of the hospice and non-hospice cohorts. Overall, the hospice group had slightly more females than the non-hospice group (48% vs. 45%) and patients in the hospice group were slightly younger than patients in the non-hospice group (74% and 67% of patients were ≤79 years of age, respectively).

## *Discussion*

This study provides evidence that, for certain well-defined terminally ill populations, costs are lower for patients who choose hospice care than for those who do not. Furthermore, for certain well-defined terminally ill populations, among the patients who died, patients who choose hospice care live longer on average than similar patients who do not choose hospice care. This pattern persisted across most of the disease states studied. Hospice care is widely used by patients with cancer, which was reflected in the high proportion of patients choosing hospice care in our cancer diagnoses groups. Notable among the findings, however, is that the CHF-related group, where relatively few patients receive hospice care, shows lower cost and higher time until death for the patients who choose hospice care.

Although the data suggest some longevity benefit to hospice, the causality for reduced cost seems stronger than for greater time until death, because patients who happen to live longer after their indicative event may have greater opportunity to choose hospice. Alternatively, these patients will also have greater opportunity to enter a track of aggressive, non-hospice treatment. While the study's design does not provide comprehensive results for longevity, the hypothesis that longer surviving patients may more likely choose hospice seems counterintuitive to the finding of lower costs for patients choosing hospice. This is an important area for further research.

A critical question is whether the selection criteria—either for the defined cohorts or for the individuals who choose hospice care—biased the results. The administrative data used

do not capture significant clinical measures or psycho-socio-economic data such as education or income. Hospice enrollment was not randomly assigned, and the individuals who choose hospice may have tended to avoid expensive care even if they had no access to the hospice benefit. One approach to identifying such bias is to assume that high spending (or low spending) before hospice enrollment is a predictor of an individual's probability of obtaining (or avoiding) aggressive medical treatment. However, certain of the indicative diagnosis definitions (for example, breast and ovarian cancers) required a history of obtaining aggressive medical treatment, so such look-back methods may have limited value for these cohorts. In addition, the attempt to use pre-hospice treatment to adjust for "propensity to treat" bias would discount the possibility that changes in their medical condition could cause some people to dramatically change their choices about the desired kind of medical care.

Although the Medicare 5% sample contains information about race, we did not include that factor in our analysis. African-American patients have been shown to be less likely to choose hospice services than non-minority patients.[26] Racial disparities deserve further investigation, although the authors do not have a strong intuitive sense of the cost bias that might have been introduced by failure to consider race.

We believe that our "indicative event" definitions identified individuals with similar health status, although the more complicated indicative events, which require a combination of circumstances, probably produced more homogenous cohorts than the simpler indicative events (for example, the first appearance of a pancreatic cancer diagnosis). For most indicative events, the individuals were well enough to have passed medical clearance to receive aggressive treatment. They were all sick enough to die within two years of the event. The limited success of predictive modeling[21] argues against using existing models (or simpler look-back approaches) to create matched cohorts and we did not attempt to do so. The analysis does exclude all individuals who die within 15 days of the indicative event, so that the non-hospice group would not include individuals who die immediately after the intervention, so have no opportunity to choose hospice.

Our trimming rules had almost no impact on which cohort had higher mean or median costs and no impact on which cohort had longer time until death. One of the few exceptions is cost for CHF, where a large number of non-hospice patients died within a few days after the indicative hospitalization event. For CHF, including these very short times until death patients would shift mean and median costs for the non-hospice cohort to be lower than for the hospice cohort. This exception does not weaken our view about the relative costs of hospice patients, as hospice would have had little opportunity to reduce costs for these patients.

The study does raise temporal bias issues. Patients who choose hospice care may incur lower expenses, with or without hospice care, because they may desire to avoid aggressive treatment. This may explain some of the cost findings for cancer of the esophagus, stomach, liver, gallbladder and pancreas, where the indicative event was defined by the appearance of a diagnosis, rather than a more aggressive medical intervention. However, for the other conditions studied, the indicative event screen required that all patients in both the hospice and non-hospice cohorts have a history of choosing aggressive treatment—and access to such aggressive treatment. For example, a diagnosis of brain cancer followed by a surgical intervention and radiation treatment does not suggest a patient who avoids aggressive treatment or one who has little access to aggressive care.

The question "How is it possible that hospice can prolong life?" is critically important to answer. Hospice care promotes itself as providing compassionate care, emphasizing pain management, comfort and quality of life. These kinds of support may tend to prolong life, although the evidence base for much of what hospice achieves has yet to be assembled. Terminally ill patients who choose hospice avoid the hazards of aggressive medical treatment, which may contribute to the longer time until death observed in these patients. We suggest, however, that the longer time until death may be due to significantly longer time until death by a relatively small number of patients, rather than short increases by a large number of patients. This hypothesis may find support through further data analysis or clinical research to identify whether some hospice patients survive

one or more crisis periods better than do non-hospice patients. We hope this study may prompt additional investigation into the appropriate length of hospice enrollment needed to achieve the goals of end-of-life care. The appropriate length continues to be debated, especially as the mean length of hospice enrollment has declined from a high of 74 days in 1992 to 59 days in 1998,[27] although the decline appears to have stopped in more recent years.[28]

Another important question to answer, which our study did not address, is "Do the differences in time until death matter to patients and families?" In our study sample, the average time until death from the indicative event ranged from about 6 months to about 1 year. The hospice patients had an increase in time until death compared with the non-hospice patients that ranged from days to months. This increase in time until death may be particularly important to family members if pain management, comfort and quality of life can be maintained.

Finally, the question "Do these results apply to other kinds of patients?" must be asked. In performing this study, we chose very narrowly defined patient cohorts and removed patients with short or long survival periods. These cohorts were unusual in that administrative data, by itself, was used to identify a precise point in the patient's treatment and course of disease. The diagnoses from which we chose patients account for a majority of Medicare deaths, but the criteria used to choose cohorts generally produce many fewer deaths. Further research should be undertaken to determine whether other kinds of patients follow disease courses similar to those reported in this study. Future research in this area will elucidate the applicability of these findings.

Although the use of administrative data presents some limitations, it also has strengths. Well-known weaknesses include incomplete or inaccurate coding by healthcare providers during the course of billing. However, we believe these weaknesses do not bias the results of our study. One important strength of using the Medicare 5% sample is that this administrative data is taken from actual Medicare payments for actual patients rather than modeled patients or expenses. These data were produced by the Medicare payment adjudication system, so, unlike using data from a small controlled study or charges generated by hospital charge masters, the findings require little translation to make them applicable to likely aggregate results for Medicare as a payer.

Most analyses of the cost of end-of-life care, including this study, have not considered the substantial out of pocket costs to families.[29] Medicare hospice services require minimal cost sharing, and, unlike the regular Medicare program, drugs are covered. Medicare cost sharing practically guarantees that, if our findings are true, the cost to patients will be less for hospice care, although this is a fertile topic for further investigation. Had we considered the value of the Medicare Part A deductible, the Medicare Part B coinsurance and deductible and the cost of prescription drugs, the total cost savings for hospice care would have been more dramatic than shown.

We caution that while the choice of hospice or non-hospice appears to have an important influence on average time until death time, the variance in time until death is very large for both cohorts. In other words, for an individual, the choice of hospice or non-hospice has very low predictive value for individuals. We hope that this study will generate hypotheses that can be tested in a clinical environment to produce evidence-based recommendations.

Predicting the date of an individual's death has been a challenge for the Medicare program's definition of hospice eligibility and the costs of care for Medicare beneficiaries at the end of their life is an immense cost issue for the financially-beleaguered program.[30] This study provides important information that may guide physician recommendations that are both compassionate and cost effective.

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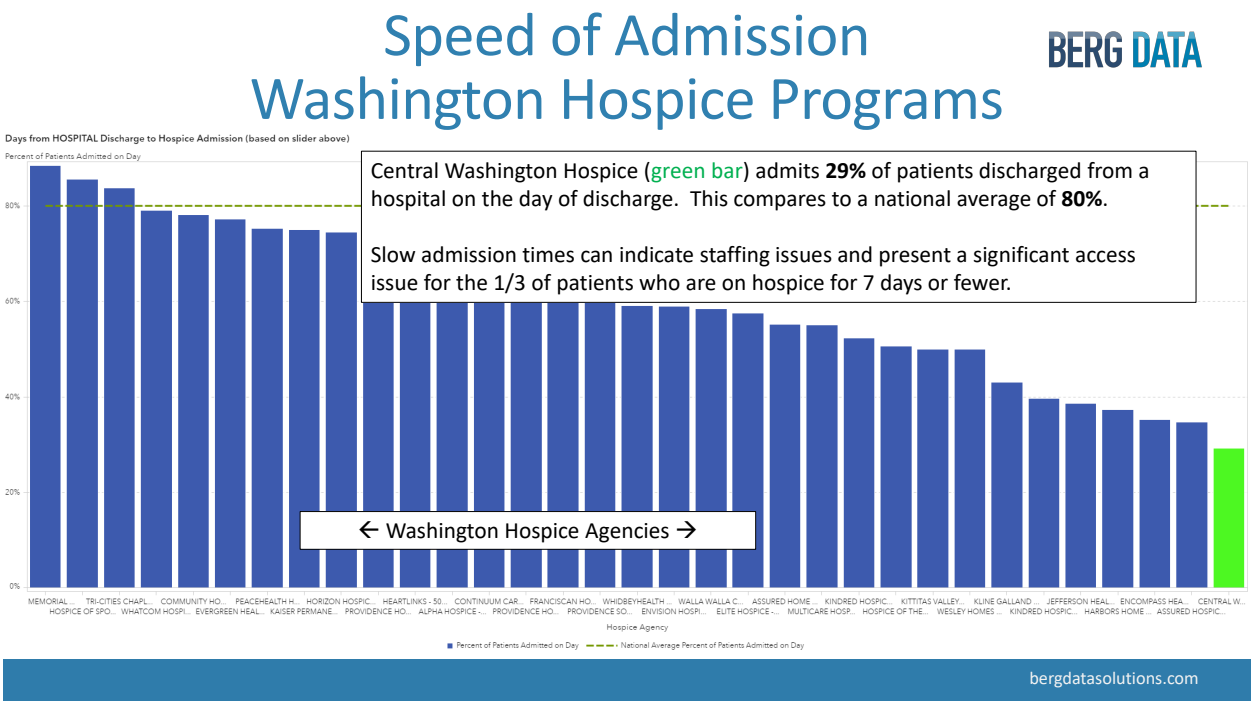
# Exhibit 1


Speed of Admission
Washington Hospice Programs
BERG DATA
Days from HOSPITAL Discharge to Hospice Admission (based on slider above)
Percent of Patients Admitted on Day
Central Washington Hospice (green bar) admits 29% of patients discharged from a hospital on the day of discharge. This compares to a national average of 80%.
Slow admission times can indicate staffing issues and present a significant access issue for the 1/3 of patients who are on hospice for 7 days or fewer.
← Washington Hospice Agencies →
Hospice Agency
Percent of Patients Admitted on Day
National Average Percent of Patients Admitted on Day
bergdatasolutions.com

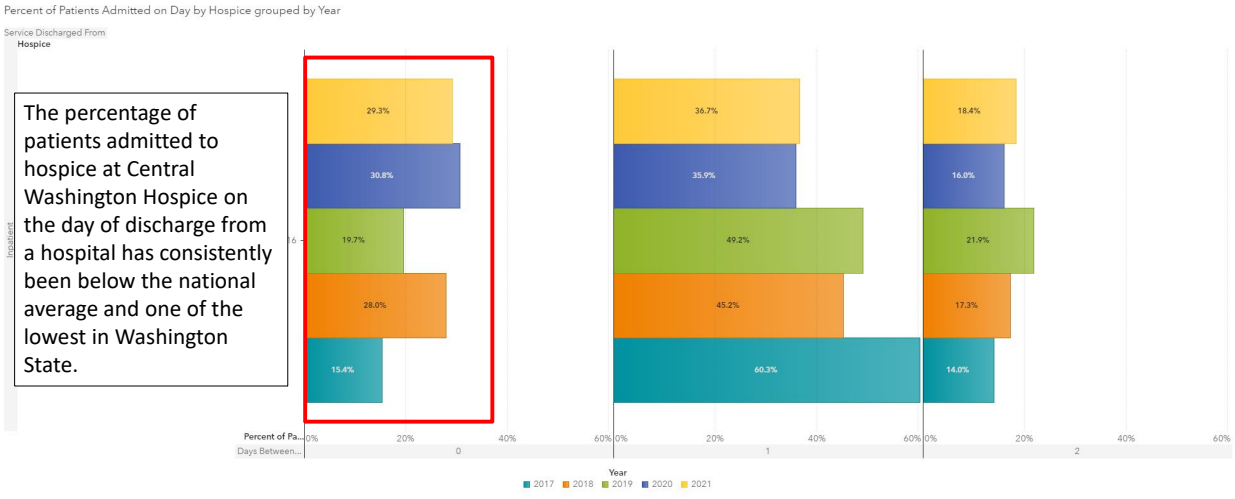
**Wenatchee Hospice LLC dba Advanced Hospice Northwest of Wenatchee**

**Certificate of Need Application**

# Exhibit 2

## Central Washington Hospice
## Speed of Admission for Hospital Discharges
## 2017-2021

BERG DATA




The percentage of patients admitted to hospice at Central Washington Hospice on the day of discharge from a hospital has consistently been below the national average and one of the lowest in Washington State.

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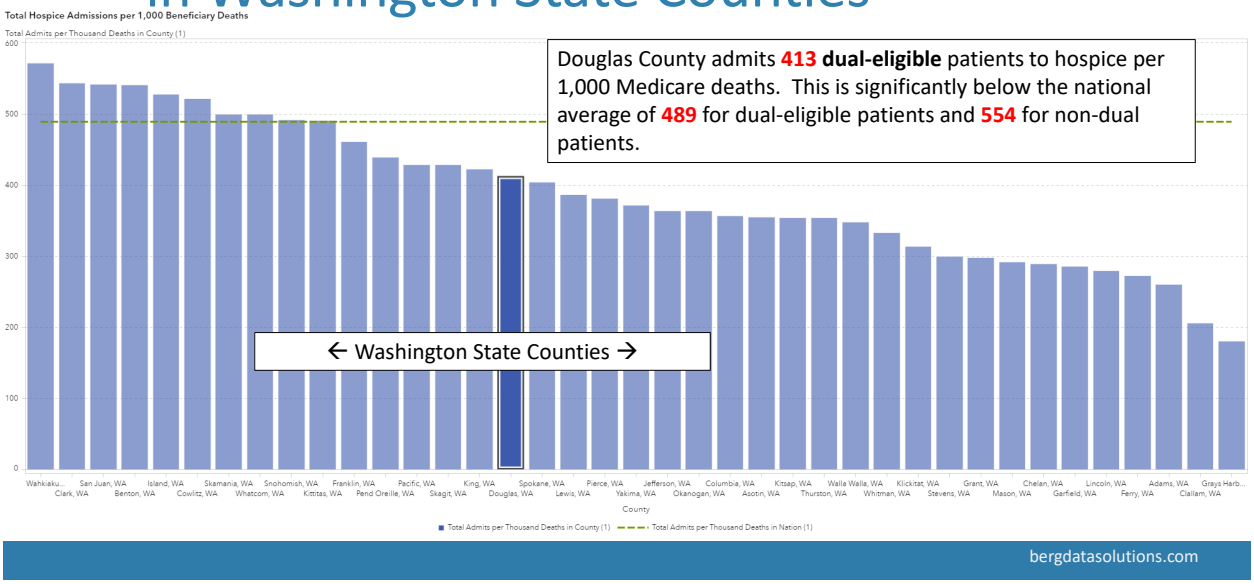
# Exhibit 3

## Dual-Eligible Hospice Utilization Rates in Washington State Counties

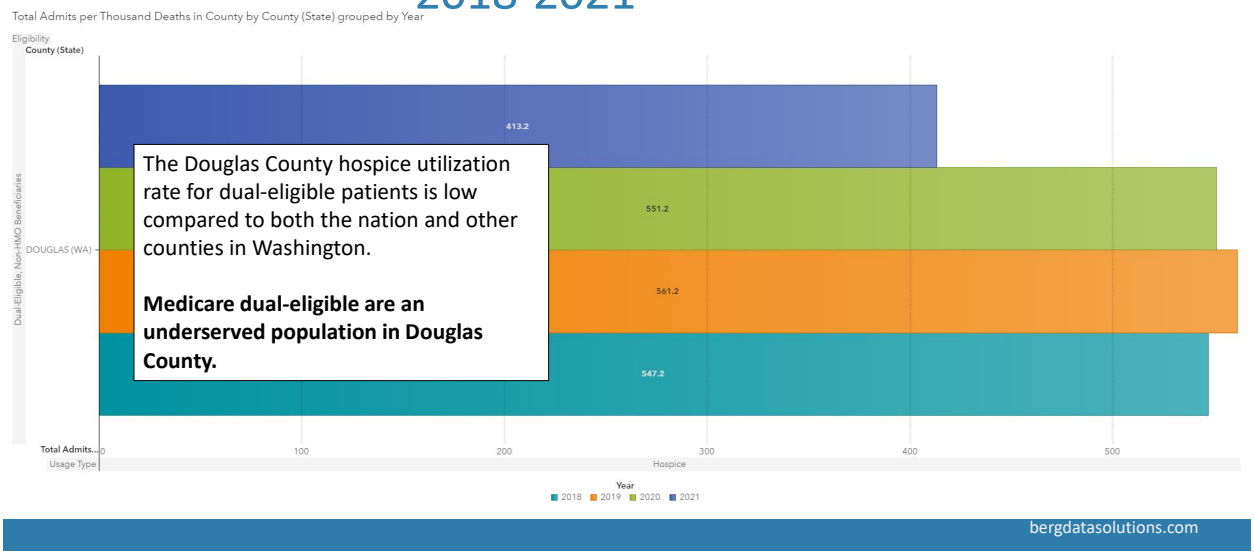
BERG DATA



# Exhibit 4

## Douglas County Dual-Eligible Hospice Admissions per 1,000 Deaths 2018-2021

BERG DATA

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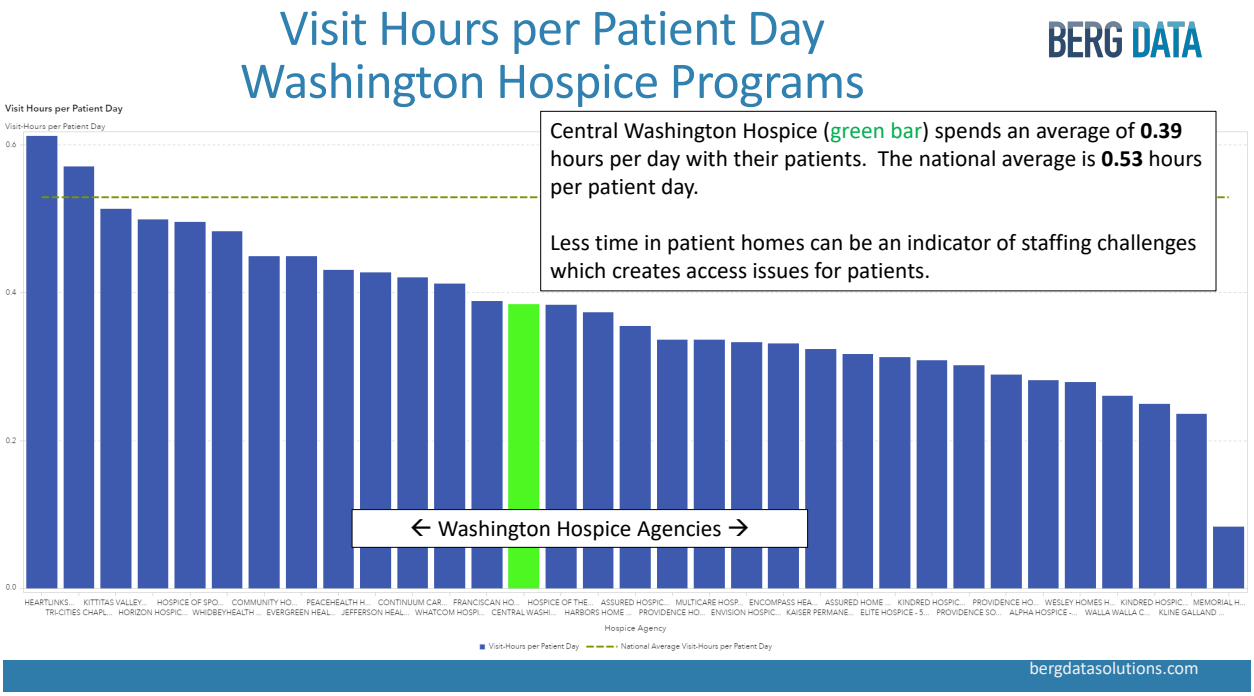
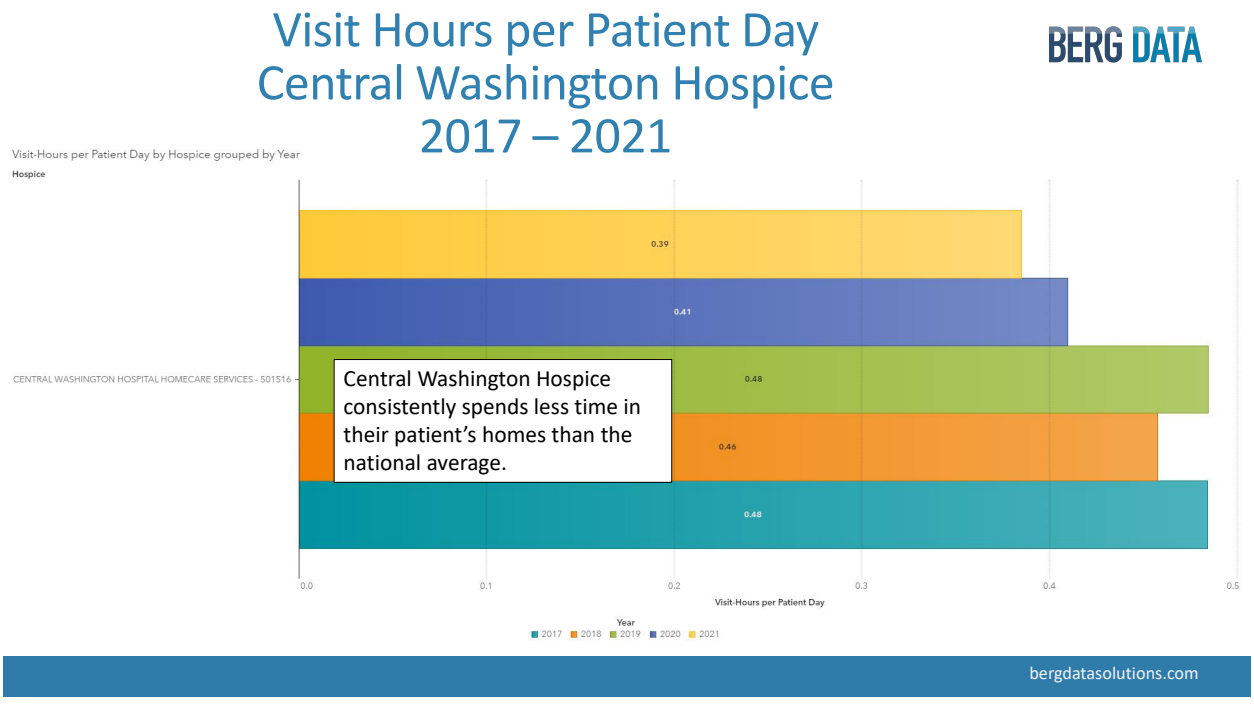
# Exhibit 5


Visit Hours per Patient Day
Washington Hospice Programs
BERG DATA
Visit Hours per Patient Day
Visit-Hours per Patient Day
0.6
0.4
0.2
0.0
Central Washington Hospice (green bar) spends an average of 0.39 hours per day with their patients. The national average is 0.53 hours per patient day.
Less time in patient homes can be an indicator of staffing challenges which creates access issues for patients.
← Washington Hospice Agencies →
HEARTLINKS... KITTITAS VALLEY... HOSPICE OF SPO... COMMUNITY HO... PEACEHEALTH H... CONTINUUM CAR... FRANCISCAN HO... HOSPICE OF THE... ASSURED HOSPIC... MULTICARE HOSP... ENCOMPASS HEA... ASSURED HOME ... KINDRED HOSPIC... PROVIDENCE HO... WESLEY HOMES H... KINDRED HOSPIC... MEMORIAL H...
TRI-CITIES CHAPL... HORIZON HOSPIC... WHIDBEYHEALTH ... EVERGREEN HEAL... JEFFERSON HEAL... WHATCOM HOSPI... CENTRAL WASHI... HARBORS HOME ... PROVIDENCE HO... ENVISION HOSPIC... KAISER PERMANE... ELITE HOSPICE - S... PROVIDENCE SO... ALPHA HOSPICE -... WALLA WALLA C... KLINE GALLAND ...
Hospice Agency
Visit-Hours per Patient Day
National Average Visit-Hours per Patient Day
bergdatasolutions.com

# Exhibit 6


Visit Hours per Patient Day
Central Washington Hospice
2017 – 2021
BERG DATA
Visit-Hours per Patient Day by Hospice grouped by Year
Hospice
CENTRAL WASHINGTON HOSPITAL HOMECARE SERVICES - 501516
0.39
0.41
0.48
0.46
0.48
Central Washington Hospice consistently spends less time in their patient's homes than the national average.
0.0
0.1
0.2
0.3
0.4
0.5
Visit-Hours per Patient Day
Year
2017 2018 2019 2020 2021
bergdatasolutions.com

# Exhibit 7

**Douglas County Hospice Utilization by Race – 2021 – Berg Data Solutions**

| Race | Douglas County Race Percent | State Average Race Percent | National Average Race Percent |
|---|---|---|---|
| White | 96.7% | 90.6% | 84.9% |
| Black | 0.0% | 2.1% | 8.8% |
| Asian | 0.0% | 2.8% | 1.6% |
| Hispanic or Latino | 0.0% | 0.8% | 2.2% |
| North American Native | 0.0% | 1.0% | 0.4% |
| Other | 0.0% | 1.8% | 1.3% |
| Unknown | 0.0% | 1.1% | 0.8% |
| Total | 100.0% | 100.0% | 100.0% |

NOTE: Demographic groups with less than 11 patients are suppressed per CMS requirements