LEGACY CARE
HOSPICE

Certificate of Need Application
Establishment of
Medicare/Medicaid Certified Hospice Agency
Thurston County

January 2025

Washington State Department of Health

Certificate of Need Application
Hospice Agency

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

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

Signature and Title of Responsible Officer: Judith Grey MPA RN Judith Grey, MPA, RN Member Email Address: jgreycch@gmail.com	**Date:** January 28, 2025 **Telephone Number:** 201-919-4905
Legal Name of Applicant: Legacy Care Hospice, LLC **Address of Applicant:** 7 Deer Run Rockaway, NJ 07866	**Provide a brief project description:** ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ **Estimated capital expenditure:** $40,000
Identify the county proposed to be served for this project: Thurston County.	

Section 1
APPLICANT DESCRIPTION

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

   The legal name of the applicant is Legacy Care Hospice, LLC (Legacy). Legacy is registered with the Washington Secretary of State.

   The mailing address of Legacy is:
   7 Deer Run
   Rockaway, NJ 07866

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

   Legacy is a Washington State limited liability company organized under chapter 25.15 RCW. Legacy's UBI number is 605 669 557.

   The members of Legacy include Kevin Basara, RN (75%) and Judith Grey, RN, MPA (25%). The members are uniquely qualified to increase trust in, and use of, hospice by Black and Indigenous People of Color (BIPOC) in Thurston County. Mr. Basara is Kenyan and is fluent in both English and Swahili. He has worked in hospice for the past six years in roles including Administrative Director, RN Case Manager, Clinical Manager, and Hospice Clinical Manager.

   Judith Grey, RN, MPA served as the COO and then the CEO of one of the largest and most recognized hospice agencies in New Jersey. This agency successfully served Trenton and similar communities where 20-25% of the community is Black. The agency was sold pre-COVID, and since that time, Ms. Grey has served as the COO and Head of Hospice Operations for two different providers in the NY/NJ metro area. In 2024, Ms. Grey established a consulting firm and provides support to hospice agencies related to compliance and clinical operations. She has proven expertise in new start/licensure operations, QAPI and policy/procedure development.

   Both members have experienced first-hand how trust issues in the BIPOC community impact use of hospice, and how this translates to differences in care for a dying person. The lack of hospice most typically means pursuing more intensive treatments at end of life, including mechanical ventilation, gastronomy tube insertion, hemodialysis, CPR, and multiple ED visits.

Both members are also versed in literature demonstrating the benefit to the BIPOC community of black ownership of hospice. Black ownership of hospice care plays a crucial role in increasing hospice utilization in black communities by tackling mistrust of the healthcare system, providing culturally sensitive care, and facilitating better access to end-of-life services through targeted outreach and community engagement. Studies have shown that this leads to more equitable care for Black patients and their families. Both are committed to realizing the promise of more equitable care.

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

   Questions regarding this application should be sent to:

   Judith Grey, Member
   Legacy Care Hospice LLC
   jgreycch@gmail.com
   201-919-4905 Cell

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).**

   This question is not applicable.

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

   An organizational chart is included in **Exhibit 1**.

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:**
   - **Facility and Agency Name(s)**
   - **Facility and Agency Location(s)**
   - **Facility and Agency License Number(s)**
   - **Facility and Agency CMS Certification Number(s)**
   - **Facility and Agency Accreditation Status**

   Legacy Hospice LLC does not operate any other health care facilities; and neither member has owned or operated (been the licensee) of any hospice.

Section 2
PROJECT DESCRIPTION

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

   This question is not applicable because there is no existing agency.

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

   This question is not applicable.

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

   The name of the planned agency is Legacy Care Hospice LLC. A lease agreement will be provided with the response to request for supplemental information.

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

   According to the CN Program's final hospice agency need calculations, there is no need for additional agency in the County. However, the use rate, or the penetration rate of Thurston County residents choosing hospice is lower than the Statewide rate and is decreasing. This is inconsistent with national trends, and an indicator of access concerns. Further, and while the population is small, Legacy proposes specific outreach and programming to serve people who identify as Black, Indigenous, and/or people of color (BIPOC). According to published Medicare CMS data, the use hospice for these communities for the Black community appears to at least 50% lower than that of the rate of White County residents.

   Legacy is requesting approval under WAC 246-310-290 (12), which states:

   > The department may grant a certificate of need for a new hospice agency in a planning area where there is not numeric need.
   > (a) The department will consider if the applicant meets the following criteria:
   > (i) All applicable review criteria and standards with the exception of numeric need have been met;
   > (ii) The applicant commits to serving Medicare and Medicaid patients; and
   > (iii) A specific population is underserved; or
   > (iv) The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.

In the case of this application, all other review criteria, and standards, with the exception of numeric need are met. Legacy commits to serving Medicare and Medicaid patients. We also will demonstrate that the BIPOC community is underserved.

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

   Yes, Legacy understands that the State's expectation is that we will serve all in the County that seek our services. We welcome the opportunity to be available and accessible to individuals regardless of where they reside in Thurston County.

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

   Legacy's estimated timeline for project implementation is as follows:

Event	Anticipated Month/Year
CN Approval	September 2025
Design Complete (if applicable)	NA
Construction Commenced	NA
Construction Completed (if applicable)	NA
Agency Providing Medicare and Medicaid Hospice Services in the Proposed County	January 2026

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

   The following services will be provided to Thurston County residents:

X Skilled Nursing	X Durable Medical Equipment (contracted)
X Home Health/Care Aide	IV Services
X Physical Therapy (contracted)	X Nutritional Counseling
X Occupational Therapy (contracted)	X Bereavement Counseling
X Speech Therapy (contracted)	X Symptom and Pain Management
X Respiratory Therapy (contracted)	X Pharmacy Services (contracted)
X Medical Social Services	X Respite Care
X Palliative Care	X Spiritual Counseling
X Other (please describe): Music therapy, art therapy, and various cultural therapies.	

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

   Legacy does not propose expanding any existing agency. This question is not applicable.

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

   This question is not applicable.

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

Legacy will provide a full range of hospice services designed to meet the physiological, psychological, social, and spiritual needs of BIPOC people and their families, as well as others choosing our care as they face the end of life and bereavement in Thurston County.

We will have specific outreach to the BIPOC community. Data provided in this CN application confirms the underuse of hospice by this community. 2022 data from the National Hospice and Palliative Care Organization (NHPC) demonstrates that nearly 54% of white Medicare patients used the Medicare hospice benefit compared to 41% of Black Medicare beneficiaries.

The themes from our conversations with community leaders parallel the literature and strongly suggest that underutilization is tied to mistrust of the medical profession and a lack of knowledge about hospice. We have been told locally what we know nationally: that we have to be trusted and be active in the places where the BIPOC community gathers: churches, barber shops, hair salons; etc. Multiple experts note that word of mouth from a trusted source makes a difference. We know that this, along with supporting primary care and oncology providers to be culturally sensitive in guiding families toward making end of life care plans, is the work we need to do.

We expect that we will serve predominantly adults but will have our staff trained and ready to provide care for pediatric patients and their families if so requested.

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

A copy of the letter of intent is included in **Exhibit 2**.

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.

Yes, Legacy will apply for a State in-home services agency license and will seek and secure Medicare certification and a Medicaid contract.

Section 3
NEED
(WAC 246-310-210)

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

   This question is not applicable.

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

   The projected utilization is detailed in **Table 1**:

Table 1
Projected Admissions and Patient Days and Admissions, 2026-2029

Thurston	2026	2027	2028
Admissions	122	214	275
Patient Days	7,294	12,795	16,442
Average Daily Census	20	35	45

For **Admissions**, the assumptions are conservatively based on stopping the declining use rate in Thurston County for all residents and in closing the gap in the BIPOC community.

For **ALOS**, Legacy has assumed the ALOS would be 59.79, which is the Washington State average from the Department's methodology.

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

In Washington State, the need for additional hospice services is determined by the methodology contained in WAC 246-310-290 (7). While the methodology does not identify the need for an additional provider at this time, Legacy identified the following in its evaluation of publicly available data:

- Hospice penetration is calculated by taking deaths in hospice as a percentage of all deaths. As shown in **Table 2**, the use of hospice by all Thurston County residents, regardless of age or race/ethnicity has been trending downward since at least 2019; the rate of decline is most pronounced in the under 65 population (a decline of nearly 40%). Contrary to national trends, statewide use has been decreasing as well. Reduced rates mean that access is somehow constrained and that providers are not available as demand/referrals are made.

Table 2:
Department of Health Methodology
0-64 and 65+ Hospice Penetration Rates By Year and Rate of Change

Age	Region	2019, Based on 2016-2018 Survey Data	2020 Based on 2017-2019 Survey Data	2021 Based on 2018-2020 Survey Data	2022 Based on 2019-2021 Survey Data	2023 Based on 2020-2022 Survey Data	2024 Based on 2021-2023 Survey Data	% change (2019 - 2024)
0-64	Thurston	24.86%	23.20%	20.97%	18.31%	16.10%	15.26%	-38.6% Decrease
	WA State	27.89%	27.41%	25.67%	23.16%	21.09%	20.44%	26.7% Decrease
65+	Thurston	51.68%	50.59%	51.45%	48.11%	46.64%	47.06%	-8.9% Decrease
	WA State	61.56%	60.52%	60.15%	58.07%	56.80%	54.75%	-11.1% Decrease

S*ource: Department of Health Certificate of Need Hospice Methodologies; 2019-2024*

Further confirmation of the underservice in Thurston is demonstrated by the data, depicted in **Table 3**, showing that the penetration rate in Thurston County is consistently below the state rate.

Table 3:
Department of Health Methodology
0-64 and 65+ Comparison of Thurston County and State Penetration Rates

Age	Region	2019, Based on 2016-2018 Survey Data	2020 Based on 2017-2019 Survey Data	2021 Based on 2018-2020 Survey Data	2022 Based on 2019-2021 Survey Data	2023 Based on 2020-2022 Survey Data	2024 Based on 2021-2023 Survey Data
0-64	Thurston	24.86%	23.20%	20.97%	18.31%	16.10%	15.26%
	WA State	27.89%	27.41%	25.67%	23.16%	21.09%	20.44%
	Variance Thurston/State	***12% Lower***	***18% lower***	***22% lower***	***26.5% lower***	***30% lower***	***34% lower***
65+	Thurston	51.68%	50.59%	51.45%	48.11%	46.64%	47.06%
	WA State	61.56%	60.52%	60.15%	58.07%	56.80%	54.75%
	Variance Thurston/State	***19% lower***	***19.5% lower***	***17% lower***	***20.5% lower***	***21.5% lower***	***16.5% lower***

Source: Department of Health Certificate of Need Hospice Methodologies; 2019-2024

Most relevant to this application is the underservice, or BIPOC disparities, within the County. As shown in **Table 4**, 58% of the County is white; yet 95.8% of all Medicare hospice admissions are white. The Black community represents 4% of the County's population, but less than 1% of hospice admissions. In fact, the admissions are so low in the BIPOC community that the penetration rate cannot be calculated. If the Black community's penetration rate were the same as white, expected Medicare deaths in hospice admissions would be 24, not <11. We assume that the under service is as glaringly low in the under 65 population as well.

Table 4
Thurston County Hospice Admissions by Race, 2023

Race	% of Total Population	Hospice Admissions 2023	% of Total Hospice Admissions	Medicare Deaths of Beneficiaries	% of Beneficiary Deaths	Penetration Rate
White	58.2%	1,073	95.8%	2,098	91.0%	51.1%
Black	3.9%	<11	< 1%	47	2.0%	NA
Asian	6.5	24	2.1%	59	2.6%	40.7%
Hispanic or Latino	11.6%	<11	< 1%	11	0.5%	NA
American Indian	1.5%	<11	< 1%	25	1.1%	NA
Other/Non-White	18.3%	23	2%	43	1.9%	53.5%
Unknown	NA	<11	< 1%	23	1.0%	
Total	**100.0%**	**1,120**	**100.0%**	**2,306**	**100.0%**	**48.6%**

Source: Berg Data Solutions

2020 research conducted by Johns Hopkins compared hospice use among Medicare beneficiaries who identified as either Black or White and compared their end-of-life usage of hospice and related services[1]: The research:

> *Examined patients who received hospice care for three or more days in the last six months of life, and if these people had multiple hospitalizations, made any emergency department visits, or were given intensive medical procedures during the same time period. Ultimately, their study population contained 1,212 participants (31.2% Black and 48% female, with a mean age of 81).*
>
> *The researchers found that 34.9% of Black study participants who died used hospice services over the study period, compared with 46.2% of white participants. Black Americans were significantly less likely than white Americans to use three or more days of hospice. Also, Black Americans were more likely to have multiple emergency room visits and hospitalizations, or to undergo intensive treatments in the last six months of life — regardless of the cause of death. This was especially true for noncancer deaths.*

A more recent study compared both hospice use and hospice length of stay by race and ethnicity among Medicaid only individuals and those with dual eligibility for Medicare and Medicaid[2]. As demonstrated in Thurston County data, this study found that non-Hispanic Black and Hispanic decedents had lower rates of hospice use than non-Hispanic White decedents. Legacy's members have experience in specific outreach strategies needed for underserved groups, particularly the BIPOC community.

Further advancing the research cited above, other articles acknowledge this disparity and attribute it to several factors: lack of knowledge of hospice, mistrust and distrust of the medical profession, and underrepresentation of Blacks/African American health care professionals. Unfortunately, the lack of trust means that the terminally ill too often experience otherwise unnecessary emergency room visits and hospital admissions. It also means that families experience additional stress and distance from their loved one. It also adds costs, including both out of pocket, and to the system, and is a less-than-ideal way for end-of-life care to be provided.

To overcome these obstacles and barriers, the members of Legacy have found that hospice providers need to be accepted and embedded within the community and provide outreach in locations where people gather. In addition, being of, and from the community is a benefit. We also need to work with the local health care providers to ensure that patients and their families in need of hospice services know how to access them.

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[1] Johns Hopkins Medicine Newsroom: Study Documents Racial Differences in U.S. Hospice Use and End-of-Life Care Preferences, 10/28/2020

[2] JAMA Health Forum. 2023; 4(12): e234240, "Racial and Ethnic Differences in Hospice Use Among Medicaid-Ony and Dual-Eligible Decedents"

According to Claritas, Thurston County's 2025 population is estimated at nearly 300,000; growing to nearly 306,000 by 2030. While the total population is expected to grow by just over 2% in the next five years, there are segments of the population expected to grow much more rapidly. Specific to this application, it is the non-white populations. As shown in **Table 5**, the Black/African American population is projected to be 12,000, or 4% of the total population in 2025. It is also expected to grow by 22% and reach nearly 5% of the total population (10x faster than the total population) by 2030.

Table 5
Thurston County Population by Race and Ethnicity

	2010	2020	2025 Est	Pct of Tot Pop	Pct Chg. 2020-2025	2030 proj	Pct of Tot Pop	Pct Chg. 2025-2030
Tot. Pop.	**250,823**	**293,311**	**298,937**	**100.0%**	**1.9%**	**305,712**	**100.0%**	**2.3%**
Hispanic	17,485	28,700	34,785	11.6%	21.2%	41,547	13.6%	19.4%
American Indian/Alaskan Native	3,484	4,427	4,597	1.5%	3.8%	4,795	1.6%	4.3%
Asian	13,028	17,237	19,454	6.5%	12.9%	21,930	7.2%	12.7%
Black/African American	6,721	9,386	11,767	3.9%	25.4%	14,401	4.7%	22.4%
Other - Non-White	20,843	47,484	54,587	18.3%	15.0%	62,477	20.4%	14.5%

Source: Claritas

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.

For all the reasons outlined above in Q3, this application is not an unnecessary duplication. Per our conversations with community groups and per our review of each existing agency's website, no agency has specific programming or outreach to BIPOC communities.

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

Legacy Hospice will serve all residents of Thurston County that meet Medicare requirements and choose to be cared for by our Agency.

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

Our specific programming will target the declining use of hospice generally and engagement of the underserved BIPOC communities in the benefits of hospice utilization.

7. **Provide a copy of the following policies:**
    - **Admissions Policy**
    - **Charity Care**
    - **Patient Rights & responsibilities**
    - **Non-discrimination Policy**
    - **Medical Aid in Dying Policy**

The requested draft policies are included in **Exhibit 3**.

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

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

    This information was included in response to Q3, above. For additional context, the Black community in Thurston County, is diverse and has been a part of the County's history since American settlers arrived in 1845. Early Black residents typically worked as laborers, domestic servants, and on steamboats. Some also became business owners, restaurateurs, barbers, or bootblacks. Dr. Thelma Jackson, community activist and educator, published a book in 2022, entitled, *The History of Blacks in Thurston County: 1950-1975* . While meeting with Dr. Jackson recently, she shared with me some of the most surprising revelations from the research. Though the historic roots of this region seem inclusive with George Bush, a Black pioneer, who along with others, settled the first American colony on Puget Sound, these roots were overshadowed in later years by practices that excluded Blacks from having equal access to jobs, housing, and a life free of oppression.

    During that period and still to this day, most Black families in the county lived in the Lacey area. This was presumed to be due to its proximity to the military bases. However, research demonstrated that restrictive racial covenants were on the books in many cities, actively preventing Blacks from finding housing in other parts of our county. The unincorporated land in Lacey had no such covenants and provided an opportunity for Blacks to own homes, work, and raise families. Many of these racist covenants were still on the books as late as 2022 in Thurston County.

The political unrest in East Africa in the 1990s also resulted in new immigrants that had been granted political asylum choosing Thurston County

The Thurston Regional Planning Council's website states that: *Nearly 30% of Thurston County residents is a person of color – identifying as Hispanic, Latino, or a race other than white. Although Thurston County's population has become more diverse, there are many inequities among racial and ethnic communities in our populatio*n.

Per the Regional Planning Council, the median household income for people of color (those identifying as Hispanic, Latino, or a race other than white) has historically been lower than that of white households. This is also the case for household incomes in general. For 2019-2023, 25.4% of households of color made less than $35,000 per year compared to 13% of white households. Household incomes are lowest for householders who identify as American Indian or Alaska Native.[3]

Our target communities, American Indian and Black/African, also have homelessness rates more than double the rate of the total population. While the goal should be to reduce the rate of homelessness across the board, we are prepared, and have experience, providing hospice for the homeless.

The Confederated Tribes of the Chehalis Reservation and the Nisqually Indian Tribe also have significant membership and services in the County; and we look to engaging them to best support their Members.

[3] U.S. Census Bureau, American Community Survey (ACS), 2019-2023

CERTIFICATE OF NEED REVIEW CRITERIA
FINANCIAL FEASIBILITY (WAC 246-310-220)

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

   The requested information is included in **Exhibit 4**. The pro forma includes the staffing, outreach and other costs associated with growing hospice use by the underserved populations as well as meeting the general Thurston County unmet need.

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

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

   A draft Medical Director Agreement is included as **Exhibit 5**. None of the other agreements are relevant to this project.

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

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

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

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

A draft lease will be provided with our response to screening.

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

Table 6: Proposed Capital Expenditure

Line Item	Cost
Office Equipment and Computers/ Communication Devices/ Furniture, including Sales Tax	$35,500.00
Leasehold Improvements/Signage/ Including sales Tax	$4,500.00
Total	**$40,000.00**

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.**

Judith Grey, Member, will be responsible for funding the capital. Included as **Exhibit 6** is a financial letter demonstrating the availability of funds.

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.**

   Startup costs prior to opening are estimated at $79,000.

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

   Judith Grey, member, will be responsible for startup costs.

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

   The fact that our targeted underserved communities choose hospice at low rates, suggests that they are currently using higher-cost health care services (ED visits, extended hospitalizations. Increasing hospice utilization means better care and reductions in total costs and charges for health care at end of life. This is due to the fact that patients enrolled in hospice are less likely to be hospitalized, admitted to intensive care, or undergo unnecessary invasive procedures. A 2022 Journal of the American Medical Association article demonstrated a reduction in total health care expenditures for hospice patients[1]. Per the article:

   > ***Conclusions and Relevance.*** *In this population-based cohort study of community-dwelling Medicare beneficiaries, hospice enrollment was associated with lower total health care costs for the last 3 days to 3 months of life. Importantly, we found no evidence of cost shifting from Medicare to families related to hospice enrollment. The magnitude of lower out-of-pocket spending to families who enrolled with hospice is meaningful to many Americans, particularly those with lower socioeconomic status.*

   Other studies demonstrate, and our experience concurs, that hospice admissions in the last six months of life are correlated with increased patient satisfaction ratings, better pain control, reductions in hospital days, fewer hospital deaths, and fewer deaths occurring with an ICU admission during hospitalization.

[1] *JAMA Health Forum.* 2022;3(2): e215104. doi:10.1001/jamahealthforum.2021.5104

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

Legacy's charges for hospice services will not be determined by its capital expenditures nor its initial pre-opening and operating deficits. As such, the project will not affect the charges for hospice, and, importantly, this project will have no effect on billed rates to patients, providers, or payers.

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 provides the requested information for Legacy.

Table 7 : Estimated Sources of Revenue by Payer

Payer	Percentage of Gross Revenue
Medicare/Medicare Advantage	87%
Medicaid	8%
Commercial/VA/Tricare	4%
Self-Pay/Other	1%
Total	100%

Source: Applicant

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 project does not assume the addition of a County by an existing agency.

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

A listing of the equipment is included below. Equipment is limited to that needed to furnish an office and provide staff with technology and equipment. Details on the specific equipment are included in Table 8 below. Including Thurston County sales tax rates, the estimated cost is $35,500.

Table 8
Equipment List

Item
Desktop, Laptop Computers and Tablets
Cell Phones
Desk, Desk Chairs, and Side Chairs
Conference Table and Chairs
Copy Machine
Staff Amenities: Refrigerator, Microwave, and Coffee Machine

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

This information is included in **Exhibit 6**.

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.

There is no debt financing for this project. This question is not applicable

15. Provide the most recent audited financial statements for:

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

Legacy is a new entity. No audited financial statements exist. The information included in **Exhibit 6** demonstrates the availability of funds for startup. If the Department requires further information, please advise in screening.

CERTIFICATE OF NEED REVIEW CRITERIA
Structure and Process (Quality) of Care (WAC 246-310-230)

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 details the projected FTEs for the first three years of operation for Thurston County.

Table 9: Thurston County Projected FTEs by Year

Staff	2026	2027	2028
Administrator	1.00	1.00	1.00
Medical Director	0.15	0.20	0.25
Clinical Director	1.00	1.00	1.00
Registered Nurse	2.00	3.51	4.50
Hospice Aide	2.50	4.39	5.63
MSW	0.80	1.40	1.80
Chaplain	0.67	1.17	1.50
Alterative Therapists	0.40	0.70	0.90
Intake	0.00	1.00	1.00
Office Manager	0.50	0.75	1.00
Outreach/Engagement	0.50	1.00	1.00
Volunteer Coordinator	0.50	1.00	1.00
PT/OT/SP/RT	*Contracted*		
Dietitian	*Contracted*		
Nurse Practitioner	0.20	0.35	0.45
Total	**10.02**	**17.12**	**21.03**

Source: Applicant

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 question is not applicable.

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

The Members developed the staffing based on experience, and then reviewed successful recent CN decisions in the Puget Sound area to test our assumptions. We also reviewed publicly available Medicare costs reports for agencies in the southern Puget Sound area **Table 10** depicts our projected staff to patient ratio. The ratios included in the table represent the average ratio across the three-year projection period.

Table 10
Proposed Staff to Patient ADC Ratio

Type of Staff	Staff / Patient Ratio
Skilled Nursing (RN)	1:10
Medical Social Worker	1:25
Hospice Aide	1:08
Chaplain	1:30
Music Therapist	1:50
Nurse Practitioner	1:100

Source: Applicant

In addition to the staffing above, all staff will receive training in community engagement, and will spend time building relationships in the places that the BIPOC community gathers.

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

For the reasons outlined in Q3 above, we are confident in the staffing mix.

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

Legacy is currently identifying and interviewing potential Medical Directors. The Medical Director will be under contract.

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

   A draft contract is included in **Exhibit 5**.

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.)**

   These individuals are not yet known. We anticipate outreach to potential staff even before the scheduled CN decision date in September. In fact our intent is to be licensed in September, which means key staff will be recruited in the summer of 2025.

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

   This question is not applicable.

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

   We understand the workforce challenges in the Southern Puget Sound, and have experienced them elsewhere. We also recognize that if we are to move the needle in BIPOC penetration or use of hospice, we must have trained and competent staff that are culturally sensitive, and demonstrate a strong understanding of the community and historical non-trust issues, and be patient. Our strategies will include:
   - Having job descriptions that are clear in our target community, our expectations and our offer of training.
   - Conducting searches for qualified candidates through the major employment sites and LinkedIn. In addition, we are familiar with the Department of Defense's Patriotic Employer Program and will reach out to the large National Guard and Reserve population in the Southern Puget Sound.
   - Participating in job fairs to increase opportunities, and support and encourage staff interested in part-time only employment.
   - Utilize our relationships with the target communities we serve to access skilled and qualified staff from those communities.
   - Engage with recruiters that specialize in the positions they are hiring for and have success in the Southern Puget Sound.
   - Link with schools, colleges, and universities.
   - Offer competitive compensation packages (including 401K plans with generous matches), paid time off, a wide selection of health insurance options, dental insurance, vision insurance, life insurance, and excellent work/life balance.

- Providing comprehensive in-service training and professional development opportunities

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

Legacy's business hours will be Monday through Friday from 8:30 a.m. to 5:00 p.m. In addition, a Hospice RN will be available 24 hours a day/7 days per week. Families are able to access the hospice nurse after hours by calling the 24/7/365 triage phone line. The on-call RN will have full access to the patient's record, assist them with any concerns, help manage their symptoms, and dispatch a nurse or other team member when any additional care is needed.

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

This question is not applicable.

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

This question is not applicable.

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

This question is not applicable.

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

Legacy will establish ancillary and support services, with at least the following:

- Inpatient Care
- PT/OT/ST/RT/IV therapy
- X-Ray
- Pharmacy
- Durable Medical Equipment
- Medical Supplies

- Laboratory
- Dietary/Nutritionist
- Ambulance
- Biowaste removal
- Specialty therapies

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

This question is not applicable.

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

This question is not applicable.

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

Because of our emphasis, we will want close relationships with the organizations in the County that support the BIPOC community, including churches and the tribes. We will establish working relationships with black owned businesses and black providers.

In addition, we will work with at least : r

- Discharging hospitals, physicians, and coordinators
- Home Health and home care agencies
- Nursing Homes, Assisted Living and Adult Family Homes
- VA
- HMOs and other payers
- Area Aging on Aging

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)

1. **A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or**
2. **A revocation of a license to operate a health care facility; or**
3. **A revocation of a license to practice a health profession; or**
4. **Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.**

No member of the LLC have any history with respect to the items noted in Q18. Our screening will also ensure that neither the selected medical director nor an other licensed staff or contractor has any such history.

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

This project is laser focused on addressing current underuse of hospice by the BIPOC community. it is also directed at reversing the current declining use of hospice in Thurston County. In both cases, we will be "growing the pie" and not impacting existing providers.

Importantly, we know that we need to coordinate with existing providers and build trust, and it is through this coordination that we will reduce the current fragmentation—both within the health care community, but more importantly within the family, that occurs when pursuing more intensive treatments at the end of life.

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.

As noted in response to other questions in this Section, we will outreach and develop partnership to facilitate transitions in care and reduce the current fragmentation and under utilization.

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

There are no facilities or agencies owned or operated by the LLC or by its Members. That said, both members are active in the hospice community and currently hold positions that require expertise in, and teaching of, . compliance, clinical operations and Quality Assurance and Process Improvement.

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

This question is not applicable.

Section 3
CERTIFICATE OF NEED REVIEW CRITERIA
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.

Legacy only considered two options: establish a Medicare certified hospice agency in Thurston County or, after reviewing available data, forego the opportunity.

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

Table 11 provides a comparison of the options considered.

Table 11
Advantages and Disadvantages of Options Considered

	For-go the Opportunity	Undertake the Project Described in this Application
Patient Access to Health Care Services	No ability to address declining penetration rates for all residents and to improve access for the BIPOC community.	Use member expertise to increase penetration rates and improve end of life care for the BIPOC community.
Capital Cost	No capital	Low capital cost.
Legal Restrictions	None	Certificate of Need required
Staffing Impacts	None	Requires investments and training of new staff.
Quality of Care	No improvement	Use member expertise to provide high-quality hospice option for BIPOC residents and the County at large.
Cost or Operation Efficiency	None	Improved access likely to reduce total costs of care for in the last months of life by reducing unnecessary procedures, ED visits, specialty provider visits and hospitalizations.

Source: Applicant

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.**

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 Application references a number of Journal articles citing the need to improve access to hospice generally, and to our target BIPOC community in particular. The Application also references the higher costs (measured as both economic and tolls on the family) associated with persons at end of life pursuing more intensive treatments at end of life, including mechanical ventilation, gastronomy tube insertion, hemodialysis, CPR, and multiple ED visits. Black ownership in hospice care should change the trajectory in Thurston County by tackling mistrust of the healthcare system, providing culturally sensitive care, and facilitating better access to end-of-life services through targeted outreach and community engagement. These are improvements that the Department of Health understands and values.

Hospice Agency Superiority

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

Legacy is the only applicant. This question is not applicable.

Multiple Applications in One Year

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

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

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

   Legacy is not submitting any other applications.

Exhibit 1 – Organizational Chart

Legacy Care Hospice LLC Organizational Chart

Legacy Care Hospice LLC

Kevin Basara 75%
Judith Grey 25%

Exhibit 2 – Letter of Intent

LEGACY CARE
HOSPICE

December 28, 2024

Eric Hernandez, Program Manager
Certificate of Need Program
Via email: eric.hernandez@doh.wa.gov; DOH HSQA CHS CON <CN@doh.wa.gov>

Dear Mr. Hernandez:

Please accept this letter as Legacy Care Hospice, LLC's Letter of Intent to establish a Medicare certified/Medicaid eligible hospice agency. Per WAC 246-310-080, the following information is provided:

1. A Description of the Extent of Services Proposed:
Legacy Care Hospice, LLC proposes to establish a Medicare certified/Medicaid eligible hospice agency.

2. Estimated Cost of the Proposed Project:
The estimated cost of the project is $40,000.

3. Description of the Service Area:
The primary service area for the hospice agency will be Thurston County.

Should you have any questions, please contact Judith Grey our consultant at 201-919-4905.

Sincerely,

Docusigned by
Basara

Kevin Basara, RN CHPN
Principal

Exhibit 3 – Draft Policies & Procedures

DRAFT ADMISSION CRITERIA AND PROCESS

Policy No. 1-009

PURPOSE

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

POLICY

Legacy Care Hospice will admit any patient with a life-limiting illness that meets the admission criteria.

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

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

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

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

Legacy Care Hospice reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Legacy Care Hospice cannot meet his/her needs.

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

Admission Criteria

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

2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified

individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.

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

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

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

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

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

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

9. The patient must reside within the geographical area that the Legacy Care Hospice services.

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

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

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

PROCEDURE

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

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

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

   A. Patient's geographical location

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

C. Hospice personnel's education and experience

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

E. Urgency of identified need for assessment

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

   A. Such notification and approval will be documented.

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

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

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

   B. Explain the patient's rights and responsibilities and grievance procedure. (See "Bill of Rights" Policy No. 9-005.)

   C. Provide the patient with a copy of Legacy Care Hospice notice of privacy practices.

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

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

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

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

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

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

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

   A. Level of services required and frequency criteria

B. Eligibility (according to organization admission criteria)

C. Source of payment

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

   A. Nature and goals of care and/or service

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

   C. Access to care after hours

   D. Costs to be borne by the patient, if any, for care

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

   F. Safety information

   G. Infection control information

   H. Emergency preparedness plans

   I. Available community resources

   J. Complaint/grievance process

   K. Advance Directives

   L. Availability of spiritual counseling in accordance with religious preference

   M. Hospice personnel to be involved in care

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

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

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

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

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

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

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

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

15. The hospice registered nurse will complete an initial assessment during this visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment" Policy No. 1-013)

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

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No.1-014)

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

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

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

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

    A. Patient

    B. Physician

    C. Referral source (if not physician)

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

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

24. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Executive Director/Administrator will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal

organization's recommendation. The patient and family/caregiver, as appropriate, and physician will be involved in deliberations about the denial of care or conflict about care decisions.

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

DRAFT CHARITY CARE
Policy No. 5-017

PURPOSE

To identify the criteria to be applied when accepting patients for charity care.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria without delay. In addition, the patient's ability to pay for services will be evaluated for state of federal assistance programs.

Legacy Care Hospice will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The organization will consistently apply the charity care policy.

PROCEDURE

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

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

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

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

5. When financial declarations reveal the patient is able to make partial payment for services, the Executive Director will determine the sliding-fee schedule to be implemented.

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

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

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

DRAFT BILL OF RIGHTS

Policy No. 9-005

PURPOSE

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

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights and responsibilities as described. A patient, who has not been judged to lack legal capacity, may designate someone (surrogate decision maker), to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

If the patient has been judged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction:

1. The rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf, OR

2. The patient may exercise his or her rights, or designate a legal representative to exercise his or her rights to the extent allowed by court order.

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

PROCEDURE

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

   A. Have his or her property and person treated with respect.

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

   C. Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.

   D. Be advised in advance of the right to participate in planning the care or service and in planning changes in the care and service; hospice patients have the right to refuse care or treatment.

E. Be involved in developing his or her hospice plan of care.

F. Refuse care or treatment.

G. Choose his or her attending physician.

H. Have a confidential clinical record maintained by the organization. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.

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

J. Access to care/service is based upon nondiscrimination.

K. Have communication needs met.

L. Receive information about the services covered under the hospice benefit.

M. Receive information about the scope of services that the hospice will provide and specific limitations on those services.

N. Be advised that the Hospice Organization complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and how such rights are implemented by the organization.

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

P. Receive written information describing the organization's grievance procedure which includes the contact information, contact phone number, hours of operation, and mechanism(s) for communication problems. The program shall describe in writing patient and family responsibilities and the mechanism to file a grievance and obtain a receipt that the information has been received by the patient or family.

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

R. Receive information addressing any beneficial relationship between the organization and referring entities.

S. Be informed verbally and in writing of any changes in payment information as soon as possible, but no later than 30 days from the date that the organization becomes aware of the change.

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

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

V. Be assured that the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

2. The patient and family/caregiver responsibilities will be explained upon admission and as needed. The patient and family/caregiver are responsible for:

   A. Being fully informed by a physician of his or her medical condition, unless medically contraindicated and to be afforded the opportunity to participate in the planning of his or her medical treatment, including pain and symptom management and to refuse to participate in experimental research.

   B. Cooperating with the primary doctor, program staff and other caregivers.

   C. Advising the program of any problems or dissatisfaction with patient care.

   D. Notifying the program of address or telephone changes or when unable to keep appointments.

   E. Providing a safe environment in which care can be given. In the event that conduct occurs such that the patient's or staff's welfare or safety is threatened, service may be terminated.

   F. Obtaining medications, supplies and equipment ordered by the patient's physician if they cannot be obtained or supplied by the program.

   G. Reporting unexpected changes in the patient's condition.

   H. Understanding and accepting the consequences for outcomes if the care, services and/or treatment plan are not followed.

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

4. The Bill of Rights statement will be explained and distributed to the patient prior to the initiation of organization services. This explanation will be in a language or communication method he/she can reasonably be expected to understand.

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

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

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

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

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

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

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

9. All organization personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually.

DRAFT NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS

Policy No. 8-013

PURPOSE

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

POLICY

In accordance with Title VI of the Civil Rights Act of 1964, Section 1157 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Legacy Care Hospice will, directly or through contractual or other arrangement, admit and treat all persons without regard to race, color, or place of national origin in its provision of services and benefits, including assignments or transfers within facilities.

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

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

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

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

PROCEDURE

1. The Section 504/ADA Compliance Coordinator designated to coordinate the efforts of Legacy Care Hospice to comply with the regulations will be the Executive Director/Administrator. Contact the Executive Director/Administrator at _____ (insert telephone number.)

2. Legacy Care Hospice will identify an organization or person in their service area who can interpret or translate for persons with limited English proficiency and who can disseminate information to and communicate with sensory impaired persons. These contacts will be listed and kept in the policy manual. (See "Facilitating Communication" Policy No. 9-006.)

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

4. The following statement will be posted in the reception of the organization in English and at least the top 15 non-English languages spoken in the state: "Patient services are provided without regard to race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, or national origin."

5. The following statement will be printed in English and other non-English languages spoken in the state on brochures, other printed public materials and in a conspicuous location on the organization's web site accessible from the home page: "Patient services are provided without regard to race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions) , sexual orientation, disability (mental or physical), communicable disease, or national origin."

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

7. Grievances must be submitted to the Section 504 Coordinator within 30 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

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

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

10. The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

11. The grievant may appeal the decision of the Section 504 Coordinator by filing an appeal in writing to Legacy Care Hospice within 15 days of receiving the Section 504 Coordinator's decision.

12. Legacy Care Hospice will issue a written decision in response to the appeal no later than 30 days after its filing.

13. The Section 504 Coordinator will maintain the files and records of Legacy Care Hospice relating to such grievances.

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

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

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

DRAFT MEDICAL AID IN DYING
Policy No. 9-018

PURPOSE

To provide general guidelines for supporting hospice patients who live in a state with legal **Medical Aid in Dying** (MAID) regulations and who express interest in this option or who acquire life-ending medication per their state regulations.

POLICY

Legacy Care Hospice recognizes the patient's right to make a choice that fits their own personal goals of care, values and beliefs. That right extends to the legal right under various state laws such as The Washington Death with Dignity Act, Initiative 1000 to end their lives with prescribed medication. No patient will be denied services based on their interest in pursuing MAID.

Current hospice patients who express interest in this type of care will be given the information available on the state website. Legacy Care Hospice doesn't take an active role in MAID by qualifying a patient, prescribing life-ending medications or physically assisting the patient in taking any life ending medications. Legacy Care Hospice does recognize and respects an individual's right to access aid through the law. Any Legacy Care Hospice employee/volunteer may choose to request a reassignment if providing care to a patient considering MAID is within their personal ability, values and beliefs.

PROCEDURE

1. Once a Legacy Care Hospice employee confirms that the patient has life-ending medications acquired through the MAID Act the employee will request contact information for the provider that qualifies and prescribed the life-ending medications.

2. The Legacy Care Hospice employee will notify the hospice team that the patient has life-ending medication in the home and who the qualifying prescribing provider is for the medical record. The RN Case Manager will record the provider's information in the medical record.

3. The IDG team will follow the same plan of care by the attending physician and hospice medical director.

Exhibit 4- Pro Forma

Hospice ProForma

Legacy Hospice - Thurston County

Legacy Hospice

	Cert Date Anticipated January 1, 2026		
	2026	**2027**	**2028**
Admissions	122	214	275
ALOS	59.79	59.79	59.79
Average Daily Census	20.0	35.1	45.0
Total Days (rounded)	7,294	12,795	16,442
General Inpatient Care	36	64	82
Inpatient Respite Care	73	128	164
Routine Home Care	7,170	12,577	16,162
Continuous Home Care	15	26	33
Total Days by LOC	7,294	12,795	16,441

Revenue

	65% at 1-60 days/35% ALOS > 60 Days	65% at 1-60 days/35% ALOS > 60 Days	65% at 1-60 days/35% ALOS > 60 Days
Medicare	1,489,416	2,613,589	3,357,992
Medicaid	129,299	226,825	291,469
Commercial	64,649	113,413	145,735
Self Pay & Other	17,230	30,223	38,837
Gross Revenue	1,700,594	2,984,050	3,834,033
Contractual Adjustments	(59,521)	(104,442)	(134,191)
Operating Revenue	1,641,073	2,879,608	3,699,842
Avg. Daily Rate	$ 224.99	$ 225.06	$ 225.02
Deductions from Revenue			
Charity Care	(20,462)	(35,894)	(46,124)
Provision for Bad Debts	(32,412)	(56,874)	(73,074)
Deductions from Revenue	(52,874)	(92,768)	(119,198)
TOTAL REVENUE	**1,588,199**	**2,786,840**	**3,580,644**

Patient Care Costs

Salaries and Benefits			
Hospice Employees	571,167	1,004,240	1,289,921
Payroll Taxes and Benefits	119,945	210,890	270,883
Total Salaries and Benefits	691,112	1,215,130	1,560,804
Contracted Services	438	768	986
Pharmacy - Medications & IV Supplies & Lab	48,870	85,727	110,155

	2026	2027	2028
DME Costs (Equipment, oxygen)	64,917	113,876	146,325
Medical Supplies	32,969	57,833	74,313
Other Direct Costs	611	2,144	2,749
General Inpatient Costs	35,961	63,931	81,911
Inpatient Respite Costs	40,315	70,689	90,571
5% R&B Expense	3,623	10,593	13,612
Mileage	9,776	34,315	43,994
Total Patient Care Costs	928,592	1,655,006	2,125,420

	2026	2027	2028
Administrative and Facility Costs			
Salaries			
Administrative Employees	502,400	705,700	749,000
Payroll Taxes and Benefits	105,504	148,197	157,290
Total Salaries and Benefits	607,904	853,897	906,290
Advertising	2,604	9,140	11,718
Auto (cars, gas, parking, tolls) + Admin Mileage	2,532	8,887	11,394
Amortization	5,278	5,278	5,278
Bank svc charges	11	38	49
Payroll svcs & Recruiting	10,752	11,075	11,407
Background Screening/Pre Emp Health	2,797	9,818	12,587
Business Licenses and Permits	794	2,788	3,575
Computer and internet	457	1,605	2,057
Dues & Subs	582	2,043	2,619
Insurance	8,804	30,903	39,620
Legal & Prof fees	37,320	5,214	6,685
Meals and Entertainment	756	2,654	3,402
Office exp and supplies	7,530	26,430	33,885
Other Cost			
Rent & Operating Costs	76,134	78,418	80,771
Repairs/Maintenance/Janitorial	2,613	2,646	2,659
Software	84,000	84,000	84,000
Taxes (Includes B&O and Permits)	29,539	51,833	66,597
Phone	6,222	21,839	27,999
Travel	881	3,092	3,964
Uniforms	276	969	1,242
Miscellaneous	2,799	3,587	4,115
Total Other Admin Costs	282,681	362,257	415,623
Total Administrative Costs	890,585	1,216,154	1,321,913
Total Costs	1,819,177	2,871,160	3,447,333
Income (Loss) from Operations.	(230,979)	(84,319)	133,312

Legacy Balance Sheet

Projected Proforma Balance Sheet

	2026	2027	2028
Assets			
Current Assets			
Cash	435,306	311,983	415,505
Accounts Receivable	163,452	286,812	368,508
Allowance for Doubtful Accounts	(3,269)	(5,736)	(7,370)
Prepaid Rent			
Total Current Assets	595,489	593,059	776,643
Leasehold Improvements	35,807	35,807	35,807
Furniture & Equipment	43,359	43,359	43,359
Accumulated Depreciation/Amortization	(5,278)	(10,556)	(15,834)
Total Property & Equipment	73,888	68,610	63,332
Other Assets			
Security Deposit	6,300	6,300	6,300
TOTAL ASSETS	675,677	667,969	846,275
Liabilities			
Current Liabilities			
Accounts Payable	86,694	133,689	163,373
Payroll Liabilites	49,962	79,578	94,888
Credit Cards Payable	20,000	20,000	20,000
Total Current Liabilities	156,656	233,267	278,261
TOTAL LIABILITIES	156,656	233,267	278,261
Equity			
Members' Contributions	750,000	750,000	750,000
Members' Distributions			
Net Income	(230,979)	(84,319)	133,312
Retained Earnings	(230,979)	(315,298)	(181,986)
TOTAL EQUITY	519,021	434,702	568,014
TOTAL LIABILITIES & EQUITY	675,677	667,969	846,275

Exhibit 5 – Draft Medical Director Agreement

LEGACY CARE HOSPICE
HOSPICE MEDICAL DIRECTOR AGREEMENT

This contractual Agreement is entered into this _____ day of _____, 20_____ by and between **LEGACY CARE HOSPICE, LLC** hereinafter referred to as **"HOSPICE"** and _____, hereinafter referred to as **"MEDICAL DIRECTOR"**.

WHEREAS, the Federal Regulations and this State's Rules and Regulations engage Hospice in the provision of comprehensive Hospice services as defined for the palliation and management of symptoms related to a terminal condition;

WHEREAS, Hospice is required to provide services under the medical direction of a duly licensed physician who serves as the Hospice Medical Director;

WHEREAS, Hospice intends to enter into this Agreement to provide medical direction for its interdisciplinary team(s); to ensure that community physicians have a physician contact on the Hospice staff; and to ensure that patient care meets all regulatory requirements.

NOW, THEREFORE, and in consideration of the mutual covenants, conditions and obligations herein contained, the parties hereby agree as follows:

1. DEFINITIONS

a. "Hospice Interdisciplinary Team" means the team of staff (paid and volunteer) who provide Hospice services. The Hospice Interdisciplinary Team is a medically directed, nurse coordinated, team that is supported by volunteers and ancillary services whose mission is to meet the physical, psychosocial, spiritual and interdisciplinary needs of terminally ill patients, their family members and significant others in close collaboration with a patient's physician.

b. "Palliative Care" means services, treatments and therapies designed to cause relief from symptoms related to a terminal condition.

c. "Plan of Care," means the Interdisciplinary plan developed by the Hospice Interdisciplinary Team, the patient, patient caregiver (individual family member or friend or institution such as a nursing home), and the attending physician. The Plan of Care is the overriding legal medical document related to the treatments and services of a Hospice patient.

d. "Progress Note" means a written statement entered into a patient's medical record by a member of the Hospice Interdisciplinary Team that addresses treatments and/or services related to the goals and objectives in a Plan of Care.

2. TERM OF AGREEMENT

a. The effective date of this Agreement shall be_____. This Agreement will renew automatically for successive of one (1) year terms unless terminated by Hospice or Medical Director in accordance with this Agreement. This Agreement may be amended at any time with the mutual consent of both parties. Either party upon thirty (30) days written notice to the other party may cancel this Agreement.

3. DUTIES OF THE MEDICAL DIRECTOR – shall include but not limited to the following:

a. Providing medical direction on a 24 hour, seven day a week basis for the care and treatment rendered by the Hospice for home based patients and as occasionally needed nursing home based patients.

b. Consulting with attending physician, as requested, regarding pain and symptom management.

c. Consulting with attending physicians to assure a continuum of medical care in the event that the attending physician is unable to respond to the care needs of a patient or is unable to retain responsibility for a patient's care.

d. Reviewing, certifying and re-certifying patient eligibility for Hospice services in accordance with Hospice policies and procedures. From time to time, make a direct visit to re-certify a patient and complete progress note in a timely manner.

e. Serving as a medical resource to any member of the Hospice Interdisciplinary Team through telephone consultation and presence at Hospice Interdisciplinary Team meetings.

f. Working closely with the Clinical Director and Executive Director to promote and maintain continuity of care, assure quality of care and compliance with program policies and procedures as well as Federal and State Regulations.

g. Remaining current in techniques of palliative medicine through medical education both in the form of meetings and home study.

h. Serving on the Professional Relations Team and working to achieve positive relationships with all providers through the provision and promotion of physician and provider education about Hospice and the services of Legacy Care Hospice.

i. As the opportunity arises, providing in-services and/or grand rounds to medical students, resident physicians, nurses and social workers.

j. Participate in the Medicare program and be registered in PECOS system.

k. Participating in the Legacy Care Hospice's QAPI and Compliance committee.

l. Serving as a team member of Legacy Care Hospice's Professional Advisory Committee.

4. RESPONSIBILITIES OF HOSPICE

a. Assessing Continued Eligibility. Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice.

b. Professional Management Responsibility.

- Compliance with Law. Hospice shall retain responsibility as the care provider to all Hospice Patients and family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of the Plan of Care, authorization of all services and management of the care through IDG meetings.

- Management of Plan of Care. Hospice shall retain professional management responsibility to ensure Services are furnished in a safe and effective manner by qualified personnel in accordance with Hospice Patient's Plan of Care.

- Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients.

- Evaluation of Medical Director Services. Hospice shall develop, maintain and conduct an ongoing, comprehensive evaluation of the quality and appropriateness of the provision of Medical Director Services. Such evaluations shall be conducted at least annually.

5. **SERVICES** – Provided by the Medical Director shall be rendered with the express authorization of Hospice, in accordance with program policies and procedures of the Hospice, rules and regulations of the Federal and State Government, Medicare Conditions of Participation and any other applicable regulatory or accrediting agency, in a safe and effective manner by a qualified physician. The standards of medical practice and professional duties of the Medical Director shall be in accordance with standards of healthcare recognized by law and the Hospice. The Medical Director shall comply with all applicable provisions of law and other rules and regulations of any and all governmental authorities relating to licensure and regulation of physicians and the Hospice program.

6. **COVERAGE** - Will be arranged and provided by the Medical Director through the prearranged services of another qualified physician to serve when he/she is absent and not available to carry out his/her duties. Advanced notice of this coverage will be provided to the Clinical Director or Executive Director.

7. **PROFESSIONAL STANDARDS, CREDENTIALS AND QUALIFICATIONS** –

- Professional Standards – Medical Director shall ensure that all services are provided competently and efficiently and shall met or exceed the standards of care of medical services. Medical Director services shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements.

- Credentials – Medical Director represents and warrants that he/she has and will maintain in good standing during the term of this Agreement, licensure as required by state and federal regulations.

- Qualifications – Medical Director agrees to criminal background check performed by Hospice and will be qualified when found not to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals.

- Disciplinary Action – Medical Director represents and warrants that he/she is not under suspension nor subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Medical Director and is not under any formal or informal investigation nor preliminary inquiry by such department or agency for possible disciplinary actions.

- Health Requirements – Upon request, Medical Director will provide to Hospice copies of the following information:
  - Health Screening. Evidence of a health screening within the past year of contract date, confirming a Hepatitis B inoculation series or a signed declination form.
  - Tuberculosis Screening. Evidence of an initial 2-step Tuberculosis screening (or negative Chest X-Ray report for prior positive) and evidence of the results of a tuberculosis screening every twelve months thereafter.

8. **CLINICAL PRIVILEGES -**

a. The Medical Director shall have admitting privileges at one or more acute care and long term care facilities where the Hospice has inpatient and/or respite contracts.

b. The physician (s) who provides coverage for the Medical Director shall have admitting privileges at one or more acute care and long term care facilities where the Hospice has inpatient and/or respite contracts.

9. **EXCLUSIONS** – Medical Director represents and warrants that he/she has not been, at any time, excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid, nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration

law.

10. **CONFIDENTIALITY -** Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice Patients (collectively, "Patient Information") and may be required to disclose certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be entitled to injunctive relief to prevent a breach or threatened breach of this section, in addition to all other remedies that may be available. Following the discovery of a breach of unsecured protected health information (PHI), the Provider is required to notify Hospice of the breach so that Hospice can, in turn, notify the affected individuals. To the extent possible, the Provider should identify such individuals whose unsecured PHI has been, or is reasonably believed to have been, breached. Such notice should be given without unreasonable delay and not later then 60 days following discovery of breach.

11. **COMPENSATION**

☐ Hospice agrees to pay the Medical Director the hourly rate of $_____.

☐ Hospice will reimburse Medical Director per patient visit _____% of the Medicare Allowable Rate.

☐ Hospice will not provide any other benefits of employment to the Medical Director.

12. **INSURANCE -** The Medical Director shall maintain, at his/her own cost, professional malpractice liability insurance with coverage limits not less than $1,000,000 per occurrence.

b. Such insurance shall name Hospice as an "additional insured without separate limits".

b. In addition, The Medical Director shall maintain, at his/her own cost Workers' Compensation coverage, and will provide evidence of active participation in a Worker's Compensation Policy/Program

The Medical Director shall provide Hospice with reasonable proof of such insurances, and shall request in writing, with a copy to Hospice, that the insurance carrier provide Hospice with notice of non-renewal or cancellation of the policy or any decrease in coverage no less than sixty (60) days prior to the effective date of non-renewal, cancellation or decease.

13. **GOVERNING LAW -** This Agreement shall be construed and governed by the parties of the State of Washington, and the invalidity or unenforceability of any provision hereof shall in no way affect the validity or enforceability of any other provisions.

14. **ENTIRE AGREEMENT** - This Agreement shall be construed and governed by the parties and supersedes all prior negotiations and agreements.

15. **MODIFICATION** - This Agreement shall not be modified or amended except by a written document executed by both parties to the Agreement. Any such modification(s) shall be attached hereto.

16. **RELATIONSHIP OF PARTIES –** It is mutually understood and agreed upon that the Medical Director is an independent contractor of Hospice for the purposes of the duties performed under this Agreement.

17. **CONFIDENTIALITY OF AGREEMENT -** Medical Director and Hospice agree that the terms of this Agreement shall be confidential and shall not be disclosed unless both parties mutually agree in writing to any disclosure except as may be required by law.

IN WITNESS WHEREOF, Hospice and Medical Director have duly executed this Agreement on the day and year as noted below:

_____

MEDICAL DIRECTOR (Print Name)

_____

(Signature)

_____

(Date)

_____

HOSPICE EXECUTIVE DIRECTOR (Print Name)

_____

(Signature)

_____

(Date)

Exhibit 6 – Funding Letter

SIMON QUICK
ADVISORS

January 27, 2025

Re: Judith Grey

To Whom It May Concern,

Our client, Judith Grey, has asked me to provide this confidential verification of their investment assets with Simon Quick Advisors, LLC.

As of the date of this letter, Judith Grey maintains accounts for which Simon Quick Advisors, LLC, serves as the investment adviser. As of January 27th, 2025, her accounts have a balance in excess of $2,000,000. These funds are held in accounts at unaffiliated financial institutions under the management of Simon Quick Advisors, LLC.

Please feel free to contact me with any questions.

Sincerely,

Steve Pisano, J.D., AIF®

Chief Compliance Officer

spisano@simonquickadvisors.com

P: 973-525-1045

Disclaimer

Please remember that past performance may not be indicative of future results. Different types of investments involve varying degrees of risk, and there can be no assurance that the future performance of any specific investment, investment strategy, or product (including the investments and/or investment strategies recommended or undertaken by Simon Quick Advisors, LLC, or any non-investment related content, made reference to directly or indirectly in this presentation will be profitable, equal any corresponding indicated historical performance level(s), be suitable for your portfolio or individual situation, or prove successful. Due to various factors, including changing market conditions and/or applicable laws, the content may no longer be reflective of current opinions or positions. Moreover, you should not assume that any discussion or information contained in this presentation serves as the receipt of, or as a substitute for, personalized investment advice from Simon Quick Advisors, LLC ("Simon Quick"). To the extent that a reader has any questions regarding the applicability of any specific issue discussed above to his/her individual situation, he/she is encouraged to consult with the professional advisor of his/her choosing. Simon Quick Advisors is neither a law firm nor a certified public accounting firm and no portion of the newsletter content should be construed as legal or accounting advice. Simon Quick Advisors, LLC (Simon Quick) is an SEC registered investment adviser with a principal place of business in Morristown, NJ. Simon Quick may only transact business in states in which it is registered, or qualifies for an exemption or exclusion from registration requirements. A copy of our written disclosure brochure discussing our advisory services and fees is available upon request.

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