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Riverview Lutheran Retirement Community of Spokane, d/b/a RiverCare Home Health

Certificate of Need Application

Proposing the Establishment of a Medicare/Medicaid

Certified Home Health Agency in Spokane County

September 20, 2024

Contents List

Washington State Department of Health

Certificate of Need Application
Home Health 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 [signature] RiverCare Manager	Date 9/20/24
Email Address cdunker@riverviewretirement.org	Telephone Number 509-482-9500
Legal Name of Applicant Riverview Lutheran Retirement Community of Spokane DBA RiverCare Address of Applicant 1801 E. Upriver Drive Spokane, WA 99207	Provide a brief project description ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $ 16,000.00

Identify the county proposed to be served for this project. Note: Each home health 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.

Spokane County

Section 1

Application Description

Applicant Description

1. **Provide the legal name(s) and address(es)of the applicant(s).**

   Riverview Lutheran Retirement Community of Spokane
   1801 E. Upriver Drive,
   Spokane, WA 99207

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

   C Corporation, (UBI) 328054106

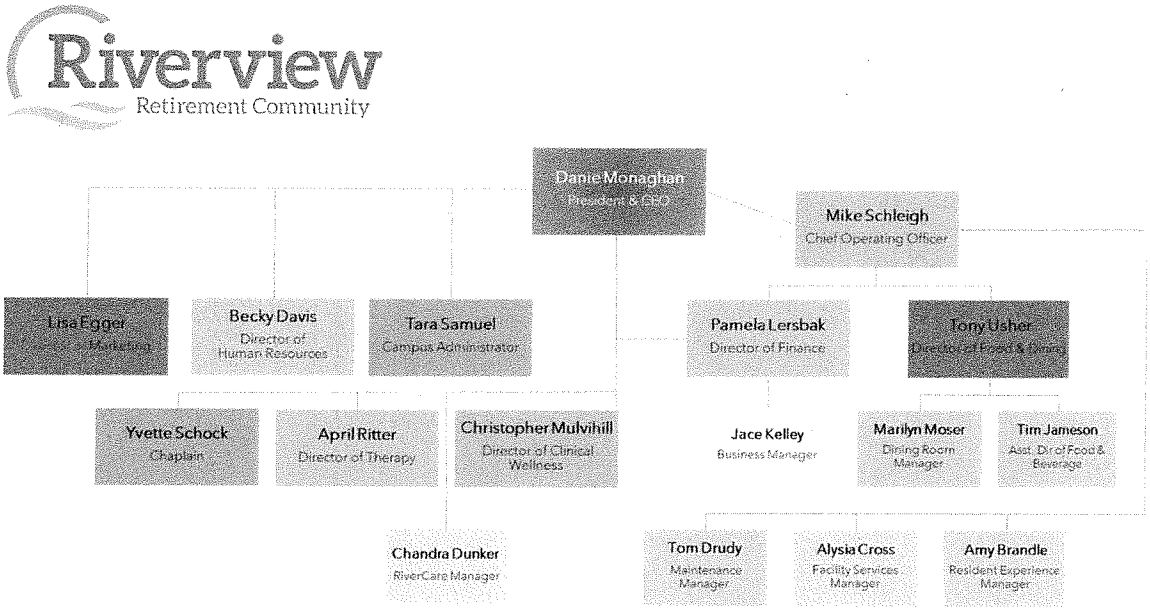
3. **Provide the name, title, address, telephone number, and email address of the contact person for this application.**

   Chandra Dunker
   RiverCare Manager
   1801 E. Upriver Drive
   Spokane, WA 99207
   (509) 482-8159
   Cdunker@riverviewretirement.org

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. No other contact at the moment.

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



- Governing Board: Oversees the entire Riverview Retirement Community.
- Danie Monaghan: President & CEO of Riverview Retirement Community.
- RiverCare: A new business line that operates under Riverview Retirement Community.
    - Director/Manager: Responsible for:
        - Personnel
        - Staffing
        - Operations
        - Budgeting
        - Compliance
    - Clinical Manager: Oversees:
        - Clinical operations
        - Compliance
        - Quality measures
        - Training and clinical supervision
        - Conducts ride-along evaluations at least once a year for all clinical staff.
    - Therapist and Clinical Staff: Responsible for:
        - Overseeing assistant therapists and assistant clinical staff with documentation and visits
        - Maintain standards of practice
        - Develop patient plan of care

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers.**

1. Riverview Lutheran Retirement Community of Spokane dba "Terrace"
   1801 E. Upriver Drive, Spokane, WA 99207
   UBI #328054106
   CMS #: Not Applicable
   Accreditation Status: Active
   Type of Facility: Assisted Living

2. Riverview Lutheran Retirement Community of Spokane Riverview Memory Care dba "Veranda"
   1952 N. Granite St. Spokane, WA 99207
   UBI #328054106
   CMS #: Not Applicable
   Accreditation Status: Active
   Type of Facility: Memory Care

3. RiverCare
   2360 N. Stone St. Unit B, Spokane, WA 99207
   UBI #328054106
   CMS #: Not Applicable (New Agency)
   Accreditation Status: Active
   Type of Facility: Home Health

4. Riverview Rehabilitation Center dba Riverview Therapy
   1841 E. Upriver Drive, Spokane, WA 99207
   UBI #328054106
   CMS #: Not Applicable (New Agency)
   Accreditation Status: Active
   Type of Facility: Outpatient therapy

Section 2

Project Description

Project Description

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

   This is a new home health agency for Riverview Lutheran Retirement Community of Spokane dba RiverCare.

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

   This is a new home health agency for Riverview Lutheran Retirement Community of Spokane dba RiverCare.

3. **Provide the name and address of the proposed agency.**

   RiverCare
   1841 E. Upriver Drive
   Spokane, WA 99207

4. Provide a detailed description of the proposed project.

Riverview Lutheran Retirement Community of Spokane 35-acre campus is one of only four Continuing Care Retirement Communities (CCRC-c) in Spokane. Riverview offers a diverse range of services and living options, making it an inviting choice for seniors in Spokane. With its expansive 35-acre campus, residents can begin their journey in independent living homes and seamlessly transition to assisted living, memory care, or an adult family home as their needs evolve. This flexibility is vital for ensuring that residents have appropriate support throughout their aging process.

The community's capacity to serve up to 326 independent residents, 131 in assisted living, and 34 in memory care highlights its commitment to accommodating a variety of needs. Established in 1959, Riverview has fostered a legacy of satisfaction among its residents, underlining its dedication to enhancing active adult living. As a non-profit organization, Riverview emphasizes community engagement by actively listening and responding to the needs and ideas of its residents and their families.

In response to the closure of Riverview's Skilled Nursing Home in 2020, driven by COVID-19 and shifting patient preferences, Riverview has established RiverCare. Research indicates that most patients prefer and benefit from receiving care at home, which can also be more cost-effective than institutional care, as reported by the National Association for Home Care & Hospice in 2024 (Attachment A). RiverCare was created to address the growing demand for home care and skilled nursing services in the community. Upon approval, RiverCare plans to provide Medicare and Medicaid certified home health services to residents of Spokane County starting in 2025.

RiverCare is dedicated to offering exceptional services tailored to the diverse needs of our patients. Our experienced professionals work closely with community providers to develop personalized care plans for homebound patients who qualify for skilled services. These care plans are crafted in collaboration with the patient's attending physician to ensure the best outcomes. Our interdisciplinary team is comprised of skilled nursing care, physical therapy, occupational therapy, speech therapy, social work, and home health aide services, all focused on providing patient-centered care.

Riverview is confident that by offering home health services as an integral part of the continuum of care, we can enhance the quality of patient outcomes, reduce hospital admissions and readmissions, and boost patient satisfaction. This approach aims to effectively lower overall costs for Medicare and Medicaid patients while ensuring they receive the best possible care in their preferred setting.

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

RiverCare is dedicated to expanding home health services to Spokane County as soon as the certificate of need is approved. With Riverview's strong reputation in the Spokane community, this expansion is expected to proceed smoothly. According to the Employment Security Department, Spokane County was estimated to be the fourth largest county in Washington State in 2021 (Attachment B). Additionally, the U.S. Census Bureau QuickFacts reported a population growth of 1.2% in Spokane County from 2020 to 2021, significantly higher than the 0.4% growth rate for Washington State (Attachment C). The county has experienced substantial population increases, with the largest annual growth reaching 3.6% from 2019 to 2020 (Attachment D).

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:**

Event	Anticipated Month/Year
CN Approval	March 2025
Design Complete (if applicable)	N/A
Construction Commenced* (if applicable)	N/A
Construction Completed* (if applicable)	N/A
Agency Prepared for Survey	April 2025
Agency Providing Medicare and Medicaid hospice services in the proposed county.	May 2025

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

X Skilled Nursing	X Occupational Therapy
X Home Health Aide	☐Nutritional Counseling
☐Durable Medical Equipment	☐Bereavement Counseling
X Speech Therapy	X Physical Therapy
☐Respiratory Therapy	☐IV Services
X Medical Social Services	☐Applied Behavioral Analysis
☐ Other (please describe)	

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

There is no existing home health agency.

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

There is no existing home health agency.

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

RiverCare's goal is to deliver healthcare services primarily for patients aged 65 and above. While RiverCare focuses on this age group, we do not discriminate based on age; instead, we assess the appropriateness of care based on diagnosis and insurance eligibility. We are actively working on securing insurance contracts to offer services for Medicare Advantage, private insurance, Medicare, and Medicaid. RiverCare is dedicated to addressing a wide range of medical conditions, from simple to complex diagnoses. Our services encompass care for conditions like wound care, CHF, Parkinson's Disease, Diabetes, COPD, cancer, stroke, joint replacement, limb injuries, hip fractures, Alzheimer's Disease, Dementia, medication management and teaching, feeding tubes, hypertension, serious infections, and chronic health conditions.

11. Provide a copy of the applicable letter of intent that was submitted according to WAC 246-310-080.

August 16, 2024

Certificate of Need Program
Office of Community Health Systems
Washington Department of Health
111 Israel Road S.E.
Tumwater, WA 98501

RE: Letter of Intent for a Certificate of Need Application for Riverview Lutheran Retirement Community of Spokane, d/b/a RiverCare Home Health

Dear Mr. Hernandez,

Riverview Lutheran Retirement Community of Spokane, d/b/a RiverCare Home Health in accordance with WAC 246-310-080, hereby submits this letter of intent to apply for a Certificate of Need to establish a home health agency in Spokane County, Washington.

Riverview has a rich history serving the Spokane community since 1959 on a 35-acre campus. As a local non-profit, we listen to our community members and are responsive to our residents' needs and ideas. As such, we are applying for the Certificate of Need to help our residents and the greater community to be able to access quality home health services in a timely manner. RiverCare will provide Home Care along with our Home Health services to include skilled nursing, physical therapy, occupational therapy, speech therapy and social worker.

RiverCare is estimated to cost $16,000.00 for start-up supplies plus $24,666 for application fee. RiverCare will need to purchase technology, supplies for care, collateral and marketing supplies. Office space has already been acquired within Riverview Retirement Community. Payment will be made by check when the application is sent in.

We look forward to one day serving our community with home health services. Thank you for the opportunity to submit this application. Please feel free to contact me with any questions or concerns.

Sincerely,

Chandra Dunker
RiverCare Manager
cdunker@riverviewretirement.org

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.

Washington License HIS.FS 61373295
Medicare #: N/A
Medicaid #: N/A

Section 3
Certificate of Need Criteria

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.

1. **List all home health providers currently operating in the planning area.**
   According to records requested from the Washington Department of Health, since 2005, 67 in-home care agencies have either closed or expired, while there are currently 53 active in-home care agencies in Spokane County (Attachment 1). Among these, 12 agencies are considered comparable to RiverCare. However, Assured Home Health and CenterWell Home Health are listed twice, so they should be counted as a single agency. This adjustment changes the number of comparable active home health agencies to 10.

   Chart:

Medicare & Medicaid Certified	**Legal Entity**	**DBA**	**Website Confirms Service Area & Services**	**Agency Should Be Counted**
Y	Assured Home Health	Assured	Y	Y
Y	Assured Home Health	Assured	Y	Y
Y	CenterWell Home Health	CenterWell	Y	Y
Y	CenterWell Home Health	CenterWell	Y	Y
Y	Eden Home Health	Eden	Y	Y
Y	Inland Home Healthcare	Inland Home Health	Y	Y
Y	Intrepid USA Healthcare Services	Intrepid	Y	Y Notice of Closure
Y	Providence Elder Place	Providence Elder Place	Y	Y
Y	Providence VNA Home Health	VNA Home Health	Y	Y
Y	Serengeti Care	Serengeti Care	Y	Y
Y	Sunshine Home Health Care	Sunshine Home Health	Y	Y
Y	Touchmark Home Health	Touchmark Home Health	Y	Y
Y	Orchard Prairie	Orchard Prairie	Y	Y
Y	AAging Better In-Home Care	AAging	Y	N
Y	Addus HomeCare, Arcadia Home Care and Staffing	Addus	Y	N
N	All Ways Caring HomeCare Spokane	All Ways Caring	Y	N

Y	Amazing Touch Home Health Agency, LLC	Amazing Touch Home Health	N	N
Y	Angel Senior Care	Angel Care	N	N
N	Apria Healthcare, LLC	Apria	N	N Equipment Services
Y	Aveanna Healthcare	Aveanna	Y	N
N	Beneficial In-Home Care Inc.	Beneficial In-Home Care	N	N
Y	Bogden House WA	Bogden House	Y	N Group Home
N	Brightstar Care of North Spokane	Brightstar Care	Y	N
N	Brookdale at Home Spokane	Brookdale	N	N
N	Care to Stay Home	Care to Stay Home	Y	N Non- Medical In-Home Care
Y	Comfort Keepers #1113	Comfort Keepers	Y	N
Y	Dementia Care Solutions	Dementia Care	N	N Counseling
Y	Family First	Family First	Y	N
Y	Family Resource Home Care	Family Resource	Y	N
Y	Gentiva	Gentiva	Y	N
Y	Greenstaff Home Care	Greenstaff	Y	N
Y	Havenwood Caregiver Services	Havenwood Home Care	Y	N
Y	Home Instead of Spokane	Home Instead	Y	N
Y	Horizon Hospice and Palliative Care	Horizon	Y	N
Y	Hospice of Spokane	Hospice of Spokane	Y	N
Y	Lincare	Lincare	Y	N Medical Equipment
N	Love at Home Senior Care	Love at Home	Y	N
Y	Loving Neighbor	Loving Neighbor	Y	N
N	Maxim Healthcare Services Inc.	Maxim	Y	N All Ages Home Care
Y	New Horizons In-Home Care	New Horizons	N	N
Y	Option Care	Option Care	Y	N Infusion Center
Y	Precision Home Care LLC	Precision	N	N
Y	Providence Hospice Spokane	Providence Hospice	Y	N Hospice Care
Y	Right at Home of Spokane	Right at Home	N	N
Y	Rotech	Rotech	Y	N Medical

				Supplier
N	RWW Home And Community Rehab Services, INC	RWW	N	N
Y	S and S Health Care	S & S	Y	N
Y	Seattle Children's Hospital Home Care Services	Seattle Children's Hospital Home Care	N	N
N	Stepping Stone's Pediatric Therapy	Stepping Stone's	N	N
N	Senior Helpers	Senior Helpers	N	N
Y	Silver Steps	Silver Steps	N	N
N	Total Care Inc	Total Care	Y	N
Y	Visiting Angels	Visiting Angels	N	N

2. Complete the numeric methodology.

Under the Washington Administrative Code (WAC) 246-310-210, the Department of Health establishes regulations for determining the need for home health agencies. Since 1987, the Washington State Health Plan has been used to project home health agency needs in each county by estimating the number of home health visits required in a given area. According to the 2020 U.S. Census, Spokane County had a total population of 539,339. By 2024, the estimated population is expected to reach 553,170, reflecting an average annual growth rate of 1.3%, based on U.S. Census data (Attachment C). Additionally, projections by Trinity NAC in 2022 estimate a growth rate of up to 19% for residents aged 65 and older in both Washington State and the Spokane area (Attachment H).

The methodology uses the following factors:

- Identify projected populations of a County, broken down by age groups
- Apply estimated home health use by age group
- Apply estimated number of visits per age group
- Divide number of projected visits by an average of 10,000 visits per agency
- Number of agencies needed per visit minus the current home health agencies equals number of new agencies needed in county

Spokane County Need Projection – Table 1				
Row	**Population by Age**	**Population 2024**	**Population 2025**	**Population 2026**
1*	0-64 years	448,387	454,216	460,120
2*	65-79 years	83,035	84,114	85,207
3*	80+ years	22,142	22,430	22,722
SHP Formula				
4*	0-64 years (.005* 10)	.005	.005	.005
5*	65-79 years (.044* 14)	.044	.044	.044
6*	80+ years (.183* 21)	.183	.183	.183
Projected Visits				
0-64 years		22,419	22,711	23,006
65-79 years		51,150	51,814	52,488
80+ years		85,088	86,198	87,320
TOTAL		158,657	160,723	162,814
Visits per Agency 10,000		15.87	16.07	16.28
Agencies Needed		15	16	16
Current HH Agencies		*10/12	*10/12	*10/12
New HH Agencies Need		**5/3**	**6/4**	**6/4**

*10 Active Home Health Agencies if 2 agencies (Assured & CenterWell) are combined since listed 2 times. 12 agencies if not combined. Average is 5.

Applying the numeric methodology indicates that Spokane County has a significant need for additional home health agencies, even when considering a conservative growth rate of 1.3%. Whether there are 10 or 12 current home health agencies, a shortage persists. Several key factors further emphasize this need:

1. The number of baby boomers turning 65 is increasing by 10,000 daily.

2. There is a growing trend for individuals to prefer receiving care at home rather than in institutional settings.

3. According to Trella Health reports, only 66% of patients in Spokane County are admitted within the 48-hour requirement.

4. Home health utilization rates in Washington are at 17.6%, compared to the national average of 24.8%, as noted in the 2024 Post-Acute Care Industry Report, Edition 1 (Attachment F).

Given these factors, it is clear that current home health agencies in Spokane County cannot adequately meet the home health needs of its residents.

3. If applicable, provide a discussion identifying which agencies identified in response to Question 1 should be excluded from the numeric need methodology and why. Examples for exclusion could include but are not limited to: not serving the entire geography of the planning area, being exclusively dedicated to DME, infusion, or respiratory care, or only serving limited groups.

Based on the list from the Department of Health, it was determined that among the 53 in-home service agencies in Spokane County, only 12 qualify to be counted in the numerical methodology, with 2 of these being duplicate listings. Additionally, there are:

- 3 equipment suppliers
- 3 specialty providers
- 1 notice of closure
- 34 in-home providers or non-certified Medicare and Medicaid agencies

This breakdown highlights that a significant portion of the agencies are either duplicates or do not meet the criteria for certified home health services, contributing to the shortage of qualified home health agencies in the area.

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.

Existing services are not available and accessible due to the following reasons:

- With 10,000 baby boomers turning 65 each day, research from McKnights Senior Living (Attachment G) indicates that 7 out of 10 will require home health support.

- As previously mentioned, the numerical methodology reveals a need for 4-6 additional home health agencies in Spokane County, average being 5 agencies. This shortage means that approximately 3,382 individuals, or about one-third of those eligible for home health services, are currently unable to access the care they need. This underscores the urgent requirement to expand the capacity of home health services in the area to meet the growing demand. See Table 2.

- According to data retrieved from CHARS reports, hospital inpatient referrals in Spokane County occur at twice the average rate compared to the overall inpatient referral rate for Washington. This suggests that there is a significant demand for post-hospitalization care in Spokane County, further emphasizing the need for more home health agencies to adequately support patient transitions from hospital to home care.

- Eastern Washington has higher age-adjusted mortality rates for the 10 leading causes of death compared to Western Washington. Specifically, for 6 out of these 10 leading causes—Alzheimer's disease, unintentional injuries, chronic lower respiratory diseases, diabetes, suicide, and chronic liver disease and cirrhosis—Eastern Washington's rates exceed the national average. This highlights the region's need for enhanced healthcare services, including home health care, to address and manage these prevalent health challenges more effectively (Attachment H).

Home Health Population Unmet Needs – Table 2				
	2024	2025	2026	2027
Population needs not meet	3,382	3,425	3,470	3515
Patients for each new HH	676	685	694	703
Visits for 5 New HH per HH	16,760	16,850	16,940	17,030

5. For existing agencies, using the table below, provide the home health agency's historical utilization broken down by county for the last three full calendar years.

This is a new home health agency and has had no historical utilization for the last three years.

Table 3 **County**	Identify Year	Identify Year	Identify Year
Total number of admissions	N/A	N/A	N/A
Total number of visits	N/A	N/A	N/A
Average number of visits/patient	N/A	N/A	N/A

6. **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.**

2025

- Predicted there will be 685 patients available per new home health agency.
- With 5 new agencies, there would be a total of (685 \times 5 = 3,425) potential patients.
- Due to the timeline, we would only provide services for 8 months of the year or 456 patients.
- At an 80% productivity rate during these 8 months, each agency can serve about 365 patients in total.
- Assuming we plan for each patient to receive 18 visits, we would conduct (365 \times 18 = 6,570) visits overall in 2025.

2026

- We project that RiverCare could serve 555 patients.
- If maintaining the same practice of 18 visits per patient, we will conduct (555\times 18 = 9,990) visits in 2026.

2027

- We project that with year-over-year growth we could serve 562 patients.
- For 562 patients, with 18 visits each, we will conduct (562\times 18 = 10,116) visits in 2027.

This plan shows a gradual increase in the number of patients served each subsequent year, reflecting a growing capacity or demand for services.

Table 4:

Agency Year **# Patients – 80% productivity**	May – Dec. 2025 456 – 80%	2026 694 - 80%	2027 703 - 80%
Total number of admissions	365	555	562
Average visits per agency	6,570	9,990	10,116
Projected number of visits/patient	18	18	18

7. **Identify any factors in the planning area that could restrict patient access to home health services.**

There are considerable unmet needs in Spokane County. Therefore, the demand outweighs the restrictions. Factors that restrict patient access to home health care services are listed below:

- Staffing shortages: The COVID-19 pandemic has led to a significant decrease in the number of healthcare professionals, resulting in challenges for patients trying to secure timely appointments as required by CMS. Many healthcare providers are facing capacity issues and, as a result, are not

accepting new patients. This strain on the healthcare system further underscores the urgent need to expand home health services and resources to ensure patients receive the care they need when they need it.

- Lack of Caregiver Support: Accessing home health services often requires the support of family or friends, but not everyone has a reliable support system or the financial means to hire additional caregiver support. This lack of support can create significant barriers for individuals who qualify for home health care, potentially impacting their ability to remain safely and independently at home. Expanding home health services, including affordable and accessible support options, is crucial to address this gap and ensure all individuals receive the necessary care and assistance.

- Transportation: Transportation barriers can significantly hinder individuals' ability to attend medical appointments, leading to delayed care and potentially worsening health conditions. This issue underscores the importance of home health care services, which bring essential medical attention directly to patients' homes. Improving access to home-based care can help mitigate the impact of transportation challenges, ensuring that individuals receive timely and necessary health services.

- Insurance: Recent changes in Medicare and the growing popularity of Medicare Advantage plans present both opportunities and challenges in the healthcare landscape.

    - Changes in Medicare: Modifications to Medicare policies may affect coverage options, reimbursement rates, and the types of services available to beneficiaries, which can influence patients' access to care.

    - Increase in Medicare Advantage Plans: The rise of Medicare Advantage plans has broadened choices for beneficiaries, often providing additional benefits that traditional Medicare does not cover. However, while these plans offer enhanced services, they may also come with network restrictions and varying out-of-pocket costs, which can create confusion.

    - Health Insurance Non-Coverage: Gaps in coverage for certain healthcare services continue to be a concern, especially for individuals with complex health needs who require comprehensive care. Many services—like certain therapies and home health support—might not be fully covered under all plans, leaving patients to bear the costs out of pocket.

These factors can complicate patients' access to necessary healthcare services, reinforcing the need for expanded home health care options that cater to diverse insurance scenarios and address these evolving challenges.

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

   See answer to Section 2 question #4 (this question is asked twice)

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

   See answer in Section 2 question #5 (this question is asked twice)

10. **Identify how this project will be available and accessible to underserved groups.**

    Expanding the capacity and accessibility of home health services in Spokane County is crucial given the current shortfall that leaves approximately 3,382 individuals without necessary care. RiverCare's initiatives are well-targeted to address this gap in services:

    1. Charitable Foundation:
       - By offering financial assistance, RiverCare can make home health services more affordable, removing one of the financial barriers to access.
       - This can potentially increase the number of patients utilizing home health services as they face fewer financial constraints.
    2. RiverCare Services:
       - Transportation Support: Facilitating transportation can significantly improve access for patients who have difficulties reaching healthcare services, thus encouraging more consistent use of home health offerings.
       - Caregiver Support: Providing caregiver assistance alleviates the burden on families and enhances the patient's experience by ensuring continuity and quality of care at home.
       - Care Coordination: Streamlining care coordination can optimize resource use and improve patient outcomes by making healthcare processes more efficient and less burdensome for patients and families.

    Together, these efforts not only address immediate access issues but also lay the groundwork for long-term improvements in home health service delivery. By increasing service capacity and accessibility, RiverCare is poised to help meet the needs of the underserved population in Spokane County and improve overall home health utilization rates in Washington.

11. Provide a copy of the following policies:

- Admissions Policy – Attachment 2
- Charity Care or Financial Assistance Policy – Attachment 3
- Patient Rights and Responsibilities Policy – Attachment 4
- Non-discrimination Policy – Attachment 5
- Discharge Policy– Attachment 6
- Violence in the Workplace – Attachment 7
- Patient and Personnel Safety – Attachment 8

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

Financial feasibility of a home health 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.**

     See RiverCare Home Health Analysis on next page (page 23)

   - **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.**

     See RiverCare Home Health Analysis on next page (page 23)

   - **Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.**

     See RiverCare Home Health Analysis on next page (page 23)

   - **For existing agencies proposing the addition of another county, provide historical revenue and expense statements, including the current year.**

     Not applicable. This is not an existing agency.

Riverview Retirement Community
Rivercare Home Health Analysis
Updated 9/2024

	2025	2026	2027	2028	Assumptions
REVENUE					
Service Fees Home Health					
Medicare	-	317,141	646,967	659,907	Mix 80%
Medicaid	-	59,464	121,306	123,733	Mix 15%
Private Pay	-	19,821	40,435	41,244	Mix 5%
Other	-	-	-	-	
Non Operating	-	-	-	-	
TOTAL REVENUE	-	396,426	808,709	824,883	
EXPENSES					
Salaries and Wages	107,254	322,014	495,568	510,002	**See FTEs below by position**
Employee Benefits	15,103	48,272	73,755	75,903	**Based on Riverview Retirement's benefit package**
Payroll Taxes	9,136	27,692	42,623	43,865	**Includes FICA, SUI, WC, WA FMLA**
Advertising and Promotion	2,000	2,000	2,000	2,000	
Depreciation and Amortization	2,000	2,000	2,000	2,000	**Furniture, IT Equipment (see capital list)**
Dues and Subscriptions	100	100	100	100	
Education and Training	1,000	1,000	1,000	1,000	**Educational seminars**
Information Technology/Computers	13,000	13,000	13,000	13,000	**Staff will use iPads/Billing, Clinical software**
Insurance		18,367	18,918	19,485	
Legal and Professional	500	500	500	500	
Licenses and Fees	25,000	8,000	500	500	**Includes CON $25,000 and HH License $7,500**
Medical Supplies		2,500	5,000	5,000	
Other - Copying and Printing		800	800	800	**Forms and brochures**
Other - Meals and Relations		200	200	200	**Staff and patient relations**
Postage		50	50	50	**Billing statements**
Purchased Services - Utilities	200	200	200	200	
Repairs and Maintenance		50	50	50	
Supplies	2000	2,000	2,000	2,000	**includes uniforms and office supplies**
Telephone and Pagers	1000	1,000	1,000	1,000	**Director and manager**
Travel Expenses	500	500	500	500	**Mileage and educational seminars**
Total Expenses	178,793	450,244	659,764	678,155	
Operating profit (loss)	(178,793)	(53,818)	148,945	146,728	

POSITION FTE SUMMARY:	**2025**	**2026**	**2027**	**2028**
Executive Administrator	0.75	0.75	0.75	0.75
Scheduler		0.375	0.375	0.375
Clinical RN Manager	0.5	1	1	1
RN/LPN		0.5	1	1
Caregiver		0.5	1	1
PT		0.5	1	1
OT		0.5	1	1
ST		0.1	0.2	0.2
TOTAL FTEs	1.3	4.2	6.3	6.3

UTILIZATION/CENSUS:	Rate 2025	FTE	Billable Hours	Visits
Caregiver/RN/LPN	74.81	1	1664	1248
PT	180.58	1	1664	1040
OT	181.83	1	1664	1040
ST	196.29	0.2	332.8	208
Totals			5325	3536

Note - 2% rate increase each year

2. Provide the following agreements/contracts:

- Management agreement – Not applicable
  No management agreement

- Operating agreement – Not applicable
  No operating agreement

- Medical director agreement – Not applicable
  No medical director agreement

- Joint Venture agreement – Not applicable
  No joint venture 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 a new home health agency site, documentation of site control includes one of the following:

a. **An executed purchase agreement or deed for the site.**

See Attachment 9

b. **A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**

Not applicable

c. **An executed lease agreement for at least three years with options to renew for not less than a total of two years.**

Not applicable

d. **A draft lease agreement.**

Not applicable

4. **Complete the table below 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 below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate**

Table 6:

Item		Cost
a. Land Purchase		$
b. Utilities to Lot Line		$
c. Land Improvements		$
d. Building Purchase		$
e. Residual Value of Replaced Facility		$
f. Building Construction		$
g. Fixed Equipment (not already included in the construction contract)		$
h. Movable Equipment		$12,500
Computer	$1,500	
Cellular Phone	$1,000	
iPads	$5,000	
Furniture (CAPEX)	$5,000	
i. Architect and Engineering Fees		$
j. Consulting Fees		$
k. Site Preparation		$
l. Supervision and Inspection of Site		$
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)		
1. Land		$
2. Building		$
3. Equipment		$
4. Other		$
n. Washington Sales Tax		$
Total Estimated Capital Expenditure		**$12,500.00**

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.**

Riverview Lutheran Retirement Community of Spokane – 100%

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

Start-up Costs:	
Certificate of Need	25000
Uniforms	500
Home Health License	7500
Office Supplies	500
Collateral and Marketing	2500

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

Riverview Lutheran Retirement Community of Spokane – 100%

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

The RiverCare project might not directly affect the preset costs of home health services due to Medicare's pricing structure, it could positively influence the overall efficiency and accessibility of home health care services in Spokane County.

- Medicare Reimbursement Rates: These rates are fixed and regulate the cost structure for home health services under Medicare. This means that changes in local supply, demand, or funding models generally do not impact the reimbursement rates set by Medicare for those covered services.

- Cost-effectiveness of Home Health Care: Home health care is indeed often more cost-effective compared to institutional care, such as hospitalization or long-term care facilities. This cost-effectiveness can lead to overall reduced healthcare expenditures for both patients and the healthcare system.

- Access and Availability: While the primary costs might remain unchanged due to fixed Medicare rates, increased availability of home health services can enhance access, potentially improving outcomes and reducing the need for more expensive care options.

- Non-impact on Healthcare Costs: Since Medicare sets the reimbursement rates for many home health services, a project like RiverCare would more likely influence healthcare delivery efficiencies and patient outcomes rather than the direct costs of services.

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 healthcare services in the planning area.

This is not applicable as there are no construction costs.

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 7

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	80%	80%
Medicaid	15%	15%
Other Payers Private Pay	5%	5%
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.**

This is not applicable, new home health agency.

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

There is no equipment needed except for moveable equipment. See table below.

Table 8

h. Movable Equipment		$12,500
Computer	$1,500	
Cellular Phone	$1,000	
iPads	$5,000	
Furniture (CAPEX)	$5,000	

13. **Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source.**

This is not applicable as there is no source of funding.

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.**

This is not applicable as there is no source of funding.

15. **Provide the most recent audited financial statements for:**

See Attachment 10

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 9

Staff Category	Definition	Number of FTEs 2025	Number of FTEs 2026	Number of FTEs 2027	Number of FTEs 2028
Skilled Nurses	Registered nurses providing skilled nursing care to patients at home.	0	.5	1	1
Physical Therapists	Licensed therapists assisting patients with rehabilitation exercises.	0	.5	1	1
Occupational Therapists	Professionals helping patients with daily living activities and adaptations.	0	.5	1	1
Speech Therapists	Specialists providing therapy to improve communication and swallowing.	0	.1	.2	.2
Social Workers	Professionals offering counseling and resources for patients and families.	0	Per diem	Per diem	Per diem
Home Health Aides	Certified aides assisting with personal care and daily living tasks.	0	.5	1	1
Administrator	Employee overseeing operations, billing, and scheduling.	.75	.75	.75	.75
Clinical Manager	Daily operations. Ensure that patient care is delivered efficiently and safely, review orders, documentation.	0	.5	1	1
Care Coordinator/Scheduler	Includes receptionists and other support roles including patient/clinician scheduling	.375	.375	.375	.375
TOTALS		1.1	4.2	6.3	6.3

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.**

This is a new home health agency to only serve Spokane County.

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

To provide assumptions for projecting the number and types of Full-Time Equivalents (FTEs) for this project, we considered the following factors:

- Project Scope and Objectives: Clearly defined goals and deliverables influence how many FTEs are required.
- Timeline: Determining the duration of the project startup is indeed crucial for forecasting the necessary FTEs and anticipated growth over the first three years of operations
- Workload Estimation: Estimating the workload required for clinicians can be guided by industry benchmarks and data from similar agencies. This approach helps ensure that staffing levels are adequate to meet resident needs while maintaining high-quality care.
- Skill Sets Required: Clearly defining the skills and expertise needed for each position is crucial for determining the types of FTEs required.
- Resource Availability: By assessing the capabilities and willingness of your existing staff, you can enhance flexibility, maximize the talent within your team, and meet the needs of residents without immediately resorting to hiring additional personnel.
- Budget Constraints: By leveraging the existing interest in home health services alongside Riverview's strong financial position, we can enhance the quality and availability of care for residents, which could lead to improved satisfaction and potentially attract more residents.

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

Introducing home health services at Riverview Retirement Community is indeed a strategic way to address the needs of our residents after the closure of our skilled nursing facility. By starting small, we can focus on building a strong foundation of high-quality care, ensuring consistency and reliability in our services. With our

existing reputation for quality, this phased approach allows you to fine-tune operations and build trust within the community.

To effectively estimate the number of patients and visits, we considered the current underutilization rates, the rate of admissions for home health services, and the fact that a significant portion of eligible patients are not currently receiving services in Spokane County. By analyzing these factors, you can project the demand for your services and plan resource allocation accordingly.

Given that RiverCare has access to existing staff in assisted living, memory care, and therapy, we can leverage this resource to create more flexibility in staffing and potentially reduce the need to hire as many additional personnel.

Our strategies are as follows:

- Cross-Training Staff: Train current employees in multiple roles so that they can fill in as needed across different areas, such as having therapists assist in home health when necessary or Certified Nursing Assistants work in our home care, home health and assisted living programs. This increases flexibility and allows you to allocate staff more efficiently based on demand.

- Assess Current Workloads: Evaluate the current workloads of therapy team members to identify if they can handle additional clients or responsibilities without compromising care quality.

- Flexible Scheduling: RiverCare's flexible scheduling options allow existing staff to pick up extra hours or shifts in areas where there is a need, while also respecting their work-life balance.

By assessing the capabilities and willingness of RiverCare's existing staff, we can enhance flexibility, maximize the talent within our team, and meet the needs of residents.

5. **If you intend to have a medical director, 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.**

RiverCare does not intend on using a medical director at this time. RiverCare has a strategic plan in place for managing clinical operations through a partnership with Meza Care and by appointing a Registered Nurse as the Clinical Manager. This approach can ensure that even without a dedicated medical director, clinical operations are effectively managed to ensuring compliance with healthcare regulations. RiverCare will directly work with patient's attending physicians for orders, medication management, required documentation, face to face visits and follow-up appointments.

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

RiverCare does not intend on using a medical director.

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.)**

Table 10

Name	Title	License Number	Schedule	Timeline for Hire
Danie Monaghan	President & CEO	NA	FT	NA
Chandra Dunker	RiverCare Manager	NA	FT	NA
Christopher Mulvihill	Director of Clinical Wellness	RN60754106	PRN	NA
Unknown	Clinical Manager	NA	FT	February 2025
Unknown	Care Coordinator/Scheduler	NA	.375	October 2024
April Ritter	Director of Therapy – OT	OT00004324	PRN	NA
Elizabeth Cloward	Registered Nurse License	RN00135533	PRN	NA
Katrina Brecht	Physical Therapist License	PT00009229	PRN	NA
Sandra Richardson	Physical Therapist Assistant License	P160045531	PRN	NA
Sonja Barrera	Physical Therapist License	PT00006086	PRN	NA
Kylie Smith	Physical Therapist Assistant License	P160838961	PRN	NA
Jayme Butler	Occupational Therapy Assistant License	OC60896662	PRN	NA
Laura Harper	Speech Language Pathologist License	LL00003974	PRN	NA
Samantha MacCallum	Occupational Therapist License	OT60924416	PRN	NA
Yelena Berlova	Physical Therapist Assistant License	P160473303	PRN	NA
Roberta Choma	Occupational Therapist License	OT00000198	PRN	NA
Jade Collins	Home Health Aide	CNA Class 9/9/2024	.5	August 2024

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

New home health agency, this does not apply.

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.**

RiverCare is taking a comprehensive approach to address staffing shortages by implementing various strategies for recruiting and retaining employees. By sponsoring new hires for their Certified Nursing Assistant courses and providing wages during their training, RiverCare is not only creating opportunities for new entrants but also investing in the development of their workforce. This can foster loyalty and reduce turnover.

Negotiating higher wages for experienced and licensed candidates is another effective way to attract skilled professionals in a competitive market. Regular reviews of recruitment strategies by agency leadership ensure that Riverview can adapt to changing needs and continuously improve its approach.

Additionally, offering a referral bonus can be a powerful incentive for current employees to bring in qualified candidates, leveraging their networks and enhancing team cohesion. The interest expressed by current employees to transition into home health services is a positive indicator of engagement and a smooth expansion into this area.

Riverview's strong reputation for quality care is an excellent asset, naturally drawing candidates who have heard good things about the organization. Maintaining this reputation will be vital as we continue to recruit and expand services.

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

RiverCare's intended hours of operation, from Monday through Friday, 7:30 am to 6:00 pm, with an on-call nurse for weekends and nights, ensures that patients have access to care throughout the week. By having a rotating nurse on call, RiverCare can provide necessary support for urgent needs outside regular hours. It's also beneficial that Riverview offers support for phone calls outside regular operating hours, helping to manage any patient concerns that may arise during those times.

Having the Clinical Manager and Administrator available on call further strengthens this support system, ensuring that any significant issues can be addressed efficiently. Directing patients with immediate emergency needs to call 911 is an appropriate and standard protocol, ensuring they receive the urgent care required. This structure helps maintain continuity of care while managing resources effectively.

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

New home health agency, this does not apply.

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

New home health agency, this does not apply.

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

New home health agency, this does not apply.

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

Amazon Business
Cintas
Costco
Direct Supply
Lab Corp – Drug testing for employees
Medline
Paycom – Payroll System
Phoenix Textiles
Point Click Care - Healthcare Software
Staples Advantage
Sysco
US Foods Inc
Walter E Nelson Co of Western Washington
West Coast Paper

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

New home health agency, this does not apply.

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

New home health agency, this does not apply.

17. For a new agency, provide the names of healthcare facilities with which the home health agency anticipates it would establish working relationships.
Table 11

Skilled Nursing Facilities	
North Central Care Center	Royal Park Health & Rehabilitation
Cheney Care Center	Avalon Care Center
Garden Plaza of Post Falls	Alderwood Manor
Spokane Health & Rehabilitation	Maplewood Gardens
Providence St. Joseph Care Center	Aurora Valley Care
Touchmark on South Hill	Regency at Northpoint
Avamere at South Hill	Sullivan Park Care Center
Spokane Valley Health & Rehabilitation	Rockwood South Hill
Sunshine Health & Rehabilitation	
Hospitals	
Providence Sacred Heart Medical Center	Providence Holy Family Hospital
MultiCare Deaconess Hospital	MultiCare Valley Hospital

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 health care facility; or
b. A revocation of a license to operate a healthcare facility; or
c. A revocation of a license to practice as 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.

Riverview and RiverCare have no history with the above actions described. Therefore, this question is not applicable.

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

RiverCare is dedicated to enhancing the continuity of healthcare services within the Spokane community, building upon its strong legacy of providing comprehensive care. Our approach centers on fostering collaborations with key stakeholders, including hospitals, healthcare providers, and ancillary facilities, to ensure seamless transitions across different levels of care.

1. Commitment to Continuum of Care:
    - RiverCare aims to bridge gaps in healthcare delivery by expanding access to home health services. This initiative supports the growing preference for in-home care, providing patients with personalized and comfortable healthcare solutions.
    - By leveraging home health services, we ensure patients receive consistent and coordinated care, minimizing the disruptions that can occur during transitions between different care settings.

2. Collaborative Partnerships:
    - Our marketing and leadership teams actively engage with community partners to assess local needs and integrate services effectively.
    - Partnerships with local hospitals and healthcare providers enable us to align care plans, share vital patient information securely, and coordinate discharge planning.

3. Community Engagement and Needs Assessment:
    - We maintain open lines of communication with community members and healthcare professionals to identify emerging health concerns and service gaps. This proactive approach allows us to adapt services to meet the evolving needs of the population.

4. Cost-Effective Solutions:
    - Transitioning to home-based care offers a cost-effective alternative to traditional institutional care, addressing both consumer demand and financial sustainability.

5. Addressing Closure of Skilled Nursing Facility:
    - The decision to transition away from the skilled nursing facility was informed by a comprehensive analysis of community needs, emphasizing a shift toward in-home care solutions that align with current healthcare trends.

By integrating these strategies, RiverCare is committed to delivering uninterrupted and comprehensive healthcare services. This approach not only addresses current community needs but also lays the foundation for a sustainable and responsive healthcare system in Spokane.

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.

To ensure that the proposed project aligns appropriately with the existing healthcare system in the service area, it is crucial to establish a clear and cooperative relationship with local healthcare entities. This approach involves strategic planning and communication to integrate effectively within the current healthcare landscape.

1. Alignment with Regional Health Strategies:
    - Our project supports regional health goals by addressing specific gaps in care identified through collaboration with local health authorities and community health assessments.
    - By focusing on home health services, we contribute to the regional strategy of reducing institutional care dependency.
    - RiverCare has an established relationship with Spokane Regional Health.

2. Collaboration with Healthcare Providers:
    - RiverCare is engaged in ongoing dialogues with nearby hospitals, clinics, and independent healthcare providers to ensure our services complement and enhance their offerings.
    - We coordinate closely on patient care plans, ensuring our home health services extend and complement the acute care provided by hospitals, improving patient outcomes through coordinated follow-up care.

3. Strategic Partnerships with Health Networks:
    - We have established and will continue to foster partnerships with existing health networks and community health organizations to ensure services are complementary rather than duplicative.
    - These partnerships promote resource sharing and joint initiatives that benefit the larger community and improve access to care.

By being attuned to the needs and operations of the existing healthcare system, RiverCare's project is designed to be a valuable addition to the Spokane area's healthcare landscape.

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 facilities current compliance status.

Riverview has no facilities owned or operated that reflect a pattern of condition level findings and is not applicable.

22. If information provided in response to the question above show 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.

This question is not applicable as there are no pattern of condition level findings.

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.

   Prior to deciding on the establishment of RiverCare, Riverview considered several alternatives to address the needs of its residents following the closure of the Skilled Nursing Facility in 2020. Here is a summary of the alternatives considered:

   1. Reopening the Skilled Nursing Facility: Riverview explored the possibility of reopening the existing Skilled Nursing Facility. However, it was determined that the building did not meet current health and safety standards, and renovating it to comply would require a significant financial investment, costing millions of dollars.

   2. Developing a CORF Therapy Department: As an alternative to reopening the facility, Riverview developed a Comprehensive Outpatient Rehabilitation Facility (CORF) therapy department to cater to the therapy needs of its residents. This aimed to provide necessary rehabilitation services onsite without extensive infrastructure costs.

   3. Partnership with Community Skilled Nursing Facility: Riverview formed a partnership with a nearby community skilled nursing facility. This collaboration was intended to fulfill nursing care needs that could not be met onsite, offering residents an option for skilled nursing care through an external provider.

   Despite these efforts, residents continued to express dissatisfaction with the lack of timely home health services and skilled nursing availability onsite. The demand for a continuum of care and the trends indicating a preference for at-home care solutions highlighted the need for a more tailored approach.

   Ultimately, Riverview decided to establish RiverCare, a new home health agency designed to better serve its residents and the broader Spokane community. This solution was seen as the most responsive and cost-effective way to meet community needs by providing home-based care, which aligns with patient preferences and cost-saving objectives. Additionally, the Therapy department services are transitioning to an outpatient model for those without skilled needs or homebound requirements, expanding their reach and accessibility within the community.

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.**

When comparing the establishment of RiverCare to the alternatives that were considered and ultimately rejected, several factors contribute to this project's superiority:

Patient Access to Healthcare Services:

- RiverCare: By establishing a home health agency, RiverCare enhances access to healthcare services directly within the community and homes, addressing the residents' voiced needs for timely home health services and a continuum of care.

- Reopening the Skilled Nursing Facility: While this would provide on-site skilled care, the significant cost and time required to renovate the building and meet safety standards could delay access improvement.

- Partnership with Community Facility: Although partnerships offer skilled nursing care, they don't provide timely services and continuity within the residents' preferred settings, as they require offsite relocation for care.

Capital Cost:

- RiverCare: Establishing a home health agency involves lower upfront costs compared to renovating the existing Skilled Nursing Facility. It also leverages existing resources with minimal new infrastructure.

- Reopening the Skilled Nursing Facility: This option demands a multi-million-dollar investment for renovations, representing a significant capital outlay with long-term financial implications.

Legal Restrictions:

- RiverCare: Operating a home health agency typically involves fewer regulatory challenges compared to nursing home operations, particularly concerning building codes and onsite care standards.

- Reopening the Skilled Nursing Facility: Compliance with updated fire and safety standards presents legal challenges and potential liabilities if not addressed appropriately.

Staffing Impacts:

- RiverCare: This model can utilize existing staff for home health roles and outpatient services, potentially enhancing job satisfaction through varied work environments and schedules.

- Reopening the Skilled Nursing Facility: Reopening requires hiring additional skilled staff for all operational hours, increasing staffing complexity and costs.

Quality of Care:

- RiverCare: Provides personalized and flexible care in the comfort of the patient's home, which can improve patient outcomes and satisfaction by catering directly to individual preferences.

- Reopening the Skilled Nursing Facility: While it centralizes care, it may not align with patient preferences for home-based care options, potentially affecting satisfaction and engagement.

Cost or Operation Efficiency:

- RiverCare: Home health services are generally more cost-effective in the long run due to lower operational costs and the ability to scale services based on demand.

- Reopening the Skilled Nursing Facility: High operational costs tied to facility management and the full-time staffing requirement can strain financial resources.

Overall, the establishment of RiverCare surpasses the other alternatives by effectively balancing cost, accessibility, compliance, and quality of care while meeting the evolving preferences and needs of the residents and the wider community.

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.**

Not applicable, this project does not involve construction.

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.**

The establishment of RiverCare highlights several aspects that involve improvements and innovations in the financing and delivery of health services, aiming to foster cost containment while promoting quality assurance and cost-effectiveness:

1. Home-Based Care Model:
   - Cost Containment: Delivering care in patient homes reduces the need for expensive institutional infrastructure, leading to significant savings in overhead and operational costs. Avoiding the high costs associated with maintaining a traditional nursing facility, such as utilities, maintenance, and staffing, helps contain costs effectively.

- Quality Assurance: By providing personalized care in familiar environments, this model supports better health outcomes and patient satisfaction. Home care allows for tailored care plans that meet individual needs, improving the quality of service delivery.

2. Integrated Health Services:
   - Efficiency: Integration of services, such as home health and outpatient therapy, allows for streamlined care coordination. This holistic approach minimizes redundancies, enhances resource utilization, and improves overall operational efficiency.

   - Continuum of Care: By ensuring a seamless transition between different levels of care, quality of care is maintained, and unnecessary costs from rehospitalizations or emergency care can be reduced.

3. Leveraging Technology:
   - Efficiency in Care Management: Using electronic health records and digital tools for scheduling and care management improves communication between healthcare providers, enhancing the accuracy of care delivery and reducing administrative costs.

4. Community Partnerships:
   - Collaborative Care Networks: By establishing partnerships with local healthcare providers, RiverCare can expand service offerings while sharing resources and expertise, which reduces individual organizational costs and strengthens community-wide care delivery systems.

   - Resource Sharing: Collaborations can include shared staffing agreements, joint training programs, and coordinated marketing efforts, all of which contribute to cost efficiencies while maintaining or enhancing the quality of care.

These strategies highlight RiverCare's commitment to innovative care delivery and cost management, ensuring high-quality, efficient, and accessible healthcare services for the community.

Section 4
Home Health Agency Tie Breakers

Section 4

Home Health Agency Tie Breakers (1987 State Health Plan, Volume II, pages B35-36)
If two or more applicants meet all applicable review criteria and there is not enough need projected for all applications to be approved, the department will approve the agency that better improves patient care, reduces costs, and improves population health through increased access to services in the planning area. Ensure that sufficient documentation and discussion of these items is included throughout the application under the relevant section

Section 5
Attachments

Attachment 1

Public Disclosure Request In-Home Care Agencies in Spokane County

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Fa Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

Filtered By:

Boards = All Boards

Credential Type = IHS - In Home Services Agency License

Credential Status = All Credential Status

Run Date = 8/16/2024

Number of records = 1450

Credential #	Status	First Issuance Date	Effective Date	Expiration Date
IHS.FS.00000202	EXPIRED		04/01/2008	03/31/2010
IHS.FS.60721619	ACTIVE	01/27/2017	01/28/2024	01/27/2026
IHS.FS.60797888	EXPIRED	11/01/2017	11/01/2017	11/01/2018
IHS.FS.00000205	ACTIVE	07/01/2002	01/01/2023	12/31/2024
IHS.FS.60196608	CLOSED	03/03/2011	03/04/2012	03/03/2014
IHS.FS.60151094	CLOSED			
IHS.FS.60450034	CLOSED	04/08/2014	04/09/2017	01/15/2019
IHS.FS.60254174	CLOSED			
IHS.FS.00000160	CLOSED	01/01/2007	05/01/2014	04/30/2016
IHS.FS.00000226	ACTIVE		09/01/2024	08/31/2026
IHS.FS.61399174	ACTIVE	08/30/2023	08/30/2023	08/30/2024
IHS.FS.60268554	ACTIVE	04/03/2012	04/04/2023	04/03/2025
IHS.FS.60080351	EXPIRED	06/04/2009	06/01/2009	05/31/2010
IHS.FS.00000223	ACTIVE		05/01/2024	04/30/2026
IHS.FS.60214206	ACTIVE	04/01/2011	04/02/2024	04/01/2026
IHS.FS.60109573	ACTIVE	11/02/2009	11/03/2022	11/02/2024
IHS.FS.00000475	CLOSED		04/01/2015	02/15/2017
IHS.FS.00000344	ACTIVE		06/01/2024	05/31/2026
IHS.FS.00000233	ACTIVE		12/01/2023	11/30/2025
IHS.FS.61104480	ACTIVE	11/12/2020	11/13/2023	11/12/2025

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Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Fa Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.61562871	ACTIVE	07/09/2024	07/09/2024	07/09/2025
IHS.FS.60224383	ACTIVE	09/28/2011	09/29/2022	09/28/2024
IHS.FS.61186295	ACTIVE	07/30/2021	07/31/2024	07/30/2026
IHS.FS.60274513	CLOSED	06/28/2012	06/29/2015	05/30/2016
IHS.FS.60016733	ACTIVE	07/09/2009	07/10/2023	07/09/2025
IHS.FS.60205057	CLOSED	02/07/2011	02/07/2011	03/05/2012
IHS.FS.60273404	CLOSED	03/23/2012	03/06/2016	09/01/2016
IHS.FS.60334699	CLOSED	05/09/2013	05/09/2013	05/09/2014
IHS.FS.60312634	EXPIRED	01/30/2013	01/31/2018	01/30/2020
IHS.FS.60308064	ACTIVE	12/20/2012	12/21/2023	12/20/2025
IHS.FS.00000296	ACTIVE		01/01/2024	12/31/2025
IHS.FS.00000251	CLOSED		11/01/2017	03/15/2018
IHS.FS.00000260	EXPIRED		07/01/2019	06/30/2021
IHS.FS.61143181	ACTIVE	03/31/2022	03/31/2023	03/30/2025
IHS.FS.00000284	CLOSED		01/01/1899	02/28/2005
IHS.FS.60277946	ACTIVE	03/20/2012	03/21/2023	03/20/2025
IHS.FS.60234026	CLOSED	12/08/2011	12/08/2011	03/20/2012
IHS.FS.60665846	ACTIVE	09/16/2016	09/17/2023	09/16/2025
IHS.FS.61014910	ACTIVE	03/12/2020	03/13/2023	03/12/2025
IHS.FS.61110634	EXPIRED	09/16/2021	09/16/2021	09/15/2022
IHS.FS.60863143	ACTIVE	06/01/2018	04/01/2024	03/31/2026
IHS.FS.60938634	CLOSED	02/20/2019	11/01/2020	09/06/2022

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IHS.FS.00000122	CLOSED	01/01/2005	11/01/2018	02/28/2019
IHS.FS.60333309	CLOSED	06/12/2013	08/01/2017	05/23/2018
IHS.FS.00000281	CLOSED		08/01/2011	06/12/2013
IHS.FS.00000280	CLOSED	10/06/2006	08/01/2011	12/20/2012
IHS.FS.00000472	CLOSED		05/01/2012	12/20/2012
IHS.FS.60857773	ACTIVE	05/23/2018	08/01/2023	07/31/2025
IHS.FS.60114824	EXPIRED	12/14/2009	12/14/2009	12/14/2010
IHS.FS.60308060	ACTIVE	12/20/2012	12/21/2023	12/20/2025
IHS.FS.00000297	CLOSED		01/01/2012	01/01/2013
IHS.FS.00000443	CLOSED		11/01/2015	03/06/2017
IHS.FS.61493845	ACTIVE	11/13/2023	11/13/2023	11/13/2024
IHS.FS.00000308	ACTIVE		09/01/2023	08/31/2025
IHS.FS.60386792	CLOSED	01/24/2014	01/25/2015	01/09/2015
IHS.FS.60530827	CLOSED	01/09/2015	01/09/2015	06/01/2016
IHS.FS.00000322	CLOSED		02/27/2008	03/27/2009
IHS.FS.61354806	ACTIVE	09/01/2022	09/01/2022	10/26/2024
IHS.FS.60596369	CLOSED	10/26/2015	10/27/2020	09/01/2022
IHS.FS.00000329	CLOSED		01/01/1899	08/31/2005
IHS.FS.00000330	CLOSED		02/01/2010	01/03/2011
IHS.FS.00000332	ACTIVE		03/01/2023	02/28/2025
IHS.FS.00000337	ACTIVE		10/01/2023	09/30/2025
IHS.FS.60332848	EXPIRED	03/08/2013	03/08/2013	03/08/2014
IHS.FS.00000341	CLOSED		05/01/2014	08/30/2015
IHS.FS.61078302	EXPIRED	12/30/2020	12/31/2021	12/30/2023

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IHS.FS.61116301	EXPIRED	10/26/2020	10/26/2020	04/29/2021
IHS.FS.00000345	CLOSED		01/01/2022	02/28/2023
IHS.FS.00000346	ACTIVE		08/01/2023	07/31/2025
IHS.FS.60378264	CLOSED	11/20/2013	11/20/2013	09/19/2014
IHS.FS.00000019	CLOSED	01/01/2003	04/29/2003	04/30/2006
IHS.FS.00000365	CLOSED		05/01/2010	12/21/2010
IHS.FS.60202274	CLOSED	01/04/2011	05/01/2016	04/04/2017
IHS.FS.00000061	ACTIVE	01/01/2003	01/01/2023	12/31/2024
IHS.FS.60323022	ACTIVE	01/08/2013	01/09/2024	01/08/2026
IHS.FS.60990027	ACTIVE	06/25/2020	06/26/2023	06/25/2025
IHS.FS.61212687	EXPIRED	10/26/2022	10/26/2022	10/25/2023
IHS.FS.61573271	PENDING			
IHS.FS.00000374	ACTIVE		05/01/2023	04/30/2025
IHS.FS.61520926	ACTIVE	04/02/2024	04/02/2024	04/02/2025
IHS.FS.00000072	CLOSED		03/03/2004	02/28/2007
IHS.FS.00000279	CLOSED		02/01/2017	05/05/2017
IHS.FS.60241176	ACTIVE	09/30/2011	10/01/2024	09/30/2026
IHS.FS.00000399	CLOSED		07/01/2010	12/06/2011
IHS.FS.00000401	CLOSED		07/01/2010	04/06/2011
IHS.FS.00000402	CLOSED		07/01/2010	04/05/2011
IHS.FS.61290249	ACTIVE	08/04/2022	08/04/2023	08/03/2025
IHS.FS.60747934	CLOSED	04/04/2017	04/04/2017	04/30/2018
IHS.FS.61425233	ACTIVE	06/20/2023	06/21/2024	06/20/2026
IHS.FS.60344780	ACTIVE	03/29/2013	03/30/2024	03/29/2026
IHS.FS.00000467	ACTIVE		07/01/2024	06/30/2026

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IHS.FS.00000161	CLOSED	01/01/2007	05/03/2007	05/31/2008
IHS.FS.60536520	CLOSED	04/13/2015	04/13/2015	07/30/2015
IHS.FS.60655826	CLOSED	05/19/2016	05/20/2017	01/30/2019
IHS.FS.00000355	CLOSED		05/01/2008	04/30/2010
IHS.FS.60051588	CLOSED	05/01/2010	05/01/2018	09/19/2018
IHS.FS.61137159	ACTIVE	03/10/2021	03/11/2024	03/10/2026
IHS.FS.61373295	ACTIVE	03/24/2023	03/24/2023	03/24/2024
IHS.FS.61517003	PENDING			
IHS.FS.60510054	CLOSED	12/31/2014	12/31/2014	07/31/2015
IHS.FS.00000386	ACTIVE		08/01/2023	07/31/2025
IHS.FS.00000431	ACTIVE		09/01/2023	08/31/2025
IHS.FS.00000149	CLOSED	01/01/2006	08/01/2013	02/10/2014
IHS.FS.60450019	ACTIVE	02/10/2014	08/01/2023	07/31/2025
IHS.FS.61443955	ACTIVE	01/02/2024	01/02/2024	01/02/2025
IHS.FS.00000067	CLOSED	01/01/2004	12/22/2010	12/22/2010
IHS.FS.60202030	EXPIRED	12/22/2010	01/31/2015	01/30/2017
IHS.FS.00000441	CLOSED		01/01/1899	06/30/2004
IHS.FS.60284178	CLOSED	10/19/2012	10/20/2015	10/25/2016
IHS.FS.60145393	ACTIVE	04/30/2010	05/01/2023	04/30/2025
IHS.FS.60118992	ACTIVE	11/13/2009	11/14/2022	11/13/2024
IHS.FS.00000069	CLOSED	01/01/2004	02/18/2004	02/28/2009
IHS.FS.60127064	CLOSED			
IHS.FS.60850096	ACTIVE	06/26/2018	06/27/2023	06/26/2025
IHS.FS.00000453	ACTIVE		05/01/2024	04/30/2026

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IHS.FS.00000071	ACTIVE	01/01/2004	03/01/2023	02/28/2025
IHS.FS.60897928	CLOSED	11/29/2018	11/29/2018	09/28/2020
IHS.FS.60774915	CLOSED	09/28/2017	09/29/2018	11/29/2018
IHS.FS.61468298	ACTIVE	02/14/2024	02/14/2024	02/14/2025
IHS.FS.00000167	CLOSED	01/01/2007	07/01/2016	08/05/2016
IHS.FS.60686247	ACTIVE	08/05/2016	07/01/2024	06/30/2026
IHS.FS.00000470	CLOSED		06/29/2007	06/30/2009
IHS.FS.60468243	EXPIRED	08/01/2014	12/13/2018	12/13/2019

cility Name, Site and Mailing Addresses,

Facility Name	Site Attention	Site Address 1	Site Address 2
A New Hope		2930 E Mission Ave	
AAging Better In-Home Care		2310 N Molter Rd Ste 110	
Abundant Care		4116 E 21st Ave	
Addus HomeCare, Arcadia Home Care and Staffing		1121 N Argonne Rd Ste 210	
Advantage Plus Agency		104 S Freya St Ste 201	
Advantage Plus Caregivers. Com		2022 N Bessie Rd	
Advantage Plus Caregivers.com		4212 S Hatherly Cir	
All Seasons Home Care		917 W 18th Ave	
All Valley Home Care		1312 N Monroe St	
All Ways Caring HomeCare Spokane		924 S Pines Rd Ste 100	
Amazing Touch Home Health Agency, LLC		1908 S Whipple Rd	
Angel Senior Care		8512 N Wall St	
Angelas In Home Care		4324 W Crown Ave	
Apria Healthcare LLC		411 E North Foothills Dr Ste 200	
Assured Home Health		201 W North River Dr Ste 335	
Assured Home Health		505 N Argonne Rd Bldg C	
AtHome Care		1005 N Pines Rd Ste 40	
Aveanna Healthcare		1120 N Mullan Rd Ste 206	
Beneficial In-Home Care Inc		706 N Maple St	
Bogden House Wa		11406 E Fairview Ave	

cility Name, Site and Mailing Addresses,

Brightstar Care of North Spokane	7520 N Market St Ste 10
Brookdale at Home Spokane	601 S Park Rd
C.R.E.W. Behavioral Services	3928 N Howard St
CaliberCare	14224 E 30th Ct
Care to Stay Home	12810 E Nora Ave Ste A
CareFocus Companion Services	1500 W 4th Ave Ste 200
CareFocus Companion Services LLC	1500 W 4th Ave Ste 200
Caregivers by Wholecare Spokane	1802 E Pinecrest Rd
Center for Pediatric Therapy	6710 N Country Homes Blvd
CenterWell Home Health	12310 E Mirabeau Pkwy Ste 500
CenterWell Home Health	8502 N Nevada St Ste 2
Cheney Home Care	2219 N 6th St
Comfort Keepers	1204 N Mullan Rd
Comfort Keepers #1113	1104 W Wellesley Ave Ste D
COMPLETE NURSING SERVICES INC	920 N ARGONNE STE 308
Coram CVS/Specialty Infusion Services	5511 E 3rd Ave
Coram Specialty Infusion Services, an Apria Healthcare Company	520 E North Foothills Dr Ste 400
Dementia Care Solutions	620 N Argonne Rd Ste 4
Eden Home Health	1225 N Argonne Rd Ste 100
Empire Therapy, Empire Pediatric Therapy, Empire Concussion and Trauma Recover	501 S Bernard St Ste 100
Family First	705 W 7th Ave Ste B, McCauley Hall
Family First Senior Care	705 W 7th Ave McCauley Hall Ste B

cility Name, Site and Mailing Addresses,

Family First Senior Care Inc	521 N Argonne Rd Bldg B Ste 103
Family Home Care	22820 E Appleway Ave Ste B
Family Home Care - Private Duty	22820 E Appleway Ave
Family Home Care and Hospice	22820 E Appleway Ave
Family Home Care and Hospice	22820 E Appleway Ave
Family Resource Home Care	23403 E Mission Ave Ste 150
Freedom Care	13120 E 14th Ave
Gentiva	1326 N Whitman Ln
Gentiva Health Services	1908 N Dale Ln
Good Samaritan Society - Spokane Valley	17121 E 8th Ave
Greenstaff Home Care	2818 N Sullivan Rd Ste 100-19
Havenwood Caregiver Services	303 E Wellesley Ave
Hearts 'N Hands Home Health	205 N University Rd Ste 1
Hearts'n Hands	606 N Pines Rd Ste 102
HOME CARE OF WASHINGTON INC	1050 N ARGONNE STE 100
Home Instead of Spokane	1616 W Wellesley Ave Ste A
Home Instead Senior Care	1616 W Wellesley Ave Ste A
HOME INSTEAD SENIOR CARE /SPOKANE	1604 W DEAN
Homewatch	8623A N Division St
Horizon Hospice and Palliative Care	608 E Holland Ave
Hospice of Spokane dba: Spokane Pallative CARE	121 S Arthur St
Imagine Behavioral and Developmental Services, LLC	901 N Monroe St Ste 200
Independent Services Corp	1716 N Union Rd
Inland Home Healthcare	907 W Boone Ave Ste B

cility Name, Site and Mailing Addresses,

Inland Home Healthcare	907 W Boone Ave Ste B
Interim Healthcare of Spokane, Inc	1625 W 4th Ave
Intrepid USA Healthcare Services	9715 N Nevada St
Just Like Family	1228 E 19th Ave
LIFE INC	16424 E BROADWAY
Lifecare Solutions	11703 E Sprague Ave Ste C3
Lifecare Solutions	11703 E Sprague Ave Ste C3
Lincare	15310 E Marietta Ste 7 and 8
Love at Home Senior Care	1520 W Garland Ave Ste E
Loving Neighbor Home Care LLC	2818 N Sullivan Rd
Malaika Home Care, LLC	10518 N Russett Dr
Manito Home Health	104 South Freya St, Yellow Flag Bldg, Ste 109
Maxim Healthcare Services Inc	16201 E Indiana Ave Ste 3400
New Horizons In-Home Care	522 W Riverside Ave
NORTH * SOUTH * VALLEY CAREGIVERS	3914 W NORTHWEST BLVD
Omnicare of Spokane	350 E 3rd Ave
Option Care	3310 N Pines Rd
Option Care of Spokane	1328 N Ash St
Option Home Health Care Services	1326 N Ash St
Option Home Health Care Services Private Duty	1322 N Ash St
Precision Home Care LLC	3201 S Lloyd Ln
Preferred Homecare Infusion LLC	11703 E Sprague Ave Ste C3
Providence Hospice Spokane	1000 N Argonne Rd Ste 201
Providence Infusion and Pharmacy Services	15918 E Euclid Ave
Providence VNA Home Health	1000 N Argonne Rd

cility Name, Site and Mailing Addresses,

Touchmark Home Health	2929 S Waterford Dr
Vida At Home	1005 N Pines Rd Ste 40
Vida Homecare	5127 N Avalon Rd
Visiting Angels	23801 E Appleway Ave Ste 120
Visiting Angels	15413 E Valleyway Ave Bldg A Suite 101
Visiting Angels	708 N Argonne Rd Ste 8A
WALSH and ASSOCIATES	511 N ARGONNE RD STE 100
Weeping Ridge Home Health	10226 N Seminole Dr

cility Name, Site and Mailing Addresses,

QUALITY CARE IN HOME SERVICES	10218 N WHITTIER ST	
RCI Complete Home Care	1024 S Saint Charles Rd	
Reliant RX	2820 N Astor St	
ResCare HomeCare	505 N Argonne Rd Ste 202	
ResCare HomeCare	924 S Pines Rd Ste 100	
Right at Home of Spokane	104 S Freya St Turquoise Flag Bldg Ste 227A	
RiverCare	2360 N Stone St Unit B	
RiverCare	2360 N Stone St Unit B	
Romsakorn Caregiver Services	920 N Helena	
Rotech	15320 E Marietta Ave Ste 4	
S and S Health Care	11319 E Carlisle Ave Ste 104	
Senior Helpers	12815 E Sprague Ave Ste 101	
Senior Helpers	104 S Freya St Ste 114A	Tapio Professional Center, Orange Flag Building
Silver Steps	10709 E 11th Ln	
SL Start	25 W Nora Ave	
SL Start and Associates LLC	901 N Monroe St Ste 200	
Spokane Mental Health	5125 N Market St	
Stay At Home Adult Care	16904 E Broadway Ave	
Stepping Stones Pediatric Therapy	319 S Cedar St	
Sunshine Home Health Care	10410 E 9th Ave	
The Arc of Spokane	127 W Boone Ave	
The Arc of Spokane	127 W Boone Ave	
The Arc of Spokane	320 E 2nd Ave	
Touchmark Home Care	2929 S Waterford Dr	

Site City	Site State	Site Zip Code	Site County	Site Email Address
Spokane	WA	99202-3625	Spokane	hthommes@aol.com
Liberty Lake	WA	99019-8621	Spokane	brandtweaver@aagingbetter.com
Spokane	WA	99223-5426	Spokane	abundantcarespokane@gmail.com
Spokane Valley	WA	99212-2686	Spokane	mark.robinson@addus.com
Spokane	WA	99202-4891	Spokane	richard@advantageplusagency.com
Spokane Valley	WA	99212-2421	Spokane	
Spokane Valley	WA	99206-9491	Spokane	sherrie@advantageplusgivers.com
Spokane	WA	99203-1128	Spokane	skylane3@earthlink.net
Spokane	WA	99201-2623	Spokane	cash.edwards@vidaseniorresource.com
Spokane Valley	WA	99206-6445	Spokane	lbalo@rescare.com
Spokane Valley	WA	99206-5725	Spokane	amazingtouchrn@gmail.com
Spokane	WA	99208-6164	Spokane	vaughn@angelseniorcare.org
Spokane	WA	99205-6131	Spokane	
Spokane	WA	99207-2106	Spokane	ruth_bindrup@apria.com
Spokane	WA	99201-2262	Spokane	lra@lhcgroup.com
Spokane Valley	WA	99212-2876	Spokane	lra@lhcgroup.com
Spokane Valley	WA	99206-4958	Spokane	j.wayneirish@gmail.com
Spokane Valley	WA	99206-4074	Spokane	rseignemartin@pediatrichomecare.net
Spokane	WA	99201-1873	Spokane	
Spokane Valley	WA	99206-4687	Spokane	elli@bogdenhousewa.org

Spokane	WA	99217-7800	Spokane	joshua.porter@brightstarcare.com
Spokane Valley	WA	99212-0593	Spokane	agalati@brookdale.com
Spokane	WA	99205-1132	Spokane	crewbehavioralservices@gmail.com
Spokane Valley	WA	99037-9482	Spokane	bringflowers@hotmail.com
Spokane Valley	WA	99216-1045	Spokane	jayne@caretostayhome.com
Spokane	WA	99201-7239	Spokane	
Spokane	WA	99201-7239	Spokane	
Spokane	WA	99203-3938	Spokane	elizabeth@wholecareconnections.com
Spokane	WA	99208-4337	Spokane	echo.fryett@spokanecpt.com
Spokane Valley	WA	99216-2259	Spokane	staphanie.vaughngray@centerwellhomehealth.com
Spokane	WA	99208-7395	Spokane	
Cheney	WA	99004-2171	Spokane	kfauerso@cheneycare.com
Spokane Valley	WA	99206-4053	Spokane	bookkeeping@cksponkane.com
Spokane	WA	99205-1200	Spokane	wyatthowell@comfortkeepers.com
SPOKANE VALLEY	WA	99212	Spokane	
Spokane Valley	WA	99212-0726	Spokane	jodie.holba@coramhc.com
Spokane	WA	99207-2158	Spokane	erik.heikkenen@coramhc.com
Spokane Valley	WA	99212-2792	Spokane	dementiacares14@gmail.com
Spokane Valley	WA	99212-2798	Spokane	legal@empres.com
Spokane	WA	99204-2511	Spokane	mailemohsenian@icloud.com
Spokane	WA	99204	Spokane	info@familyfirsthome.com
Spokane	WA	99204-2836	Spokane	info@familyfirstseniorcare.com

Spokane Valley	WA	99212-2868	Spokane	jen@familyfirstseniorcare.com
Liberty Lake	WA	99019-9514	Spokane	administrator@FHCCARES.COM
Liberty Lake	WA	99019-9514	Spokane	
Liberty Lake	WA	99019-9514	Spokane	
Liberty Lake	WA	99019-9514	Spokane	
Liberty Lake	WA	99019-7554	Spokane	ginar@familyrhc.com
Spokane Valley	WA	99216-0403	Spokane	freedomcare@gmail.com
Liberty Lake	WA	99019-7594	Spokane	facilitylicensure@gentiva.com
Spokane Valley	WA	99212-2445	Spokane	
Spokane Valley	WA	99016-8556	Spokane	
Spokane	WA	99212	Spokane	cash.edwards@greenstaffhomecare.com
Spokane	WA	99207-1578	Spokane	bpierce@havenwoodhomecare.com
Spokane Valley	WA	99206-5094	Spokane	jeredfross8474@hotmail.com
Spokane Valley	WA	99206-6711	Spokane	
SPOKANE VALLEY	WA	99212	Spokane	
Spokane	WA	99205-1413	Spokane	ejhanson@gmail.com
Spokane	WA	99205-1413	Spokane	
SPOKANE	WA	99202	Spokane	
Spokane	WA	99208-5946	Spokane	
Spokane	WA	99218-1255	Spokane	lguske@horizonhospice.com
Spokane	WA	99202-2253	Spokane	info@hospiceofspokane.org
Spokane	WA	99201-2148	Spokane	qrobins@imaginebehavior.com
Spokane Valley	WA	99206-4834	Spokane	mhanna@isccares.com
Spokane	WA	99201-2503	Spokane	won.song@spokanecare.com

Spokane	WA	99201-2503	Spokane	rahspokane@spokanecare.com
Spokane	WA	99201-5620	Spokane	rickmorris@ncshosting.com
Spokane	WA	99218-3412	Spokane	kathryn.bevilacqua@intrepidusa.com
Spokane	WA	99203-3424	Spokane	
SPOKANE	WA	99037	Spokane	
Spokane Valley	WA	99206-6129	Spokane	vmagana@lifecaresoln.com
Spokane Valley	WA	99206-6129	Spokane	vmagana@lifecaresoln.com
Spokane Valley	WA	99216	Spokane	licensing@lincare.com
Spokane	WA	99205-2613	Spokane	
Spokane Valley	WA	99216-5198	Spokane	lovingneighborhomecare@gmail.com
Spokane	WA	99208-6729	Spokane	malaikahomecare20@gmail.com
Spokane	WA	99202	Spokane	licensing@pennantservices.com
Spokane Valley	WA	99216-2830	Spokane	spokanehh@maxhealth.com
Spokane	WA	99201-0504	Spokane	alid@nhcares.com
SPOKANE	WA	99205	Spokane	
Spokane	WA	99202-1413	Spokane	janice.tucker@omnicare.com
Spokane Valley	WA	99206-4612	Spokane	michelle.mazzenga@walgreens.com
Spokane	WA	99201-2804	Spokane	doreen.wiman@walgreens.com
Spokane	WA	99201-2804	Spokane	sarah.greener@walgreens.com
Spokane	WA	99201-2804	Spokane	
Spokane	WA	99223-6020	Spokane	tmorrison85@msn.com
Spokane Valley	WA	99206-6129	Spokane	laura.north@preferredhomecare.com
Spokane Valley	WA	99212-2680	Spokane	cheryl.cline@providence.org
Spokane Valley	WA	99216-1815	Spokane	jason.iltz@providence.org
Spokane Valley	WA	99212-2600	Spokane	debra.rappuchi@providence.org

SPOKANE	WA	99218	Spokane	
Spokane Valley	WA	99037-8834	Spokane	
Spokane	WA	99207-2112	Spokane	tammy@reliantrxwa.com
Spokane Valley	WA	99212-2869	Spokane	
Spokane Valley	WA	99206-5423	Spokane	labalo@rescare.com
Spokane	WA	98202	Spokane	npaul@myrahcares.com
Spokane	WA	99207-5508	Spokane	jkelley@riverviewretirement.org
Spokane	WA	99207-5508	Spokane	jkelley@riverviewretirement.org
Spokane	WA	99202	Spokane	
Spokane Valley	WA	99216-1870	Spokane	susan.martinez@rotech.com
Spokane Valley	WA	99206-7651	Spokane	mbrinkley@sandshealthcare.com
Spokane Valley	WA	99216-0742	Spokane	mgodek@seniorhelpers.com
Spokane	WA	99202-4868	Spokane	markdmurphy66@gmail.com
Spokane	WA	99206-2867	Spokane	vilma.silverstapes@gmail.com
Spokane	WA	99205-4800	Spokane	
Spokane	WA	99201-2148	Spokane	crussell@embassyllc.com
Spokane	WA	99217-6131	Spokane	
Spokane Valley	WA	99037-8512	Spokane	christine@stayathomeauditcare.com
Spokane	WA	99201-7029	Spokane	hello@ssptherapy.com
Spokane Valley	WA	99206-3510	Spokane	nathan@shfi.ocm
Spokane	WA	99201-2309	Spokane	
Spokane	WA	99201-2309	Spokane	
Spokane	WA	99202-1402	Spokane	lrichardson@arc-spokane.org
Spokane	WA	99203-4407	Spokane	dave.cox@touchmark.com

Spokane	WA	99203-4400	Spokane	jwc@touchmark.com
Spokane Valley	WA	99206-4958	Spokane	josh@vidainhomecare.com
Spokane Valley	WA	99216-2400	Spokane	avolon172@gmail.com
Liberty Lake	WA	99019-9687	Spokane	
Spokane Valley	WA	99037-8554	Spokane	cindy@spokanevisitingangels.com
Spokane Valley	WA	99212-2700	Spokane	denisej1210@gmail.com
SPOKANE	WA	99212	Spokane	
Spokane	WA	99208-8631	Spokane	israelrodriguezjr@yahoo.com

Site Phone #	Mail Attention	Mail Address1	Mail Address2
(509)535-2906		2930 E Mission Ave	
(509) 714-2133		2310 N Molter Rd Ste 110	
(509) 866-1372		4116 E 21st Ave	
		2300 Warrenville Rd Ste 100	
(509) 714-1794		104 S Freya St Ste 201	
(800) 972-4106		2022 N Bessie Rd	
		9116 E Sprague Ave # 528	
(509) 994-8524		917 W 18th Ave	
(509) 448-7400		1312 N Monroe St	
(509) 847-0300		924 S Pines Rd Ste 100	
(469) 456-2804		1908 S Whipple Rd	
(509) 326-4357		8512 N Wall St	
(509) 434-6198		4324 W Crown Ave	
	Attn: Clinical Services and Licensing	7353 Company Dr	
		PO Box 51266	
		PO Box 51266	
		PO Box 14141	
	Attn: Licensing	400 Interstate North Pkwy SE Ste 1600	
(509) 323-0390		706 N Maple St	
		15911 E Cooper Rd	

(509) 241-8527		7520 N Market St Ste 10
(509) 922-7224		601 S Park Rd
(509) 862-0707		3928 N Howard St
(509) 981-9890		PO Box 444
(509) 340-1359		12810 E Nora Ave Ste A
(509) 324-6421		1500 W 4th Ave Ste 200
	Attn: Licensing	7227 Lee Deforest Dr
		2000 Warfield Dr
		PO Box 48070
509-473-4900		6330 Sprint Pkwy Ste 300
	Attn: Licensing	6330 Sprint Pkwy Ste 300
(509) 235-6196		2219 N 6th St
(509) 484-2345		1204 N Mullan Rd
(509) 484-2345		1104 W Wellesley Ave Ste D
(509)927-7511		920 N ARGONNE STE 308
(303) 672-8631	Attn: Licensure and Certification	1 Cvs Dr # MC1160
(509) 482-4266		555 17th St Ste 1500
		7213 E Liberty Ave
	Attn: Legal Dept	4601 NE 77th Ave Ste 300
(509) 701-7651		501 S Bernard St Ste 100
(509) 326-5525		705 W 7th Ave Ste B, McCauley Hall
(509) 326-5525		705 W 7th Ave McCauley Hall Ste B

(509) 326-5525		521 N Argonne Rd Bldg B Ste 103
(509) 473-4949		22820 E Appleway Ave Ste B
(509)473-4900		22820 E Appleway Ave
(509)473-4900		22820 E Appleway Ave
(509)473-4900		22820 E Appleway Ave
		PO Box 130
		PO Box 1791
	Attn: Regulatory	PO Box 4060
(509) 327-5857		1908 N Dale Ln
(509) 924-6161		17121 E 8th Ave
(509) 894-8983		2818 N Sullivan Rd Ste 100-19
(509) 535-1546		303 E Wellesley Ave
(509) 475-7540		205 N University Rd Ste 1
(509) 475-7540		606 N Pines Rd Ste 102
(509)847-0300		1050 NORTH ARGONNE STE 100
(509) 835-5898		1616 W Wellesley Ave Ste A
(509) 835-5898		1616 W Wellesley Ave Ste A
(509)835-5898		6520 212TH ST SW STE 208
(509)467-3995		8623A N Division St
(509) 489-4581		608 E Holland Ave
		PO Box 2215
(509) 328-2740		901 N Monroe St Ste 200
(509) 921-5914		1716 N Union Rd
(240) 899-0319		907 W Boone Ave Ste B

(240) 899-0319		907 W Boone Ave Ste B
(509) 456-5665		1625 W 4th Ave
509-466-0954		14841 Dallas Pkwy Ste 625
		1228 E 19th Ave
(509)922-6351		16424 E BROADWAY
(509) 921-6560		11703 E Sprague Ave Ste C3
480-446-9010		PO Box 40700
	Attn: Licensing Department	19387 US Highway 19 N
(509) 474-0663		1520 W Garland Ave Ste E
(509) 304-8051		2818 N Sullivan Rd
(774) 262-3858		10518 N Russett Dr
(509) 210-3741		104 South Freya St, Yellow Flag Bldg, Ste 109
(253)671-9909	Licensure Department Chanel Chandler	7227 Lee Deforest Dr
		3125 Chad Dr Ste 290
(509)325-0621		3914 W NORTHWEST BLVD
(509) 838-0870		350 E 3rd Ave
		3000 Lakeside Dr Ste 300N
		485 E Half Day Rd Ste 300
		485 E Half Day Rd Ste 300
		485 E Half Day Rd Ste 300
(509) 844-2096		3201 S Lloyd Ln
		PO Box 40700
(425) 293-2819		1000 N Argonne Rd Ste 201
(509) 924-1826		15918 E Euclid Ave
(509) 534-4300		1000 N Argonne Rd

(509)230-5485	10218 N WHITTIER ST	
(360) 953-7904	1024 S Saint Charles Rd	
(509) 343-3400	2820 N Astor St	
(509)927-9111	505 N Argonne Rd Ste 202	
(509) 847-0300	924 S Pines Rd Ste 100	
(509) 315-5787	104 S Freya St Turquoise Flag Bldg Ste 227A	
(509) 482-8473	1801 E Upriver Dr	
(509) 482-8473	1801 E Upriver Dr	
(509) 534-6616	920 N Helena	
	3600 Vineland Rd Ste 114	
(509) 533-0005	11319 E Carlisle Ave Ste 104	
(509)922-4333	12815 E Sprague Ave Ste 101	
(509) 922-4333	104 S Freya St Ste 114A	Tapio Professional Center, Orange Flag Building
(509) 368-1048	10709 E 11th Ln	
(509)328-2740	25 W Nora Ave	
(509) 328-2740	901 N Monroe St Ste 200	
(509) 838-4651	5125 N Market St	
(509) 928-2227	16904 E Broadway Ave	
(509) 209-7429	319 S Cedar St	
(509) 321-9050	10410 E 9th Ave	
(509)328-6326	127 W Boone Ave	
(509)328-6326	127 W Boone Ave	
(509) 328-6326	320 E 2nd Ave	
(509) 536-2929	2929 S Waterford Dr	

(509) 536-2929	2929 S Waterford Dr
(509) 473-9549	1005 N Pines Rd Ste 40
(509) 868-4177	5127 N Avalon Rd
	23801 E Appleway Ave Ste 120
(509) 922-1141	15413 E Valleyway Ave Bldg A Suite 101
(509) 922-1141	708 N Argonne Rd Ste 8A
(509)921-0585	511 N ARGONNE RD STE 100
	12402 Osprey Rd

Mail City	Mail State	Mail Zip	Mail County	Mail Email Address
Spokane	WA	99202-3625	Spokane	hthommes@aol.com
Liberty Lake	WA	99019-8621	Spokane	brandtweaver@aagingbetter.com
Spokane	WA	99223-5426	Spokane	abundantcarespokane@gmail.com
Downers Grove	IL	60515-1717	DuPage	
Spokane	WA	99202-4891	Spokane	richard@advantageplusagency.com
Spokane Valley	WA	99212-2421	Spokane	
Spokane Valley	WA	99206-3601	Spokane	
Spokane	WA	99203-1128	Spokane	skylane3@earthlink.net
Spokane	WA	99201-2623	Spokane	cash.edwards@vidaseniorresource.com
Spokane Valley	WA	99206-6445	Spokane	lbalo@rescare.com
Spokane Valley	WA	99206-5725	Spokane	amazingtouchrn@gmail.com
Spokane	WA	99208-6164	Spokane	vaughn@angelseniorcare.org
Spokane	WA	99205-6131	Spokane	
Indianapolis	IN	46237-9274	Marion	ruth.bindrup@apria.com
Lafayette	LA	70505-1266		
Lafayette	LA	70505-1266		
Spokane Valley	WA	99214-0141	Spokane	
Atlanta	GA	30339-5047	Cobb	
Spokane	WA	99201-1873	Spokane	
Mead	WA	99021-8781	Spokane	

Spokane	WA	99217-7800	Spokane	joshua.porter@brightstarcare.com
Spokane Valley	WA	99212-0593	Spokane	agalati@brookdale.com
Spokane	WA	99205-1132	Spokane	crewbehavioralservices@gmail.com
Veradale	WA	99037-0444	Spokane	
Spokane Valley	WA	99216-1045	Spokane	jayne@caretostayhome.com
Spokane	WA	99201-7239	Spokane	
Columbia	MD	21046-3236	Howard	
Nashville	TN	37215-3424	Davidson	elizabeth@wholecareconnections.com
Spokane	WA	99228-1070	Spokane	
Overland Park	KS	66211-1157	Johnson	
Overland Park	KS	66211-1157	Johnson	
Cheney	WA	99004-2171	Spokane	kfauerso@cheneycare.com
Spokane Valley	WA	99206-4053	Spokane	bookkeeping@cksponkane.com
Spokane	WA	99205-1200	Spokane	wyatthowell@comfortkeepers.com
SPOKANE VALLEY	WA	99212	Spokane	
Woonsocket	RI	02895-6146	Providence	erik.heikkenen@coramhc.com
Denver	CO	80202-3900	Out of State	
Spokane Valley	WA	99212-1532	Spokane	
Vancouver	WA	98662-6736	Clark	
Spokane	WA	99204-2511	Spokane	mailemohsenian@icloud.com
Spokane	WA	99204	Spokane	info@familyfirsthome.com
Spokane	WA	99204-2836	Spokane	info@familyfirstseniorcare.com

Spokane Valley	WA	99212-2868	Spokane	jen@familyfirstseniorcare.com
Liberty Lake	WA	99019-9514	Spokane	administrator@FHCCARES.COM
Liberty Lake	WA	99019-9514	Spokane	
Liberty Lake	WA	99019-9514	Spokane	
Liberty Lake	WA	99019-9514	Spokane	
Liberty Lake	WA	99019-0130	Spokane	
Veradale	WA	99037-1791	Spokane	
Mooresville	NC	28117-4060	Iredell	
Spokane Valley	WA	99212-2445	Spokane	
Spokane Valley	WA	99016-8556	Spokane	
Spokane	WA	99212	Spokane	cash.edwards@greenstaffhomecare.com
Spokane	WA	99207-1578	Spokane	bpierce@havenwoodhomecare.com
Spokane Valley	WA	99206-5094	Spokane	jeredfross8474@hotmail.com
Spokane Valley	WA	99206-6711	Spokane	
SPOKANE	WA	99212	Spokane	
Spokane	WA	99205-1413	Spokane	ejhanson@gmail.com
Spokane	WA	99205-1413	Spokane	
LYNNWOOD	WA	98036	Snohomish	
Spokane	WA	99208-5946	Spokane	
Spokane	WA	99218-1255	Spokane	lguske@horizonhospice.com
Spokane	WA	99210-2215	Spokane	
Spokane	WA	99201-2148	Spokane	qrobins@imaginebehavior.com
Spokane Valley	WA	99206-4834	Spokane	mhanna@isccares.com
Spokane	WA	99201-2503	Spokane	won.song@spokanecare.com

Spokane	WA	99201-2503	Spokane	rahspokane@spokanecare.com
Spokane	WA	99201-5620	Spokane	rickmorris@ncshosting.com
Dallas	TX	75254-7641	Dallas	
Spokane	WA	99203-3424	Spokane	
SPOKANE	WA	99037	Spokane	
Spokane Valley	WA	99206-6129	Spokane	vmagana@lifecaresoln.com
Mesa	AZ	85274-0700	Maricopa	vmagana@lifecaresoln.com
Clearwater	FL	33764-3102	Pinellas	
Spokane	WA	99205-2613	Spokane	
Spokane Valley	WA	99216-5198	Spokane	lovingneighborhomecare@gmail.com
Spokane	WA	99208-6729	Spokane	malaikahomecare20@gmail.com
Spokane	WA	99202	Spokane	licensing@pennantservices.com
Columbia	MD	21046-3236	Howard	chachandl@maxhealth.com
Eugene	OR	97408-7440	Lane	
SPOKANE	WA	99205	Spokane	
Spokane	WA	99202-1413	Spokane	janice.tucker@omnicare.com
Bannockburn	IL	60015-5405	Lake	
Buffalo Grove	IL	60089-8806	Out of State	
Buffalo Grove	IL	60089-8806	Out of State	
Buffalo Grove	IL	60089-8806	Out of State	
Spokane	WA	99223-6020	Spokane	tmorrison85@msn.com
Mesa	AZ	85274-0700	Maricopa	
Spokane Valley	WA	99212-2680	Spokane	cheryl.cline@providence.org
Spokane Valley	WA	99216-1815	Spokane	jason.iltz@providence.org
Spokane Valley	WA	99212-2600	Spokane	debra.rappuchi@providence.org

SPOKANE	WA	99218		
Spokane Valley	WA	99037-8834	Spokane	
Spokane	WA	99207-2112	Spokane	tammy@reliantrxwa.com
Spokane Valley	WA	99212-2869	Spokane	
Spokane Valley	WA	99206-5423	Spokane	labalo@rescare.com
Spokane	WA	98202	Spokane	npaul@myrahcares.com
Spokane	WA	99207-5181	Spokane	ceskelsen@riverviewretirement.org
Spokane	WA	99207-5181	Spokane	ceskelsen@riverviewretirement.org
Spokane	WA	99202	Spokane	
Orlando	FL	32811-6460	Orange	
Spokane Valley	WA	99206-7651	Spokane	mbrinkley@sandshealthcare.com
Spokane Valley	WA	99216-0742	Spokane	mgodek@seniorhelpers.com
Spokane	WA	99202-4868	Spokane	markdmurphy66@gmail.com
Spokane	WA	99206-2867	Spokane	vilma.silverstapes@gmail.com
Spokane	WA	99205-4800	Spokane	
Spokane	WA	99201-2148	Spokane	crussell@embassyllc.com
Spokane	WA	99217-6131	Spokane	
Spokane Valley	WA	99037-8512	Spokane	christine@stayathomeauditcare.com
Spokane	WA	99201-7029	Spokane	hello@ssptherapy.com
Spokane Valley	WA	99206-3510	Spokane	nathan@shfi.ocm
Spokane	WA	99201-2309	Spokane	
Spokane	WA	99201-2309	Spokane	
Spokane	WA	99202-1402	Spokane	lrichardson@arc-spokane.org
Spokane	WA	99203-4407	Spokane	dave.cox@touchmark.com

Spokane	WA	99203-4400	Spokane	jwc@touchmark.com
Spokane Valley	WA	99206-4958	Spokane	josh@vidainhomecare.com
Spokane Valley	WA	99216-2400	Spokane	avolon172@gmail.com
Liberty Lake	WA	99019-9687	Spokane	
Spokane Valley	WA	99037-8554	Spokane	cindy@spokanevisitingangels.com
Spokane Valley	WA	99212-2700	Spokane	denisej1210@gmail.com
SPOKANE	WA	99212	Spokane	
Nine Mile Falls	WA	99026-5000	Stevens	

Secretary of State #	Contact Name	Contact Email
601158662	A New Hope, Inc	
604057599	AAging Better In-Home Care LLC	brandtweaver@aagingbetter.com
604104699	Wilcox Angela	abundantcarespokane@gmail.com
601299559	Addus Healthcare Inc	natlcontracts@addus.com
602964534	Advantage Plus Agency Inc	richard@advantageplusagency.com
602964534	Advantage Plus Agency Inc	richard@advantageplusagency.com
603347903	Everlasting US Inc.	sherrie@advantageplusacaregivers.com
603138888	All Seasons Home Care LLC	
602666543	All Valley Home Care Inc	
601882866	Res Care Washington Inc	labalo@allwayscaring.com
604981761	Amazing Touch Home Health Agency, LLC	amazingtouchrn@gmail.com
603165643	Guardian Angel Home Care LLC	vaughn@angelseniorcare.com
602752485	Angela Rose Floyd	angelarosefloyd@comcast.net
600599301	Apria Healthcare LLC	Kristine.laplace@apria.com
603060013	Spokane Home Care Services LLC	justin_mathiason@chs.net
602938091	Northeast Washington Home Health Inc	lra@lhcgroup.com
601686453	Your Problems Solved Inc	j.wayneirish@gmail.com
602135267	Pediatric Home Care, Inc	mglockling@ihpnet.com
602022142	Beneficial In-Home Care Inc	cross@bihc.biz
604555794	Healthcare Harmony LLC	elli@bogdenhousewa.org

605463652	Paisley Madison Inc.	joshua.porter@brightstarcare.com
602769662	BKD Personal Assistance Services LLC	splunkettwuerger@brookdale.com
603619653	C.R.E.W. Services and Consulting LLC	crewservicesconsulting@gmail.com
603112618	CaliberCare Corp	bringflowers@hotmail.com
602808712	RJ Care Services LLC	rob@caretostayhome.com
601407644	Maxim Healthcare Services Inc	chachandl@maxhealth.com
603063700	CareFocus Companion Services LLC	
603244219	Caregiver Source Inc	elizabeth@wholecareconnections.com
602744444	Center for Pediatric Therapy LLC	echo.fryett@spokanecpt.com
601758647	CenterWell Certified HealthCare Corp.	facilitylicensure@centerwellhomehealth.com
601758647	CenterWell Certified HealthCare Corp.	facilitylicensure@centerwellhomehealth.com
600403577	Cheney Care Center Association	keith.fauerso@cheneycare.com
602161002	Davenkaren Enterprises Inc	darcyantles@comfortkeepers.com
604670606	Howell Senior Services LLC	wyatthowell@comfortkeepers.com
602423043	ENTER NET DEVELOPMENT CORP	
601617839	Coram Alternate Site Services Inc	mclicensing@cvscaremark.com
600599301	Apria Healthcare LLC	Kristine.laplace@apria.com
603427263	Gladyannas LLC	nkbeach27@gmail.com
604331802	Eden Home Health of Spokane County, LLC	legal@empres.com
603460844	Inland Empire Therapy Associates, LLC	mailemohsenian@icloud.com
604248455	Family First Services LLC	info@familyfirsthome.com
604248455	Family First Services LLC	info@familyfirsthome.com

602532333	Family First Senior Care Inc	jen@familyfirstseniorcare.com
603254615	Family Home Care LLC	jeff.wiberg@fhccares.com
602097818	Family Home Care Corporation	
602097818	Family Home Care Corporation	
602097818	Family Home Care Corporation	
604180775	Geras LLC	ambert@familyrhc.com
602930863	Freedom Care	freedomcare@gmail.com
602306941	Odyssey HealthCare Operating B, LP	facilitylicensure@gentivahs.com
601903932	Gentiva Health Services USA Inc	
600363550	Evangelical Lutheran Good Samaritan Society	scollett@good-sam.com
605321407	Greenstaff Home Care, LLC	cash.edwards@greenstaffhomecare.com
602513639	Okeeffe Enterprises LLC	jokeeffe@havenwoodhomecare.com
603302686	Hearts N Hands Home Care	jeredfross8474@hotmail.com
603369824	Hearts N Hands Home Health	heartsnhandshomecare@hotmail.com
602136653	Home Care of Washington	
604910160	Skurffy Werks, LLC	erik.hanson@homeinstead.com
603518638	LCA Enterprises Inc.	christie.amans@homeinstead.com
602019579	FLAG INCORPORATED	
602083208	David and Penny Inc	
601701491	Horizon Health LLC	lguske@horizonhospice.com
601139100	Hospice of Spokane	info@hospiceofspokane.org
603259078	Imagine Behavioral and Developmental Services, LLC	hmorago@caravelautism.com
601561781	Independent Services Corp	mhanna@isccares.com
604458678	Aaron and Hur Healthcare, P.C.	won.song@spokanecare.com

604458678	Aaron and Hur Healthcare, P.C.	won.song@spokanecare.com
601288070	Interim Healthcare of Spokane Inc	rickmorris@ncshosting.com
601972425	Intrepid of Washington Inc	jeff.dietz@intrepidusa.com
603142619	Just Like Family Inc	patsea49@msn.com
601494208	LIFE INC	
602311106	Lifecare Solutions Inc	laura.north@preferredhomecare.com
602311106	Lifecare Solutions Inc	laura.north@preferredhomecare.com
601056369	Lincare Inc.	licensing@lincare.com
603241632	Andy's Home Care Inc	andy@loveinhome.care
604475552	Loving Neighbor Home Care LLC	lovingneighborhomecare@gmail.com
604538788	Malaika Home Care, LLC	malaikahomecare20@gmail.com
604833090	Orchard Prairie Healthcare LLC	amy.serr@manitohh.com
601407644	Maxim Healthcare Services Inc	chachandl@maxhealth.com
605375060	Altru Home Care, LLC	alid@nhcares.com
602343412	NORTHSIDE IN HOME CAREGIVERS LLC	
602547226	Evergreen Pharmaceutical LLC	OCRSeattle_Management@CVSHealth.com
601778100	Option Care Enterprises Inc	oc-peandl@optioncare.com
601140022	Spokane Healthcare Associates Inc	
601327118	Option Home Health Care Services Inc	michelle.mazzenga@walgreens.com
601622117	Option Home Health Care Services Private Duty	doreen.wiman@walgreens.com
604810271	Precision Home Care LLC	tmorrison85@msn.com
604019866	Preferred Homecare Infusion LLC	laura.north@preferredhomecare.com
313007977	Providence Health and Services - Washington	cheryl.cline@providence.org
313007977	Providence Health and Services - Washington	windy.kheldgaard@providence.org
313007977	Providence Health and Services - Washington	windy.kheldgaard@providence.org

602688528	QUALITY CARE IN HOME SERVICE	
603316539	RCI Home Service Industries LLC	jphannum@gmail.com
602748354	Reliant RX LLC	tammyk@reliantrxwa.com
602700923	Southern Home Care Service Inc	
601882866	Res Care Washington Inc	labalo@allwayscaring.com
604673475	JNM Compassion Healthcare, Inc.	nickpaul76@hotmail.com
328054106	Riverview Lutheran Care Center	jkelley@riverviewretirement.org
328054106	Riverview Lutheran Care Center	jkelley@riverviewretirement.org
601800455	Romsakorn Gampanat	romsakorn@comcast.net
601044154	Northwest Home Medical INC	provider.services@rotech.com
601555893	S and S Health Care Inc	mbrinkley@sandshealthcare.com
602569075	Senior Assist LLC	mgodek@seniorhelpers.com
603364126	SH Care Inc.	tmurphy@seniorhelpers.com
605081418	Silver Steps LLC	vilma.silversteps@gmail.com
600339315	SL Start and Associates Incorporated	
603065608	SL Start and Associates LLC	kinderhafen@charter.net
600335200	Frontier Behavioral Health	kmiller@fbhwa.org
603151540	Concierge Northwest Corp	christine@stayathomeadultcare.com
602985256	Stepping Stones Pediatric Therapy PLLC	
602919416	Sunshine Home Health Care LLC	gretchena@shfi.com
600397826	The Arc of Spokane	jmiller@arc-spokane.org
600397826	The Arc of Spokane	jmiller@arc-spokane.org
600397826	The Arc of Spokane	jmiller@arc-spokane.org
601155999	Touchmark on South Hill, a Limited Partnership	kari.miller@touchmark.com

601155999	Touchmark on South Hill, a Limited Partnership	kari.miller@touchmark.com
604286452	Vida At Home, LLC	josh@vidainhomecare.com
602613450	Allen Joshua David	avolon172@gmail.com
604903389	Neighborhood Care, LLC	llakin@visitingangels.com
602707011	Trondheim LLC	cindy@spokanevisitingangels.com
604001326	A Lot of Extra TLC LLC	d.johnson@visitingangels.com
601561772	WALSH and ASSOCIATES	
603393514	Weeping Ridge Home Health LLC	israelrodriguezjr@weepingridge.com

Attachment 2

Admissions Policy

RiverCare Home Health

Delivery of Services

HH 400: Admission Policies	WAC 246-335-520: Delivery of Services
Date of Origin: 08/27/2024	Effective Date: 08/27/2024

Policy Statement:

Acceptance of patients by the agency is based on an initial assessment visit and a reasonable expectation that home health services can meet the medical needs of the patient.

Procedure:

1) The following criteria must be met before the patient is admitted for care:

   a) Home healthcare services starting within seven (48) Hours of receiving and accepting a physician or practitioner referral for services. Longer time frames are permitted when one or more of is documented:

      i. Longer time frame for the start of services is requested by the physician or practitioner
      ii. Longer time frame for the state of services is requested by the patient, designated family member, legal representative, or referral source
      iii. Start of services was delayed due to agency having challenges contacting patient, designated family member, or legal representative

2) The home care plan of care will include any nonmedical services available to meet the patient or family needs as identified in plans of care

3) The Clinical Director or designee will receive referrals for services by the agency.

4) Requests for home health services are documented on the intake/referral form.

5) The Clinical Director assesses the patient referral for appropriateness of admission to the program consistent with the following criteria:

   a) Be confined to the home

   b) The patient is under the care of a licensed healthcare professional

   c) A healthcare professional approves the home health services and participates in establishing the plan of care and signs the plan of care

   d) The patient's needs can be adequately and safely met with the support of home health services

e) A willingness on the part of the patient to participate in a healthcare professional directed plan of care.

f) Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner

g) Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or

h) Have a continuing need for occupational therapy

6) Patients, who do not meet agency requirements, but might benefit from a referral to other community-based agencies, will be referred to those agencies.

7) A plan for preserving and disposing of patient records when ceasing operations according to WAC 246-335-550 (7) and (8) and policy HH 1005

Attachment 3

Policy on Receiving Charitable Giving
Policy on Providing Charitable Care

Riverview Policy on Receiving Charitable Giving

1. Purpose

The purpose of this policy is to establish guidelines and procedures for receiving charitable donations and contributions to ensure that they are managed ethically, transparently, and in alignment with the organization's mission and values. This policy aims to uphold the integrity of the organization while fostering positive relationships with donors and stakeholders.

2. Scope

This policy applies to all employees, departments, and divisions of the organization involved in the acceptance, processing, and management of charitable donations, including monetary gifts, in-kind contributions, and sponsorships.

3. Objectives

1. **Alignment with Organizational Values:** Ensure that all received charitable contributions align with the organization's mission, values, and strategic goals.
2. **Transparency and Accountability:** Manage donations with transparency and accountability to maintain donor trust and organizational integrity.
3. **Compliance:** Adhere to relevant laws, regulations, and internal policies regarding the acceptance and use of charitable contributions.
4. **Effective Use of Resources:** Utilize received contributions in a manner that maximizes their intended impact and supports the organization's objectives.

4. Guidelines for Receiving Charitable Contributions

1. **Eligibility Criteria:**
    - Accept contributions that support causes and projects aligned with the organization's mission and values.
    - Avoid accepting contributions that may create conflicts of interest or have conditions that could undermine the organization's integrity.
2. **Types of Contributions:**
    - **Monetary Donations:** Cash or check donations, which should be deposited promptly into the organization's designated accounts.

- **In-Kind Donations:** Goods, services, or other non-cash contributions, which should be evaluated for their value and relevance.
- **Sponsorships:** Financial or in-kind support for specific events or initiatives, provided they align with the organization's goals and are properly documented.

3. **Acceptance and Approval:**
   - All charitable contributions must be reviewed and approved by designated personnel or committees as outlined in the organization's approval hierarchy.
   - Ensure that the acceptance of contributions is documented with a written acknowledgment or agreement, including details about the donor, the contribution, and any specific terms or conditions.
4. **Donor Recognition:**
   - Acknowledge and thank donors promptly and appropriately for their contributions.
   - Recognize significant contributions publicly, where appropriate, in a manner that reflects the organization's gratitude and maintains donor privacy as requested.
5. **Conflict of Interest:**
   - Avoid accepting donations that may present a conflict of interest or could be perceived as compromising the organization's independence or ethical standards.
   - Disclose any potential conflicts of interest to management or the appropriate committee before accepting a contribution.
6. **Compliance and Legal Considerations:**
   - Ensure that all received charitable contributions comply with applicable laws and regulations, including tax laws and reporting requirements.
   - Maintain accurate records of all received contributions and provide necessary documentation to comply with reporting and audit requirements.
7. **Use of Donations:**
   - Utilize donated funds or in-kind contributions in accordance with the donor's intentions and organizational needs.

- Ensure that donations are used efficiently and effectively to further the organization's mission and objectives.

8. **Record Keeping and Reporting:**
    - Maintain detailed records of all received contributions, including donor information, contribution amounts, and any associated documentation.
    - Prepare and submit regular reports on charitable giving activities to senior management and the board of directors, highlighting the impact and alignment with organizational goals.

5. Responsibilities

1. **Board of Directors:**
    - Oversee the organization's policies and practices related to receiving charitable contributions and ensure alignment with strategic objectives.
2. **Fundraising or Development Committee (if applicable):**
    - Review and approve major contributions and sponsorships.
    - Ensure adherence to policy guidelines and evaluate the impact of received contributions.
3. **Management:**
    - Implement and enforce the policy on receiving charitable contributions within their departments or teams.
    - Ensure that all received contributions are processed and documented according to policy.
4. **Employees:**
    - Follow the guidelines and procedures outlined in this policy when receiving and processing charitable contributions.
    - Report any concerns or irregularities related to the acceptance of contributions.

6. Training and Awareness

- Provide training to employees on the policy for receiving charitable contributions to ensure understanding and compliance.

- Update training materials regularly to reflect changes in policies, regulations, or best practices.

7. Policy Review

- This policy will be reviewed annually or as needed to ensure its relevance and effectiveness.
- Any changes or updates to the policy will be communicated to all relevant employees and stakeholders.

8. Enforcement

Violations of this policy may result in disciplinary action, up to and including termination of employment. The organization reserves the right to take corrective action and address any issues related to the acceptance and management of charitable contributions.

This Policy on Receiving Charitable Giving is designed to guide the organization in managing donations and contributions with integrity and transparency, ensuring alignment with its mission and values while fostering positive relationships with donors and stakeholders.

Riverview policy on Providing Charitable Care

Purpose

This policy outlines the guidelines and procedures for providing charitable care within our organization. Charitable care aims to ensure that individuals in need receive necessary medical services regardless of their ability to pay.

Scope

This policy applies to all employees, healthcare providers, and administrative staff involved in delivering or managing charitable care services within the organization.

Policy Statement

Our organization is committed to providing compassionate, high-quality care to all patients, including those who may not have the financial resources to pay for services. Charitable care is provided based on need and without regard to the patient's ability to pay.

Eligibility Criteria

1. **Financial Need Assessment:** Patients seeking charitable care must undergo a financial need assessment. This assessment will consider income, household size, and any other relevant financial information.
2. **Documentation Requirements:** Patients must provide documentation to support their financial need, including proof of income, tax returns, and any other relevant financial statements.
3. **Special Circumstances:** In cases of extraordinary financial hardship or emergency situations, exceptions to documentation requirements may be made at the discretion of Riverview President and CEO.

Application Process

1. **Initial Inquiry:** Patients can inquire about charitable care services through the admissions department, billing office, or directly with healthcare providers.
2. **Application Form:** Patients must complete a charitable care application form, available in the admissions department or on our website.
3. **Review Process:** The completed application and supporting documents will be reviewed by Riverview President and CED and a designated review committee.

4. **Decision Notification:** Patients will be notified of the decision within 30 days of submitting their application. The notification will include details about the extent of the charitable care provided and any required follow-up steps.

Scope of Charitable Care

1. **Service Coverage:** Charitable care may cover a range of services, including but not limited to, home health and home care.
2. **Discounts and Waivers:** Charitable care may involve discounts on services or complete waivers of charges, depending on the patient's financial situation and the availability of resources.
3. **Limitations:** Charitable care may not cover elective procedures or services not deemed medically necessary. Additionally, limitations may be imposed based on resource availability.

Responsibilities

1. **RiverCare Manager:** Oversees the charitable care process, ensures compliance with this policy, and provides guidance to patients and staff.
2. **Healthcare Providers:** Inform patients about the availability of charitable care and assist with the application process as needed.
3. **Administrative Staff:** Support the charitable care process by managing documentation, scheduling, and communication with patients and families.

Confidentiality

All information related to charitable care applications and financial assessments will be kept confidential and used only for the purpose of determining eligibility and providing care.

Compliance and Review

1. **Regulatory Compliance:** This policy complies with all relevant federal, state, and local regulations regarding charitable care and financial assistance.
2. **Policy Review:** This policy will be reviewed annually and updated as necessary to ensure continued relevance and compliance with applicable laws and regulations.

Contact Information

For questions or additional information about charitable care please contact the RiverCare Manager 509-483-6483.

This policy aims to support the ethical and equitable provision of care to those in need while maintaining the integrity and sustainability of our organization's resources.

Attachment 4

Patient's Rights and Responsibilities Policy

RiverCare Home Health

Patient Bill of Rights

HH 700: Bill of Rights	WAC: 246-335-435 Patient's Bill of Rights
Date of Origin: 02/01/2023	Effective Date: 02/01/2023

Policy:

The Agency will provide a written Bill of Rights to the patient and/or patient representative.

Purpose:

1) To document rights that belong to patients, families and designated patient representatives by the Washington State In-Home Services licensing law.

Procedure:

1) Each patient admitted to home care services is given a written Bill of Rights before services are delivered.

2) The Administrator or designee will review the Bill of Rights with the patient and/or patient representative upon admission.

3) The patient and/or patient representative will sign documentation indicating acknowledgment and understanding of the Bill of Rights.

4) A copy of the Bill of Rights will be left with the patient. A copy of the Bill of Rights will be retained in the patient care record, or the record may contain documentation of receipt of the Bill of Rights by the patient or patient representative.

5) The agency will ensure that all rights are implemented and updated as appropriate.

RiverCare Home Health

HH 705: Patient Bill of Rights	WAC: 246-335-435 Patient's Bill of Rights
Date of Origin: 02/01/2023	Effective Date: 02/01/2023

As a patient receiving services from the agency, I have the right to:

1) Receive quality services from the home care agency for services identified in the plan of care

2) Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services

3) A statement advising of the right to ongoing participation in the development of the plan of care

4) A statement advising of the right to have access to the department's listing of licensed home care agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations

5) A listing of the total services offered by the home care agency and those being provided to the patient

6) Refuse specific services

7) The name of the individual within the home care agency responsible for supervising the patient's care and the manner in which the individual may be contacted

8) Be treated with courtesy, respect, privacy

9) Be free of verbal, mental, sexual, and physical abuse, neglect, exploitation, and discrimination

10) Have property treated with respect

11) Privacy and confidentiality of personal information, and healthcare related records

12) Be informed of what the home care agency charges for services, to what extent payment may be expected from care insurance, public programs, or other sources, and what charges the patient may be responsible for paying

13) A fully itemized billing statement upon request, including the date of each service and the charge. Agencies providing services through a managed care plan are not be required to provide itemized billing statements

14) Be informed about advanced directives and POLST, and the agency's scope of responsibility

15) Be informed of the agency's policies and procedures regarding the circumstances that may cause the agency to discharge a patient

16) Be informed of the agency's policies and procedures for providing back-up care when services cannot be provided as scheduled

17) A description of the agency's process for patients and family to submit complaints to the home care agency about the services and care they are receiving and to have those complaints addressed without retaliation

18) Be informed of the department's complaint hotline number, 1-800-633-6828, to report complaints about the licensed agency or credentialed healthcare professionals and be aware that the hotline can be called at any time;

19) Be informed of the DSHS and harm hotline number 1-866-END –HARM to report suspected abuse of children and vulnerable adults.

20) Be informed that the use of physical or chemical restraints will not be initiated or tolerated by the home care agency

21) The home health agency must ensure that the patient rights under this section are implemented and updated as appropriate

Attachment 5

Non-Discrimination Policy

RiverCare Home Health

HH 706: Non-Discrimination Policy	
Date of Origin: 08/27/2024	Effective Date: 08/27/2024

Non-Discrimination Policy

Nondiscrimination Notice The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex (including sexual orientation and gender identity), or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities. You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use. You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

2. By phone: Call 1-800-368-1019. TTY users can call 1-800-537-7697.

3. In writing: Send information about your complaint to: Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Attachment 6

Discharge Policy

RiverCare Home Health

HH 405: Discharge Policies	WAC 246-335-520: Delivery of Services
Date of Origin: 02/01/2023	Effective Date: 02/01/2023

Policy Statement:

The agency has established specific criteria for discharging patients.

Procedure:

1) In order to minimize the possibility of patient abandonment, patients shall be given at least a forty-eight (48) hour written notice prior to discharge.

2) Forty-eight (48) hour written notice discharge is not required if any of the following exists:

   a) The home care aide/caregiver is abused or threatened, or the environment is considered unsafe for the worker

   b) Significant patient non-compliance

   c) Failure to pay for services rendered

   d) If the patient or family representative refuse to allow for the provision of a safe environment.

   e) When repeated attempts by home care staff to establish a care regime are unsuccessful and there exists noncompliance with the plan of care that renders the patient and the home environment to be unsafe.

3) Discharge is appropriate when any of the following conditions exists:

   a) The patient or the healthcare professional requests termination of services

   b) The patient has been rehabilitated to his or her maximum potential and goals for care have been met

   c) The patient becomes physically able to obtain needed services on an outpatient basis

   d) The patient does not respond to concerted efforts to carry out the home health plan of care

   e) The patient's clinical status worsens, and hospitalization or nursing home care becomes appropriate

f) Another person (e.g., a family member) is capable of providing the required service and has been prepared to assume this responsibility.

g) Patient elect's hospice before the end of the 30-day period, the HHA will receive a full 30-day period payment.

h) Patient's death would result in a full 30-day period payment, unless the death occurred in a low utilization payment adjusted 30-day period.

i) Patient is discharged because they are no longer eligible, has received visits meeting the LUPA threshold for the payment group, then the HHA would receive the full 30-day period payment.

j) If a patient's enrollment in a Medicare Advantage (MA) plan becomes effective med period, the 30-day period payment will be proportionally adjusted with a partial payment adjustment since the patient is receiving coverage under MA. Beginning with the effective date of enrollment, the MA plan will receive a capitation payment for covered services.

k) The claim may be submitted upon discharge before the end of the 30-day period.

l) Medicare HH PPS requires the HHA to provide all bundled home health services (except DME) either directly or under arrangement while a patient is under an open home health plan of care during an open episode.

m) If a patient is admitted to an inpatient facility and the inpatient stay overlaps the 60-day recertification and no recertification assessment, then the new certification begins with the new start of care.

4) Patients and/or family members will be informed of any impending discharge from services when the agency is ceasing operations, or the agency is unable to meet the patient's needs.

5) A home health agency discharging a patient that is concerned about the ongoing care and safety may submit a self-report to appropriate state agencies which identifies the reason for discharge and the steps take to mitigate safety concerns.

6) The criteria for discharging the patient will be documented in the clinical record.

Attachment 7

Violence in the Workplace

RiverCare Home Health

HH 1115: Violence in the Workplace	WAC: 246-335-555 Quality Improvement Program
Date of Origin: 02/01/2023	Effective Date: 02/01/2023

Policy Statement:

Each health care setting shall develop and implement a plan to reasonably prevent and protect employees from violence at the work setting. The complexity of the plan will depend upon the size of the agency, the geographic service area and the number of employees.

Procedure:

A. Definitions:

1) "Health care setting" means:

   a) Hospitals as defined in RCW 70.41.020;

   b) Home health, hospice, and home care agencies under chapter 70.127 RCW, subject to RCW 49.19.070;

   c) Evaluation and treatment facilities as defined in RCW 71.05.020;

   d) Behavioral health programs as defined in RCW 71.24.025; and

   e) Ambulatory surgical facilities as defined in RCW 70.230.010.

2) "Department" means the department of labor and industries.

3) "Employee" means an employee as defined in RCW 49.17.020.

4) "Workplace violence," "violence," or "violent act" means any physical assault or verbal threat of physical assault against an employee of a health care setting on the property of the health care setting. "Workplace violence," "violence," or "violent act" includes any physical assault or verbal threat of physical assault involving the use of a weapon, including a firearm as defined in RCW 9.41.010, or a common object used as a weapon, regardless of whether the use of a weapon resulted in an injury.

B. Every three (3) years:

Each health care setting shall develop and implement a plan to prevent and protect employees from violence at the setting. In a health care setting with a safety committee establish pursuant to RCW 49.17.050 and related rules, or workplace violence committee that is comprised of employee-elected and employer-selected members where the number of employee-elected members equal or exceed of employer-selected members, that committee shall develop, implement, and monitor progress on the plan.

1) The plan developed shall outline strategies aimed at addressing security considerations and factors that may contribute to or prevent the risk of violence, including but not limited to the following:

    a) The physical attributes of the health care setting, including security systems, alarms, emergency response, and security personnel available

2) The plan developed under subsection 1) of this section shall outline strategies aimed at addressing security considerations and factors that may contribute to or prevent the risk of violence, including but not limited to the following:

    a) The physical attributes of the health care setting, including security systems, alarms, emergency response, and security personnel available

    b) Staffing, including staffing patterns, patient classifications, and procedures to mitigate employees time spent alone working in areas at high risk for workplace violence

    c) Job design, equipment, and facilities

    d) First aid and emergency procedures

    e) The reporting of violent acts

    f) Employee education and training requirements and implementation strategy

    g) Security risks associated with specific units, areas of the facility with uncontrolled access, late night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas; and

    h) Processes and expected interventions to provide assistance to an employee directly affected by a violent act.

3) Each health care setting shall annually review the frequency of incidents of workplace violence including identification of the causes for and consequences of, violent acts at the setting and any emerging issues that contribute to workplace violence. The health care setting shall adjust the plan developed necessary based on this annual review.

4) In developing the plan the health care setting shall consider any guidelines on violence in the workplace or in health care settings issued by the department of health, the department of social and health services, the department of labor and industries, the federal occupational safety and health administration, Medicare, and health care setting accrediting organizations.

C. Violence prevention training:

1) On a regular basis, as set forth in the plan developed above, each health care setting shall provide violence prevention training to all applicable employees, volunteers, and contracted security personnel, as determined by the plan.

2) The training shall occur within ninety days of the employee's initial hiring date unless he or she is a temporary employee.

3) The method and frequency of training may vary according to the information and strategies identified in the plan. Training may include, but are not limited to, classes that provide an opportunity for interactive questions and answers, hands on training, video training, brochures, verbal training, or other verbal or written training that is determined to be appropriate under the plan. Trainings must address the following topics, as appropriate to the particular setting and to the duties and responsibilities of the particular employee being trained, based upon the hazards identified in the plan.

a) The health care setting's workplace violence prevention plan

b) General safety procedures

c) Violence predicting behaviors and factors

d) The violence escalation cycle

e) De-escalation techniques to minimize violent behavior

f) Strategies to prevent physical harm with hands-on practice or role play

g) Response team processes

h) Proper application and use of restraints, both physical and chemical restraints

i) Documentation and reporting incidents

j) The debrief process for affected employees following violent acts; and

k) Resources available to employees for coping with the effects of violence.

l) A description of actions taken by employees and the health care setting in response to the act. Each record shall be kept for at least five years following the act reported, during which time it shall be available for inspection by the department upon request.

D. Violent acts—Records:

Each health care setting shall keep a record of any violent act against an employee, a patient, or a visitor occurring at the setting. Each record shall be kept for at least five years following the act reported, during which time it shall be available for inspection by the department upon request. At a minimum, the record shall include:

1) The health care setting's name and address

2) The date, time, and specific location at the health care setting where the act occurred

3) The name, job title, department or ward assignment, and staff identification or social security number of the victim if an employee

4) A description of the person against whom the act was committed as:

   a) A patient

   b) A visitor

   c) An employee

   d) Other

5) A description of the person committing the act as:

   a) A patient

   b) A visitor

   c) An employee

   d) Other

6) A description of the type of violent act as a:

   a) Threat of assault with no physical contact

   b) Physical assault with contact but no physical injury

c) Physical assault with mild soreness, surface abrasions, scratches, or small bruises

d) Physical assault with major soreness, cuts, or large bruises

e) Physical assault with severe lacerations, a bone fracture, or a head injury

f) Physical assault with loss of limb or death

7) An identification of any body part injured

8) A description of any weapon used

9) The number of employees in the vicinity of the act when it occurred

10) A description of actions taken by employees and the health care setting in response to the act.

E. Workplace violence plan—Security and safety assessment:

1) Every three years, each health care setting shall develop and implement a plan to prevent and protect employees from violence at the setting. In a health care setting with a safety committee established pursuant to RCW 49.17.050 and related rules, or workplace violence committee that is comprised of employee-elected and employer-selected members where the number of employee-elected members equal or exceed the number of employer-selected members, that committee shall develop, implement, and monitor progress on the plan.

2) The plan developed under subsection (1) of this section shall outline strategies aimed at addressing security considerations and factors that may contribute to or prevent the risk of violence, including but not limited to the following:

a) The physical attributes of the health care setting, including security systems, alarms, emergency response, and security personnel available

b) Staffing, including staffing patterns, patient classifications, and procedures to mitigate

c) employees time spent alone working in areas at high risk for workplace violence

d) Job design, equipment, and facilities

e) First aid and emergency procedures

f) The reporting of violent acts

g) Employee education and training requirements and implementation strategy

h) Security risks associated with specific units, areas of the facility with uncontrolled access, late night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas; and

i) Processes and expected interventions to provide assistance to an employee directly affected by a violent act.

3) Each health care setting shall annually review the frequency of incidents of workplace violence including identification of the causes for and consequences of, violent acts at the setting and any emerging issues that contribute to workplace violence. The health care setting shall adjust the plan developed on as necessary based on this annual review.

4) In developing the plan, the health care setting shall consider any guidelines on violence in the workplace or in health care settings issued by the department of health, the department of social and health services, the department of labor and industries, the federal occupational safety and health administration, Medicare, and health care setting accrediting or available for inspection by the department upon request.

Attachment 8

Patient and Personnel Safety

RiverCare Home Health

HH 1110: Patient and Personnel Safety	WAC: 246-335-555 Quality Improvement Program
Date of Origin: 02/01/2023	Effective Date: 02/01/2023

Policy Statement:

All accidents, incidents, or unusual occurrences involving patients or employees will be reported immediately to the Administrator or Clinical Director.

Procedure:

1) If unsafe or potentially unsafe conditions exist, or are recognized in a patient's environment, any member of the agency staff will take appropriate action to alleviate or rectify the condition through patient education and/or referral to another community resource.

2) As part of the initial assessment visit, and during subsequent visits to the patient's home, staff will be alert to unsafe conditions and intervene appropriately.

3) An initial risk assessment of the environment will be made in which agency staff performs their duties to determine occupational exposure. These results of the risk assessment will inform policies and procedures development and level of staff training and education

4) The presence of an unsafe home environment that increases patient risk will be reported to the Clinical Director and will be addressed through performance improvement monitoring and corrective action.

5) Staff will report to the Administrator or Clinical Director, any situations in which they believe their personal safety may be compromised.

Attachment 9

Deed

First American

40 E Spokane Falls Blvd
Spokane WA 99202
Phone: 509-456-0550
Fax: 866-537-9602

Spokane County Parcel Information

Parcel ID # **35093.1003** Map Grid: 018 Township: 25N Range: 43 Section: 09 Quarter: SW

Property Address: 1801 E Upriver Dr
Spokane, WA 99207

Owner Information

Name: Riverview Village

Mail Address: 1801 E Upriver Dr
Spokane, WA 99207-5181

Taxpayer Name: Riverview Village

Taxpayer Address: 1801 E Upriver Dr WA 99207-5181

Assessor Information

Property Identification #: 35093.1003

Parcel Description: 65 - Service - Professional

Property Size: 0.17 Acres (7,500 Sq.Ft.)

Lot Width: 0 Lot Depth: 0

Census Tract: 001800

Census Block: 1008

Tax Code Area: 0010

Levy Rate: 13.17812316

LegalID escription

RIBLET & STRACK'S SUB OF BLK 10 OF ROSS PARK ADD; W 45FT OF LTS 4 & 5 BLK A AND E1/2 OF VAC JANE'S ST W OF & ADJ SD LTS DEPT REV #06963-001

Assessments

Tax Year	Improvement Value	Land Value	Total Value
2012	$0	$16,880	$14,010
2011	$0	$16,880	$14,854
2010	$0	$16,880	$14,854

Taxes

2012 Taxes: $192.83

Spokane County Parcel Information

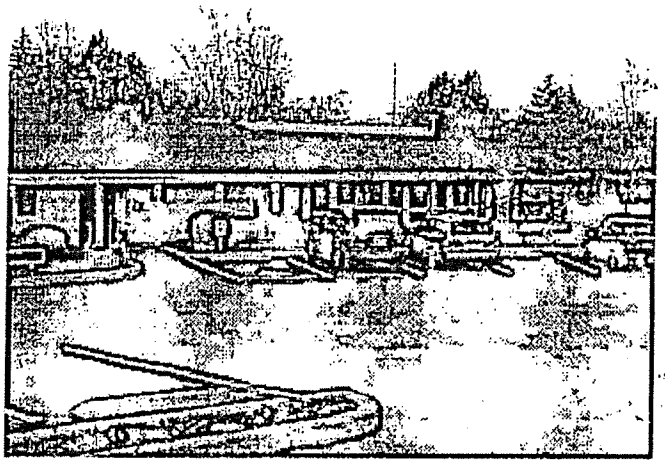
First American

40 E. Spokane Falls Blvd
Spokane, WA 99202
Phone. 509-456-0550
Fax: 866-537-9602

Parcel ID # **35093.1004** Map Grid: 018 Township: 25N Range: 43 Section: 09 Quarter: SW

Property Address: 1801 E Upriver Dr
Spokane, WA 99207

35093.1004 - East end of Community Center



Owner Information

Name: Riverview Village

Mail Address: 1801 E Upriver Dr
Spokane, WA 99207-5181

Taxpayer Name: Riverview Village

Taxpayer Address: 1801 E Upriver
Dr WA 99207-5181

Assessor Information

Property Identification #: 35093.1004

Parcel Description: 65 - Service - Professional

Property Size: 0.25 Acres (10,866 Sq. Ft.)

Lot Width: 0 Lot Depth: 0

Census Tract: 001800

Census Block: 1008

Tax Code Area: 0010

Levy Rate: 13.17812316

LegalID escription

RIBLET & STRACKS SUB OF BLK 10 ROSS PARK ADD; LTS 4 & 5 BLK A EXC W 45FT DEPT REV #05016-001

Assessments

Tax Year	Improvement Value	Land Value	Total Value
2012	$278,600	$24,450	$251,531
2011	$278,600	$24,450	$266,684
2010	$278,600	$24,450	$266,684

Taxes

2012 Taxes: $3,462.11

Commercial Improvements

Ext.: C01	Improvement Desc.:	Commercial Swimming Pool	Year Built: 1985	Remodeled: 0	Quality: Avg		
Size: 450 SF	Floors: 1		Width x Length: 15.00x30.00	AC:	Units:		
Ext.: C01	Improvement Desc.:	Community Center	Year Built: 1985	Remodeled: 0	Quality: Avg		
Size: 4227 SF	Floors: 1		Width x Length: 0.00x0.00	AC:	Units:		

Transfer Information

Rec. Date:	07/09/97	Sale Price: $167,575	Doc Num: 0004119736	Doc Type:	
Owner:	RIVERVIEW VILLAGE		Grantor:	RIVERVIEW LUTHERAN HOME	
Orig. Loan Amt:			Title Co:	TRANSNATION TITLE INSURANCE	
Finance Type:		Loan Type:	Lender:		

TRANSNATION. TITLE INS CO WD $10.00

4119736
Page: 1 of 3
07/09/1997 04:34P
Spokane Co. WA

RETURN TO:

Casey, Gore & Grewe, P.S.
316 West Boone, Suite 880
Spokane, WA 99201

TAX PARCEL NUMBER: 35093.1004
The tax parcel number is provided at the request of the Auditor and shall not be construed as part of the legal Document.

STATUTORY WARRANTY DEED

Bm 2087 3S 3

THE GRANTOR, RIVERVIEW LUTHERAN HOME OF SPOKANE WASHINGTON, a Washington nonprofit corporation, also known as RIVERVIEW LUTHERAN HOME, a corporation, for and in consideration of ONE HUNDRED SIXTY-SEVEN THOUSAND, FIVE HUNDRED SEVENTY-FIVE AND NO/100 DOLLARS ($167,575.00) in hand paid, conveys and warrants to RIVERVIEW VILLAGE, a Washington nonprofit corporation, the following-described real estate, situated in the County of Spokane, State of Washington:

Lots 4 and 5 in Block "A" of RIBLET AND STACK'S SUBDIVISION OF BLOCK 10 ROSS PARK, except the West 45 feet thereof as per plat thereof recorded in Volume "B" of Plats Page 44; Situate in the City of Spokane, County of Spokane, State of Washington.

Subject to the following exceptions:

1. Encroachments resulting from the construction of the Community Center on adjoining property owned by Grantee.

2. Lack of access to a public road from the property above described.

3. 1997 and future General Taxes, Aquifer Protection and Stormwater fees.

4. General Taxes and potential supplemental assessments, including other amounts due thereunder, which results from any changes in tax exempt status. This property is currently carried on the tax rolls as exempt from taxes. On the date of conveyance or change in use which removes it from exempt

97000872S

97000872S

Excise Tax Paid on Sale Amt. Pd 2782.87
Spokane County Treas.
By 7/9/97

- 1 -

status, the property will become subject to General Property taxes from that date forward.

5. Supplemental assessments for General Taxes for prior years under the provisions of RCW 84.36.810 levied against this property, if any.

6. All covenants, conditions, restrictions, reservations, easements or other servitudes, if any, disclosed by the recorded documents of the plat of RIBLET AND STACK'S SUBDIVISION OF LOT 10 ROSS PARK, in Volume "B" of Plats, Page 44. Rights or benefits, if any, which may be disclosed by said recorded documents affecting property outside the boundary of the property conveyed herein.

7. Agreement and the terms and conditions thereof recorded October 19, 1983 under Recording No. 8310190224 regarding vacation of Maud Street and Lucille Avenue and Local Improvement District for improvement of North Crescent Avenue.

8. Easement rights and maintenance agreements, if any, for utilities which may have been granted in vacated streets and alleys prior to their vacation.

9. Unrecorded leaseholds, if any, rights of vendors and holders of security interests on personal property installed upon said property; and rights of tenants to remove trade fixtures at the expiration of the term.

10. Rights, reservations, covenants, conditions and restrictions presently of record; easements and encroachments not materially affecting the value or unduly interfering with Grantee's intended use of the property.

11. Standard Exceptions identified in Schedule B, Paragraph B, of the preliminary title insurance commitment issued by Transnation Title under Order No. BM208735.

DATED this 27 day of June, 1997.

RIVERVIEW LUTHERAN HOME
OF SPOKANE WASHINGTON

BY: PATRICK O'NEILL, PRESIDENT

BY: EDIE VOLOSING, SECRETARY

TRANSNATION. TITLE INS CO WD $10.00

STATE OF WASHINGTON)
:ss
County of Spokane)

On this 27 day of June, 1997, before me, the undersigned, a Notary Public in and for the State of Washington, personally appeared PATRICK O'NEILL and EDIE VOLOSING, to me known, or proven on the basis of satisfactory evidence, to be the President and Secretary respectively, of RIVERVIEW LUTHERAN HOME OF SPOKANE WASHINGTON, who executed the within and foregoing instrument and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the uses and purposes therein mentioned, and on oath stated that each was authorized to execute said instrument and that the seal affixed is the corporate seal of said corporation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year first above written.

Notary Public in and for the State of Washington, residing at Spokane

My Appointment Expires: 3-13-98

jmj\n\riverview\village\2424.re\statutory.dee

ROBERT J. SIMONSEN NOTARY PUBLIC STATE OF WASHINGTON MY COMMISSION EXPIRES

Attachment 10

Audit

Consolidated Financial Statements

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2023 AND 2022

CPAs | CONSULTANTS | WEALTH ADVISORS

CLAconnect.com

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
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YEARS ENDED DECEMBER 31, 2023 AND 2022

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
Riverview Lutheran Retirement Community of Spokane
dba: Riverview Retirement Community
Spokane, Washington

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying consolidated financial statements of Riverview Lutheran Retirement Community of Spokane dba: Riverview Retirement Community (a Washington nonprofit corporation), which comprise the consolidated statements of financial position as of December 31, 2023 and 2022, and the related consolidated statements of activities and changes in net assets (deficit), and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Riverview Retirement Community as of December 31, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Riverview Retirement Community and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Riverview Retirement Community's ability to continue as a going concern for one year after the date the consolidated financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Riverview Retirement Community's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Riverview Retirement Community's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating statements of financial position and the consolidating statements of activities and changes in net assets (deficit) are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Bellevue, Washington
May 23, 2024

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
DECEMBER 31, 2023 AND 2022

	2023	2022
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 3,280,085	$ 1,453,138
Investments	12,134,560	11,981,605
Accounts Receivable, Net	124,503	1,809,994
Prepaid Expenses and Other Assets	162,917	138,452
Total Current Assets	15,702,065	15,383,189
ASSETS LIMITED OR RESTRICTED AS TO USE		
Restricted for Debt Service and Reserve	1,456,498	1,415,986
Other Assets Limited or Restricted as to Use	1,008,184	849,971
Total Assets Limited or Restricted as to Use	2,464,682	2,265,957
PROPERTY, BUILDINGS, AND EQUIPMENT, NET	30,755,803	33,338,940
Total Assets	$ 48,922,550	$ 50,988,086
LIABILITIES AND NET ASSETS (DEFICIT)		
CURRENT LIABILITIES		
Accounts Payable	$ 263,056	$ 546,077
Accrued Payroll and Related Liabilities	559,643	498,887
Line of Credit	-	865,000
Accrued Interest	364,941	373,289
Applicants' Deposits	300,183	109,000
Patient Trust Liability	4,026	7,076
Current Maturities of Long-Term Debt	631,694	598,534
Current Portion of Entrance Fees Refundable Upon Re-Occupancy	2,513,864	2,112,074
Total Current Liabilities	4,637,407	5,109,937
LONG-TERM LIABILITIES		
Long-Term Debt, Net	16,789,472	17,391,080
Entrance Fees Refundable Upon Re-Occupancy, Net of Current Portion	32,771,794	32,709,458
Deferred Revenue from Nonrefundable Entrance Fees	4,017,840	4,266,190
Total Long-Term Liabilities	53,579,106	54,366,728
Total Liabilities	58,216,513	59,476,665
NET ASSETS (DEFICIT)		
Net Assets (Deficit) Without Donor Restrictions:		
Without Board Designations	(10,117,278)	(9,180,658)
With Donor Restrictions	823,315	692,079
Total Net Assets (Deficit)	(9,293,963)	(8,488,579)
Total Liabilities and Net Assets (Deficit)	$ 48,922,550	$ 50,988,086

See accompanying Notes to Consolidated Financial Statements.

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATED STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS (DEFICIT)
YEARS ENDED DECEMBER 31, 2023 AND 2022

	2023	2022
CHANGE IN NET ASSETS WITHOUT DONOR RESTRICTIONS		
REVENUE		
Resident Service Revenue, Net	$ 12,591,820	$ 11,739,587
Entrance Fees Earned	554,841	505,541
Loss on Fair Market Value Refund of Residency Agreements	(176,320)	(578,880)
Termination Income from Nonrefundable Portion of Residency Agreements	268,709	362,739
Tenant Reimbursements	179,499	182,091
Investment Income (Loss), Net	1,754,864	(2,123,257)
Contributions	11,604	34,242
Gain on Disposal of Assets	18,157	21,362
Grant Revenue	754,653	1,577,009
Other Revenue	355,653	288,095
Total Revenue	16,313,480	12,008,529
EXPENSES		
Health Services	4,628,353	4,292,117
Recreational Therapy Services	350,727	253,265
Chaplaincy Services	95,065	80,559
Dining Services	2,088,466	1,857,342
Environmental Services	665,683	624,324
Plant Operations and Security	2,356,191	2,230,205
Fiscal and Administration	2,335,351	2,532,925
Interest Expense	1,081,420	1,016,521
Taxes and Insurance	573,537	551,822
Depreciation	3,046,883	3,247,806
Total Expenses	17,221,676	16,686,886
CHANGE IN NET ASSETS (DEFICIT) WITHOUT DONOR RESTRICTIONS	(908,196)	(4,678,357)
CHANGE IN NET ASSETS WITH DONOR RESTRICTIONS		
Contributions	34,538	28,424
Investment Income (Loss), Net	68,274	(65,291)
Change in Net Assets with Donor Restrictions	102,812	(36,867)
CHANGE IN NET ASSETS (DEFICIT)	(805,384)	(4,715,224)
Net Assets (Deficit) - Beginning of Year	(8,488,579)	(3,773,355)
NET ASSETS (DEFICIT) - END OF YEAR	$ (9,293,963)	$ (8,488,579)

See accompanying Notes to Consolidated Financial Statements.

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2023 AND 2022

	2023	2022
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets (Deficit)	$ (805,384)	$ (4,715,224)
Adjustments to Reconcile Change in Net Assets (Deficit) to Net Cash Provided by Operating Activities:		
Depreciation	3,046,883	3,247,806
Amortization of Debt Issuance Costs	25,517	25,517
Amortization of Bond Premium	-	(11,504)
Nonrefundable Contracts - Entrance Fees Received	575,200	1,461,620
Nonrefundable Contracts - Termination Income	(268,709)	(362,739)
Entrance Fees Earned	(554,841)	(505,541)
Loss on Fair Market Value Refund of Residency Agreements	176,320	578,880
Realized (Gain) Loss on Investments	(530,093)	172,709
Unrealized (Gain) Loss on Investments	(973,261)	2,409,892
Gain on Disposal of Assets	(18,157)	(21,362)
Net Change in:		
Accounts Receivable	1,685,491	(1,613,349)
Prepaid Expenses	(24,465)	(2,695)
Accounts Payable	(105,275)	105,461
Accrued Payroll and Related Liabilities	60,756	(9,442)
Accrued Interest	(8,348)	831
Patient Trust Liability	(3,050)	2,113
Applicants' Deposits	191,183	(25,500)
Net Cash Provided by Operating Activities	2,469,767	737,473
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sale of Investments	2,477,607	994,915
Purchase of Investments, Net of Sales	(1,363,918)	(1,368,046)
Proceeds from Sale of Property, Building, and Equipment	25,275	27,691
Purchase of Property, Buildings, and Equipment	(648,611)	(1,583,637)
Net Cash Provided (Used) by Investing Activities	490,353	(1,929,077)
CASH FLOWS FROM FINANCING ACTIVITIES		
Principal Payments on Long-Term Debt	(593,965)	(598,450)
Proceeds from (Payments on) Line of Credit	(865,000)	865,000
Refundable Contracts - Entrance Fees Received	2,300,800	5,846,480
Refundable Contracts - Entrance Fees Refunded	(2,012,994)	(4,472,107)
Net Cash Provided (Used) by Financing Activities	(1,171,159)	1,640,923
CHANGE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	1,788,961	449,319
Cash, Cash Equivalents, and Restricted Cash - Beginning of Year	2,172,172	1,722,853
CHANGE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - END OF YEAR	$ 3,961,133	$ 2,172,172

See accompanying Notes to Consolidated Financial Statements.

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)
YEARS ENDED DECEMBER 31, 2023 AND 2022

	2023	2022
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION		
Cash and Cash Equivalents - Unrestricted	$ 3,280,085	$ 1,453,138
Cash and Cash Equivalents - Restricted for Debt Service	612,844	608,296
Cash and Cash Equivalents - Restricted for Debt Service Reserve	64,178	103,662
Cash and Cash Equivalents - Patient Trust Fund	4,027	7,076
Total Cash, Cash Equivalents, and Restricted Cash	$ 3,961,134	$ 2,172,172
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION		
Interest Paid in Cash	$ 1,064,251	$ 1,013,492
Noncash Acquisition of Property, Buildings, and Equipment	$ 913	$ 178,660

See accompanying Notes to Consolidated Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Riverview Lutheran Retirement Community of Spokane dba: Riverview Retirement Community is incorporated under the Washington State Nonprofit Corporation Act for the purpose of owning, operating, and providing retirement housing for the elderly in the local Spokane community and the surrounding communities. Riverview Retirement Community is exempt from federal income tax under Internal Revenue Code (IRC) Section 501(c)(3). Riverview Retirement Community operates four divisions: Riverview Village provides independent living services, Riverview Terrace provides assisted living services, Riverview Memory Care provides memory care services, and Riverview Rehabilitation Center provides outpatient diagnostic, therapeutic, and restorative services.

Riverview Resident Assistance Foundation (the Foundation), a Washington nonprofit corporation and a 501(c)(3) organization, was incorporated on January 19, 2017. The Foundation was organized to generate donations and to provide financial assistance to residents of Riverview Retirement Community who outlive their financial assets. The Foundation is deemed a Type 1 Supporting Organization by the Internal Revenue Service (IRS) and Riverview Retirement Community is identified as the Supported Organization. The initial board of directors of the Foundation was appointed by the board of directors of Riverview Retirement Community and all new members of the Foundation board of directors must first be approved by the board of directors of Riverview Retirement Community.

The financial position of the Foundation and the results of its activities, changes in its net assets, and its cash flows for the year then ended have been consolidated into the financial statements of Riverview Retirement Community. Riverview Retirement Community and Riverview Resident Assistance Foundation are collectively referred to as the Corporation.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Riverview Retirement Community and Riverview Resident Assistance Foundation (the Corporation). All inter-organization transactions have been eliminated in consolidation.

Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting pursuant to accounting principles generally accepted in the United States of America.

Performance Indicator

Change in net assets (deficit) without donor restrictions as reflected in the accompanying statements of activities and changes in net assets is the performance indicator. Items excluded from the performance indicator, consistent with industry practice include, if present, contributions of and assets released from donor restrictions related to long lived assets and investment returns restricted to use by donors or by law.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Cash and Cash Equivalents

Cash and cash equivalents include cash, money market accounts, commercial paper, and other securities with maturities of three months or less at date of acquisition that are not otherwise held by an investment advisor or restricted by donors or other external parties.

Investments

Investments are stated at fair value based on quoted market prices. Investments acquired by gift are recorded at fair value on the date received. Investments in marketable securities are adjusted to fair value through recognition of unrealized gains and losses in the performance indicator as they are classified as trading securities. Gains or losses are calculated based on specific identification of the investments. Dividend, interest, and other investment income are recorded net of related custodial and advisory fees. See Note 8 for fair value hierarchy disclosures.

Accounts Receivable

The Corporation provides services to residents even though they may lack adequate funds or may participate in programs that do not pay full charges. The Corporation receives payment for health services from residents, insurance companies, Medicare, Medicaid, and other third-party payors. As a result, the Corporation is exposed to certain credit risks. The Corporation manages its risk by regularly reviewing its accounts, by providing appropriate allowances for uncollectible accounts, and by having secured the accounts through its Residency and Patient Agreements with the residents of the community.

Accounts receivable are stated at the amount management expects to collect. If necessary, management provides for possible uncollectible amounts through a charge to revenue and a credit to a valuation allowance based on its assessment of the current status of individual balances. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and credit to resident accounts receivable.

Assets Limited or Restricted as to Use

Assets limited or restricted as to use include assets that are restricted for debt reserve and debt service or limited as to use by the board of directors or donors for various reasons (see Note 4).

Property, Building, and Equipment

Property, building, and equipment are recorded at cost, or fair value when received, if donated. The cost basis includes any interest, finance charges, major replacements and improvements, and other related costs capitalized during construction. The Corporation capitalizes fixed assets with a cost greater than $5,000. Maintenance, repairs, and minor replacements are charged to expense when incurred.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property, Building, and Equipment (Continued)

Depreciation is computed using the straight-line method over the estimated useful lives of the assets, which range from 3 to 30 years. When assets are retired or otherwise disposed of, the cost of the asset and its related accumulated depreciation are removed from the accounts, and any resulting gain or loss is recognized in revenue or expense for the period.

The Corporation, using its best estimates based on reasonable and supportable assumptions and projections, reviews for impairment of long-lived assets when indicators of impairment are identified. The review addresses the estimated recoverability of the assets' carrying value, which is principally determined based on projected undiscounted cash flows generated by the underlying tangible assets. When the carrying value of an asset exceeds estimated recoverability, an asset impairment is recognized. No impairment losses were present for the years ended December 31, 2023 and 2022.

Applicants' Deposits

The Corporation requires each applicant for residency to pay a $3,000 (nonresident) or $1,500 (resident) fee to join the waiting list for the independent living, assisted living, or memory care units. This deposit enables the Corporation to objectively determine which applicant will prevail when more than one applicant is interested in the same unit by awarding the unit to the applicant that has been on the waiting list longest. The waiting list deposits are fully refundable for any reason at any time prior to applying the deposit to a resident agreement. When an independent living unit becomes available, the applicant is required to pay a nonrefundable $4,000 entrance fee deposit to reserve a specific independent living unit prior to occupancy.

Patient Trust Liability

Patient trust liability consists of patients' funds held under agency agreement with the Corporation. A corresponding asset is recorded in assets limited or restricted as to use.

Entrance Fees Refundable Upon Re-Occupancy

Residency Agreements are 75% or 80% refundable at the time of re-occupancy after termination of the contract. There are a limited number of residency agreements in which the refund is equal to 80% of the entrance fee received from subsequent resident of the unit. The refundable portion of entrance fees as of December 31, 2023 and 2022 was $35,285,658 and $34,821,532, respectively. As of December 31, 2023 and 2022, $2,513,864 and $2,112,074, respectively, of the refundable portions due to residents were included in current portion of entrance fees refundable upon re-occupancy and will be refunded at the time the unit is reoccupied by another resident. Actual refunds of such entrance fees were $2,012,994 and $4,472,107 for the years ended December 31, 2023 and 2022, respectively. The nonrefundable portion of the entrance fee for the Residency Agreements is described in the following paragraph.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Deferred Revenue from Nonrefundable Entrance Fees

The nonrefundable portion (20% or 25% of the entrance fee) of the Residency Agreements is recorded as deferred revenue. The nonrefundable deferred entrance fees are amortized to income on a straight-line basis over the estimated remaining life expectancy of the resident which is estimated at the time of entrance and is adjusted annually based on actuarially determined, estimated, remaining life expectancy of the resident. Upon voluntary or involuntary termination, the remaining unamortized balance of the nonrefundable portion of the entrance fee is recognized as income. Amounts amortized to income relating to these types of contracts were $554,841 and $505,541, respectively, for the years ended December 31, 2023 and 2022, and are presented in entrance fees earned in the consolidated statements of activities and changes in net assets (deficit). At December 31, 2023 and 2022, the Corporation had nonrefundable entrance fees, net of accumulated amortization, of $4,017,840 and $4,266,190, respectively, related to entrance fees received that will be recognized as revenue in future years.

Net Assets

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

Net Assets Without Donor Restrictions – Net assets without donor restrictions represent unrestricted resources available to support the Corporation's operations and restricted resources which have become available for use by the Corporation in accordance with the intention of the donor.

Net Assets With Donor Restrictions – Net assets with donor restrictions represent net assets subject to donor-imposed stipulations that they be maintained by the Corporation in perpetuity. The board of directors has interpreted Washington's enacted Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of permanently restricted donations absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as net assets with donor restrictions (a) the original value of gifts donated, (b) the original value of subsequent gifts, and (c) accumulations to the permanently restricted fund made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. Generally, the donors of these assets permit the Corporation to use all or part of the investment return on these assets.

Management reports contributions restricted by donors as increases in net assets without donor restrictions if the restrictions expire in the reporting period in which the revenue is recognized.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Loss on Fair Value Refund of Residency Agreements

The Corporation entered into certain residency agreements during a previous downturn in the economy that adjusts refunds to prior occupants for market changes. The difference between the entrance fee paid by the former resident and the increase of the total refund paid to the former resident is recognized as loss on fair market value of refund of residency agreements in the consolidated statements of activities and changes in net assets.

Contributions and Grants

The Corporation reports unconditional contributions and grants of cash and other assets at fair value at the date the contribution is received. Conditional contributions are reported at fair value at the date the conditions are substantially met. The gifts are reported as restricted support if they are received with donor stipulations that limit the use of the donated assets.

Tax-Exempt Status

The Corporation has been recognized by the IRS as a nonprofit corporation as described in Section 501(c)(3) of the IRC and is exempt from federal income taxes on related activities. No tax provision has been made in the accompanying statements of activities and changes in net assets.

Concentrations of Risk

The Corporation's cash, cash equivalents, investments, and assets limited or restricted as to use consist of various financial instruments. These financial instruments may subject the Corporation to concentrations of risk as, from time to time, cash and investment balances may exceed amounts insured by the Federal Deposit Insurance Corporation (FDIC) and the Securities Investor Protection Corporation (SIPC), the fair value of debt securities are dependent on the ability of the issuer to honor its contractual commitments, and the fair value of investments are subject to change. Management monitors the financial condition of these institutions on an ongoing basis and does not believe significant credit risk exists at this time.

Concentration of credit risk results from the Corporation granting credit without collateral to its residents and patients, most of whom are local residents and may be insured under third-party payor agreements. See Note 3 for the mix of receivables from residents and third-party payors at December 31, 2023 and 2022.

Unemployment Self-Insurance

The Corporation self-insures for unemployment benefits. Provision for self-insurance claims is made in the period the claims are paid.

Advertising

The Corporation follows the policy of expensing advertising costs as incurred. The Corporation's advertising expense for the years ended December 31, 2023 and 2022 was $111,196 and $175,884, respectively.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Use of Estimates

The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Reclassifications

Certain financial statement reclassifications have been made to prior year balances for comparability purposes and had no impact on changes in net assets (deficit) or net assets (deficit) as previously reported.

Adoption of New Accounting Standards

In June 2016, the Financial Accounting Standards Board (FASB) issued ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments (ASC 326)*. ASC 326 requires companies to measure credit losses utilizing a methodology that reflects expected credit losses and requires a consideration of a broader range of reasonable and supportable information to inform credit loss estimates. Riverview Retirement Community adopted this standard as of January 1, 2023, the first day of its 2023 fiscal year, using the modified retrospective approach and it did not have a material impact on its consolidated financial statements.

Subsequent Events

The board of directors and management have evaluated subsequent events through May 23, 2024, the date the consolidated financial statements were available to be issued.

NOTE 2 LIQUIDITY AND AVAILABILITY

As of December 31, 2023 and 2022, the Corporation had a working capital of $11,064,658 and $10,273,252, respectively.

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the statement of financial position date, comprise of the following:

	2023	2022
Cash and Cash Equivalents	$ 3,280,085	$ 1,453,138
Investments	12,134,560	11,981,605
Accounts Receivable, Net	124,503	1,809,994
Total Financial Assets	$ 15,539,148	$ 15,244,737

As part of the Corporation's liquidity management plan, cash in excess of daily requirements is invested in short-term investments and money market funds.

NOTE 2 LIQUIDITY AND AVAILABILITY (CONTINUED)

Additionally, the Corporation maintains a $500,000 line of credit, as discussed in more detail in Note 6. As of December 31, 2023, $500,000 remained available on the Corporation's line of credit.

NOTE 3 ACCOUNTS RECEIVABLE

Accounts receivable consisted of the following at December 31:

	2023		2022	
	Amount	Percentage	Amount	Percentage
Medicare	$ 216,840	45 %	$ 243,889	34 %
Managed Care	173,946	36	158,501	32
Private Payors	24,906	5	138,520	16
Medicaid	66,056	14	55,904	11
Grant Receivable	-	-	1,577,009	7
Accounts Receivable, Gross	481,748	100 %	2,173,823	100 %
Less: Expected Credit Loss	(357,245)		(363,829)	
Accounts Receivable, Net	$ 124,503		$ 1,809,994	

The opening and closing balances of accounts receivable were as follows:

	Accounts Receivable
Balance as of January 1, 2022	$ 492,545
Balance as of December 31, 2022	1,809,994
Balance as of December 31, 2023	124,503

As part of the Corporations response to the COVID-19 pandemic, it filed for the Employee Retention Credit (ERC) for the first three quarters of 2021. Under the ERC program organizations that qualify given the number of employees and those that have experienced a reduction of income or partial shut-down due to COVID-19 may qualify. The employee retention tax credit is a refundable tax credit businesses can claim on qualified wages.

Grants from government are recognized when all conditions of such grants are fulfilled or there is reasonable assurance that they will be fulfilled.

Grants related to this program are classified as contributions and grants. For the years ended December 31, 2023 and 2022, the Corporation had approximately $754,652 and $1,577,009, respectively, reported as grant revenue in the consolidated statements of operations and changes in net assets (deficit). As of December 31, 2023 and 2022, Health Services had approximately $-0- and $1,577,009, respectively, reported as accounts receivable in the consolidated statements of financial position.

NOTE 4 ASSETS LIMITED OR RESTRICTED AS TO USE

Assets limited or restricted as to use consisted of the following at December 31:

	2023	2022
Restricted for Debt Service and Reserve:		
Series 2012 Bond Debt Service Reserve Fund	$ 843,654	$ 807,690
Series 2012 Bond Debt Service Fund	612,844	608,296
Subtotal	1,456,498	1,415,986
Other Assets Limited or Restricted as to Use:		
Beneficial Interest in Perpetual Trust and Endowments	422,077	371,988
Riverview Resident Assistance Foundation	571,420	461,244
Beneficial Interest in Innovia Foundation Funds	10,660	9,663
Patient Trust Funds	4,027	7,076
Subtotal	1,008,184	849,971
Total Assets Limited or Restricted as to Use	$ 2,464,682	$ 2,265,957

NOTE 5 PROPERTY, BUILDINGS, AND EQUIPMENT

Property, buildings, and equipment consisted of the following at December 31:

	2023	2022
Land	$ 4,067,427	$ 4,067,427
Land Improvements	6,120,698	6,109,798
Buildings	33,118,464	33,118,464
Building Improvements	25,919,448	25,689,654
Equipment and Furnishings	6,494,153	6,537,418
Vehicles	466,852	534,678
Subtotal	76,187,042	76,057,439
Less: Accumulated Depreciation	(46,633,752)	(43,729,419)
Subtotal	29,553,290	32,328,020
Construction in Progress	1,202,513	1,010,920
Total Property, Buildings, and Equipment, Net	$ 30,755,803	$ 33,338,940

Approximately $930,000 of the construction in progress at December 31, 2023, relates to the Adult Family Homes. The Adult Family Homes were substantially completed as of December 31, 2022, however, they are not yet placed into service as of December 31, 2023.

The rest of the construction in progress costs are related to unit renovations and other routine costs. The construction in progress projects are funded by operations.

NOTE 6 LONG-TERM DEBT

Long-term debt consisted of the following at December 31:

Description	2023	2022
Washington State Housing Finance Commission 5% Fixed Rate Demand Elderly Housing Revenue Bonds, Series 2012	$ 13,635,000	$ 14,233,534
Memory Care Building Note Payable	4,259,523	4,254,953
Long-Term Debt, Gross	17,894,523	18,488,487
Less: Unamortized Debt Issuance Costs	(473,357)	(498,873)
Carrying Amount of Long-Term Debt	17,421,166	17,989,614
Less: Current Maturities	(631,694)	(598,534)
Long-Term Debt, Net	$ 16,789,472	$ 17,391,080

Series 2012 Fixed Rate Revenue Bonds

On December 3, 2012, the Washington State Housing Finance Commission (the Commission) issued its $15,695,000 Nonprofit Housing Revenue and Refunding Revenue Bonds (Riverview Retirement Community Project), Series 2012 bonds. The proceeds of the Series 2012 bonds were used (1) to refund the Series 1997 bonds, (2) to finance and refinance capital improvements, (3) to fund a debt service reserve fund, (4) to pay capitalized interest on the Series 2012 bonds and (5) to pay the costs of issuing the Series 2012 bonds. The Series 2012 bonds were issued pursuant to a Master Trust Indenture agreement between the Commission and U.S. Bank N.A., as Bond Trustee.

These bonds were issued in two tranches: $2,060,000 of 5.00% term bonds due January 1, 2023 with a yield of 4.25% and $13,635,000 of 5.00% term bonds due January 1, 2048. Principal is payable annually on January 1, which commenced on January 1, 2014 and interest payments are made semi-annually on January 1 and July 1, which commenced on January 1, 2013. Pledged collateral includes gross receivables, equipment, and a deed of trust on the properties. Holders of the Series 2012 Bonds and Washington Trust Bank who financed the $6 million credit agreement hold parity collateral positions in the pledged collateral. The bond proceeds included a $125,495 premium that is amortized over 10 years.

NOTE 6 LONG-TERM DEBT (CONTINUED)

Memory Care Building Note Payable

On October 6, 2017, the Corporation and Washington Trust Bank signed a $6,000,000 credit agreement to finance the construction of the memory care building. On September 26, 2022, the Corporation and Washington Trust Bank signed a change in terms agreement. The note bears interest and is based on the regular five-year Federal Home Loan Bank Intermediate/Long Term, Fixed Advance rate (the FHLB Rate) as published by the Federal Home Loan Bank of Des Moines, plus a margin of two and one-quarter percent (2.25%). The interest rate was 4.45% and 4.50% as of December 31, 2023 and 2022, respectively. Principal is payable monthly through October 1, 2032.

The note included issuance costs of $127,085, which are amortized over the term of the note. Pledged collateral includes gross receivables, equipment, and a deed of trust on the properties. Holders of the Series 2012 Bonds and Washington Trust Bank who financed the $6 million credit agreement hold parity collateral positions in the pledged collateral.

Aggregate maturities of long-term debt are as follows:

Year Ending December 31,	Amount
2024	$ 631,694
2025	673,081
2026	715,503
2027	759,838
2028	805,736
Thereafter	14,308,671
Total Maturities	$ 17,894,523

Interest expense consisted of the following for the years ended December 31:

	2023	2022
Interest Expense	$ 1,055,903	$ 1,002,508
Amortization - Bond Premium	-	(11,504)
Amortization - Debt Issuance Costs	25,517	25,517
Total Interest Expense	$ 1,081,420	$ 1,016,521

Line of Credit

During the year ended December 31, 2013, the Corporation obtained a $2,000,000 short-term line of credit with Washington Trust Bank which has been renewed annually since inception. As of August 1, 2023 the maximum principal amount was reduced to $500,000. The credit line is unsecured. The maturity date is August 1, 2024. The variable interest rate on the line of credit was 8.50% and 7.50% at December 31, 2023 and 2022, respectively. Principal outstanding on this line of credit shall not exceed the lesser of $500,000 or the maximum nonparty indebtedness permitted in the Master Trust Indenture dated December 1, 2012, that relates to the Series 2012 Bonds.

NOTE 7 NET ASSETS WITH DONOR RESTRICTIONS

Net assets with donor restrictions consisted of the following at December 31:

	2023	2022
Residence Assistance Foundation Fund	$ 564,056	$ 432,820
Oscar and Marie Peterson Memorial Fund	249,259	249,259
Innovia Foundation	10,000	10,000
Total Net Assets with Donor Restrictions	$ 823,315	$ 692,079

The Corporation's endowment consists of funds in the Oscar and Marie Peterson Memorial fund and Innovia Foundation. Its endowment includes donor-restricted endowment funds. As required by ASC 958-205, *Not-for-Profit Entities*, net assets associated with endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions.

Net assets with donor restrictions are comprised of investments to be held in perpetuity, the income from which is unrestricted.

The Corporation has interpreted the UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as net assets with donor restrictions (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as net assets without donor restrictions until those amounts are appropriated for expenditure by the Corporation, in a manner consistent with the standard of prudence prescribed by UPMIFA.

In accordance with UPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- Duration and preservation of the fund;
- Purpose of the Corporation and donor-restricted endowment fund;
- General economic conditions;
- Possible effects of inflation and deflation;
- Expected total return from income and the appreciation of investments;
- Other resources of the Corporation, and
- Investment policies of the Corporation.

NOTE 7 NET ASSETS WITH DONOR RESTRICTIONS (CONTINUED)

Endowments activity by net assets class for the years ending December 31 were as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment Assets - December 31, 2021	$ 226,732	$ 259,259	$ 485,991
Investment Return:			
Investment Income	9,516	-	9,516
Net Change in Value	(85,873)	-	(85,873)
Investment Fees	(8,156)	-	(8,156)
Total Investment Return	(84,513)	-	(84,513)
Cash Disbursements	(19,827)	-	(19,827)
Endowment Assets - December 31, 2022	122,392	259,259	381,651
Investment Return:			
Investment Income	12,278	-	12,278
Net Change in Value	47,047	-	47,047
Investment Fees	(7,758)	-	(7,758)
Total Investment Return	51,567	-	51,567
Cash Disbursements	(481)	-	(481)
Endowment Assets - December 31, 2023	$ 173,478	$ 259,259	$ 432,737

NOTE 8 FINANCIAL INSTRUMENTS

FASB Accounting Standards Codification (ASC) 820 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. FASB ASC 820 also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities; or net assets value per share (or its equivalent) with the ability to redeem the investment in the near term.

NOTE 8 FINANCIAL INSTRUMENTS (CONTINUED)

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

Following is a description of the valuation methodologies used for instruments measured at fair value on a recurring basis and recognized in the statement of financial position at December 31, 2023 and 2022, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Cash and Cash Equivalents: Cash and cash equivalents approximate fair value due to the short maturity of such instruments. Cash and cash equivalents held by investment advisors are included in money market funds.

Investments: Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Level 1 securities include cash and cash equivalents held for investment, exchange-traded equities and mutual funds, debt securities, and fixed income securities. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with identical characteristics, discounted cash flows, or net asset values. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

The following tables present the fair value hierarchy for those assets measured at fair value on a recurring basis at December 31:

	2023			
	Level 1	Level 2	Level 3	Total
Assets:				
Money Market Funds	$ 910,539	$ -	$ -	$ 910,539
Fixed Income Funds	4,259,432	-	-	4,259,432
Equity Funds	8,857,851	-	-	8,857,851
Beneficial Interest in Perpetual Trust and Endowments	-	-	571,420	571,420
Total Investments	$ 14,027,822	$ -	$ 571,420	$ 14,599,242

	2022			
	Level 1	Level 2	Level 3	Total
Assets:				
Money Market Funds	$ 962,747	$ -	$ -	$ 962,747
Fixed Income Funds	4,179,834	-	-	4,179,834
Equity Funds	8,732,993	-	-	8,732,993
Beneficial Interest in Perpetual Trust and Endowments	-	-	371,988	371,988
Total Investments	$ 13,875,574	$ -	$ 371,988	$ 14,247,562

NOTE 8 FINANCIAL INSTRUMENTS (CONTINUED)

The financial instruments are classified as follows in the consolidated statements of financial position at December 31:

	2023	2022
Investments	$ 12,134,560	$ 11,981,605
Assets Limited or Restricted as to Use	2,464,682	2,265,957
Total	$ 14,599,242	$ 14,247,562

Investment income (loss) for the years ended December 31 consists of the following:

	2023	2022
Interest and Dividends	$ 386,837	$ 463,302
Realized Gain (Loss)	530,093	(172,709)
Unrealized Gain (Loss)	973,261	(2,409,892)
Investment Fees	(67,053)	(69,249)
Total Investment Income (Loss)	$ 1,823,138	$ (2,188,548)

NOTE 9 RETIREMENT PLAN

Employee Retirement Plan

The Corporation maintains a safe harbor 403(b) retirement plan for all eligible employees. Riverview matches 100% of the employee's contribution up to 3% of the employee's wage and 50% of contributions over 3% up to 5% of an employee's wage. The employer match in the 403(b) plan vests immediately. For the years ended December 31, 2023 and 2022, the Corporation's contributions to the plan were $139,892 and $137,346, respectively.

NOTE 10 RESIDENT REVENUE

Resident revenue is reported at the amount that reflects the consideration to which the Corporation expects to be entitled in exchange for providing resident care. These amounts are due from residents, third-party payors (including health insurers and government programs), and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Corporation bills the residents and third-party payors several days after the services are performed. Revenue is recognized as performance obligations are satisfied. For the years ended December 31, 2023 and 2022, approximately 3% and 2%, respectively, of resident service revenue was derived under federal and state third-party reimbursement programs.

NOTE 10 RESIDENT REVENUE (CONTINUED)

Performance obligations are determined based on the nature of the services provided by the Corporation. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Corporation believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to residents in the facility receiving health care services or housing residents receiving services in the facility. The Corporation considers daily services provided the comprehensive outpatient rehabilitation facility, and monthly rental for housing services as a separate performance obligation and measures this on a monthly basis, or upon move-out within the month, whichever is shorter. Nonrefundable entrance fees are considered to contain a material right associated with access to future services, which is the related performance obligation. Revenue from nonrefundable entrance fees is recognized ratably in future periods covering a resident's life expectancy using a time-based measurement.

Revenue for performance obligations satisfied at a point in time is generally recognized when goods are provided to the residents and customers in a retail setting (for example, gift shop, salon, transportation, and cafeteria meals) and the Corporation does not believe it is required to provide additional goods or services related to that sale.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Corporation has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period.

The Corporation determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Corporation's policy and/or implicit price concessions provided to residents. The Corporation determines its estimates of contractual adjustments based on contractual agreements, its policies, and historical experience. The Corporation determines its estimate of implicit price concessions based on its historical collection experience.

The Corporation recognizes the majority of its revenues over a period of time from its payors based on fees for services performed. Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare

The licensed comprehensive outpatient rehabilitation facility participate in the Medicare program. This federal program is administered by the Centers for Medicare and Medicaid Services (CMS).

NOTE 10 RESIDENT REVENUE (CONTINUED)

Medicare (Continued)

The comprehensive outpatient rehabilitation facility is paid under Medicare Part B if resident is eligible and meets the coverage guidelines for skilled rehabilitation care. Annual cost reports are required to be submitted to the designated Medicare Administrative Contractor. Rehabilitation facilities licensed for participation in the Medicare and Medical Assistance programs are subject to a six-year licensure renewal.

Medicaid

The assisted living facilities participate in the Medicaid program administered by the Washington State Department of Social and Health Services.

Other

Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined daily rates.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care.

These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Corporation's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in an implicit price concession impacting transaction price, were not significant in 2023 or 2022.

Generally, residents who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Corporation estimates the transaction price for residents with deductibles and coinsurance based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent charges to the estimate of the transaction price are generally recorded as adjustments to resident and client services revenue in the period of the change. Additional revenue recognized due to changes in its estimates of implicit price concessions, discounts, and contractual adjustments were not considered material for the years ended December 31, 2023 or 2022. Subsequent changes that are determined to be the result of an adverse change in the resident's ability to pay are recorded as provision for uncollectible accounts and were not considered material for the years ended December 31, 2023 and 2022.

NOTE 10 RESIDENT REVENUE (CONTINUED)

The Corporation has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors: payors, geography, service lines, method of reimbursement, and timing of when revenue is recognized. Tables providing details of these factors are presented below.

The composition of service fees and health care revenue by service line for the years ended December 31 consisted of the following:

	2023	2022
Independent Living	$ 3,009,211	$ 2,482,005
Assisted Living	7,732,366	6,811,815
Rehabilitation Center	416,051	364,897
Memory Care	2,081,422	2,370,270
Total Resident Revenue	$ 13,239,050	$ 12,028,987

The composition of service fees and health care revenue by primary payor for the years ended December 31 consisted of the following:

	2023	2022
Private Payors	$ 12,808,775	$ 11,674,052
Third-Party Payors	430,275	354,935
Total Resident Revenue	$ 13,239,050	$ 12,028,987

Revenue from resident and patient deductibles and coinsurance are included in the categories presented above based on the primary payor.

The opening and closing balances of deferred revenue were as follows:

	Deferred Revenue
Balance as of January 1, 2022	$ 3,732,030
Balance as of December 31, 2022	4,266,190
Balance as of December 31, 2023	4,017,840

Financing Component

The Corporation has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from residents and third-party payors for the effects of a significant financing component due to the Corporation's expectation that the period between the time the service is provided to a resident and the time that the resident or a third-party payor pays for that service will be one year or less. However, the Corporation does, in certain instances, enter into payment agreements with residents that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

NOTE 10 RESIDENT REVENUE (CONTINUED)

Contract Costs

The Corporation has applied the practical expedient provided by FASB ASC 340-40-25-4 and all incremental customer contract acquisition costs are expensed as they are incurred as the amortization period of the asset that the Corporation otherwise would have recognized is one year or less in duration.

NOTE 11 COMMITMENTS AND CONTINGENCIES

The Corporation is party to various claims and legal actions in the normal course of business. In the opinion of management, the Corporation has substantial meritorious defenses to pending or threatened litigation and based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the financial position of the Corporation.

NOTE 12 FUNCTIONAL EXPENSES

The financial statements report certain expense categories that are attributable to more than one life plan service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, including depreciation, interest, and other occupancy costs, are allocated to a function based on a square-footage or units-of-service basis. Allocated life plan services costs not allocated on a units-of-service basis are otherwise allocated based on revenue.

NOTE 12 FUNCTIONAL EXPENSES (CONTINUED)

Functional expenses consisted of the following for the years ended December 31:

	2023		
	Program Services	Management and General	Total
Salaries and Benefits	$ 6,596,780	$ 1,746,668	$ 8,343,448
Purchased Services	688,148	312,992	1,001,140
Supplies	302,858	21,156	324,014
Depreciation	2,285,162	761,721	3,046,883
Interest	1,027,349	54,071	1,081,420
Taxes and Insurance	292,376	15,388	307,764
Other	2,400,245	716,762	3,117,007
Total Expenses	$ 13,592,918	$ 3,628,758	$ 17,221,676

	2022		
	Program Services	Management and General	Total
Salaries and Benefits	$ 6,530,078	$ 1,616,887	$ 8,146,965
Purchased Services	118,291	-	118,291
Supplies	365,345	26,000	391,345
Depreciation	2,435,855	811,951	3,247,806
Interest	965,695	50,826	1,016,521
Taxes and Insurance	524,231	27,591	551,822
Other	1,985,782	1,228,354	3,214,136
Total Expenses	$ 12,925,277	$ 3,761,609	$ 16,686,886

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

	Riverview Retirement Community	Foundation	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 3,280,085	$ -	$ -	$ 3,280,085
Investments	12,134,560	-	-	12,134,560
Accounts Receivable, Net	119,393	5,110	-	124,503
Prepaid Expenses and Other Assets	162,917	-	-	162,917
Total Current Assets	15,696,955	5,110	-	15,702,065
ASSETS LIMITED OR RESTRICTED AS TO USE				
Restricted for Debt Service and Reserve	1,456,498	-	-	1,456,498
Other Assets Limited or Restricted as to Use	436,764	571,420	-	1,008,184
Total Assets Limited or Restricted as to Use	1,893,262	571,420	-	2,464,682
PROPERTY, BUILDINGS, AND EQUIPMENT, NET	30,755,803	-	-	30,755,803
Total Assets	$ 48,346,020	$ 576,530	$ -	$ 48,922,550
LIABILITIES AND NET ASSETS (DEFICIT)				
CURRENT LIABILITIES				
Accounts Payable	$ 263,056	$ -	$ -	$ 263,056
Accrued Payroll and Related Liabilities	559,643	-	-	559,643
Line of Credit	-	-	-	-
Accrued Interest	364,941	-	-	364,941
Applicants' Deposits	300,183	-	-	300,183
Patient Trust Liability	4,026	-	-	4,026
Current Maturities of Long-Term Debt	631,694	-	-	631,694
Current Portion of Entrance Fees Refundable Upon Re-Occupancy	2,513,864	-	-	2,513,864
Total Current Liabilities	4,637,407	-	-	4,637,407
LONG-TERM LIABILITIES				
Long-Term Debt, Net	16,789,472	-	-	16,789,472
Entrance Fees Refundable Upon Re-Occupancy, Net of Current Portion	32,771,794	-	-	32,771,794
Deferred Revenue from Nonrefundable Entrance Fees	4,017,840	-	-	4,017,840
Total Long-Term Liabilities	53,579,106	-	-	53,579,106
Total Liabilities	58,216,513	-	-	58,216,513
NET ASSETS (DEFICIT)				
Net Assets (Deficit) Without Donor Restrictions:				
Without Board Designations	(10,129,752)	-	12,474	(10,117,278)
With Donor Restrictions	259,259	576,530	(12,474)	823,315
Total Net Assets (Deficit)	(9,870,493)	576,530	-	(9,293,963)
Total Liabilities and Net Assets (Deficit)	$ 48,346,020	$ 576,530	$ -	$ 48,922,550

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
DECEMBER 31, 2022
(SEE INDEPENDENT AUDITORS' REPORT)

	Riverview Retirement Community	Foundation	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 1,453,138	$ -	$ -	$ 1,453,138
Investments	11,981,605	-	-	11,981,605
Accounts Receivable, Net	1,809,994	-	-	1,809,994
Prepaid Expenses and Other Assets	138,452	-	-	138,452
Total Current Assets	15,383,189	-	-	15,383,189
ASSETS LIMITED OR RESTRICTED AS TO USE				
Restricted for Debt Service and Reserve	1,415,986	-	-	1,415,986
Other Assets Limited or Restricted as to Use	388,727	461,244	-	849,971
Total Assets Limited or Restricted as to Use	1,804,713	461,244	-	2,265,957
PROPERTY, BUILDINGS, AND EQUIPMENT, NET	33,338,940	-	-	33,338,940
Total Assets	$ 50,526,842	$ 461,244	$ -	$ 50,988,086
LIABILITIES AND NET ASSETS (DEFICIT)				
CURRENT LIABILITIES				
Accounts Payable	$ 546,077	$ -	$ -	$ 546,077
Accrued Payroll and Related Liabilities	498,887	-	-	498,887
Accrued Interest	373,289	-	-	373,289
Applicants' Deposits	109,000	-	-	109,000
Patient Trust Liability	7,076	-	-	7,076
Current Maturities of Long-Term Debt	1,463,534	-	-	1,463,534
Current Portion of Entrance Fees Refundable Upon Re-Occupancy	2,112,074	-	-	2,112,074
Total Current Liabilities	5,109,937	-	-	5,109,937
LONG-TERM LIABILITIES				
Long-Term Debt, Net	17,391,080	-	-	17,391,080
Entrance Fees Refundable Upon Re-Occupancy, Net of Current Portion	32,709,458	-	-	32,709,458
Deferred Revenue from Nonrefundable Entrance Fees	4,266,190	-	-	4,266,190
Total Long-Term Liabilities	54,366,728	-	-	54,366,728
Total Liabilities	59,476,665	-	-	59,476,665
NET ASSETS (DEFICIT)				
Net Assets (Deficit) Without Donor Restrictions:				
Without Board Designations	(9,209,082)	-	28,424	(9,180,658)
With Donor Restrictions	259,259	461,244	(28,424)	692,079
Total Net Assets (Deficit)	(8,949,823)	461,244	-	(8,488,579)
Total Liabilities and Net Assets (Deficit)	$ 50,526,842	$ 461,244	$ -	$ 50,988,086

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATING STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS (DEFICIT)
YEAR ENDED DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

	Riverview Retirement Community	Foundation	Eliminations	Total
CHANGE IN NET ASSETS WITHOUT DONOR RESTRICTIONS				
REVENUE				
Resident Service Revenue, Net	$ 12,591,820	$ -	$ -	$ 12,591,820
Entrance Fees Earned	554,841	-	-	554,841
Loss on Fair Market Value Refund of Residency Agreements	(176,320)	-	-	(176,320)
Termination Income from Nonrefundable Portion of Residency Agreements	268,709	-	-	268,709
Tenant Reimbursements	179,499	-	-	179,499
Investment Income, Net	1,754,864	-	-	1,754,864
Contributions	11,604	-	-	11,604
Gain on Disposal of Assets	18,157	-	-	18,157
Grant Revenue	754,653	-	-	754,653
Other Revenue	355,653	-	-	355,653
Total Revenue	16,313,480	-	-	16,313,480
EXPENSES				
Health Services	4,628,353	-	-	4,628,353
Recreational Therapy Services	350,727	-	-	350,727
Chaplaincy Services	95,065	-	-	95,065
Dining Services	2,088,466	-	-	2,088,466
Environmental Services	665,683	-	-	665,683
Plant Operations and Security	2,356,191	-	-	2,356,191
Fiscal and Administration	2,347,825	-	(12,474)	2,335,351
Interest Expense	1,081,420	-	-	1,081,420
Taxes and Insurance	573,537	-	-	573,537
Depreciation	3,046,883	-	-	3,046,883
Total Expenses	17,234,150	-	(12,474)	17,221,676
CHANGE IN NET ASSETS (DEFICIT) WITHOUT DONOR RESTRICTIONS	(920,670)	-	12,474	(908,196)
CHANGE IN NET ASSETS WITH DONOR RESTRICTIONS				
Contributions	-	47,012	(12,474)	34,538
Investment Income, Net	-	68,274	-	68,274
Change in Net Assets With Donor Restrictions	-	115,286	(12,474)	102,812
CHANGE IN NET ASSETS (DEFICIT)	(920,670)	115,286	-	(805,384)
Net Assets (Deficit) - Beginning of Year	(8,949,823)	461,244	-	(8,488,579)
NET ASSETS (DEFICIT) - END OF YEAR	$ (9,870,493)	$ 576,530	$ -	$ (9,293,963)

RIVERVIEW LUTHERAN RETIREMENT COMMUNITY OF SPOKANE
DBA: RIVERVIEW RETIREMENT COMMUNITY
CONSOLIDATING STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS (DEFICIT)
YEAR ENDED DECEMBER 31, 2022
(SEE INDEPENDENT AUDITORS' REPORT)

	Riverview Retirement Community	Foundation	Eliminations	Total
CHANGE IN NET ASSETS WITHOUT DONOR RESTRICTIONS				
REVENUE				
Resident Service Revenue, Net	$ 11,739,587	$ -	$ -	$ 11,739,587
Entrance Fees Earned	505,541	-	-	505,541
Loss on Fair Market Value Refund of Residency Agreements	(578,880)	-	-	(578,880)
Termination Income from Nonrefundable Portion of Residency Agreements	362,739	-	-	362,739
Tenant Reimbursements	182,091	-	-	182,091
Investment Loss, Net	(2,123,257)	-	-	(2,123,257)
Contributions	34,242	-	-	34,242
Gain on Disposal of Assets	21,362	-	-	21,362
Grant Revenue	1,577,009	-	-	1,577,009
Other Revenue	288,095	-	-	288,095
Total Revenue	12,008,529	-	-	12,008,529
EXPENSES				
Health Services	4,292,117	-	-	4,292,117
Recreational Therapy Services	253,265	-	-	253,265
Chaplaincy Services	80,559	-	-	80,559
Dining Services	1,857,342	-	-	1,857,342
Environmental Services	624,324	-	-	624,324
Plant Operations and Security	2,230,205	-	-	2,230,205
Fiscal and Administration	2,561,349	-	(28,424)	2,532,925
Interest Expense	1,016,521	-	-	1,016,521
Taxes and Insurance	551,822	-	-	551,822
Depreciation	3,247,806	-	-	3,247,806
Total Expenses	16,715,310	-	(28,424)	16,686,886
CHANGE IN NET ASSETS (DEFICIT) WITHOUT DONOR RESTRICTIONS	(4,706,781)	-	28,424	(4,678,357)
CHANGE IN NET ASSETS WITH DONOR RESTRICTIONS				
Contributions	-	56,848	(28,424)	28,424
Investment Loss, Net	-	(65,291)	-	(65,291)
Change in Net Assets With Donor Restrictions	-	(8,443)	(28,424)	(36,867)
CHANGE IN NET ASSETS (DEFICIT)	(4,706,781)	(8,443)	-	(4,715,224)
Net Assets (Deficit) - Beginning of Year	(4,243,042)	469,687	-	(3,773,355)
NET ASSETS (DEFICIT) - END OF YEAR	$ (8,949,823)	$ 461,244	$ -	$ (8,488,579)

Section 6
List of References

Attachment A
National Association for Home Care and Hospice, 2024, accessed August 2024, *<https://nahc.org/home-health-providers/>*

Attachment B
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Attachment D
USA Facts Organization, 2024, accessed August 2024, *<https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/washington/county/spokane-county/>*

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Trella Health 2024, Post -Acute Care Industry Report, Edition 1, accessed August 2024 *<https://www.trellahealth.com/resource-center/post-acute-care-industry-trend-report-2024-edition/?&utm_source=internal-link&utm_medium=website&utm_campaign=industry-trend-report-july-2024-press-release>*

Attachment G – McKnights Senior Living, Volume 22, Number 2, April 2024

Attachment H – Washington State University, Community Health and Spatial Epidemiology Lab, accessed August 2024 *<https://www.chaselab.net/WAReport_Leaflet/index.html#glance>*

Attachment A

National Association for Home Care and Hospice, 2024

Home Health Provider Hub

Resources and benefits for those offering skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to patients in their homes.

ledicare is the largest payer for home health ervices.

› be eligible for Medicare's home health benefit, ieficiaries must be in need of skilled nursing care on ı intermittent basis (including physical therapy or ieech-language pathology) or have a continuing need r occupational therapy to treat their illnesses or uries and must be unable to leave their homes without nsiderable effort.

edicare pays a predetermined payment rate for a 30- y period of home health care. The bundled payment vers all items and services, with the exclusion of rable medical equipment provided to the beneficiary ing the 30-day period. There is no limit to the number days for which a beneficiary is entitled to home health e and Medicare does not require copayments or a luctible for home health services.

The majority of patients prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care.

NAHC supports its members in several ways. NAHC advocates for home health care providers through Congressional members and federal regulators to promote the value of home health care. Educational opportunities are offered throughout the year and a multitude of resources are available to assist providers with day-to-day operations.

Here to help those in Home Health Care

Individualized member support with member discussion boards, direct access to specialists on key issues, and in-depth casework support.

Policy updates on key home health policy changes, guidance on key regulatory requirements, webinars and live educational offerings geared toward you.

Speak up and be directly apart of the conversation and engage with other experts in the field through our online messaging boards.

2023-2024 Home Care Salary & Benefit Report

The Home Care and Hospice Reports are the only national compensation studies available exclusively for home health and hospice. Compare marketplace data for 60+ jobs and 18 benefits. Includes salary, hourly, and per visit data. Covers CEO, CFO, and Case Manager to RN, LPN, HCA, MSW, PT, OT, ST, Medical Director, Office Support staff and more! Data are reported by auspice, profit type, revenue, state, and CBSA.

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Home Health Provider News

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Home Health Leaders: MedPAC Home Health Margin Estimates are Dangerously Flawed, Risk Misleading Policymakers

NEWS | HOME HEALTH, WORKFORCE

Home Health RNs Receive 3.88% Hourly Rate Increase in 2023

November 8, 2023

December 8, 2023

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RIHC 2023 Home Care Chartbook, Co-Sponsored by NAHC, Illustrates New and Changing Trends in Home Care

November 8, 2023

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Home Health Provider Resources

The State of Home Health and Hospice 2024

2025 Home Health Prospective Payment System Rate Update, Proposed Rule

Workplace Violence Prevention Handbook

Remote Patient Monitoring Certificate Program

"hrough the HHFMA Mentorship program I have had several formal and iformal conversations with my assigned mentor. This has provided the oportunity to evaluate and achieve my career goals within the industry – ke being appointed to the HHFMA Workgroup. The knowledge I have ained since joining the industry has been extensive and the HHFMA entorship program has played a major role in my career development. I ill continue to contribute to the success of this initiative, including ecoming a mentor myself."

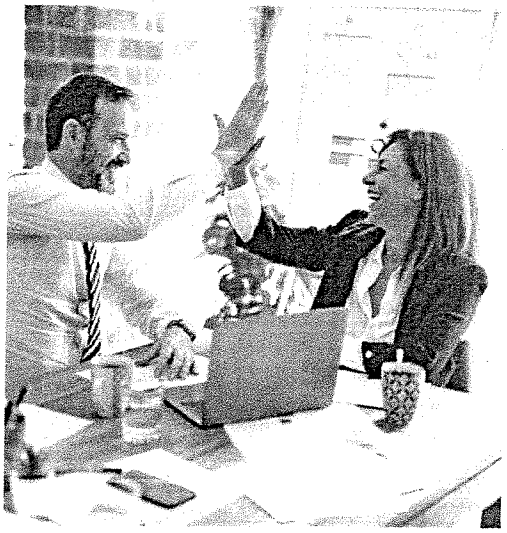
Gagnon

O, Androscoggin Home Health and Hospice

Join your peers and fellow leaders as part of the NAHC community. JOIN NOW »

Find a Business Partner that knows Home Care and Hospice through the NAHC Business Partner directory. Members get access to exclusive discounts offered by our member partners.

FIND A BUSINESS PARTNER »



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National Association for Home Care & Hospice
228 Seventh Street, SE
Washington, DC 20003
P: (202) 547-7424
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Attachment B

Employment Security Department

Spokane County profile

by Doug Tweedy, regional labor economist - *updated March 2022*

Overview | Geographic facts | Outlook | Labor force and unemployment | Industry employment | Wages and income | Population | Useful links | PDF Profile copy (https://media.esd.wa.gov/esdwa/Default/ESDWAGOV/labor-market-info/Libraries/Regional-reports/County-Profiles/Spokane-county-profile-2022.pdf)

Overview (https://media.esd.wa.gov/esdwa/Default/ESDWAGOV/labor-market-info/Libraries/Regional-reports/County-Profiles/Spokane%20County%20Profile%202020.pdf)

Regional context

Spokane County is situated east of the Cascade Range and on the western slope of the Coeur d'Alene Mountains next to the Idaho border. Spokane County ranks in the middle of other counties in terms of land area, which was 1,763.79 square miles in 2010. It was the eighth most densely populated county at 267.2 persons per square mile in 2010. Spokane is the most populous county in Eastern Washington and ranks fourth in the state.

The city of Spokane is the second-largest city in Washington state. It serves as the business, transportation, medical, industrial and cultural hub of the region, the inland Northwest. In 2020, the city of Spokane had 228,989 residents, 42.5 percent of the county's population.

Local economy

Spokane County was created by an act passed by the Territorial Assembly in 1858. After settlement in the 1870s, Spokane became the hub in the inland Northwest for mining, timber and railroad activities.

Of all the forces that shaped the Spokane County economy, none is more powerful than Spokane's historic role as a regional center of services for the surrounding rural populations of Eastern Washington and Northern Idaho. Regional services include government and higher education, medical services, retail trade and finance.

Fairchild Air Force Base is the county's largest employer. Fairchild will be getting more planes in 2021 with an increase of 200 service personnel. In addition, manufacturing has had a solid base due to the nexus of the Bonneville dam power generation, rail systems and the Interstate highway system. Spokane is competitive with other urban centers in attracting national and international investment in the form of tourism and conventions, the military and research. These investments in turn support the creation and expansion of still other complementary businesses, creating a well-rounded and diversified economy.

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Geographic facts

	Spokane County	Rank in state
Land area, 2010 (square miles)	1,763.79	19
Persons per square mile, 2010	267.2	8

Source: U.S. Census Bureau QuickFacts

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Outlook

For 2021, a significant increase in jobs was posted in the private sector. The increase was mainly due to a decrease of business restrictions due to the pandemic. The increase will probably be permanent going forward due in large part to Spokane business being able to adapt to changing environments. Much of the increase were in industries considered essential during the pandemic. And a high number of these industries can accommodate changing staffing patterns such as telework and telehealth.

Key industries posting increases in 2021 are transportation and warehousing, advanced manufacturing, health services, professional and business services, and agriculture.

Several new developments will continue to create jobs. A Health Sciences campus opened in 2014 with health programs from Washington State University, Eastern Washington University and Gonzaga. Private firms specializing in research and development and biotechnology have made Spokane their home because of the Health Sciences/Medical School campus at River Pointe and will play an increasingly important role in the area's economy. Amazon built two fulfillment centers (warehouse), which in addition to warehousing will increase air and road transportation employment. Spokane may benefit from a migration of west coast IT firms moving to Spokane trying to reduce stress for their workers. Contributing to labor stress in major urban areas are increased cost of living, labor shortages and high commute times. According to Spokane economic development professional's targets will continue in industries such as advanced manufacturing and materials, energy products and services, information technology and digital services, and logistics and distribution businesses.

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Labor force and unemployment

Current labor force and unemployment statistics are available on the *Labor area summaries* (https://esd.wa.gov/labormarketinfo/labor-force)page on ESD's labor market information website.

In, 2021, the Spokane county labor force averaged 284,871. The unemployment rate was estimated at 5.5 percent, with 15,678 unemployed residents. The number of unemployed is half what it was last year during the pandemic. The decrease has created labor shortages across industries as workers move to jobs that pay more.

Source: Employment Security Department/DATA Division, County Data Tables

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Industry employment

Current industry employment statistics are available on the *Labor area summaries* (https://esd.wa.gov/labormarketinfo/labor-area-summaries) page on ESD's labor market information website.

Spokane County is the largest labor market in Eastern Washington and Northern Idaho. Spokane's economy survived the "Great Recession" and emerged more diversified. Steady growth is forecasted for the future.

Spokane MSA (which includes Stevens and Pend Oreille counties) posted significant job increases in the last half 2021. Business was impacted significantly from the COVID-19 pandemic during the first half of 2021 but rebounded significantly as restrictions were released during the second half of the year. A majority of Spokane jobs were listed as essential during the pandemic. Giving Spokane a good foundation for recovery. Those include advanced manufacturing, professional and business services, and transportation and warehousing. Health services and education were also impacted, but probably more of a temporary impact, and should return to pre-pandemic levels in 2022. Altogether, those five industries have medium sized employers that are flexible and efficient in their markets. The health sciences and medical school development has been a game changer for Spokane. High-tech companies in manufacturing, scientific and technical industries are creating new jobs and will continue to expand the economic base in 2022.

- For, 2021, Spokane-Spokane Valley MSA nonfarm jobs averaged 253,300 compared to 2020 of 243,600.
- Goods-producing employment recorded 32,700 jobs in 2021, an increase of 900 jobs from 2020.
- Service-providing employment totaled 220,600 in 2021, an increase of 8,800 jobs from the 2020. Transportation/warehousing and Leisure/hospitality jobs posted the largest increases.

For historical industry employment data, *contact an economist. (https://esd.wa.gov/labormarketinfo/contact)*

Source: Employment Security Department/DATA Division, County Data Tables

Industry employment by age and gender

The Local Employment Dynamics (LED) database, a joint project of state employment departments and the U.S. Census Bureau, matches state employment data with federal administrative data. Among the products is industry employment by age and gender. All workers covered by state unemployment insurance data are included; federal workers and non-covered workers, such as the self-employed, are not. Data are presented by place of work, not place of residence. Some highlights:

In 2020, the largest job holder age group in Spokane County was the 25 to 44-year-olds with 44.2 percent of the workforce. This percentage was closely followed by job holders aged 55+ at 23.4 percent of the workforce

In 2020, men and women had equal shares of jobs in Spokane County at 50 percent each.

- Male-dominated industries included construction (84.6 percent), manufacturing (75.6 percent) and transportation and warehousing (75.3 percent).
- Female-dominated industries included healthcare and social assistance (74.9 percent), educational services (66.1 percent) and finance and insurance (63.4 percent).

Source: Employment Security Department/DATA Division, County Data Tables

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Wages and income

In 2020, Spokane County averaged 218,202 jobs covered by unemployment insurance with a total payroll over $11.7 billion.

The county's average annual wage was $53,681 in 2020, which ranked 13th among all Washington counties. The state's average annual wage was $76,801 and the state less King County was $50,834.

Personal income

Personal income includes earned income, investment income, and government payments such as Social Security and Veterans Benefits. Investment income includes income imputed from pension funds and from owning a home. Per capita personal income equals total personal income divided by the resident population.

Per capita income reached $50,038 in 2020, 17th in the state. This is 16 percent below the U.S. average and 25 percent below the state average of $67,126.

Median household income over the period 2016 to 2020 was $60,101, well below the state's $77,006 according to the U.S. Census Bureau QuickFacts.

Over the period 2016 to 2020, 13.4 percent of the population was living below the poverty level in Spokane County. This is well above 9.5 percent for the state.

Source: Employment Security Department/DATA Division, County Data Tables; Bureau of Economic Analysis; U.S. Census Bureau QuickFacts.

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Population

Spokane County's population was estimated at 539,339 in 2021, making it the fourth-largest county in the state. The city of Spokane is the largest city with 42.5 percent of the county's population.

The population's total percent change from 2020 to 2021 was 1.2 percent. The increase was due to both natural increase and in-migration.

Source: U.S. Census Bureau QuickFacts

Population facts

	Spokane County	Washington state
Population 2021	546,040	7,738,692
Population 2020	539,339	7,705,281
Percent change, 2020 to 2021	1.2%	0.4%

Source: U.S. Census Bureau QuickFacts

Age, gender and ethnicity

Most of the people moving into the county are in search of jobs and tend to be younger. Even with the in-migration of younger individuals, the large swell of baby boomers will continue to increase the median age. At some point, the aging of Spokane County may decrease with the influx of younger individuals, who may stay in the area and start families and a concurrent loss of retirees who migrate out of Spokane County to follow the sun.

Spokane County is far less diverse than either the state or the nation. In 2021, 88.9 percent of the county was white compared to 78.5 percent of the state and 76.3 percent of the nation. Hispanics or Latinos made up 6.1 percent of the population compared to 13.0 percent in the state.

Source: U.S. Census Bureau QuickFacts

Demographics

	Spokane County	Washington state
Population by age, 2021		
Under 5 years old	6.0%	6.0%
Under 18 years old	22.0%	21.8%
65 years and older	16.6%	15.9%
Females, 2021	50.4%	49.9%
Race/ethnicity, 2021		
White	88.9%	78.5%
Black	2.0%	4.4%
American Indian, Alaskan Native	1.8%	1.9%
Asian, Native Hawaiian, other Pacific Islander	3.0%	10.4%
Hispanic or Latino, any race	6.1%	13.0%

Source: U.S. Census Bureau QuickFacts

Educational attainment

Spokane County had more adults 25 years and older who were high school graduates in the 2016 to 2020 period at 94.1 percent than the state at 91.7 percent or the nation at 88.5 percent.

In terms of a bachelor's degree or higher, Spokane County had fewer adults aged 25 and older with higher education at 31.6 percent than the state at 36.7 percent.

Source: U.S. Census Bureau QuickFacts

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Useful links

- County data tables (https://media.esd.wa.gov/esdwa/Default/ESDWAGOV/labor-market-info/Libraries/Regional-reports/County-Data-Tables/Spokane%20County%20data%20tables.xlsx)
- Census Bureau County Profile (https://data.census.gov/cedsci/profile?q=Spokane%20County,%20Washington&g=0500000US53063)
- 2020 Census State Profile (https://www.census.gov/library/stories/state-by-state/washington-population-change-between-census-decade.html)
- Population density history (https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/population-density/population-density-county#slideshow-12)
- Community Indicators Initiative of Spokane (http://www.communityindicators.ewu.edu/)
- EWU | Institute for Public Policy and Economic Analysis (http://www.ewu.edu/CBPA/Centers-and-Institutes/IPPEA.xml)
- Greater Spokane Incorporated (http://www.greaterspokane.org/)
- Self Sufficiency Calculator for Washington State (http://www.thecalculator.org/)
- Spokane County home page (https://www.spokanecounty.org/)
- Spokane County on ChooseWashington.com (http://choosewashingtonstate.com/why-washington/our-region/)
- Spokane County on ofm.wa.gov (https://ofm.wa.gov/washington-data-research/county-and-city-data/spokane-county)
- Spokane County Thumbnail History (http://www.historylink.org/File/7686)
- U.S. Census Bureau QuickFacts (https://www.census.gov/quickfacts/fact/table/spokanecountywashington/PST045216)
- Washington Ports (http://www.washingtonports.org/)
- Workforce Development Areas and WorkSource Office Directory (https://seeker.worksourcewa.com/microsite/content.aspx?appid=MGSWAOFFLOC&pagetype=simple&seo=officelocator)

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Unemployment Handbook (https://media.esd.wa.gov:443/esdwa/Default/ESDWAGOV/Unemployment/ESD-Handbook-for-Unemployed-Workers.pdf)
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Tekoi er a Belau (/languages/palauan)

(/employee)

Attachment C

United States Census Bureau

okane County, Washington

Population and People
539,339

Education
34.2%

Housing
224,910

Business and Economy
12,935

Race and Ethnicity
35,356

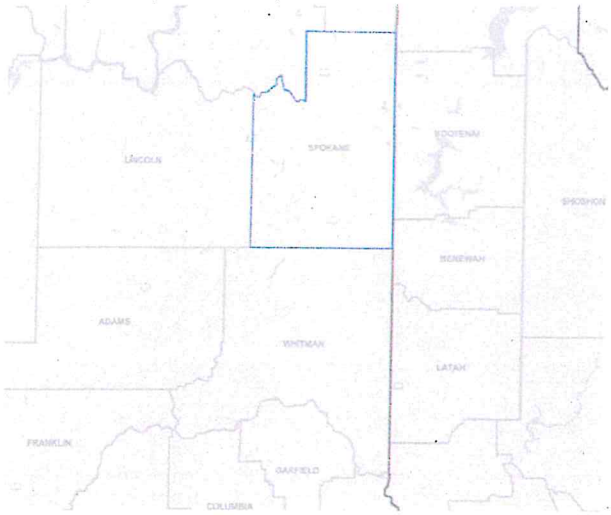
Income and Poverty
$69,075

Employment
68.4%

Health
4.7%

Families and Living Arrangements
220,870

kane County, Washington Reference Map



U.S. Census Bureau

opulations and People

and Sex

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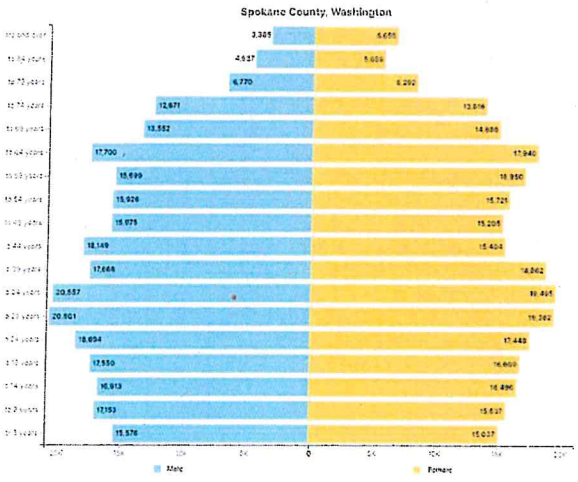
4

lation Pyramid: Population by Age and Sex



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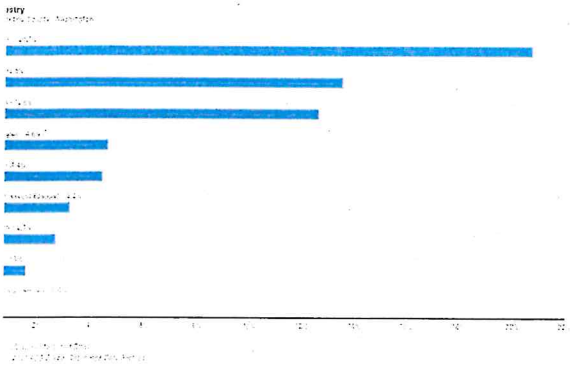

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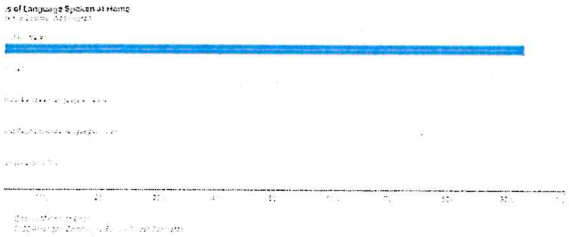

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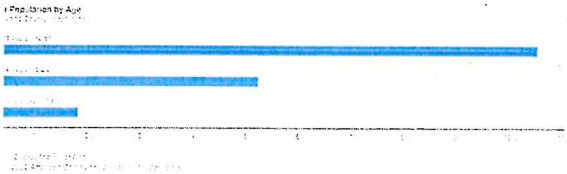

idential Mobility

earby Counties

Attachment D

USA Facts Organization

Our Changing Population: Spokane County, Washington

The ages, races, and population density of Spokane County, Washington tell a story. Understand the shifts in demographic trends with these charts visualizing decades of population data.

2010 Population
472,102

2022 Population
549,690

Population Change
+ 16.4 %

Latest update: 6th July 2023

USA / Washington / Spokane County / Year: 2010 TO Year: 2022

How has the population changed in Spokane County?

The population of **Spokane County, Washington** in **2022** was **549,690, 16.4% up** from the **472,102** who lived there in **2010**. For comparison, the US population grew **7.7%** and Washington's population grew **15.5%** during that period.

County changes over time

Over the past 50 years, some counties have merged or split, and the resulting data was redistributed to other counties. The Census Bureau reports population estimates for counties based on their existing boundaries at the end of each decade. **Read more**

SHARE THIS

Source: Census Bureau

How many people live in Spokane County?

Spokane County's population **grew 16.4%** from the **472,102** people who lived there in **2010**. For comparison, the population in the US **grew 7.7%** and the population in Washington **grew 15.5%** during that period.

Population in Spokane County

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Source: Census Bureau

How has Spokane County's population changed over the years?

Spokane County's population increased **12** out of the **12** years between year **2010** and year **2022**. Its largest annual population increase was **3.6%** between **2019 and 2020**. Between **2010** and **2022**, the county grew by an average of **1.3%** per year.

Annual population change in Spokane County

SIGN UP FOR THE NEWSLETTER

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Source: Census Bureau

How has Spokane County's racial and ethnic populations changed?

In **2022**, the largest racial or ethnic group in Spokane County was the **white (non-Hispanic)** group, which had a population of **453,924**. Between **2010** and **2022**, the **white (non-Hispanic)** population had the **most growth increasing** by **44,179** from **409,745** in **2010** to **453,924** in **2022**.

Population by race and ethnicity in Spokane County

Hide Hispanic ethnicity

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Source: Census Bureau

How has the racial and ethnic makeup of Spokane County changed?

In **2022**, Spokane County was more diverse than it was in 2010. In **2022**, the **white (non-Hispanic)** group made up **82.6%** of the population compared with **86.8%** in **2010**.

Between **2010** and **2022**, the share of the population that is **Hispanic/Latino** grew the most, increasing **2.4** percentage points to **6.9%**. The **white (non-Hispanic)** population had the largest decrease dropping **4.2** percentage points to **82.6%**.

Racial makeup of Spokane County

Hide Hispanic ethnicity

American Indian/Alaska Native (non-Hispanic) Asian (non-Hispanic) Black (non-Hispanic) Hispanic/Latino Multiracial (non-Hispanic) Native Hawaiian and Other Pacific Islander (non-Hispanic) White (non-Hispanic)

American Indian/Alaska Native (non-Hispanic) Asian (non-Hispanic) Black (non-Hispanic) Hispanic/Latino Multiracial (non-Hispanic) Native Hawaiian and Other Pacific Islander (non-Hispanic) White (non-Hispanic)

SHARE THIS

Source: Census Bureau

How old is the population in Spokane County?

Among six age groups — 0 to 4, 5 to 19, 20 to 34, 35 to 49, 50 to 64, and 65 and older — the **65+** group was the fastest growing between **2010** and **2022** with its population **increasing 56.7%**. The **0 to 4** age group **declined the most dropping 0.8%** between **2010** and **2022**.

Population by age in Spokane County

SHARE THIS

Source: Census Bureau

How has the distribution of ages in Spokane County changed?

The share of the population that is 0 to 4 years old **decreased** from **6.4%** in **2010** to **5.5%** in **2022**.

The share of the population that is 65 and older **increased** from **13%** in **2010** to **17.5%** in **2022**.

Age makeup of Spokane County

0 to 4 5 to 19 20 to 34 35 to 49 50 to 64 65+

0 to 4 5 to 19 20 to 34 35 to 49 50 to 64 65+

SHARE THIS

Source: Census Bureau

How have the age and sex demographics of Spokane County changed?

These population pyramids group the populace by age and sex (**female** and **male**). A wider pyramid base means that the population is young. A wider top means that the population is older.

Total population in 2010

Total population in 2022

SHARE THIS

Source: Census Bureau

What's the size of the US population and how has it changed?

Between **2010** and **2022**, **Texas** had the **largest growth** with **4.8 million** new residents. **Illinois** had the largest decline with **258,513 fewer** people.

Among counties, **Maricopa County, Arizona** had the largest growth with **726,341** more people. **Los Angeles County, California** had the **largest decline** with **100,509 fewer** residents.

TOTAL POPULATION IN 2010
TOTAL POPULATION IN 2022
POPULATION CHANGE (#)
POPULATION CHANGE (%)

84

9,321,647

TOTAL POPULATION IN 2010

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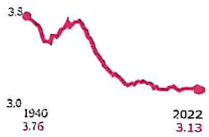
Source: Census Bureau

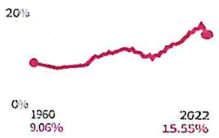
More on population from USAFacts

Explore more data on population

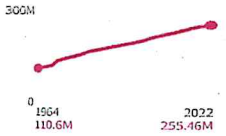
Average number of people in a family



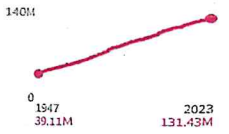
Percent of young adults aged 25-34 living at home



Voting-age population during elections



Households



Browse population metrics

Search USAFacts

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An overview of the US–Mexico border
Around 15 million people live in the US–Mexico border region.
PUBLISHED ON JULY 30, 2024

When was your state founded?

The oldest state in the United States is Delaware, established in 1787, and the youngest is Hawaii, established in 1959.

PUBLISHED ON JULY 17, 2024

Data Methodology

The Census Bureau's Population and Housing Estimates Program (PEP) data by county includes details like counts by age, race, or ethnicity and goes back for decades. But how the Census Bureau reported and grouped those populations changed over time.

Race categories

Users will notice that the race categories change depending on the years selected in this interactive tool. This occurs because the Census Bureau has changed the race and ethnicity categories it makes available. To allow for comparisons over time, the race categories change depending on the earliest year selected in the comparison tool.

If the earliest year selected in the tool is from before 1990, the data only includes three race categories: 'white', 'Black', and 'other'. As a result, any comparison that includes data from before 1990 only includes these three race categories. Race categories other than 'Black' and 'white' are included in the 'other' race category for years after 1990 when comparing to pre-1990 data.

Any comparison where the earliest year is between 1990 and 1999 includes two additional categories: 'American Indian/Alaska Native' and 'Asian or Pacific Islander.' Separate reporting for 'Asian' and 'Hawaiian Native/Pacific Islander' are combined for years after 2000 when the comparison year is in the 1990s.

Data from 2000 onward considers 'Asian' and 'Hawaiian Native/Pacific Islander' as separate groups and also includes the 'multiracial' category. These categories do not exist for earlier years and do not appear in comparisons in this tool if a year prior to 2000 is selected. Prior to 2000, the Census Bureau did not separately identify people who were two or more races. All persons were grouped into singular race categories. In 2000, the Census added the 'Two or more races' category to the data. The Census Bureau states that the number of people in the separate race categories (i.e., 'white', 'Black', etc.) was impacted by this change as some people who would have previously been grouped within a single race category were grouped into the two or more category with the change. Pre-2000 and post-2000 data comparisons will result in lower values for the separate race categories in proportion to the 'two or more race' population.

Ethnicity categories

In addition to the changes in race categories over time, the Hispanic ethnicity also became available at the county level beginning in 1990. People of Hispanic ethnicity may be of any race. To consider Hispanic people as a distinct group, the tool above defaults to excluding Hispanic people from the race categories when the comparison years selected are both from 1990 and later. The resulting race/ethnicity comparison groups are: "Black, non-Hispanic", "white, non-Hispanic", "American Indian/Alaska Native, non-Hispanic", "Asian or Pacific Islander, non-Hispanic" and "Hispanic". There is also an option for users to hide the distinct Hispanic ethnicity, which then allocates Hispanic people to their designated race category.

Census reporting and update cycle

The Census Bureau releases annual provisional population estimates based on the previous decennial census and other data on births, deaths, and migration/immigration. Every decade, the Bureau reconciles these estimates and releases final data.

These provisional estimates are 'postcensal estimates', and the final estimates are 'intercensal estimates'. USAFacts used the final intercensal estimates for 1970 through 2009 and the provisional postcensal estimates for 2010 and after.

The most recent county-level data available by age, race, sex, and ethnicity are the Vintage 2020 Population Estimates (census.gov) for 2010 to 2019 and the Vintage 2022 Population Estimates (census.gov) for 2020 through 2022. We will update this experience, including the 2010-2019 estimates, when the Bureau releases county-level 2010-2020 intercensal estimates by age, sex, race, and ethnicity.

Use caution when interpreting population changes that use different estimate vintages. The 2010-2020 postcensal estimates are known to underestimate the population by about 1% nationally. This underestimate is, effectively, zero for 2010 and grows each year to reach 1% by 2020. The estimate years differ from the base 2010 decennial census; underestimates will be resolved in 2023 when the Census Bureau releases its 2010-2020 intercensal estimates.

Geography changes

In 2022, the Census Bureau accepted a new county-equivalent map for the state of Connecticut to better reflect the actual governance system in the state. This resulted in a new map that divides the state into 9 counties in place of the prior 8-county map. This presents a significant hurdle for providing context to Connecticut's state population changes over time. The Census Bureau, in addressing this concern, has indicated that they will release alternative population estimates for Connecticut for the past 5 years using the more recent 9-county designations. USAFACTS will be paying attention to those releases to determine if those results can be combined with these other data to provide a time series of population change for the new counties. While this is being determined, we have inserted the data from the Vintage 2021 Population Estimates (census.gov) for reporting for Connecticut at the county level, that align to the old, 8-county system to provide that context over time. State and National numbers use the 2022 Vintage estimates and we will continue to use the most recent estimates for the state and nation even when older data must be substituted for the county-level data. Until some additional data becomes available and is evaluated, we will limit Connecticut's county-level data to 2021.

USAFacts is a not-for-profit, nonpartisan civic initiative making government data easy for all.

Attachment E

Department of Health, Washington State Health Plan

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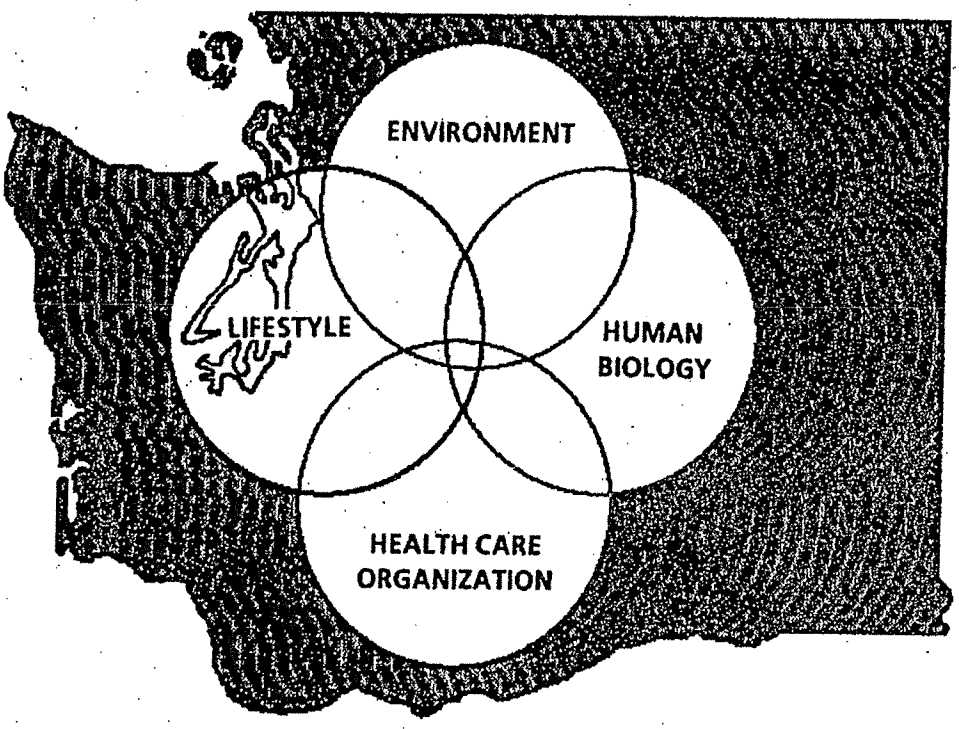
WASHINGTON STATE HEALTH PLAN



VOLUME 2: PERFORMANCE STANDARDS FOR HEALTH FACILITIES AND SERVICES

Adopted by the State Health Coordinating Council
January 21, 1987

Approved by Governor Booth Gardner
May 12, 1987

(5) Any Type A or Type B CCRC proposing a nursing home project may, at its discretion, designate it as an application against the special statewide pool of CCRC nursing home beds established under the Nursing Home Bed Need Projection Method (General Provision (f) ii and Step 2). No single project shall be considered simultaneously under both the CCRC statewide bed pool and the bed allocation of the Nursing Home Planning Area in which the project is located.

d. Home Health Agencies (HH)

Home health agency means an entity coordinating or providing the organized delivery of home health services.

Home health services means the provision of nursing services along with at least one other therapeutic service or with a supervised home health aide service to ill or disabled persons in their residences on a part-time or intermittent basis, as approved by a physician.

(1) The performance standards policies presented below are interim. The health planning system shall evaluate these standards and revise them as necessary, when data on the costs and use of home health services in the state are available.

(2) The following home health planning areas in each health planning region shall be used to determine population requirements for home health services:

Health Planning Region I

(a) Clallam/West Jefferson
(b) Whatcom
(c) Skagit
(d) San Juan
(e) Island (minus Camano Island)
(f) East Jefferson
(g) Snohomish/Camano Island
(h) King
(i) Pierce
(j) Kitsap

Health Planning Region II

(a) Grays Harbor/Pacific
(b) Thurston/Mason
(c) Lewis
(d) Cowlitz/Wahkiakum
(e) Clark/Skamania/Klickitat

Health Planning Region III

(a) Okanogan
(b) Chelan/Douglas
(c) Kittitas/Yakima
(d) Grant
(e) Benton/Franklin

Health Planning Region IV

(a) Ferry/Stevens/Pend Oreille
(b) Lincoln/Adams
(c) Spokane
(d) Walla Walla/Columbia
(e) Garfield/Asotin/Whitman

(3) The total annual number of home health visits needed in a home health planning area in the next year shall be estimated using the Interim Home Health Agency Need

Estimation Method described below. As utilization data become available, estimates used in this method shall be evaluated and adjusted.

(People under 65 x .005) x 10 visits
+ (People 65-79 x .044) x 14 visits
+ (People 80+ x .183) x 21 visits

= TOTAL VISITS

(4) The appropriate number of home health agencies in each home health planning area shall be determined based on the following policies:

(a) For planning purposes ten thousand (10,000) home health agency visits shall be considered to be the target minimum operating volume for a home health agency.

(b) Two home health agencies may be permitted in each home health planning area to allow competition and consumer choice. Where the projected aggregate need is less than 10,000 visits per year, the burden of proof shall be on a proposed new home health agency to demonstrate that competing agencies will result in greater levels of efficiency, effectiveness and equity in such an environment. In this regard, they shall address at least the considerations in Policies (5)(a)-(g) below.

(c) The maximum number of home health agencies permitted in a home health planning area shall not exceed the number of agencies derived by dividing the visits estimated under Step 3 above by the number 10,000.*

(d) For the purpose of determining the need for additional home health agencies in a home health planning area, existing home health agencies in the planning area are those agencies which can serve the area without further state approval and which provide service use and cost data requested by the health planning system.

(5) Considerations for which preference may be given in reviewing competing proposals to meet a limited need in a planning area are presented below. Preference shall be given to the project that meets the greatest number of the following criteria for preference:

*Note: Fractional numbers derived under this calculation would be rounded down to the nearest whole number.

(a) The proposed agency will meet state certification requirements.

(b) The proposed agency will serve either directly or through formal agreements with other providers the entire planning area in which it is proposed to be located.

(c) The proposed agency has a written policy and budget to serve clients without regard to their source of payment.

(d) The agency has a lower charge per visit compared to similarly-organized agencies providing comparable services in the home health planning area. "Organization" refers to whether the agency is freestanding or hospital-based.

(e) The agency assures continuity of care by having documented formal linkages to other levels of care.

(f) The agency has arrangements to provide charity care to clients who are unable to pay for services.

(g) The agency demonstrates a mechanism for measuring and responding to community concerns.

e. Hospice Services (HS)

Hospice means a private or public agency or part thereof that administers or provides hospice care.

Hospice care means care supervised by the attending physician and provided by the hospice to the terminally ill. Hospice care is primarily palliative or medically necessary care provided by a hospice multidisciplinary team with care available 24 hours per day 7 days a week.

Hospice multidisciplinary teams means a team of individuals that provides or supervises care and services offered by the hospice and that is composed of at least a physician (consultant), registered nurse, social worker, and a pastoral, spiritual or other counselor.

Hospice services are provided in a coordinated program of care organized for the purpose of providing palliative and supportive care which is designed to meet the psychosocial, psychological, and spiritual needs of patients and their families (which includes those persons related by blood, marriage, or other significant relationship as designated by the patient). Bereavement services are an essential part of hospice care.

Attachment F

Trella Health 2024

Post-Acute Care Industry Trend Report

2024 EDITION

trellahealth.com | info@trellahealth.com

About Trella Health

Trella Health's unmatched market intelligence and purpose-built CRM allow post-acute providers and suppliers to drive more effective performance and growth. Trella's solutions allow post-acute, HME, and infusion organizations to identify the highest-potential referral targets, evaluate new market opportunities, and monitor performance metrics. Paired with CRM and EHR integrations, business development teams can better manage referral relationships to advance their organizations with certainty by improving their sales and marketing strategy.

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Post-Acute Care Staffing Trends

Trella HEALTH

KEY TAKEAWAYS

- Healthcare Cost Report Information System (HCRIS) data for home health agencies and skilled nursing facilities indicate staffing challenges throughout 2022.
- Skilled Nursing Facility staff per agency decreased by 9.1% between fiscal years ending in 2019 and years ending in 2022 while Other Long-Term Care staff decreased by 24.5% over the same timeframe.
- Per-agency home health staffing total, administrative, and healthcare full-time equivalent (FTE) employees decreased between fiscal years ending in 2021 and 2022 by 2.2%, 1.8%, and 2.7%, respectively.

Per-Agency Full Time Equivalent (FTE) Employees by Fiscal Year End for Skilled Nursing Cost Reports

FTE Type	2019	2020	2021	2022
Skilled Nursing Facility	94.3	91.3	84.0	85.7
Nursing Facility	1.2	1.4	1.1	1.2
Other Long-Term Care	2.5	2.5	2.1	1.9

Per-Agency Full Time Equivalent (FTE) Employees by Fiscal Year End for Home Health Agency Cost Reports

FTE Type	2020	2021	2022
Total FTEs	21.7	22.7	22.2
Admin FTEs	6.7	6.9	6.8
Supervisor FTEs	1.0	0.9	0.9
Healthcare FTEs	14.0	14.9	14.5

STAFFING SHORTAGES IN POST-ACUTE CARE: A GROWING CONCERN

Since the start of the pandemic, post-acute care agencies have been constantly forced to provide much more healthcare with fewer employees. Between calendar years 2020 and 2021, FFS and MA admissions to skilled nursing admissions rose by 2.2%, from 2.91M to 2.98M. Comparatively, per-agency skilled nursing FTEs for fiscal years ending between 2020 and 2021 decreased by 7.9%.

Essentially, an average skilled nursing facility cared for 2.2% more patients with 7.9% fewer staff. Despite a slight increase in the per-agency skilled nursing FTEs at SNFs between 2021 and 2022, per-agency FTEs remain 9.1% below pre-pandemic levels.

While pre-pandemic per-agency FTE data isn't available using the exact same methodology for home health agencies, the data available for agencies with fiscal years ending between 2020 and 2022 presents a concerning trend. The increase in per-agency FTEs between 2020 and 2021 is almost certainly caused by a 2020 value that is much lower than 2019 and would be expected as the United States adjusted to the pandemic. However, the decrease between 2021 and 2022 indicates the potential for home health agency staffing levels to hover around those during the height of the pandemic.

The cost report data quantifies a substantial headwind for post-acute care agencies going forward. The market for nurses and therapists has become much more competitive due to increases in demand for healthcare as the population over 65 continues to represent a higher percentage of the overall population. Competitive labor markets, combined with changes in reimbursement rates that fail to keep up with inflation, require agencies to more effectively and efficiently streamline their hiring and retaining of staff.

Note: Analysis of HCRIS data was performed by fiscal year of each agency, excluding outlier data points and obvious errors. Skilled nursing reports for fiscal years ending in 2022 were limited, though provide a sufficient sample (more than 50% of agencies present other years). Home health FTEs were aggregated based on the type of FTE listed in the cost report.

FFS Skilled Nursing Admissions and Utilization by State and Reporting Period

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Reporting Period: 2022 Q4			
State	Skilled Nursing Admissions	YoY % Change in Admissions	SNF Utilization
AK	1.4K	2.4%	7.3%
AL	22.8K	-1.6%	19.5%
AR	21.8K	11.9%	20.1%
AZ	26.8K	4.7%	19.4%
CA	196.7K	21.2%	24.2%
CO	20.5K	9.7%	21.4%
CT	29.0K	6.8%	31.3%
DC	3.5K	-5.3%	22.8%
DE	7.0K	-0.6%	20.0%
FL	150.3K	7.1%	22.5%
GA	36.6K	3.3%	17.8%
HI	3.4K	2.2%	19.0%
IA	27.2K	5.9%	26.6%
ID	7.0K	6.1%	19.4%
IL	93.1K	6.8%	25.9%
IN	50.4K	3.7%	26.3%
KS	25.8K	1.9%	26.7%
KY	30.7K	-0.9%	23.6%
LA	26.1K	8.1%	20.6%
MA	63.2K	6.6%	25.2%
MD	49.6K	7.9%	27.0%
ME	6.9K	-0.6%	20.1%
MI	50.0K	-1.7%	21.6%
MN	25.9K	-7.9%	22.5%
MO	40.1K	5.8%	23.3%
MS	23.0K	2.4%	24.5%
MT	5.6K	-1.1%	16.8%
NC	48.2K	-2.4%	20.7%
ND	5.8K	-2.9%	21.4%
NE	15.2K	-1.4%	26.5%
NH	10.1K	9.3%	21.4%
NJ	76.6K	9.1%	29.5%
NM	8.4K	10.7%	18.9%
NV	11.9K	8.8%	18.2%
NY	143.0K	9.4%	26.4%
OH	76.1K	1.0%	25.7%
OK	27.8K	5.6%	22.3%
OR	10.3K	-4.2%	14.9%
PA	77.4K	3.0%	22.8%
RI	6.7K	1.9%	29.5%
SC	26.9K	7.6%	17.4%
SD	7.9K	3.1%	24.0%
TN	36.4K	0.0%	22.2%
TX	122.3K	7.9%	20.0%
UT	10.0K	5.8%	22.3%
VA	49.1K	5.2%	21.7%
VT	5.4K	6.3%	21.6%
WA	26.8K	6.9%	19.4%
WI	28.2K	-5.3%	21.2%
WV	12.9K	9.4%	19.8%
WY	4.2K	13.3%	18.4%

Reporting Period: 2023 Q4			
State	Skilled Nursing Admissions	YoY % Change in Admissions	SNF Utilization
AK	1.4K	2.3%	7.4%
AL	20.5K	-9.9%	19.7%
AR	17.4K	-20.2%	20.5%
AZ	23.3K	-13.0%	18.1%
CA	165.9K	-15.7%	25.1%
CO	17.3K	-15.4%	21.0%
CT	23.2K	-20.1%	30.1%
DC	3.2K	-8.1%	22.4%
DE	6.4K	-9.2%	19.7%
FL	134.2K	-10.7%	21.8%
GA	33.2K	-9.3%	18.1%
HI	3.7K	7.2%	20.1%
IA	21.6K	-20.5%	25.4%
ID	6.7K	-4.5%	21.4%
IL	77.4K	-16.9%	24.7%
IN	39.9K	-21.0%	25.3%
KS	22.2K	-13.9%	26.2%
KY	25.0K	-18.6%	23.4%
LA	21.9K	-16.1%	21.6%
MA	57.0K	-9.8%	25.2%
MD	43.4K	-12.5%	26.5%
ME	6.1K	-11.9%	20.8%
MI	42.9K	-14.3%	21.6%
MN	23.5K	-9.4%	22.4%
MO	34.4K	-14.1%	22.8%
MS	21.1K	-8.4%	25.3%
MT	5.1K	-8.5%	17.5%
NC	42.9K	-11.1%	20.9%
ND	5.2K	-10.7%	21.8%
NE	14.0K	-8.2%	26.2%
NH	8.7K	-13.4%	22.1%
NJ	68.8K	-10.2%	28.7%
NM	7.1K	-15.7%	19.4%
NV	10.5K	-11.9%	18.1%
NY	126.9K	-11.2%	26.4%
OH	62.5K	-17.9%	24.3%
OK	23.6K	-15.2%	22.3%
OR	10.1K	-1.8%	15.6%
PA	71.7K	-7.4%	22.9%
RI	6.0K	-10.4%	29.3%
SC	22.8K	-15.0%	17.1%
SD	7.4K	-6.7%	23.3%
TN	31.9K	-12.5%	21.6%
TX	94.4K	-22.8%	19.2%
UT	8.4K	-16.4%	22.4%
VA	41.6K	-15.2%	21.0%
VT	4.5K	-16.1%	22.1%
WA	26.2K	-2.5%	20.9%
WI	24.3K	-13.9%	20.8%
WV	10.4K	-19.4%	18.6%
WY	3.5K	-17.6%	19.6%

Skilled Nursing Utilization, 2022 Q1 - 2023 Q4

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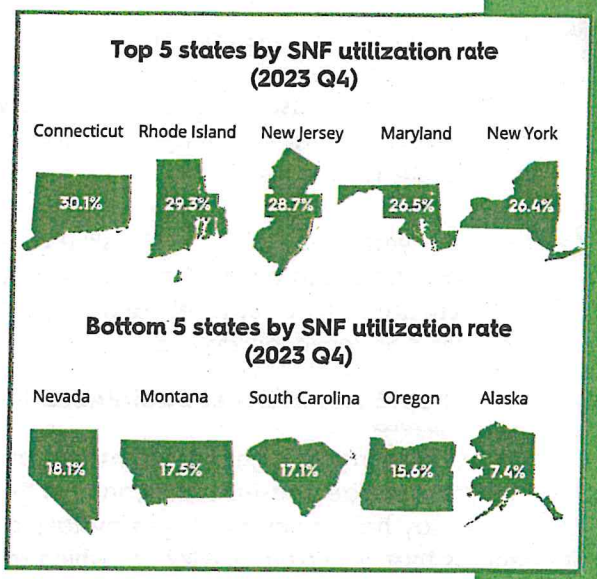
KEY TAKEAWAYS

- National FFS skilled nursing utilization remained relatively stable in the 2023 Q4 reporting period at 22.7%, compared to 22.9% in the 2022 Q4 reporting period.
- While a range of 22.7 percentage points for state-level utilization may appear to indicate significant geographic differences, this range is nearly halved (14.5 percentage points) when the outlier of Alaska is excluded.



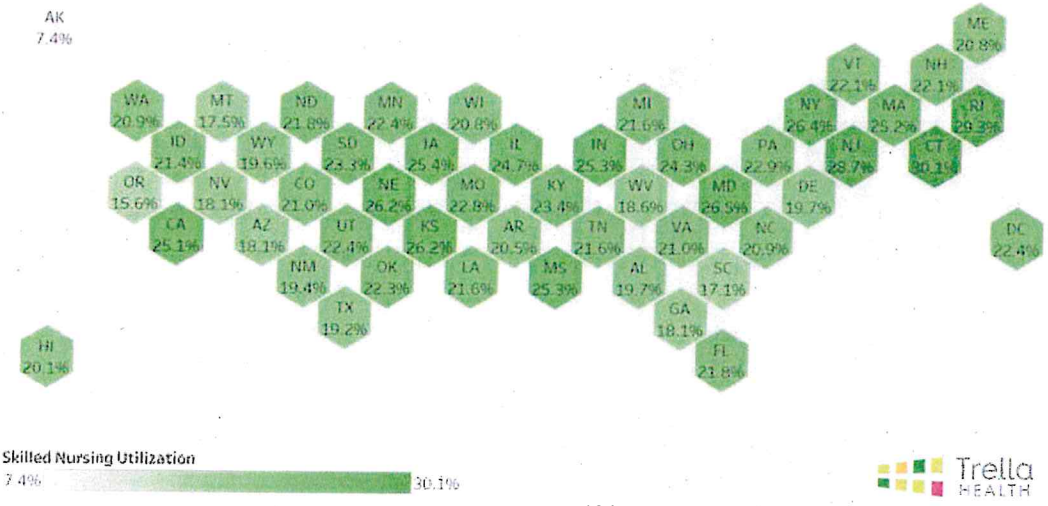
SKILLED NURSING UTILIZATION STABILIZES FROM THE PANDEMIC

While national FFS skilled nursing utilization remained stable between the 2022 Q4 and 2023 Q4 reporting periods, utilization is 2.0 percentage points below pre-pandemic benchmarks (24.7% in the 2019 Q3 reporting period).

It's possible that the skilled nursing industry still needs some time to recover from the impacts of the COVID-19 pandemic; the stability between the 2022 Q4 and 2023 Q4 reporting periods could also indicate that a slightly lower utilization is the new normal.

Despite the stability in national FFS skilled nursing utilization, state level values for this metric moved by between -1.4 and 2.0 percentage points between the 2022 Q4 and 2023 Q4 reporting periods. Some states with the largest increases in FFS skilled nursing utilization had decreases in year-over-year skilled nursing admissions. This trend could be explained by adjustments and realignment to more typical skilled nursing utilization in the context of decreasing FFS enrollment.

FFS Skilled Nursing Utilization by State



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Skilled Nursing Admissions, 2019 Q1 – 2023 Q4

KEY TAKEAWAYS

- National FFS skilled nursing admissions decreased by 13.8% year-over-year for the 2023 Q4 reporting period. This decrease was primarily driven by driven by substantial quarterly shifts for 2023 Q3 and 2023 Q4, respectively.
- National year-over-year MA skilled nursing admissions increased by 21.2% during calendar year 2021, likely driven by a relatively deflated 2020 level due to the pandemic lockdowns.

Annualized FFS skilled nursing admissions compared to enrollment

Reporting Period	2020 Q4	2021 Q4	2022 Q4	2023 Q4
Annualized Admissions	1.9M	1.8M	1.9M	1.6M
% Change		-7.4%	6.2%	-13.8%
Enrollment Calendar Year	**2020**	**2021**	**2022**	**2023**
FFS Enrollment	31.8M	30.4M	29.2M	28.2M
% Change		-4.4%	-3.9%	-3.6%

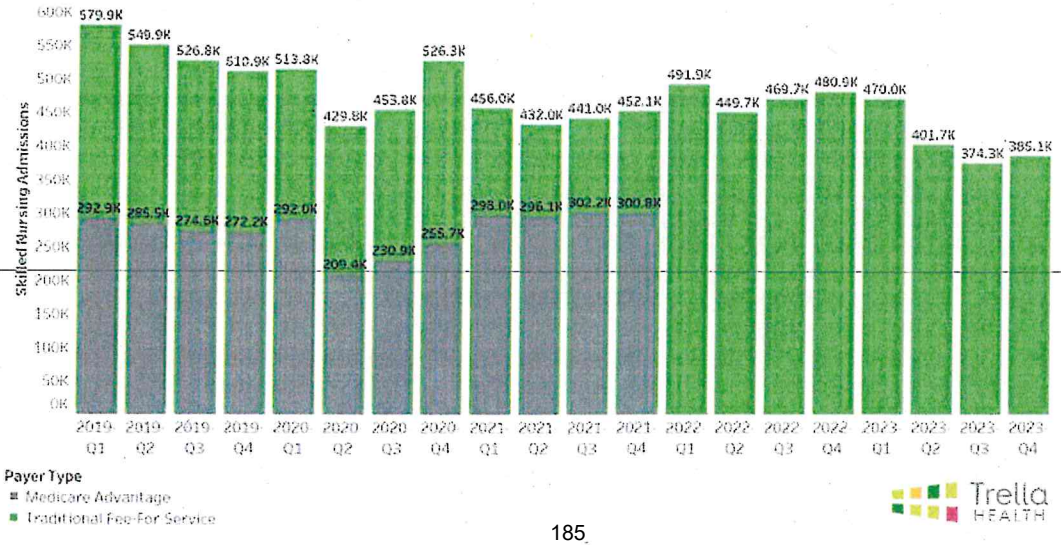
SKILLED NURSING ADMISSIONS DECREASED IN THE 2023 Q4 REPORTING PERIOD

Despite representing a higher percentage of FFS inpatient discharge instructions, skilled nursing admissions decreased significantly in the 2023 Q4 reporting period. FFS skilled nursing admissions may have been bolstered by taking on more COVID-19 patients amidst the wave of infections that occurred in 2022 Q1, which may explain an industry readjustment once the pandemic became better in-hand.

Indicated in the table above, the percentage decrease in FFS skilled nursing admissions more than tripled the decrease in FFS enrollment, making up for a smaller decrease in admissions than FFS enrollment during the 2021 Q4 reporting period and a slight increase in admissions compared to a 3.9% decrease in enrollment during the 2022 Q4 reporting period.

The long-term trajectory for Medicare Advantage skilled nursing admissions is more difficult to ascertain due to the available timeframe being considerably impacted by the COVID-19 pandemic. After a 12.2% year-over-year decrease in skilled nursing admissions during calendar year 2020, MA admissions increased by 21.2% in calendar year 2021. Despite the increase in the latest calendar year of available data, it's likely that 2022 will show an even greater increase because, relative to 2019, MA skilled nursing admissions haven't increased at the same rate as MA enrollment (2019 to 2021 admissions increased by only 6.4% compared to a 20.5% increase in MA enrollment).

National Skilled Nursing Admissions by Quarter and Payer



Hospice Admissions, Mortalities, and Utilization by State and Reporting Period

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Hospice Admissions			
State	2021 Q4	2022 Q4	2023 Q4
AK	1.2K	1.2K	1.2K
AL	31.8K	32.0K	32.3K
AR	16.8K	17.4K	17.2K
AZ	40.3K	40.7K	41.4K
CA	154.0K	156.6K	166.5K
CO	20.7K	21.8K	22.6K
CT	14.0K	14.3K	14.7K
DC	1.4K	1.4K	1.5K
DE	5.7K	5.8K	5.8K
FL	134.0K	134.7K	137.1K
GA	49.5K	48.7K	50.0K
HI	5.5K	5.6K	5.5K
IA	17.1K	17.8K	18.0K
ID	8.8K	8.8K	8.9K
IL	51.8K	52.4K	52.7K
IN	34.0K	34.4K	35.8K
KS	15.4K	16.0K	15.8K
KY	20.5K	20.8K	21.0K
LA	24.9K	24.0K	24.7K
MA	27.8K	28.6K	29.3K
MD	22.2K	22.6K	22.8K
ME	7.9K	8.1K	8.6K
MI	53.1K	52.4K	54.2K
MN	25.2K	25.5K	26.1K
MO	32.2K	32.9K	33.6K
MS	16.6K	16.5K	17.2K
MT	4.6K	4.4K	4.0K
NC	49.3K	50.4K	52.3K
ND	2.1K	2.3K	2.5K
NE	8.1K	8.4K	8.9K
NH	6.6K	6.7K	7.1K
NJ	33.3K	33.7K	33.4K
NM	9.6K	9.8K	10.0K
NV	14.2K	15.0K	15.4K
NY	45.2K	43.6K	41.6K
OH	69.7K	69.2K	68.8K
OK	22.9K	23.5K	24.1K
OR	20.8K	20.7K	20.6K
PA	64.7K	64.0K	64.1K
RI	5.7K	5.8K	6.0K
SC	30.1K	30.8K	31.8K
SD	3.4K	3.5K	3.6K
TN	34.6K	35.6K	36.4K
TX	125.2K	128.7K	132.6K
UT	12.5K	13.0K	13.2K
VA	35.6K	36.0K	36.8K
VT	2.9K	2.9K	3.1K
WA	26.0K	26.3K	27.0K
WI	31.0K	31.7K	32.6K
WV	10.5K	10.7K	10.4K
WY	1.9K	2.1K	2.1K

Mortalities			
State	2021 Q4	2022 Q4	2023 Q4
AK	4.2K	3.9K	3.8K
AL	53.4K	49.1K	46.8K
AR	31.4K	30.3K	28.7K
AZ	61.2K	57.3K	54.1K
CA	256.5K	247.6K	234.2K
CO	36.4K	36.0K	34.8K
CT	27.6K	28.3K	26.8K
DC	4.1K	3.9K	3.6K
DE	8.9K	9.0K	8.5K
FL	204.6K	192.9K	185.5K
GA	83.9K	77.9K	73.9K
HI	10.4K	10.9K	10.5K
IA	28.4K	28.3K	27.3K
ID	14.6K	13.9K	13.4K
IL	97.8K	97.3K	90.5K
IN	61.1K	59.3K	55.6K
KS	25.1K	25.1K	23.4K
KY	46.7K	45.1K	41.9K
LA	42.4K	39.4K	37.5K
MA	51.9K	52.3K	50.9K
MD	44.3K	44.0K	41.5K
ME	14.2K	14.3K	14.1K
MI	94.5K	90.4K	84.9K
MN	41.7K	41.9K	40.6K
MO	57.9K	56.8K	53.3K
MS	31.0K	29.3K	27.3K
MT	10.0K	9.4K	9.2K
NC	92.0K	89.3K	85.3K
ND	5.6K	5.6K	5.5K
NE	15.3K	15.3K	15.1K
NH	11.8K	12.1K	12.0K
NJ	67.2K	66.0K	61.6K
NM	18.2K	17.7K	16.8K
NV	24.3K	23.9K	22.1K
NY	147.3K	142.4K	133.3K
OH	114.9K	109.1K	101.6K
OK	38.7K	37.2K	34.4K
OR	36.2K	36.3K	34.5K
PA	126.2K	120.9K	114.7K
RI	9.4K	9.0K	8.7K
SC	50.2K	48.0K	45.9K
SD	7.3K	7.3K	7.0K
TN	69.3K	66.0K	62.1K
TX	198.0K	184.3K	175.4K
UT	17.0K	17.0K	16.4K
VA	67.6K	66.1K	62.9K
VT	5.7K	5.8K	5.7K
WA	54.6K	55.5K	52.5K
WI	49.7K	49.9K	47.7K
WV	23.3K	21.9K	19.8K
WY	5.1K	4.7K	4.5K

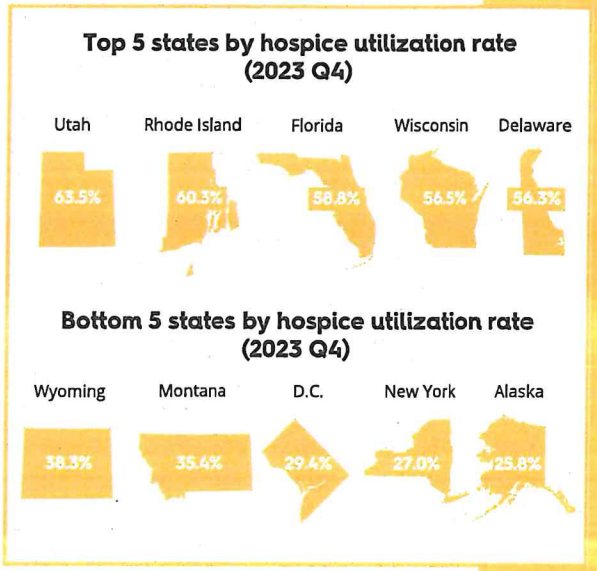
Hospice Mortalities			
State	2021 Q4	2022 Q4	2023 Q4
AK	1.0K	1.0K	1.0K
AL	23.7K	23.8K	23.9K
AR	14.0K	14.2K	13.9K
AZ	31.2K	31.1K	30.3K
CA	107.9K	109.1K	107.2K
CO	17.1K	17.6K	18.4K
CT	12.2K	12.6K	13.0K
DC	1.1K	1.1K	1.1K
DE	4.6K	4.9K	4.8K
FL	109.7K	107.6K	109.2K
GA	39.0K	38.0K	38.1K
HI	4.7K	4.8K	4.6K
IA	14.7K	15.3K	15.2K
ID	7.3K	7.2K	7.0K
IL	45.4K	45.2K	45.3K
IN	28.9K	29.3K	29.6K
KS	12.6K	13.0K	12.8K
KY	18.6K	18.6K	18.7K
LA	19.4K	19.0K	19.2K
MA	23.9K	24.1K	24.9K
MD	19.1K	19.7K	19.4K
ME	7.0K	7.2K	7.4K
MI	45.4K	44.9K	45.0K
MN	21.3K	21.7K	22.3K
MO	26.7K	27.1K	27.0K
MS	12.6K	12.5K	12.8K
MT	3.8K	3.7K	3.2K
NC	42.2K	43.3K	44.4K
ND	1.8K	2.0K	2.2K
NE	7.0K	7.4K	7.7K
NH	5.7K	5.7K	6.1K
NJ	28.6K	29.0K	28.5K
NM	7.9K	8.0K	7.9K
NV	10.9K	11.1K	11.1K
NY	38.8K	37.4K	36.0K
OH	58.5K	57.6K	56.5K
OK	17.7K	17.8K	17.7K
OR	18.2K	17.9K	17.4K
PA	55.5K	54.8K	55.0K
RI	5.0K	5.0K	5.3K
SC	24.2K	24.9K	25.1K
SD	3.0K	3.1K	3.1K
TN	29.5K	30.4K	30.6K
TX	95.0K	96.4K	95.9K
UT	9.7K	10.1K	10.4K
VA	30.2K	30.2K	30.8K
VT	2.5K	2.5K	2.5K
WA	22.5K	22.7K	23.0K
WI	26.6K	27.1K	26.9K
WV	9.1K	9.2K	9.0K
WY	1.6K	1.8K	1.7K

Hospice Utilization			
State	2021 Q4	2022 Q4	2023 Q4
AK	24.1%	25.6%	25.8%
AL	44.4%	48.6%	51.0%
AR	44.4%	46.9%	48.5%
AZ	51.0%	54.2%	56.0%
CA	42.1%	44.1%	45.8%
CO	47.0%	48.8%	52.8%
CT	44.2%	44.6%	48.4%
DC	26.5%	27.4%	29.4%
DE	51.3%	54.0%	56.3%
FL	53.6%	55.8%	58.8%
GA	46.5%	48.7%	51.5%
HI	45.4%	43.6%	43.6%
IA	51.8%	54.0%	55.9%
ID	49.9%	51.6%	52.0%
IL	46.5%	46.4%	50.0%
IN	47.3%	49.4%	53.3%
KS	50.3%	51.5%	54.6%
KY	39.8%	41.2%	44.7%
LA	45.7%	48.2%	51.2%
MA	46.1%	46.0%	48.8%
MD	43.1%	44.8%	46.8%
ME	49.3%	50.4%	52.3%
MI	48.1%	49.6%	52.9%
MN	51.1%	51.9%	54.8%
MO	46.2%	47.7%	50.7%
MS	40.6%	42.6%	46.9%
MT	38.4%	39.2%	35.4%
NC	45.9%	48.5%	52.1%
ND	31.2%	36.2%	40.1%
NE	46.1%	48.3%	50.6%
NH	48.2%	47.1%	51.0%
NJ	42.6%	44.0%	46.2%
NM	43.0%	45.1%	47.1%
NV	44.9%	46.3%	50.4%
NY	26.3%	26.3%	27.0%
OH	50.9%	52.8%	55.6%
OK	45.6%	47.7%	51.5%
OR	50.2%	49.2%	50.4%
PA	44.0%	45.3%	47.9%
RI	53.1%	55.4%	60.3%
SC	48.2%	51.8%	54.7%
SD	41.3%	42.7%	43.8%
TN	42.6%	46.0%	49.4%
TX	48.0%	52.3%	54.7%
UT	57.1%	59.5%	63.5%
VA	44.6%	45.8%	48.9%
VT	44.1%	43.2%	44.8%
WA	41.2%	40.8%	43.7%
WI	53.4%	54.3%	56.5%
WV	39.1%	42.1%	45.2%
WY	31.8%	37.6%	38.3%

Hospice Utilization, 2019 Q3 – 2023 Q4

KEY TAKEAWAYS

- Variation of the percentage of Medicare mortalities that received hospice care indicates inconsistent access or awareness of hospice services across states.
- Hospice utilization should be a key metric for evaluation of expansion opportunities: states with lower utilization could have unmet demand for hospice services while higher utilization may indicate a saturated market.



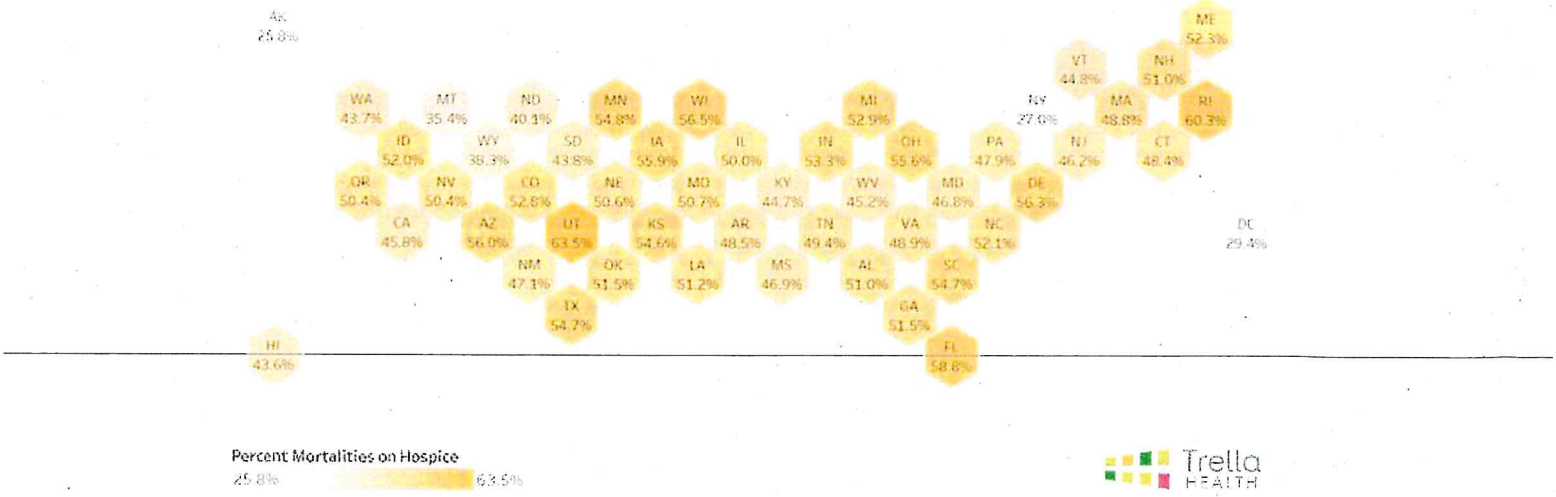
FEWER COVID-RELATED DEATHS CONTRIBUTED TO UTILIZATION INCREASES

Nationally, the percentage of Medicare mortalities that received hospice care in the 2023 Q4 reporting period increased relative to the 2021 Q4 and 2022 Q4 reporting periods.

While this increase in utilization is likely due to a decrease in deaths caused by COVID-19 (which have a lower utilization of hospice care), state-level versions of this metric indicate inconsistent access or awareness of hospice care across geographies.

Since hospice utilization has stabilized towards pre-pandemic levels, it now represents a key metric for the evaluation of expansion opportunities. Population-dense regions with hospice utilization lower than the national average should be prioritized in targeted expansion territories.

Percentage of Medicare Mortalities on Hospice by State



Hospice Admissions, 2019 Q1 – 2023 Q4

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KEY TAKEAWAYS

- National year-over-year hospice admissions increased slightly for each quarter in the 2023 Q4 reporting period, with the highest increase of 4.9% occurring in 2023 Q2.
- Slight year-over-year increases in hospice admissions observed since 2019 are likely to continue as the baby boomer generation ages into the average hospice age.
- The number of mortalities on hospice remained consistent between the 2022 Q4 and 2023 Q4 reporting periods, though a decrease in the number of Medicare mortalities caused an increase in the percentage of deaths on hospice.

Hospice admissions, mortalities, and mortalities on hospice by reporting period

	2020 Q4	2021 Q4	2022 Q4	2023 Q4
Hospice Admissions	1.5M	1.5M	1.5M	1.6M
Medicare Mortalities (FFS + MA)	2.7M	2.7M	2.6M	2.5M
Mortalities on Hospice	1.2M	1.2M	1.2M	1.2M
% of Deaths on Hospice	45.8%	45.4%	47.2%	49.8%

CONSISTENT ADMISSIONS INCREASES INDICATE A PROMISING FUTURE

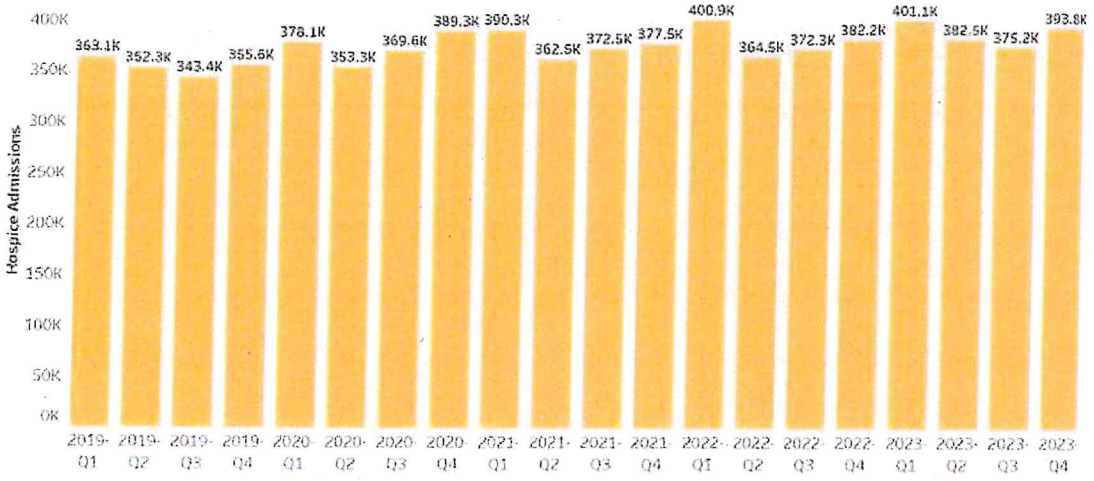
Consistent increases in the year-over-year hospice admissions for each quarter in the 2023 Q4 reporting period indicates a healthy industry poised to care for the aging baby boomer generation in years to come. During the COVID-19 pandemic the percentage of Medicare mortalities that received hospice decreased, illustrated in the table above.

However, since COVID-19 caused fewer deaths in the 2023 Q4 reporting period, the percentage of mortalities that received hospice care recovered to pre-pandemic levels.

Additionally, national hospice average length of stay (ALOS) increased by 2 days between the 2022 Q4 and 2023 Q4 reporting periods, from 62.5 to 64.5. This increase further supports increased stability in the hospice industry overall.

Note: Hospice admissions in this section does not include Medicare beneficiaries that received hospice care paid through their Medicare Advantage plan as part of the VBID hospice carve-in program, and thus could be slightly understated.

National Hospice Admissions by Quarter



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FFS Home Health Admissions and Utilization by State and Reporting Period

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Reporting Period: 2022 Q3			
State	Home Health Admissions	YoY % Change in Admissions	Home Health Utilization
AK	3.7K	0.3%	13.0%
AL	55.5K	-8.3%	28.7%
AR	34.3K	-7.4%	24.6%
AZ	47.1K	-6.6%	21.8%
CA	394.2K	-0.7%	26.3%
CO	31.6K	-8.4%	21.2%
CT	41.9K	-8.6%	31.0%
DC	3.9K	-18.1%	18.2%
DE	14.7K	-7.0%	30.8%
FL	296.1K	-10.8%	27.2%
GA	75.6K	-7.4%	24.7%
HI	4.6K	-4.2%	13.1%
IA	22.1K	-12.7%	17.2%
ID	15.0K	-7.9%	23.1%
IL	139.5K	-8.6%	23.3%
IN	51.6K	-10.8%	18.8%
KS	29.7K	-6.1%	21.2%
KY	43.9K	-11.0%	22.5%
LA	45.5K	-10.4%	23.9%
MA	115.3K	-4.3%	35.3%
MD	71.8K	-4.0%	25.6%
ME	13.7K	-16.1%	28.1%
MI	96.5K	-11.2%	24.8%
MN	33.3K	-8.5%	17.5%
MO	51.5K	-10.8%	22.6%
MS	48.9K	-10.2%	25.2%
MT	5.8K	-9.9%	11.1%
NC	88.7K	-9.4%	24.7%
ND	4.3K	-10.1%	12.4%
NE	16.1K	-6.3%	17.7%
NH	20.9K	-8.2%	33.1%
NJ	85.8K	-4.7%	24.8%
NM	14.6K	-9.3%	19.4%
NV	31.3K	-6.0%	25.4%
NY	160.7K	-6.4%	24.4%
OH	94.7K	-9.0%	22.3%
OK	50.5K	-6.3%	24.5%
OR	24.5K	-7.7%	18.8%
PA	133.3K	-7.9%	30.2%
RI	11.7K	-8.1%	31.6%
SC	65.9K	-4.3%	30.7%
SD	6.7K	1.0%	15.0%
TN	65.3K	-8.1%	23.7%
TX	208.9K	-7.5%	23.5%
UT	24.1K	-6.8%	25.9%
VA	92.7K	-8.0%	27.6%
VT	10.2K	-12.7%	27.7%
WA	46.5K	-5.2%	18.3%
WI	37.2K	-7.4%	19.3%
WV	22.2K	-8.9%	25.2%
WY	4.8K	-7.7%	14.1%

Reporting Period: 2023 Q3			
State	Home Health Admissions	YoY % Change in Admissions	Home Health Utilization
AK	3.9K	4.9%	13.1%
AL	51.3K	-7.6%	29.2%
AR	31.8K	-7.5%	24.5%
AZ	47.6K	1.0%	22.7%
CA	411.6K	4.4%	26.4%
CO	29.7K	-5.8%	20.9%
CT	40.6K	-3.1%	30.2%
DC	4.2K	6.7%	18.8%
DE	15.1K	3.1%	32.6%
FL	298.8K	0.9%	28.3%
GA	71.7K	-5.1%	24.5%
HI	4.5K	-3.0%	12.4%
IA	20.3K	-7.9%	17.4%
ID	14.4K	-3.9%	23.1%
IL	134.7K	-3.4%	23.5%
IN	47.9K	-7.1%	18.5%
KS	27.7K	-6.9%	21.3%
KY	40.4K	-7.9%	22.5%
LA	42.1K	-7.4%	24.0%
MA	115.6K	0.3%	35.6%
MD	70.3K	-2.1%	25.6%
ME	12.8K	-6.4%	27.3%
MI	87.6K	-9.2%	25.3%
MN	32.3K	-3.0%	17.8%
MO	47.8K	-7.2%	22.7%
MS	43.7K	-10.5%	24.4%
MT	5.4K	-7.0%	10.6%
NC	83.7K	-5.5%	24.9%
ND	4.3K	-1.0%	14.0%
NE	14.7K	-8.2%	17.4%
NH	19.8K	-5.6%	31.7%
NJ	83.9K	-2.2%	24.3%
NM	13.9K	-4.8%	20.2%
NV	30.8K	-1.9%	26.3%
NY	159.0K	-1.1%	24.2%
OH	89.6K	-5.3%	22.5%
OK	48.6K	-3.9%	25.5%
OR	23.6K	-3.6%	18.6%
PA	128.4K	-3.7%	30.2%
RI	11.1K	-5.2%	30.8%
SC	65.3K	-0.9%	30.9%
SD	6.1K	-9.8%	13.7%
TN	61.6K	-5.7%	23.8%
TX	192.8K	-7.7%	23.7%
UT	22.9K	-5.1%	25.8%
VA	88.6K	-4.4%	27.1%
VT	9.5K	-6.4%	25.7%
WA	43.8K	-5.8%	17.6%
WI	34.9K	-6.3%	19.3%
WV	20.4K	-8.4%	25.4%
WY	4.5K	-7.2%	14.4%

Home Health Utilization and Adherence, 2021 Q4 - 2023 Q3

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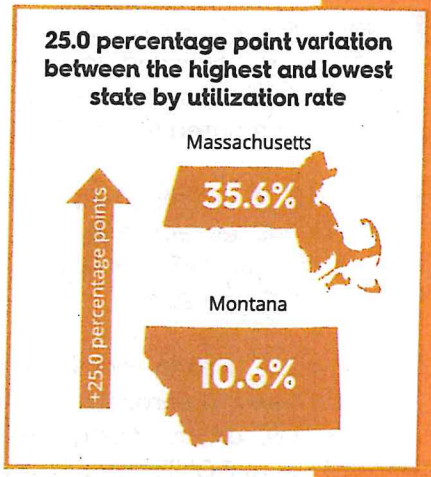
KEY TAKEAWAYS

- National FFS home health utilization in the 2023 Q3 reporting period (24.8%) increased by 0.2 percentage points compared to the 2022 Q3 reporting period (24.6%).
- The range of FFS home health utilization by state during the 2023 Q3 reporting period was 25.0 percentage points, indicating substantial geographic variation in home health care accessibility or awareness after inpatient discharge.
- Patients that adhered to inpatient discharge instructions to home health had a 30-day readmission rate 2.3 percentage points lower than patients that did not adhere to inpatient discharge instructions to home health.



HOME HEALTH UTILIZATION INCREASES

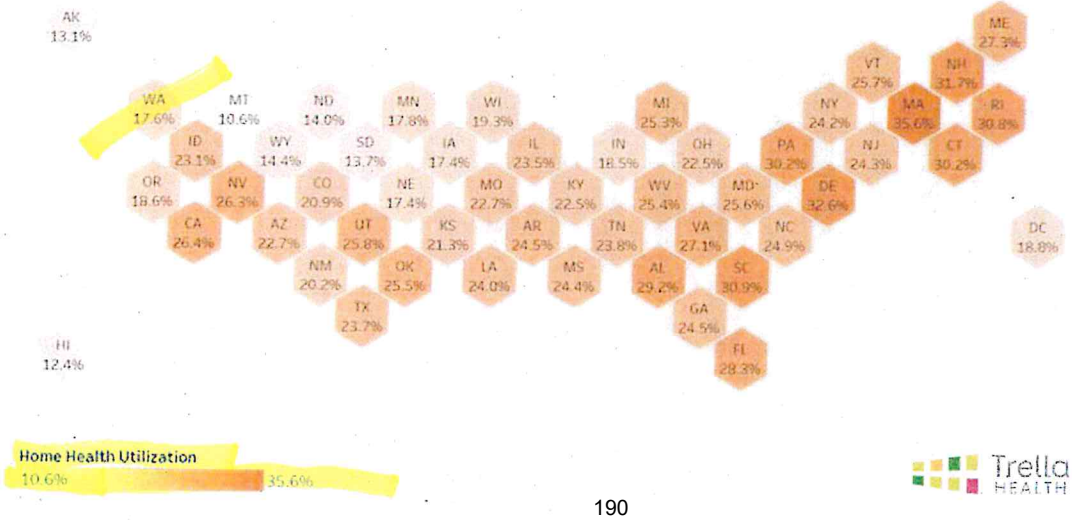
The increase in national FFS home health utilization between the 2022 Q3 and 2023 Q3 reporting periods was likely driven by the slight uptick in adherence to inpatient discharge instructions. Despite this utilization increase, the number of distinct patients that entered home health within 30 days of inpatient discharge remained largely unchanged at 1.5M.

While home health utilization remained consistent for most states between the 2022 Q3 and 2023 Q3 reporting periods, significant geographic differences in utilization indicates opportunities for expanded awareness and access to home health services.

The difference in the 30-day readmission rate for patients that adhered to home health discharge instructions (12.9%) compared to the patients who didn't adhere (15.2%) points to the importance and value of home health care after inpatient discharge.

Note: Trella's methodology for home health utilization was altered to only include admissions to home health within 30 days of inpatient discharge rather than including a home health admissions at any point during the reporting period.

FFS Home Health Utilization by State



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Home Health Admissions, 2019 Q1 – 2023 Q3

KEY TAKEAWAYS

- National year-over-year FFS home health admissions continued to decrease slightly during the 2023 Q3 reporting period, though these declines slowed compared to the 2022 Q3 reporting period.
- In the 2023 Q3 reporting period, FFS home health admissions decreased by 3.0%, compared to a 3.6% decrease in FFS enrollment between calendar years 2022 and 2023.
- MA home health admissions (+11.7%) increased faster than MA enrollment (+10.0%) during calendar year 2021, driven mostly by lower admissions in 2020 due to COVID-19 lockdowns.

Annualized FFS home health admissions compared to enrollment

R4Q Admits	R4Q 2020 Q3	R4Q 2021 Q3	R4Q 2022 Q3	R4Q 2023 Q3
Annualized Admissions	3.4M	3.4M	3.1M	3.0M
% Change		-1.6%	-7.3%	-3.0%
Enrollment Calendar Year	**2020**	**2021**	**2022**	**2023**
FFS Enrollment	31.8M	30.4M	29.2M	28.2M
% Change		-4.4%	-3.9%	-3.6%

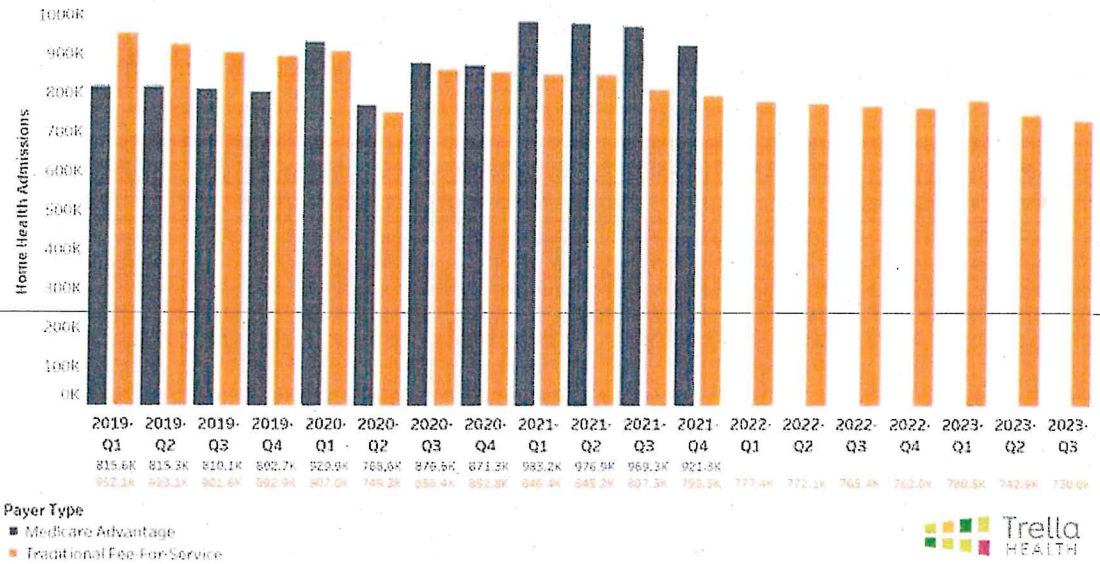
CHANGES IN HOME HEALTH ADMISSIONS RESEMBLE ENROLLMENT ADJUSTMENTS

The year-over-year change in annual FFS home health admissions for the 2023 Q3 reporting period closely resembles the change in FFS enrollment between calendar years 2022 and 2023, further validating a stabilization in the industry after the tumultuousness during the COVID-19 pandemic. However, the continued trend towards MA enrollment signals continued decreases in FFS home health admissions for the foreseeable future.

Comparatively, MA admissions in calendar year 2021 increased faster than MA enrollment. While this is likely due to a deflated base year, home health agencies will continue to see MA beneficiaries represent a higher percentage of their patient population, making it imperative to seek out and negotiate the most lucrative MA reimbursement contracts possible.

Note: The 2023 edition of the Industry Trend Report showed distinct Medicare Advantage home health patients rather than Medicare Advantage home health admissions. This year shows MA home health admissions to be more consistent with how FFS admissions are calculated.

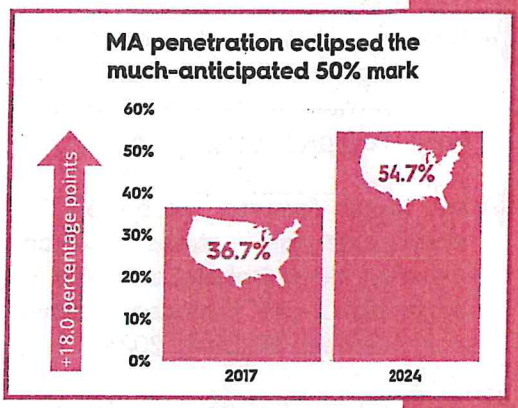
National Home Health Admissions by Quarter and Payer



National Medicare Enrollment

KEY TAKEAWAYS

- As of February 2024, over half of Medicare-eligible beneficiaries (54.7%) are enrolled in a Medicare Advantage (MA) plan.
- Fee-For-Service (FFS) enrollment declined by 0.8M from 2023 to February 2024, indicating that FFS beneficiaries are electing to switch to MA plans.
- Between 2017 and 2024, the portion of Medicare beneficiaries enrolled in an MA plan increased by 18.0 percentage points, from 36.7% to 54.7%.



INCREASES IN MEDICARE ADVANTAGE ENROLLMENT CONTINUE TO ACCELERATE

Between 2017 and 2024, annual MA enrollment grew by an average of 8.1%. Over the same timeframe, the annual MA penetration rate grew by an average of 2.5 percentage points. In each year between 2020 and 2023, the penetration rate grew by over 2.8 percentage points.

These trends indicate that not only is MA enrollment growing, but its growth is accelerating. MA plans' flexibility in offering additional incentives that FFS beneficiaries can't access likely plays a key role in enticing Medicare beneficiaries to enroll in an MA plan rather than the traditional FFS coverage.

Overall enrollment in Medicare increased by 15.6%, from 52.3M in 2017 to 60.4M in 2024 with an average annual percent increase of 2.1%. This trend is likely to continue for the next 10 years as Generation X begins to enter Medicare age and life expectancy continues to rise.

National Medicare-Eligible Enrollment by Medicare Type

Medicare Advantage Penetration by State

KEY TAKEAWAYS

- Between 2023 and February 2024, Medicare Advantage (MA) penetration grew in 49 states and DC, with rates of growth varying from -0.1 percentage point to 6.4 percentage points.
- MA plans focused expansion on southern- and middle-American states. Arkansas, Mississippi, Wyoming, North Dakota, and West Virginia all saw MA penetration rate increases above 4.4 percentage points between 2022 and 2023.
- The number of states with an MA penetration rate above 60% rose from just 1 (RI) in 2022 to 9 (ME, CT, HI, AL, MN, MI, WI, FL, and RI) in 2024.

States with largest percentage point increase in MA penetration rates

State	2022	2023	% Point Increase
AR	40.4%	46.2%	5.8
WY	9.2%	14.6%	5.4
MS	37.3%	42.2%	4.9
ND	29.3%	33.9%	4.6
WV	50.1%	54.5%	4.4

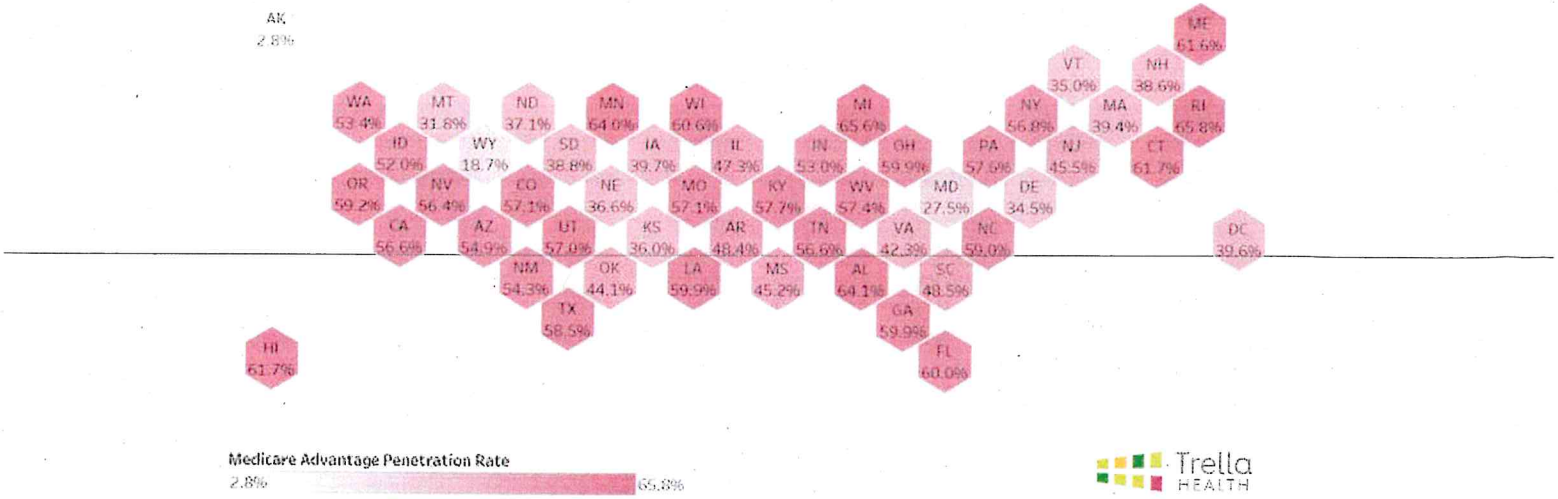
MEDICARE ADVANTAGE PLANS TARGET MARKETS WITH LOW MA PENETRATION

Between 2023 and February of 2024, Medicare Advantage (MA) enrollment increased in 49 states (Alaska decreased very slightly) and DC, indicating a broad expansion strategy by MA plans.

In 2022 and 2023, where the full year of data is available, MA penetration increased in all 50 states and DC. Of the five states with the largest percentage point increase in MA penetration rate, as shown in the table above, four had an MA penetration rate below 41% in 2022.

Comparatively, of the five states with the smallest percentage point increases, four had an MA penetration rate above 51% in 2022. This trend indicates a certain degree of market saturation in states with large numbers of MA enrollees and concerted efforts by MA plans to expand into states with more opportunity for enrollment increases.

Medicare Advantage Penetration by State, February 2024



National Medicare Advantage and Fee-For-Service Enrollment by State and Year

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Medicare Advantage Enrollment (Parts A & B) by State and Year				
State	2020	2021	2022	2023
AK	1.8K	2.3K	2.6K	2.9K
AL	485.8K	541.4K	588.2K	630.0K
AR	192.9K	222.5K	247.2K	287.6K
AZ	581.9K	632.4K	676.5K	718.2K
CA	2,903.0K	3,057.6K	3,203.3K	3,366.0K
CO	407.5K	439.3K	474.1K	508.3K
CT	309.8K	339.0K	364.4K	393.2K
DC	20.8K	23.8K	26.5K	29.7K
DE	40.9K	51.7K	62.0K	71.0K
FL	2267.6K	2443.1K	2600.1K	2749.1K
GA	760.3K	854.1K	931.0K	1004.8K
HI	133.0K	142.8K	151.3K	158.8K
IA	160.0K	181.3K	206.9K	235.3K
ID	129.6K	145.8K	161.8K	178.0K
IL	683.2K	780.2K	880.3K	958.8K
IN	460.3K	525.9K	578.5K	634.9K
KS	116.5K	140.9K	162.5K	181.6K
KY	362.2K	413.1K	460.1K	500.2K
LA	371.2K	420.0K	456.9K	495.1K
MA	363.3K	401.1K	439.1K	481.1K
MD	138.1K	176.1K	208.6K	245.4K
ME	144.5K	168.4K	187.8K	203.8K
MI	1003.6K	1105.8K	1201.3K	1297.8K
MN	506.4K	558.6K	602.0K	646.3K
MO	500.0K	556.5K	609.7K	666.0K
MS	145.3K	183.1K	217.2K	249.4K
MT	48.8K	56.0K	63.4K	70.6K
NC	824.0K	928.8K	1033.4K	1143.0K
ND	26.7K	31.2K	37.7K	44.8K
NE	71.2K	88.2K	105.0K	120.0K
NH	67.4K	81.7K	95.6K	109.9K
NJ	527.7K	580.9K	625.7K	670.2K
NM	170.4K	186.8K	204.8K	220.0K
NV	220.0K	244.9K	266.5K	288.0K
NY	1602.8K	1709.2K	1813.4K	1923.8K
OH	1091.4K	1170.1K	1256.5K	1334.8K
OK	190.2K	235.2K	269.5K	301.2K
OR	417.4K	442.7K	470.2K	495.4K
PA	1235.9K	1311.2K	1394.4K	1480.9K
RI	107.2K	116.1K	126.3K	136.1K
SC	368.0K	421.8K	472.5K	518.0K
SD	41.5K	48.1K	56.3K	64.8K
TN	588.3K	639.2K	687.1K	738.8K
TX	1823.9K	2032.8K	2206.9K	2402.7K
UT	166.1K	185.1K	203.1K	223.3K
VA	388.2K	462.7K	533.1K	594.1K
VT	21.8K	30.7K	43.0K	49.6K
WA	509.9K	566.6K	617.7K	675.5K
WI	555.1K	603.0K	652.9K	703.9K
WV	167.5K	190.0K	208.0K	228.1K
WY	5.6K	6.9K	10.3K	16.7K

Fee-For-Service Enrollment (Parts A & B) by State and Year				
State	2020	2021	2022	2023
AK	89.9K	92.8K	95.2K	98.0K
AL	498.0K	450.2K	415.6K	388.3K
AR	406.6K	383.1K	364.4K	334.6K
AZ	673.4K	653.0K	636.0K	625.3K
CA	2811.9K	2751.3K	2718.0K	2687.6K
CO	440.8K	432.3K	418.9K	408.4K
CT	313.2K	296.0K	274.9K	262.5K
DC	56.7K	54.2K	52.2K	49.5K
DE	158.4K	154.0K	150.2K	148.4K
FL	2114.9K	2058.0K	2006.8K	1955.5K
GA	864.5K	806.1K	765.9K	733.9K
HI	109.7K	108.0K	105.2K	102.3K
IA	433.8K	422.5K	408.4K	392.2K
ID	194.8K	190.7K	184.2K	178.3K
IL	1367.0K	1295.2K	1225.3K	1182.1K
IN	730.8K	683.2K	651.5K	620.0K
KS	385.1K	370.5K	358.9K	349.9K
KY	507.8K	465.5K	426.6K	397.9K
LA	449.3K	410.9K	385.9K	362.4K
MA	850.9K	835.5K	820.4K	801.5K
MD	776.1K	752.8K	738.0K	722.1K
ME	175.8K	160.4K	148.2K	138.8K
MI	965.1K	893.1K	827.5K	769.9K
MN	459.8K	430.6K	410.8K	391.9K
MO	653.8K	613.6K	579.2K	544.4K
MS	426.9K	393.5K	365.7K	341.7K
MT	170.6K	169.3K	167.2K	165.8K
NC	1080.5K	1015.9K	954.9K	891.1K
ND	96.2K	94.6K	91.2K	87.4K
NE	253.5K	243.2K	233.4K	225.1K
NH	207.5K	201.9K	196.3K	189.7K
NJ	924.0K	890.3K	870.3K	858.3K
NM	221.9K	212.7K	201.6K	193.9K
NV	270.8K	260.0K	249.1K	240.5K
NY	1703.9K	1651.0K	1599.8K	1560.2K
OH	1105.4K	1055.8K	1002.2K	965.3K
OK	497.5K	462.7K	438.7K	420.3K
OR	398.0K	389.1K	375.4K	363.5K
PA	1301.3K	1255.7K	1211.8K	1173.9K
RI	91.7K	86.7K	81.4K	77.3K
SC	666.4K	639.1K	616.8K	600.4K
SD	124.3K	121.8K	117.9K	113.5K
TN	698.0K	666.9K	637.5K	609.2K
TX	2082.1K	1970.8K	1900.9K	1820.9K
UT	208.0K	201.6K	194.4K	185.8K
VA	1001.4K	955.6K	914.1K	886.3K
VT	116.6K	111.6K	102.7K	99.3K
WA	760.7K	737.5K	712.0K	681.1K
WI	568.2K	546.0K	523.4K	500.6K
WV	246.0K	225.0K	207.5K	190.4K
WY	99.1K	101.3K	101.1K	97.7K

Medicare Advantage Penetration Rate by State and Year				
State	2020	2021	2022	2023
AK	2.0%	2.4%	2.7%	2.9%
AL	49.4%	54.6%	58.6%	61.9%
AR	32.2%	36.7%	40.4%	46.2%
AZ	46.4%	49.2%	51.5%	53.5%
CA	50.8%	52.6%	54.1%	55.6%
CO	48.0%	50.4%	53.1%	55.4%
CT	49.7%	53.4%	57.0%	60.0%
DC	26.8%	30.5%	33.7%	37.5%
DE	20.5%	25.1%	29.2%	32.4%
FL	51.7%	54.3%	56.4%	58.4%
GA	46.8%	51.4%	54.9%	57.8%
HI	54.8%	56.9%	59.0%	60.8%
IA	26.9%	30.0%	33.6%	37.5%
ID	39.9%	43.3%	46.8%	50.0%
IL	33.3%	37.6%	41.8%	44.8%
IN	38.6%	43.5%	47.0%	50.6%
KS	23.2%	27.5%	31.2%	34.2%
KY	41.6%	47.0%	51.9%	55.7%
LA	45.2%	50.5%	54.2%	57.7%
MA	29.9%	32.4%	34.9%	37.5%
MD	15.1%	19.0%	22.0%	25.4%
ME	45.1%	51.2%	55.9%	59.5%
MI	51.0%	55.3%	59.2%	62.8%
MN	52.4%	56.5%	59.4%	62.3%
MO	43.3%	47.6%	51.3%	55.0%
MS	25.4%	31.8%	37.3%	42.2%
MT	22.2%	24.9%	27.5%	29.9%
NC	43.3%	47.8%	52.0%	56.2%
ND	21.7%	24.8%	29.3%	33.9%
NE	21.9%	26.6%	31.0%	34.8%
NH	24.5%	28.8%	32.7%	36.7%
NJ	36.3%	39.5%	41.8%	43.8%
NM	43.4%	46.8%	50.4%	53.1%
NV	44.8%	48.5%	51.7%	54.5%
NY	48.5%	50.9%	53.1%	55.2%
OH	49.7%	52.6%	55.6%	58.0%
OK	27.7%	33.7%	38.1%	41.7%
OR	51.2%	53.2%	55.6%	57.7%
PA	48.7%	51.1%	53.5%	55.8%
RI	53.9%	57.3%	60.8%	63.8%
SC	35.6%	39.8%	43.4%	46.3%
SD	25.0%	28.3%	32.3%	36.3%
TN	45.7%	48.9%	51.9%	54.8%
TX	46.7%	50.8%	53.7%	56.9%
UT	44.4%	47.9%	51.1%	54.6%
VA	27.9%	32.6%	36.8%	40.1%
VT	15.8%	21.6%	29.5%	33.3%
WA	40.1%	43.4%	46.5%	49.8%
WI	49.4%	52.5%	55.5%	58.4%
WV	40.5%	45.8%	50.1%	54.5%
WY	5.3%	6.4%	9.2%	14.6%

FFS Inpatient Discharge Instructions by Post-Acute Care Destination, 2019 Q1 – 2023 Q4

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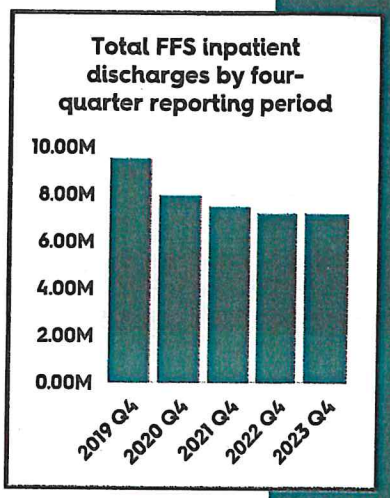
KEY TAKEAWAYS

- After increasing consistently before the COVID-19 pandemic, the percentage of inpatient discharges instructed to receive post-acute care decreased slightly from 52.9% to 52.5% between the 2022 Q4 and 2023 Q4 reporting periods.
- Inpatient discharge instructions to skilled nursing and home health shifted significantly during the pandemic, though the percentage of inpatient discharges instructed to seek skilled nursing remained stable, changing only by 0.1 percentage point from 20.2% to 20.3% between the 2022 Q4 and 2023 Q4 reporting periods. Home health instructions, however, decreased between the 2022 Q4 and 2023 Q4 reporting periods, from 23.0% to 22.5%, a significant contributor to the overall decrease in inpatient discharge instructions.

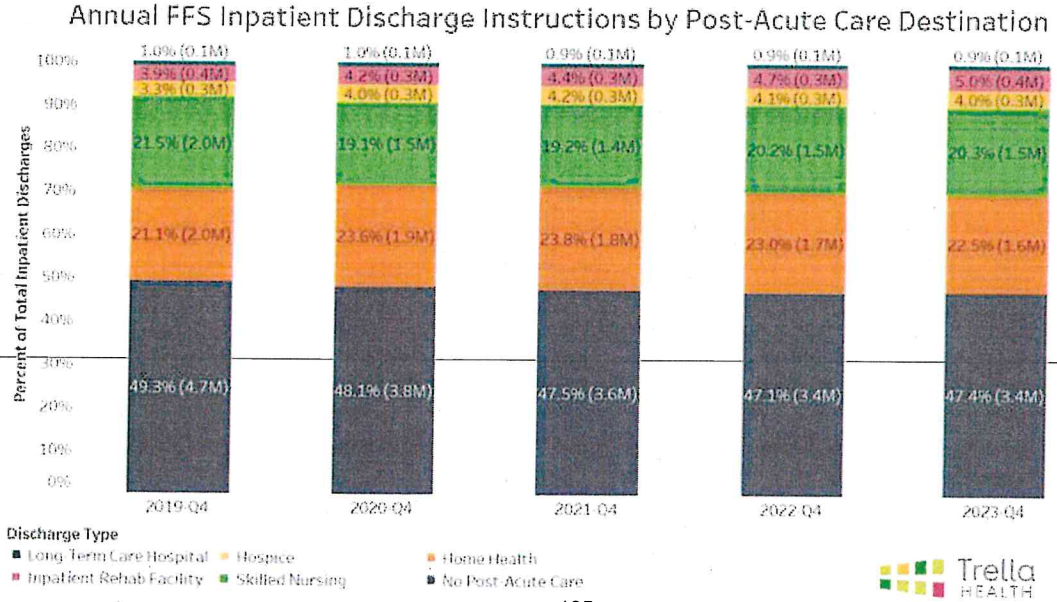


POST-ACUTE DISCHARGE INSTRUCTIONS STABILIZE AFTER TUMULT FROM THE PANDEMIC

Amidst the COVID-19 pandemic, specifically during the initial period of shutdown in 2020, there was a shift in inpatient discharge instructions indicating a heavy preference for at-home care. This resulted in a 2.7 percentage point increase in the percentage of discharges instructed to receive home health care between the 2019 Q4 and 2021 Q4 reporting periods, coinciding with a 2.3 percentage point decrease for skilled nursing instructions.

The minimal movement of inpatient discharge percentages by post-acute care destination between the 2022 Q4 and 2023 Q4 reporting periods suggests a return to the stability typically observed in years without a global pandemic.

However, the instructional rate for inpatient discharges to skilled nursing remains below pre-pandemic levels and home health instructions remain above pre-pandemic levels, leaving the possibility of future movements.



PAC Adherence and Instructional Variation by State, 2019 Q1 – 2023 Q4

Trella HEALTH

KEY TAKEAWAYS

- The portion of inpatient discharges with post-acute care instructions changed by less than one percentage point for 35 states between the 2022 Q4 and 2023 Q4 reporting periods.
- Little movement in inpatient discharges with post-acute care instructions between the 2022 Q4 and 2023 Q4 reporting periods across all states indicates a stabilized PAC industry after the COVID-19 pandemic.
- Adherence to inpatient discharge instructions between the 2022 Q4 and 2023 Q4 reporting periods remained consistent for home health, increased for hospice, and decreased for skilled nursing.

Adherence to inpatient discharge instructions (2023 Q4)

71.3% Home Health

91.1% Hospice

84.2% Skilled Nursing

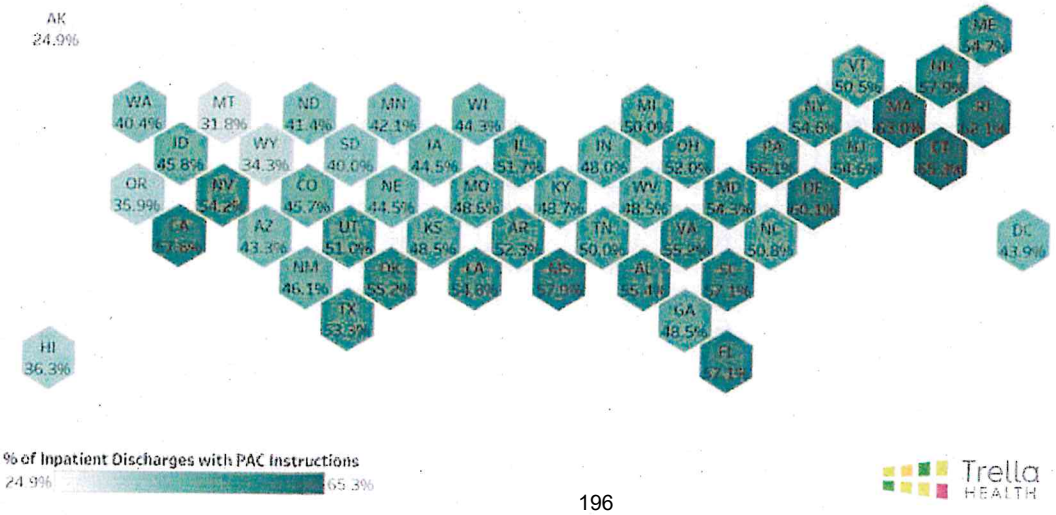
STATE POST-ACUTE INSTRUCTIONAL RATES REMAIN RELATIVELY UNCHANGED

The percentage of inpatient discharges with post-acute care instructions remained extremely stable between the 2022 Q4 and 2023 Q4 reporting periods. States with small populations, where minimal changes in discharge instruction rates can have outsized impacts on the overall rate of inpatient discharge instructions, saw the largest changes.

Adherence to inpatient discharge instructions to home health reversed its trend from the 2020 Q4, 2021 Q4, and 2022 Q4 reporting periods by increasing very slightly (0.8 percentage points) between the 2022 Q4 and 2023 Q4 reporting periods. However, the increase in the adherence rate in the latest reporting period appears to be driven primarily by a decrease in the real number of instructions (1.66M to 1.62M) with relatively consistent adhering discharges (1.17M to 1.16M).

Comparatively, between the 2022 Q4 and 2023 Q4 reporting periods, adherence to skilled nursing instructions decreased, but the number of discharge instructions to skilled nursing increased from 1.45M to 1.46M.

Percent of FFS Inpatient Discharges with PAC Instructions by State



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FFS Inpatient Discharge Instructions by State and Reporting Period

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PAC Instructions			
State	2021 Q4	2022 Q4	2023 Q4
AK	3.5K	3.6K	3.9K
AL	66.0K	63.5K	61.4K
AR	49.3K	48.5K	46.6K
AZ	62.4K	59.4K	61.7K
CA	336.0K	348.8K	365.2K
CO	39.6K	38.8K	38.6K
CT	55.3K	50.9K	49.5K
DC	12.6K	11.0K	10.0K
DE	20.9K	20.4K	21.3K
FL	337.0K	339.3K	347.1K
GA	99.5K	95.7K	91.8K
HI	6.4K	6.1K	6.3K
IA	37.5K	34.9K	33.3K
ID	14.2K	13.4K	13.8K
IL	171.6K	165.9K	164.4K
IN	88.3K	85.5K	81.9K
KS	44.6K	41.7K	40.8K
KY	58.9K	54.6K	52.3K
LA	63.1K	61.0K	58.1K
MA	149.0K	143.2K	146.9K
MD	85.5K	85.2K	85.3K
ME	15.1K	13.1K	13.3K
MI	120.1K	109.5K	101.8K
MN	48.2K	44.1K	44.8K
MO	83.7K	78.5K	74.7K
MS	51.4K	49.4K	47.6K
MT	9.4K	8.6K	8.6K
NC	119.5K	108.8K	104.6K
ND	11.9K	11.0K	11.5K
NE	24.8K	23.0K	23.7K
NH	25.2K	23.1K	23.0K
NJ	126.7K	125.5K	125.1K
NM	15.8K	15.1K	15.2K
NV	37.8K	37.0K	37.9K
NY	232.0K	228.5K	229.0K
OH	152.6K	142.3K	139.1K
OK	59.9K	57.7K	57.8K
OR	23.2K	20.9K	21.8K
PA	199.8K	186.6K	186.4K
RI	14.2K	12.8K	12.7K
SC	77.9K	77.1K	78.3K
SD	13.5K	13.0K	12.8K
TN	89.4K	86.6K	84.9K
TX	292.3K	294.7K	287.7K
UT	22.2K	21.3K	20.8K
VA	118.4K	114.1K	113.6K
VT	9.0K	7.9K	7.5K
WA	49.5K	47.9K	49.1K
WI	53.3K	49.3K	49.6K
WV	30.9K	30.6K	28.5K
WY	4.5K	4.3K	4.4K

No-PAC Instructions			
State	2021 Q4	2022 Q4	2023 Q4
AK	10.4K	10.9K	11.8K
AL	54.6K	50.9K	49.4K
AR	48.1K	46.3K	42.4K
AZ	78.1K	74.4K	80.6K
CA	263.0K	266.7K	268.7K
CO	45.1K	44.0K	45.9K
CT	27.4K	26.1K	26.4K
DC	13.4K	12.7K	12.7K
DE	14.5K	13.5K	14.1K
FL	254.4K	258.3K	261.2K
GA	102.9K	98.3K	97.2K
HI	10.1K	10.4K	11.0K
IA	43.2K	41.9K	41.6K
ID	16.8K	15.7K	16.3K
IL	160.4K	148.9K	153.8K
IN	95.7K	88.2K	88.8K
KS	47.6K	44.4K	43.4K
KY	60.8K	55.3K	55.0K
LA	54.7K	51.0K	48.0K
MA	87.5K	83.4K	86.2K
MD	72.6K	69.5K	71.9K
ME	12.5K	11.2K	11.1K
MI	118.9K	106.2K	102.0K
MN	65.5K	60.3K	61.6K
MO	84.7K	79.2K	78.9K
MS	42.6K	37.9K	34.5K
MT	19.5K	18.6K	18.4K
NC	111.8K	103.0K	101.4K
ND	17.5K	17.6K	16.3K
NE	29.1K	28.3K	29.6K
NH	16.7K	15.8K	16.7K
NJ	102.6K	100.2K	103.9K
NM	20.3K	18.0K	17.8K
NV	34.0K	32.9K	32.1K
NY	198.0K	191.0K	190.8K
OH	135.8K	123.0K	128.5K
OK	50.9K	46.4K	46.9K
OR	39.3K	39.2K	39.0K
PA	150.4K	142.9K	145.9K
RI	8.7K	7.8K	7.7K
SC	57.1K	55.5K	58.9K
SD	20.3K	18.8K	19.2K
TN	88.7K	83.9K	84.9K
TX	263.3K	253.9K	252.3K
UT	20.2K	20.3K	19.9K
VA	94.7K	90.6K	92.1K
VT	7.8K	7.0K	7.4K
WA	75.9K	73.3K	72.5K
WI	65.4K	62.5K	62.4K
WV	31.2K	29.5K	30.3K
WY	9.8K	9.4K	8.4K

% Discharges w/ PAC Instructions			
State	2021 Q4	2022 Q4	2023 Q4
AK	25.1%	24.8%	24.9%
AL	54.7%	55.5%	55.4%
AR	50.6%	51.2%	52.3%
AZ	44.4%	44.4%	43.3%
CA	56.1%	56.7%	57.6%
CO	46.7%	46.9%	45.7%
CT	66.9%	66.1%	65.3%
DC	48.4%	46.5%	43.9%
DE	59.1%	60.2%	60.1%
FL	57.0%	56.8%	57.1%
GA	49.2%	49.3%	48.5%
HI	38.8%	37.0%	36.3%
IA	46.4%	45.5%	44.5%
ID	45.8%	46.0%	45.8%
IL	51.7%	52.7%	51.7%
IN	48.0%	49.2%	48.0%
KS	48.4%	48.4%	48.5%
KY	49.2%	49.7%	48.7%
LA	53.6%	54.4%	54.8%
MA	63.0%	63.2%	63.0%
MD	54.1%	55.1%	54.3%
ME	54.8%	54.0%	54.7%
MI	50.3%	50.8%	50.0%
MN	42.4%	42.2%	42.1%
MO	49.7%	49.8%	48.6%
MS	54.7%	56.6%	57.9%
MT	32.6%	31.6%	31.8%
NC	51.7%	51.4%	50.8%
ND	40.4%	38.4%	41.4%
NE	46.0%	44.8%	44.5%
NH	60.2%	59.4%	57.9%
NJ	55.2%	55.6%	54.6%
NM	43.8%	45.6%	46.1%
NV	52.6%	53.0%	54.2%
NY	54.0%	54.5%	54.6%
OH	52.9%	53.6%	52.0%
OK	54.1%	55.4%	55.2%
OR	37.1%	34.8%	35.9%
PA	57.0%	56.6%	56.1%
RI	61.9%	62.0%	62.1%
SC	57.7%	58.2%	57.1%
SD	39.9%	40.8%	40.0%
TN	50.2%	50.8%	50.0%
TX	52.6%	53.7%	53.3%
UT	52.2%	51.2%	51.0%
VA	55.6%	55.7%	55.2%
VT	53.4%	52.9%	50.5%
WA	39.5%	39.5%	40.4%
WI	44.9%	44.1%	44.3%
WV	49.8%	50.8%	48.5%
WY	31.6%	31.1%	34.3%

Voices of Experience:
Post-Acute Care Leaders on Trends, Challenges, and Opportunities

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THEME 4:
TECH-ENABLED CARE: THE FUTURE OF POST-ACUTE EXCELLENCE

Technology is revolutionizing post-acute care. Remote patient monitoring, AI, and automation are just a few of the tools that are transforming how care is delivered. These technologies can help providers overcome workforce shortages, improve care coordination, enhance patient engagement, and drive innovation. Embracing technology is no longer optional; it's essential for staying competitive and delivering high-quality care in the evolving post-acute landscape.

"Technology has become a real ally in healthcare. Solutions like Trella Health's targeting capabilities are invaluable for our limited sales force, helping us focus on where we can make the biggest difference for patients."

– Randy Rusche, Director Business Development, AdventHealth

"We are strategically integrating AI to automate tasks and enhance clinical decision-making. Our goal is to elevate patient outcomes, optimize resource allocation, and foster a better work-life balance for our team."

– Krystal Cruz, Chief Strategy Officer, Parx Home Health Care

THEME 5:
THE HOSPICE CARVE-IN EXPERIMENT: LESSONS LEARNED AND FUTURE IMPLICATIONS FOR HOSPICE CARE

The termination of the hospice carve-in component of the Value-Based Insurance Design (VBID) model has raised important questions about the future of hospice care. While the experiment aimed to improve care coordination and reduce costs, it faced challenges in implementation and uptake. The lessons learned by CMS from this experiment will be crucial in shaping future models of hospice care within MA plans, as the industry continues to adapt to the growing prevalence of MA.

"As is typical, these proposed changes [to the hospice carve-in model] will likely face negotiation and revision before ultimately being implemented. We've seen this pattern before – anticipation, followed by back-and-forth discussions, minor adjustments, and finally, the new regulations become our reality."

– Randy Rusche, Director Business Development, AdventHealth

"Value-based care in hospice is gaining traction. I think CMS will continue exploring its potential in hospice, and that trend isn't going away."

– Aaron Swift, Regional Manager of Business Development, Sentara Healthcare

Voices of Experience:
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THEME 3:
REIMAGINING THE POST-ACUTE WORKFORCE: STRATEGIES FOR ATTRACTING AND RETAINING TOP TALENT

The post-acute care industry has grappled with a severe workforce shortage. Significant decreases in healthcare labor supply in the immediate aftermath of the COVID-19 pandemic caused increased competition among healthcare agencies for limited staff. To overcome this crisis, providers need to rethink their approach to attracting and retaining talent. This includes offering competitive pay and benefits, investing in training and development, and creating a more supportive and flexible work environment.

"We're heavily focused on technological efficiencies, especially through RPA and workflow automation. Automating tasks like referrals and EMR data entry frees up our staff to focus on what matters most – providing quality care."

– Luke James, President, VitalCaring Group

"We've revolutionized our care delivery model to maximize clinician capacity. By embracing innovative approaches like remote virtual visits and empowering clinicians to work at the top of their license, we're tackling the staffing shortage head-on."

– Aaron Swift, Regional Manager of Business Development, Sentara Healthcare

"We are committed to investing in individuals who are eager to enter the home healthcare sector, emphasizing the value of flexibility and patient safety at home. Our focus is on effectively managing this initiative within our agencies to ensure a positive and enriching experience for clinicians joining this workforce."

– Krystal Cruz, Chief Strategy Officer, Parx Home Health Care

"Our approach to staffing challenges is multifaceted: leveraging technology to accelerate recruitment process and matching, reducing documentation and administrative tasks, and implementing local initiatives to enhance retention. This combined strategy should prove effective in addressing workforce needs."

– Divesh Aidasani, Vice President, Strategy & Operations, BAYADA Home Health Care

Voices of Experience:
Post-Acute Care Leaders on Trends, Challenges, and Opportunities

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To ensure a comprehensive understanding of the current post-acute care landscape, we supplemented the data presented in this report with the perspectives and insights from a select group of post-acute care (PAC) leaders.

Their voices offer a valuable addition to the quantitative analysis, providing a deeper understanding of the qualitative impact of these trends and the strategies leaders are employing to navigate the changing landscape.

THEME 1:
REIMBURSEMENT RATE DILEMMA: ADAPTING TO A NEW FINANCIAL PARADIGM IN POST-ACUTE CARE

The financial sustainability of the post-acute care industry is being tested by fee-for-service reimbursement increases that lag well below recent inflation rates and a Medicare Advantage landscape that continues to grow while reimbursing post-acute agencies at lower rates. These financial pressures are forcing providers to explore innovative optimization solutions to remain competitive, high-quality, and profitable.

"Something's got to evolve. Reimbursement has to go up or companies need to get more efficient. It's probably some combination of both that will ensure the viability of the services in the future."

– David Baiada, CEO, BAYADA Home Health Care

THEME 2:
THE MEDICARE ADVANTAGE IMPERATIVE: ADAPTING TO A CHANGING LANDSCAPE

Medicare Advantage (MA) is rapidly growing and becoming the dominant form of Medicare coverage. This shift presents significant financial challenges for post-acute providers. Patients covered by MA plans constitute more and more of a home health agency's daily census, often pay less than traditional Medicare, and have more complex requirements. To succeed, providers must understand the MA landscape, build relationships with MA plans, and prove their value through high-quality, cost-effective care.

"Medicare Advantage is undeniably growing in the marketplace, but this growth comes at a cost: reduced care quality, shrinking margins, and increased financial pressure on providers."

– James Szymanski, SVP of Sales, Traditions Health

"The rising prevalence of Medicare Advantage, with its tendency to underpay for home health services including CMS' proposed rate cuts on original Medicare, is directly undermining our ability to adequately staff and deliver sustainable care."

– Divesh Aidasani, Vice President, Strategy & Operations, BAYADA Home Health Care

> Continuous innovation in an industry requires strong collaboration. With data-backed insights, we are shaping the future of healthcare together.
>
> – Scott Tapp, CEO, Trella Health

Trella HEALTH

A Note from Scott Tapp
CEO, Trella Health

At Trella Health, we believe in the power of data to foster meaningful change in healthcare. As part of our mission to promote industry-wide performance visibility, I am excited to share the findings of this year's Post-Acute Care Industry Trend Report.

By leveraging Trella Health's unique access to the most recent and complete data from the Centers for Medicare & Medicaid Services, this report analyzes key national and state-level trends, such as Medicare Advantage (MA) enrollment, discharge instructions, utilization rates, and more.

To complement the data-driven insights in this report, we partnered with a select group of post-acute care leaders to gain their firsthand perspectives on trends and challenges shaping the industry today, such as staffing shortages, MA shifts, and leveraging technology.

Plus, this year we deepened our analysis with expanded state-level data, offering a more granular view of trends and performance metrics across different regions.

Below are a few key takeaways from this year's report:

- Medicare Advantage enrollment continues to increase, and MA penetration eclipsed the much-anticipated 50% mark in 2023, hitting 54.7% as of February 2024.
- FFS inpatient discharge instruction rates for home health and skilled nursing continue to inch closer to pre-pandemic levels, though these rates remained more stable than previous year-over-year changes.
- Annualized changes in home health (-3.0% between 2022 Q3 and 2023 Q3 reporting periods) and skilled nursing (-13.8% between 2022 Q4 and 2023 Q4 reporting periods) FFS admissions continue to decrease due to increased MA enrollment.
- Hospice admissions increased by 2.1% between the 2022 Q4 and 2023 Q4 reporting periods. Further, hospice utilization increased to 49.8% in the 2023 Q4 reporting period, four percentage points higher than the 2020 Q4 reporting period. This was due to lower utilization rates during the pandemic when Covid-related deaths were usually not admitted into hospice.

As the industry becomes increasingly complex, more data is needed to understand the full picture. We are constantly diversifying our dataset to include more payer sources and enhance insights across the care continuum. Recently, we increased our medical and pharmacy claims volume by 2x – covering over 255 million patient lives annually. Future investments, such as increased access to MA data, will continue to fuel meaningful insights that drive positive change in healthcare.

Continuous innovation in an industry requires strong collaboration. With data-backed insights, we are shaping the future of healthcare together. Let us know what data points would help your organization achieve its goals.

Sincerely,

Scott Tapp
scott@trellahealth.com

Table of Contents

ABOUT OUR DATA SOURCES

As one of only a few companies in the country deemed both a Qualified Entity by the Centers for Medicare and Medicaid Services and an Innovator under its Virtual Research Data Center Program, Trella Health has access to 100% of Medicare Part A and Part B claims and Medicare Advantage data. The findings presented in this report were derived from Medicare FFS claims data through 2023 Q4, Medicare Advantage claims data through 2021 Q4, Healthcare Cost Report Information System (HCRIS) data available as of July 2024, and Monthly Medicare Enrollment data published by CMS through February 2024.

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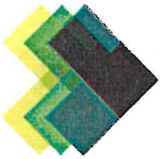

Post-Acute Care Industry Trend Report

2024 EDITION

trellahealth.com | info@trellahealth.com

Attachment G

McKnights Senior Living, Volume 22, Number 2, April 2024

Focus On BRIEFS

» Maturing loans threathen LTC borrowers

Experts are warning that long-term care borrowers could find themselves in a crunch for capital this year as banks tighten lending rules.

"Many conventional lenders are choosing not to offer extensions, putting borrowers in a crunch to find alternatives in a timely manner," Cambridge Realty Capital Managing Director Tony Marino warned in a blog.

Marino said providers would be foolish to expect a lender to continue working with them post-maturity, even if the borrower has had a good past relationship. That was a sentiment echoed by multiple lenders and deal-makers at the eCap Summit in mid-February.

Marino said borrowers should start looking for new lending partners sooner rather than later so they are not forced "to make a decision based on how quickly a new lender can close, rather than what option is best for the facility."

» NIC notes key trends for 2024

This year is likely to be one of price reconciliation, according to Lisa McCracken, NIC's head of research and analytics.

"As transaction activity has dampened in recent years and bid-ask spreads were too large to move deals forward, we anticipate that there will be an industry reset to the reality of current valuations," McCracken said.

She also predicted that buyers may find attractive assets at prices unavailable just a few years ago — and possibly below replacement cost. Depending on Fed actions, she added, investors and borrowers also could expect rate reductions in 2024. The sector also likely will see renewed interest in development following reduced building in 2023.

» Few older adults seek retirement help

An AARP survey recently found that less than one-third of adults 50 and over have engaged a financial professional for retirement planning. Respondents cited issues such as insufficient retirement savings, a high cost of hiring professionals and personal financial management preferences. The Transamerica Center for Retirement Studies told BNN that the older cohort of Generation X has, on average, about $40,000 saved for retirement. Many lower-income households have less because they don't have work-sponsored plans.

Photo: SDI Productions/Getty Images

Assisted living rate increases lower than other settings

Service rates are up across all provider types, but rises are most substantial for home health aides and homemaker services

BY KIMBERLY BONVISSUTO

Although rate increases in assisted living communities were relatively low last year, nationally increasing by 1.4% over 2022, those rates went up by 18.9% in total from 2021 to 2023, according to Genworth's Cost of Care Survey 2023.

"As we look at this year's data, costs are up, but not as drastically as in previous years, especially assisted living facilities," Genworth US Life Insurance President and CEO Jamala Arland said in a statement.

Long-term care service rates increased across all provider types, ranging between 1% and 10%, according to the survey, with the increases most substantial for home health aides and homemakers services.

The 1.4% increase in assisted living in 2023 brought the national median rate for assisted living to $64,200 annually, which works out to $5,350 monthly or $176 daily. The 2021 survey showed that assisted living median rates increased nationally by 4.65% over 2020, for an annual median cost of $54,000.

This compares with a 10% increase over 2021 prices for home health aide services, a 7.14% increase for homemaker services, a 5.56% increase for adult day healthcare services, and a 4.92% increase for a private room or a 4.4% increase for a semi-private room in a nursing home.

By comparison, according to the 2023 report, the national median rate for a private, one-bedroom room in a nursing home was $116,800 annually, and the rate for a semi-private room was $104,025 annually, representing average increases of 4.92% and 4.4%, respectively, since 2022. The national median price of adult day services increased an average 5.56% in 2023 over 2022.

Inflation and housing market trends stabilizing in the post-pandemic era were the top factors contributing to cost increases in assisted living, whereas a shortage of skilled workers was the top contributing factor for nursing homes and home health, according to Genworth.

"With 10,000 baby boomers turning 65 every day until 2030, and seven out of 10 of them likely to need long-term care service and support at some point, there is increased demand for skilled workers in the long-term care space," Arland said. ■

Attachment H

WSU Community Health and Spatial Epidemiology Lab

EASTERN WASHINGTON HEALTH PROFILE - JANUARY 2019

Authors:

Ofer Amram, PhD | Assistant Professor

Solmaz Amiri, DDes | Postdoctoral Research Associate

Anna Crowley | Undergraduate Research Assistant

Jonathan Espenschied, MD | Associate Dean

Reading the report for the first time?
Watch a short video on how to use the interactive components of the report

Do you have questions about the report or would you like to have access to the data? email us at: ofer.amram@wsu.edu

OVERVIEW

The Washington State University Elson S. Floyd College of Medicine and Washington State University Community Health and Spatial Epidemiology Lab in 2018 evaluated the community health status and health issues known to affect individuals and communities in eastern Washington. Researchers compared this region of the state and its distinctly different set of health and social issues to those in western Washington. The results are outlined in the following report.

KEY FINDINGS

- Age-adjusted mortality rates for the 10 leading causes of deaths in Washington were higher in eastern Washington than western Washington.

- Age-adjusted mortality rates for 6 out of the 10 leading causes of death (i.e., Alzheimer's disease, unintentional injuries, chronic lower respiratory diseases, diabetes, suicide, and chronic liver disease and cirrhosis) were higher in eastern Washington when compared to the United States average rates.

- Age-adjusted mortality rates for potentially preventable causes of deaths, such as unintentional injuries, chronic lower respiratory diseases, and diabetes, were higher in eastern Washington than western Washington, as well as when compared to the United States average rates.

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Defining Eastern Washington

There are 39 counties in Washington. Eastern Washington is comprised of 20 counties east of the Cascade Mountains and include Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima Counties.

The total populations of eastern Washington and Washington overall were 1,538,239 and 6,985,464, respectively, in 2015 (U.S. Census).

Counties in eastern and western Washington.

EASTERN WASHINGTON AT A GLANCE

The total population of Eastern Washington and Washington State were, respectively, 1,538,239 and 6,985,464 in 2015 (U.S. Bureau of the Census).

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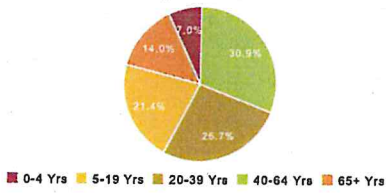
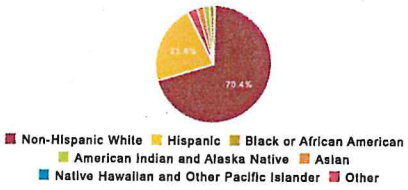
AGE

In 2017, approximately one-third (28%) of residents were under the age of 20. More than half (57%) were between 20 and 64 years of age, and 15% were 65 or older.



RACE

The majority of residents was Non-Hispanic White. The second largest ethnic group was Hispanics, comprising approximately 22% of the population. Eight percent of the population was of other races.



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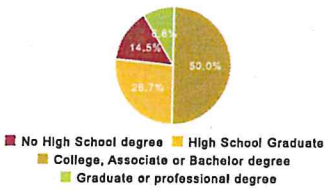
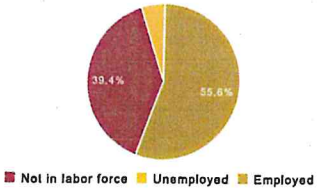
EDUCATION

Approximately 60% of residents, ages 25 and over, attained education beyond high school, with 34% earning a college degree. Twenty-seven percent (27%) of residents reported a high school diploma (or the equivalent) as their highest level of educational attainment. Fewer than 15% of residents reported they had not graduated from high school.



EMPLOYMENT

A large proportion (56%) of residents, ages 16 and over, were employed. Thirty-nine percent (39%) were not in the labor force. Five percent (5%) were unemployed.



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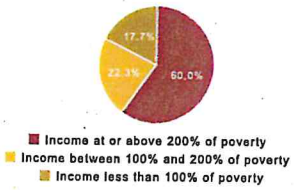
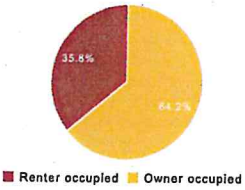
POVERTY

Nearly 18% of the population lived below the poverty level. Forty percent of residents (40%) had incomes less than twice the poverty level.



STABILITY

Sixty-four percent (64%) of households owned their property. Approximately 84% of owner-households moved into their property in 2010 or earlier, while 36% of renter-households lived at the same property since 2010 or earlier.



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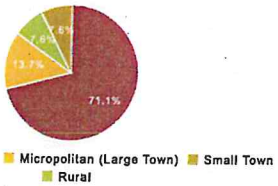
RURAL POPULATION

According to rural urban commuting area (RUCA) codes, 71% of residents lived in metropolitan areas. Fourteen percent of residents (14%) lived in micropolitan or large towns. Individuals living in small towns and rural areas constituted 15% of the population.



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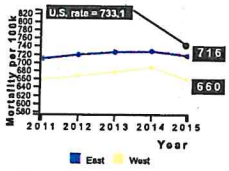
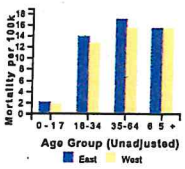
ALL CAUSES OF DEATH

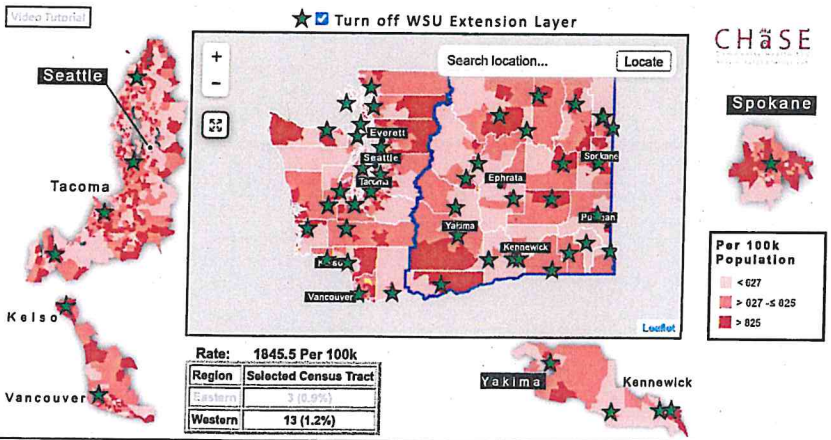
Age-adjusted all-cause mortality rates were 687.4 (95%CI= 681.6 - 693.3) per 100k in Washington State in 2015, lower than the national average of 733.1 (95%CI= 732.2 - 734.0) deaths per 100k

AGE-ADJUSTED ALL CAUSE MORTALITY RATES 2011 - 2015

Age-adjusted all-cause mortality rates in Eastern Washington as compared to Western Washington and to the national average







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PATHS TO DISPARITY

			Rural Urban (RUCA)			Socioeconomic Status(Singh Index)		
U.S. Rate - Rank	Cause of death	ICD-10	Rural Rate	p-value	Significant	More Deprived	p-value	Significant
	All Causes of Deaths	ALL	Lower	0.052	No	Higher	<0.001	Yes
2	Cancer	C00-C97	Lower	0.01	Yes	Higher	<0.001	Yes
1	Heart Disease	I00-I09,I11,I13,I20-I51	Lower	0.783	No	Higher	<0.001	Yes
6	Alzheimer's disease	G30	Lower	<0.001	Yes	Lower	0.545	No
4	Unintentional Injuries	V01-X59,Y85-Y86	Higher	0.022	Yes	Higher	<0.001	Yes
3	Chronic Lower Respiratory Diseases	J40-J47	Higher	0.407	No	Higher	<0.001	Yes
5	Cerebrovascular diseases(Stroke)	I60-I69	Higher	0.918	No	Higher	<0.001	Yes
7	Diabetes	E10-E14	Lower	0.249	No	Higher	<0.001	Yes
8	Suicide	U03,X60-X84,Y87.0	Higher	0.005	Yes	Higher	<0.001	Yes
9	Chronic liver disease and cirrhosis	K70,K73-K74	Lower	0.732	No	Higher	<0.001	Yes
10	Flu - Pneumonia	J09-J18	Lower	0.865	No	Higher	<0.001	Yes
-	Overdose	X40-X44, X60-X64, X85, Y10-Y14	Lower	0.009	Yes	Higher	<0.001	Yes

*RUCA = RUCA (rural-urban commuting area) codes use United States census tracts to classify and rural urban differences using measures of population density, urbanization, and daily commuting. RUCA primary codes of 1-3 was classified as metropolitan areas, and RUCA primary codes of 4-10 (micropolitan, small town, and rural areas) was classified as Rural areas.

*Singh Index= Area Deprivation Index (ADI) developed by Dr. Gopal Singh, representing socioeconomic status using 17 different census markers at the level of census tract. ADI was dichotomized into least-deprived to most-deprived areas based on median ADI value.

*Statistical analysis - Independent samples t-test

*P-Value significant at <0.05

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SUMMARY

For the top 10 major causes of death, mortality rates in Eastern Washington are consistently higher when compared to Western Washington.

Age-adjusted mortality rates (per 100,000), both sexes, 2011-2015

Disease	Eastern WA	Western WA	WA	United States
All-causes	716.17	659.79	672.17	733.1
Cancer	158.98*	155.96	156.58	158.50
Heart Disease	146.93	134.50	137.23	168.50
Alzheimer's disease	44.76*	43.45*	43.75	29.40
Unintentional Injuries	45.18*	35.58	37.71	43.20
Chronic Lower Respiratory Diseases	46.65*	37.85	39.82	41.60
Cerebrovascular diseases(Stroke)	37.57	33.40	34.36	37.60
Diabetes	24.53*	20.78	21.61	21.30
Suicide	15.27*	13.98*	14.24	13.30
Chronic liver disease and cirrhosis	13.44*	10.37	11.02	10.80
Flu - Pneumonia	10.97	9.60	9.91	17.80
Overdose	12.40	13.35	13.14	16.30

*Represents rates higher than the national average

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CONCLUSION

Eastern Washington had higher age-adjusted mortality rates for the 10 leading causes of deaths than western Washington. Age-adjusted mortality rates for 6 out of the 10 leading causes of death (i.e., Alzheimer's disease, unintentional injuries, chronic lower respiratory diseases, diabetes, suicide, and chronic liver disease and cirrhosis) were higher in eastern Washington when compared to the United States average rates. Considering that some deaths such as unintentional injuries, chronic lower respiratory diseases, and diabetes can be potentially prevented, efforts should address demographic, socio-economic, and environmental factors that influence mortality rates.

In eastern Washington, nearly 18% of the population lived below the poverty level, while 12% lived below the poverty level in western Washingtonians. Additionally, individuals living in small towns and rural areas constituted 15% of the population in eastern Washington, while only 2% of the population of western Washington lived in small towns and rural areas. Future studies can assess how poverty, rurality, and access to care impact higher rates of mortality in eastern Washington.

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METHODOLOGY

- Age-adjusted adjusted mortality rates were computed using the standard population age distribution of the population of the United States for the year 2000
- Registered deaths for the state were obtained from the Washington State Department of Health, Center for Health Statistics for the years 2011-2015
- Deaths with residential address matching accuracy of 80% or above were included in the analyses

ofer.amram@wsu.edu