STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

CN20-37

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CERTIFICATE OF NEED PROGRAM
DEPARTMENT OF HEALTH

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

APPLICATION FOR CERTIFICATE OF NEED
HOSPICE PROJECTS
(excludes amendments)

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

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

Signature and Title of Responsible Officer: EmpRes Healthcare Management, LLC, as Manager of Applicant, by Michael Miller, CFO **Date: 01/28/2020**	**Person To Whom Questions Regarding This Application Should Be Directed:** Jamie Brown, Vice President Eden Health/EmpRes Home Services **Telephone Number:** 360-798-8298
Legal Name of Applicant: Eden Hospice at Whatcom County, LLC **Address of Applicant:** 4601 NE 77th Ave., Ste. 300 Vancouver, WA 98662 **Telephone Number:** 360-604-4210	**Type of Project (check all that apply):** [X] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Hospice Agency to Become Medicare Certified/Medicaid Eligible

Project Summary:
Eden Hospice at Whatcom County, LLC intends to operate a Medicare certified and Medicaid eligible Hospice services to residents located in Whatcom County.

Estimated capital expenditure: $0

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

Department of Health
Certificate of Need Program
2725 Harrison Avenue, Suite 500
P 0 Box 47852
Olympia, Washington 98504-7852

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

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

PROCESSING FEE: $21,968

APPLICANT NAME:

DATE OF SUBMISSION: January 15, 2020 CHECK NUMBER

APPLICATION INFORMATION INSTRUCTIONS:

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

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

Department of Health
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501
P O Box 47852
Olympia, Washington 98504Y7852

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

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

- DO NOT bind the application.
- Please number **ALL** pages consecutively.
- All cost projections are to be in non-inflated dollars. Use the current year dollar value for all program data and projections. **DO NOT** inflate these dollar amounts.
- Capital expenditures should not include contingencies. Certificate of Need statutes and regulations allow a 12 percent or $50,000.00 *(whichever is greater)* margin before an amendment to an approved Certificate is required.
- All subsequent correspondence in relation to the application must be submitted with an original and one copy.

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

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

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

January 2020

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EDEN HOSPICE AT WHATCOM COUNTY, LLC CON EXECUTIVE SUMMARY

Eden Hospice at Whatcom County, LLC requests certificate of need (CoN) approval to establish a Medicare-certified and Medicaid hospice agency in Whatcom County to meet Department of Health Need standards for hospice admissions and average length of stay (ALOS) for hospice care. Despite ongoing efforts by existing Whatcom hospice providers, hospice admissions are 4% below expected admissions and ALOS in hospice care is at least 6% below expected ALOS. Providing Whatcom County residents with a choice of two hospices that residents in every other county in Washington State with a population greater than 100,000 residents have, will address this access barrier that projected forward through 2021, results in an evidence-based hospice unmet average daily census (ADC) need is 42 patients.

Eden's hospice will be secular. Presently, patients and their families do not have a *complete* choice with respect to end-of-life care in Whatcom County. The addition of Eden's non-affiliated/secular hospice agency will fill this important void in Whatcom County. Many residents who live a secular lifestyle will prefer a secular or neutral end-of-life experience – Eden hospice will provide this experience. Eden will eliminate critical end-of-life obstacles to hospice care for Whatcom County residents and meet patients' concerns about exercising control over their end-of-life options. As such, the many patients and families who live a secular lifestyle will turn to Eden's end-of-life care. Eden hospice will provide a care option that today simply does not exist in Whatcom County. In Washington, patients who request information about options (or a request for death with dignity assistance) cannot be fully served by a hospice service that is under the umbrella of a Catholic healthcare institution

Today, residents of Whatcom County are entitled to receive information and/or make requests about death-with-dignity, but this right is not available. The fact is, under the Catholic healthcare umbrella, such requests present difficult and defining questions about the purposes and scope of hospice as well as practical complexities for the current hospice programs and their staff. Eden removes the real and perceived concerns for patient and family control over critical end of life decisions. In the current situation, residents fear that their end-of-life care decisions are restricted by not having a choice of hospice alternatives, one religiously affiliated and one secular. A plethora of scholarly, legal and local papers have been written about this topic and how it effects access to hospice services and the care experience. Eden can provide many articles in addition to those supplied in this application.

Eden Hospice at Whatcom County, LLC is wholly owned by EmpRes Healthcare Group, Inc. EmpRes is a 100% employee-owned organization with well-established roots in Whatcom County. It currently has approximately 78 entities in Washington State and regionally including nursing homes, assisted living facilities, home health agencies, home care agencies and Medicare certified hospice agencies. In 2014, EmpRes Healthcare Group acquired an existing home health agency in Whatcom County renaming the agency as EmpRes Home Health of Bellingham, LLC of Whatcom County, LLC. EmpRes also operates Eden Home Care of Whatcom County, LLC and Evergreen at Bellingham, a 122-bed post acute care and long-term care skilled nursing home.

Returning to the overview of the barriers to hospice care for Whatcom County residents, Eden first acknowledges the years of ongoing efforts by the Whatcom Hospice Foundation and the Hospice House and Whatcom Hospice program offered through PeaceHealth St. Joseph Medical Center in supporting residents through the dying process. Barriers to hospice care that cause unmet need are many and range from complex medical conditions with very short life expectancies to medical conditions with much longer terminal prognoses and the resistance by healthcare providers, patients and their families to address the end of life and move from active treatment to accepting the terminal prognosis and move to hospice care. Increasing hospice utilization in terms of both admissions and the length of hospice care to minimum levels for both the statewide average admission rate and the statewide ALOS in hospice care can best be addressed by adding a second community hospice agency in Whatcom County. Other barriers for Whatcom County residents in using hospice services are discussed next.

Absence of Choice: Whatcom County with a projected 2020 population of 212,944 persons is the only county of the 12 counties in Washington State with a population greater than 100,000 persons with only one hospice choice. Both the national literature and local experience document the concern among terminally ill patients and their families about a loss of control in how a patient and family will address dying and this concern has been associated with the real and perceived constraints for PeaceHealth in addressing the Death with Dignity statute in Washington.[1] Since all Medicare certified hospices must have a spiritual program component this "loss of control aspect" causes delay or the rejection of hospice care altogether. However, this represents only one aspect of barriers associated with Choice. For example, EmpRes Home Health has many patients that would more rapidly convert to hospice, but hospice enrollment is currently delayed up to 14 days due to capacity constraints. Eden or another hospice agency would carry out various outreach activities to inform healthcare providers and patients about the availability of hospice services and reduce delays in the enrollment process.

Lower Use of Hospice Services Due to Absence of Choice: This absence of choice has resulted in ***lower*** use of hospice services in Whatcom County than the statewide or nationwide averages. In 2018, Whatcom County admits were 4% *below* the statewide average and 5% *below* the CMS Medicare national rate![2] This variance ***decreased the health*** of hospice patients and ***increased healthcare costs*** for patients, families and insurers.[3] The 2017 hospice agency survey enumerated a hospice daily census unmet Need of just below 35 patients. In 2018, the enumerated unmet Need declined to an average daily census of 30.4 patients due to a decline in the number of hospice patients even though the at-risk population continued to increase. These facts beg for a choice option in Whatcom County.

Lost Opportunity to Meet the Healthcare Triple Aim of Better Health, Better Healthcare and Improved Healthcare Cost Control: In short, the current situation runs counter to Washington's commitment to better health, better health services and controlling healthcare costs. Better health – Appendices 24, 25 and 26 present three of many studies that show reduced emergency room visits and hospital admissions as well as family and caregivers' perception of support associated with earlier enrollment in hospice; better health services – longer ALOS in hospice associated with longer stays in states other than Washington State that lead to higher satisfaction; and lower cost -- see Exhibit 7 prepared by Providence in the 2019 Providence Hospice Clark County application. The previously cited national Melanoma study found that Melanoma patients with 4 or more days of hospice care had end of life costs (2009) of $14,594 compared with $28,923 costs for patients who received no hospice care for a net savings of $14,329 – carrying the savings forward to 2019 at 2% annual inflation yields a per case savings of approximately $17,467 per patient.

Unmet Need Can Be Met! The 35 patient projected average daily census is not disqualifying for applicants in service areas with less than an average 35 patient census if 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 there is a specific underserved population. Eden can meet all other criteria.

Need: Eden Hospice at Whatcom County, LLC will serve Medicare and Medicaid patients as well as having a charity care policy that is consistent with most Washington State hospitals to serve indigent patients. Other counties such as Clark County have found that having a choice of providers along with a robust selection of both

[1] See Appendix 7 for **Realities of End-of-life Issues Confronted** report on the Jan. 17, 2018, standing-room-only public meeting about dying in Whatcom County where 120 persons gathered in a forum to discuss death and dying issues with A first-time-ever panel representing St. Joseph Medical Center and End-of-Life Washington

[2] State rate calculation based on DOH methodology; National rate calculation by Berg Data Solutions**,** LLC

[3] Jinhai Huo, PhD, MD, MP *et al* ("Survival and Cost-Effectiveness of Hospice Care for Metastatic Melanoma Patients", Am Journal Managed Care. 2014;20(5):366-373) studied patients 65 years of age and older with metastatic melanoma who died between 2000 and 2009. They found that the median survival rate was 6.1 months for patients with no hospice care, 6.5 months for patients with one to three days of hospice care, and 10.2 months for patients with four or more days of hospice care. While patients with four or more days of hospice care had longer survival rates, they also incurred lower end-of-life costs. They incurred on average costs of $14,594, compared to the groups who received one to three days of care, and no hospice care at all ($22,647 and $28,923 respectively).

home-based hospice services and inpatient hospice services increases utilization of hospice services. In addition, Eden Hospice, a secular hospice agency with a spiritual component, can provide an alternative for reducing the barriers to accessing hospices for patients fearful about real or perceived "end of life" concerns associated with a sectarian religious owned hospice (PeaceHealth and other religiously sponsored hospitals).

There are many other barriers to deciding to obtain hospice services and patients and families choose enrollment based on a variety of factors from caregivers who they know and at a time when they are ready to decide to select hospice services. Eden Home Health in Whatcom County sees patients recovering from serious illness and thus can employ Eden extensive outreach services to the general population and special populations such as the Lummi Native American Health Clinic as well as other tribal healthcare organizations. Rural and low-income populations also will receive outreach from Eden Hospice. Unity Care NW (that operates a federally qualified health clinic with sites in Bellingham and Ferndale) provides extensive health services in both urban and rural settings. Outreach to the veteran populations will be carried out through Eden's in-home healthcare (as well as other home health agencies) because this population is currently receiving home health services. Patients and families can then choose which hospice service is best suited to their needs and do so at an earlier time in the course of their illness when they can receive the *full* benefits of hospice services.

Financial Feasibility: EmpRes healthcare facilities are already in Whatcom County which minimizes start-up and continuing overhead associated with an independent solo operation thus reducing breakeven levels. Eden Hospice at Whatcom County, LLC will share space with EmpRes Home Health of Bellingham, LLC. For example, there is no capital expenditure associated with the project because the current total of 149 employees in our Home Health agencies have desk phone/computer setups and the field clinicians have company-issued cell phone and table from our equipment inventory. That inventory is sufficient to support the addition of Whatcom hospice staff. The co-shared office location is already wired with secure IT infrastructure. Thus, there is no need for an additional capital expenditure. Provision of working capital is provided through no-interest capital contributions from EmpRes with the source of capital contributions being cash generated from operations backed up by a $40 million line of credit commitment. With EmpRes Home Health of Bellingham, LLC and Evergreen at Bellingham (skilled nursing facility), hospice contracts for occupational therapy, physical therapy and other special therapies are readily available.

Structure and Process of Care: As an established provider in the community, Eden Hospice will work closely with the local hospital, physicians, skilled nursing facilities and other providers to ensure continuity of care while avoiding fragmentation of care. Eden Hospice will leverage its existing community relationships, both inside and outside of the County and add respite options and other relationships necessary to support the hospice patient and family members throughout the course of care and during the period of bereavement following death of the patient.

Cost Containment: There are a variety of cost containment opportunities for an Eden hospice that mitigate against any possible concerns related to a hospice average daily need census that may be slightly below the 35-patient benchmark at the time of CoN filling. By reducing *all* barriers leading to hospice services related to "end of life" concerns, the utilization of hospice services will ***increase,*** and the 35-patient benchmark easily achieved by 2021. In any case, the current average daily census for Whatcom Hospice should be unaffected since patients using Eden Hospice will come from increased admissions and length of stay resulting from hospice choice and new outreach channels as well as population growth.

Regardless of whether the average daily census need is 30, 35 or 40, there are internal cost containment opportunities related with co-location of services. First, in this co-location, minor equipment and remodeling costs can be eliminated as previously noted. Co-location with the home health agency also optimizes the existing relationships between physicians in the community and the hospice service. External cost containment can also be achieved with higher hospice utilization levels due to reduced hospital related costs. As noted in Exhibit 7, a Providence Hospice study showed that Washington State could save over $99 million annually if patients received 5 weeks of hospice care versus no hospice care. The application will further document why the Program should approve this vitally needed hospice service even though the Provisional Unmet Need is below the 35-patient average daily census before addressing the Whatcom County length of stay issue.

I. APPLICANT DESCRIPTION:

A. Provide the legal name(s) of applicant(s).

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

Eden Hospice at Whatcom County, LLC will be the applicant. It is wholly owned by EmpRes Healthcare Group Inc.

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

The applicant is a Washington limited liability corporation.

C. For Existing facilities provide the name and address of owning entity at completion of project

Not applicable.

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

EmpRes Healthcare Group, Inc.
4601 NE 77th Ave., Ste. 300
Vancouver, WA 98662

E. Provide the name and address of operating entity at completion of project same

Eden Hospice at Whatcom County, LLC
316 E McLeod Rd., Ste. 101
Bellingham, WA 98226-6491

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

Please see Appendix 4 for an organization chart showing the organization relationship to related parties.

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

Please see Appendix 8 for a list of the existing organizations.

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

The primary geographic service area of is Whatcom County, Washington.

I. Identify the facility licensure/accreditation status.

The proposed hospice will be licensed as a Washington in-home services agency/hospice and will be Medicare-certified.

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

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

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

The medical director for the proposed hospice is Gilson R. Girotto, license #OP00002078, NPI 1083690333. The medical director job description and qualifications are provided at Appendix 9 and Appendix 10.

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

With regards to search and recruitment activities for the Eden Hospice at Whatcom County, LLC, the medical director is dependent on approval of a certificate of need.

The medical director for the Eden hospice will be under contract.. The Medical Director will be under contract with Eden Hospice at Whatcom County, LLC. Please see Appendix 9 for a copy of draft contract and the proposed medical director job description and position requirements.

Table 1: Eden Hospice Medical Director, Projected FTE % and Compensation

Year	Projected FTE	Annual Compensation Based on Patient Volume
2021	N.A.	$ 34,124
2022	N.A.	$ 77,132
2023	N.A.	$ 118,216

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

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

This is not an existing facility.

II. PROJECT DESCRIPTION

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

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

Eden Hospice at Whatcom County, LLC
316 E McLeod Rd., Ste. 101
Bellingham, WA 98226-6491

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

Approval is sought for establishment of a Medicare-certified and Medicaid-eligible hospice to serve the residents of Whatcom County, Washington.

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

Table 2 below lists the scope of services comprising Medicare hospice and indicates which will be provided directly or will be contracted.

Table 2: Eden Hospice Agency Direct Provided Services or Contracted

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

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

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

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

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

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

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

E. List the equipment proposed for the project:

1. **Description of Equipment Proposed.**

Not applicable. No additional equipment is proposed for the project.

Table 3: **Estimated Equipment Expense Items**

Furnishings	$ 0
Telecommunications	$ 0
Computers/Copiers/Printers	$ 0
Total	$ 0

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

Not applicable. No equipment is being replaced.

F. Provide drawings of proposed project:

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

Please see Appendix F for a single line drawing that shows the current configuration of the office space of the EmpRes Home Health of Bellingham, LLC agency.

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

Please see Appendix 11, a single line drawing showing location of the Eden Hospice at Whatcom County agency.

c. total net and gross square feet of project.

Office space for the proposed hospice is 500 net square feet. Net and gross area are the same for the proposed OMH office space.

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

Completion and Commencement of the project is anticipated on January 1, 2021[4]

a) Patient care

The care of the hospice patient does not take place in the hospital setting but in the patient's home. Since EmpRes Home Health of Bellingham, LLC already cares for a large number of hospice-eligible patients, it is expected that the initial home visits will be undertaken by EmpRes Home Health of Bellingham, LLC staff who are currently working with the same terminally-ill patients in their homes who will be electing the Medicare hospice option.

b) Construction

No new construction is required.

[4] WAC 246-310- 010(13) provides the definition of "commencement" of the project. "Commencement of the project" means whichever of the following occurs first: In the case of a construction project, giving notice to proceed with construction to a contractor for a construction project provided applicable permits have been applied for or obtained within. sixty days of the notice; beginning site preparation or development; excavating or starting the foundation for a construction project; or beginning alterations, modification, improvement, extension, or expansion of an existing building16 In the case of other projects, initiating a health service." [underlining provided]

Project Completion

a) Patient care

Based on WAC 246-310- 010(13) 1 initiation of hospice services will represent project completion on January 1, 2021.

b) Construction

No remodeling will be required.

c) Planning Horizon

The third full year of operation will be 2023.

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

Our Values and Beliefs

Hospice is medical care with an emphasis on pain management and symptom relief for patients with life-limiting illnesses, as well as emotional and spiritual support for patients and those who love and care for them. Eden believes that choosing hospice does not mean that patients or their families and caregivers give up on life. Our Eden multidisciplinary team understands the complexity of issues and feelings that surround hospice care and end of life. Our care process is designed to ***maximize*** our patient's quality of life and support the patient's and caregivers' ability to be in control of end of life decision making. Our caregivers can provide 24-7 on-call support, clinical and skilled care, as well as spiritual and emotional counseling continuing through the bereavement process. Eden believes that through effective and compassionate care our patients can approach the end of life with dignity and comfort.

Symptom Management

Eden Hospice understands that the experience of someone diagnosed with end stage cardiac disease is very different than that of someone with cancer or pulmonary disease. That's why Eden offers symptom management to control symptoms and promote comfort. No matter what the disease or diagnosis, Eden believes in improving the quality of life when quantity is limited.

Our medical directors focus on symptom management and will work with the patients' attending physicians to order appropriate medications. Our philosophy embraces the idea of relieving pain and other symptoms so that patients are in control of their own comfort. Our goal is to make a patient as comfortable as possible.

Supplies & Equipment

Hospice home care medical equipment can dramatically improve the quality of life of those with life-limiting illnesses. Eden Hospice will manage the ordering and delivery process of the necessary equipment. Medical equipment can:

- Improve Mobility
- Make breathing easier
- Improve quality of sleep and help reduce pain

Eden Hospice will provide patients with the supplies and medical equipment related to the hospice diagnosis, including:

- Respiratory equipment including oxygen and CPAP, BIPAP and nebulizers
- Walkers
- Crutches
- Wheelchairs

Respite Care

Eden believes in supporting both the patient and the caregiver team. Respite care is provided to the patient when family/caregivers need time away. Patients are placed in a contracted facility for a length of time in accordance with plan benefits (typically up to 5 days). The contracted facility will provide care with the hospice interdisciplinary members to continue making visits and maintain emergency/crisis availability.

Respite care for your caregiver may help prevent:

- Burn-out
- Depression
- Stress, Illness, and Reduced Immunity due to Lack of Sleep

Bereavement Services

Bereavement care is an essential component of hospice care that includes anticipating grief reactions and providing ongoing support for the bereaved for a year or more after the patient has passed. Grieving and mourning are normal. Patients, families and caregivers may experience grief as a mental, physical, social, or emotional reaction. Mental reactions can include anger, guilt, anxiety, sadness, and despair. Physical reactions can include sleeping problems, changes in appetite, physical problems, or illness. Eden Hospice is committed to providing information, counseling, and resources for any reaction that may be experienced.

Eden believes that each person takes their own journey through grief and healing. Allowing patients, families and caregivers to open-up to the idea that not every person experiences and deals with the loss of a loved one in the same way. As there are many cultural and or religious practices supported in communities to help those facing loss, understand that there is no “one way” or “one plan” that can work for everybody.

Hospice bereavement programs focus on:

- Helping family members understand and move forward in the grief process by enabling their expression of thoughts and feelings and helping them identify or develop healthy coping strategies.
- Helping families problem-solve around adjustment issues.
- Providing guidance about decision-making.

- Addressing social and spiritual concerns.
- Assisting survivors to adapt to an environment without the deceased.

Volunteers

Eden Hospice recognizes that employees, patients, family members and caregivers live in a web of community-based relationships and one choice that most hospice patients elect is to remain in that community. Eden Hospice volunteers facilitate that supportive network of community relationships. Eden Hospice volunteers are drawn to volunteer work for a variety of reasons. Our volunteers have various ages, professions, and life experiences. They have a true desire to give their time to individuals dealing with a life-limiting illness. Volunteers are fully vetted through a background check.

Hospice volunteers assist with a number of helpful and meaningful activities and support the overall outreach to the community about the benefits of hospice. See below for a complete list of what volunteers can and cannot do. Our volunteers are never asked to do something they are not comfortable doing.

Hospice volunteers can*:*

- Play cards and games.
- Watch movies or television.
- Help with light errands.
- Help with light housekeeping and meal preparation.
- Support patient interests, such as music or crafting.
- Read aloud.
- Write letters.
- Do office work, such as data entry, mailings, answer phone calls, etc.
- Provide respite care to family members and/or caregivers.
- Offer companionship and support.
- Offer a calm and peaceful presence by being comforting and supportive.

Volunteers do not substitute for the needed specialized services provided by an experienced, trained and often licensed professional staff. Per the rules of Medicare participation, h*ospice volunteers may not:*

- Offer feeding assistance.
- Transfer or transport patients.
- Give medications.
- Assist with personal care.
- Provide counseling services or offer advice.

At Eden Hospice, we are committed to providing information, counseling, and resources. Our support groups can help manage the everyday care and emotional challenges of caring for a dying loved one. Our team of professionals and volunteers address the emotional, social, and spiritual needs of patients and those who love and care for them.

Our Plan for Whatcom County

As noted in the Executive Summary and throughout the application, Whatcom County residents have experienced limited access to hospice services. This limited access arises primarily out of having no choice in hospice services. Whatcom County is the only county among Washington State counties with a population exceeding 100,000 persons without at least two hospices. Of particular importance in Whatcom County is that the only choice that is available is a hospice offered by PeaceHealth, which has institutional constraints in addressing the Death with Dignity statute in Washington[5]. The national literature and local experience document the concern and barrier to access among terminally ill patients and their families about a loss of control in how a patient and family will address dying. But choice also has many other aspects. Eden Hospice will be co-located with EmpRes Home Health and its many referral sources that offer new pathways of outreach to inform patients and families about the benefits of hospice and to facilitate their decisions to select the hospice option when it can provide the most benefit.

Eden Hospice at Whatcom County has adopted four goals tailored to the unique needs and circumstances in the Whatcom County to support increasing hospice admissions and ALOS in hospice care.

1. Recognize and seek opportunities for cooperative relationships with key area providers including the Lummi Native American Health Clinic. The Nooksack Indian Tribe operates an ambulatory care clinic in Deming. Clinical services are also offered through the Samish and Semiahmoo tribes. In regard to rural and general low-income population access, Unity Care NW operates federally qualified health clinic services in multiple locations including Ferndale. The Palliative Care Institute at Western Washington University and other organizations also offer other outreach opportunities.

2. Assure that all residents considering hospice are offered informed choice as required by CMS: (a) actively address and overcome any general negative views of Medicare hospice related to real and perceived loss of control about a loss of control in how a patient and family will address dying and (b) provide a secular hospice choice that directly addresses concerns related to religious affiliation of the only available hospice services in Whatcom County.[6]

3. Carry out outreach activities in urban and rural areas of Whatcom County to inform residents about the benefits of hospice in a respectful, culturally competent approach based on collaborating with community agency representatives responsible for serving ethnically diverse populations, disease-specific populations, agencies serving low income individuals and organizations serving Veterans.

[5] *Op cit;* See footnote 1 on Page

[6] 29% of Whatcom residents report affiliation with an organized religion with 7% of the population reporting Roman Catholic affiliation. 35% of the Washington State population report affiliation with an organized religion with 12% of the population reporting Roman Catholic affiliation: Association of Religious Data Archives (ARDA) 2010

4. Work with the Western Washington University Palliative Care Institute members, community agencies and community healthcare providers design Eden Hospice services to ensure integration of services that focus on increasing admissions and ALOS of hospice stay and the care experience for the dying patient and the patient's and all of the patient's caregivers.

Based on the Department of Health's 2019 Hospice Need Methodology and allowed revisions for Whatcom County, Eden Hospice at Whatcom County will provide needed services to new populations that are financially feasible, meet all structure and process requirements and are cost effective.

I. **Provide documentation that the applicant has sufficient interest in the site or facility proposed. "Sufficient interest" shall mean any of the following:**

1. **Clear legal title to the proposed site; or**

2. **A lease for at least one year with options to renew for not less than a total of three years; or**

3. **Legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease in the event that a Certificate of Need is issued for the proposed project.**

Please see Appendix 6 for a copy of the lease agreement with extension addendum and sublease agreement.

III. PROJECT RATIONALE

Please address each county proposing to be served separately.

A. Need (WAC 246-310-210)

1. Identify and analyze the unmet hospice service needs and/or other problems toward which this project is directed.Identify the unmet hospice needs of the patient population in the proposed service area(s). The unmet patient need should not include physical plant and/or operating (service delivery) deficiencies; and

Eden Hospice at Whatcom County has carried out the DOH hospice need methodology (initial), and a second analysis modifying the provisional methodology to correct the Whatcom County existing capacity calculation that overstates Whatcom Hospice (PeaceHealth) by 20%. This capacity adjustment is necessary that demonstrate the scale of the current and projected shortfall in hospice care in the Whatcom County service area. The two numerical analyses resulted in the following findings:

Method 1:
Application of the Department of Health Hospice Need Methodology

STEP 1: Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:

- The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions during the last three years for patients 65 and over by the average number of past three years statewide total deaths age 65 and over.
- The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions during the last three years for patients under age 65 by the average number of past three years statewide total of deaths under age 65.

Table 4: Whatcom County Average Hospice Admissions and Deaths By Age Group

	2016	2017	2018	3-Year Average
Average number of unduplicated admissions for patients 65 and older	24,738	26,365	26,951	26,018
Average number of statewide total deaths age 65 and older	41,104	42,918	42,773	42,265
Percentage of patients age 65 and older who will use hospice services.	60.18%	61.43%	63.01%	**61.56%**
Average number of unduplicated admissions for patients under age 65	3,766	3,757	4,114	3,879
Average number of statewide total deaths under age 65	13,557	14,113	14,055	13,908
Percentage of patients under age 65 who will use hospice services.	27.78%	26.62%	29.27%	**27.89%**

STEP 2: Calculate the average number of total resident deaths over the last three years for each planning area by age cohort:

Calculate the average number of total resident deaths over the last three years for each Whatcom County age cohort for 2016, 2017 and 2018.

Table 5: Deaths in Whatcom County By Age Cohort and 3-Year Average

	2016	2017	2018	3-Year Average
Average number Whatcom County of total resident deaths of patients age 65 and older	1353	1329	1252	1311
Average number Whatcom County of total resident deaths of patients under age 65	365	367	360	364

STEP 3: Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort:

Table 6, which provides the Planning Area's average and projected resident deaths by age cohort.

Table 6: Whatcom County Average and Projected Deaths by Age Cohort

	2016 - 2018 Average	3 Year Statewide Avg. Death Rate	Projected Hospice Patients
Population age 65 and older for Whatcom County	1,311	61.56%	807
Population under age 65 for Whatcom County	364	27.89%	102

STEP 4: Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this use rate to determine the potential volume of hospice use by the projected population by the two age cohorts identified in Step 1, (a)(i) and (ii) of this subsection using OFM data:

Please see Table 7, which provides the potential volume of hospice use by age cohort.

Table 7: **Potential Whatcom County Hospice Volume, 2019-2021 By Age Group**

Projected Hospice Patients	2016-2018 Average Population	2019 Population	2020 Population	2021 Population	2019 Projected Patients	2020 Projected Patients	2021 Projected Patients
Whatcom County Population age 65 and Older							
807	37,426	40,902	42,640	44,217	882	920	954
Whatcom County Population Under Age 65							
102	180,629	185,418	187,812	189,267	104	106	106

STEP 5: Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity:

Please see Table 8, which provides the number of projected admissions beyond the planning area's existing capacity.

Table 8: Whatcom County Admissions & Patient Days Unmet Need, 2019-2021

2019	2020	2021	Current Capacity Admits		2019	2020	2021
Forecast Admits	Forecast Admits	Forecast Admits			Unmet Need Admits	Unmet Need Admits	Unmet Need Admits
986	1,026	1,060	875		111	151	185

STEP 6: Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years:

Please see Table 9, which provides the unmet need for both admissions and patient days in Whatcom County.

Table 9: Whatcom County Unmet Need Based on Patient Days, 2019 - 2021

2019 Unmet Need Admits	2020 Unmet Need Admits	2021 Unmet Need Admits	Multiply Admits by 60.13 Days (ALOS) to Calculate Days	2019 Unmet Need Days	2020 Unmet Need Days	2021 Unmet Need Days
111	150	185	60.13	6,681	9,016	11,111

STEP 7: Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC:

Please see Table 10, which provides the unmet need based on Average Daily Census in Whatcom County. As noted below, absent additional hospice capacity, the Planning Area will experience *unmet* ADC of 30 by the target year 2021.

Table 10: Whatcom County Unmet Need Based on ADC, 2019-2021

2019 Unmet Need Days	2020 Unmet Need Days	2021 Unmet Need Days	Divide Unmet Need Days by 365 Days to Calculate Average Daily Census	2019 Unmet Need ADC	2020 Unmet Need Days ADC	2021 Unmet Need Days ADC
6,681	9,016	11,111	365	18.30	24.70	30.44

STEP 8: Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five:

Please see Table 11, which provides the unmet need for Hospice Agencies in Whatcom County. As noted, absent additional hospice capacity, the Planning Area will experience numeric need for .87 agencies by the target year of 2020.

Table 11: Whatcom County Unmet Need for Hospice Agencies, 2021

2021 ADC (Unmet)	Agencies Needed in 2021
30.4	0.87

Source: DOH 2018-2019 Hospice Need Methodology

Method 2:
Application of the Department of Health Hospice Need Methodology
(Revised for Special Population Factors)

As noted in the introductory paragraph to the DOH Hospice Need methodology, calculating hospice need for Whatcom County requires adjustments to the methodology to produce an accurate projection of Need. The Method 1 analysis makes several simplifying assumptions to provide a high-level assessment of hospice need three years into the future. The methodology is focused on analyzing need in metropolitan counties, which with the exception of Whatcom County, have ***multiple*** hospice agencies serving residents. For non-metropolitan counties, special adjustments are made to address the development of hospice capacity in rural areas.

In Washington, Whatcom County is the only county among 12 counties with a population greater than 100,000 residents – 2020 population forecast of 212,914 residents -- having only one hospice. Within the "small metro designation" in Washington, only Franklin and Chelan, with 2020 populations of less than 100,000 persons report only a single hospice in the county.[7] In Whatcom County, the lack of choice of hospice agencies creates **unmet need** population cohorts – this unmet need is due to access to care barriers that are unique when compared with hospice need for other metropolitan counties that the DOH Need Methodology was designed to measure. The population cohorts are characterized by having lower admission rates than the statewide average admission rates for the under age 65 and age 65 and older population cohorts and more significantly have lower ALOS per hospice stay that can be directly attribute to the choice issue.

The technical reason for revising the DOH Hospice Need Methodology is to address the error in projecting the existing capacity of hospice agencies in terms of Need. Hospice capacity must be defined as days of hospice care, which is the principal way that hospice agencies are paid. It is not admissions. As is shown in Method 2, the low ALOS for hospice patients in Whatcom County results in the capacity of the Whatcom Hospice agency being dramatically overstated. Patients in Whatcom County have the 5th lowest ALOS among Washington hospices. When compared with hospices in other metropolitan counties, patients have a choice of lower or higher ALOS. Exhibits 1 – 6 (at the end of the narrative) document that ALOS is constrained by the capability of Whatcom Hospice to meet requests for hospice services.

The Revised DOH methodology addresses these special population factors on a Step-by Step basis. Revised Tables are identified with the same ordinal number with an "R" designation. The Original Table is also provided for comparison. In several steps additional Explanatory Tables are provided and the ordinal number for that Step is used with a designation of E for explanatory. Where no change is required no Original Tables are provided for economy of production reasons:

STEP 1: Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:

No change required.

[7] Small metro definition by National Center for Health Statistics 2013 Urban – Rural Classification Scheme

STEP 2: Calculate the average number of total resident deaths over the last three years for each planning area by age cohort:

No change required.

STEP 3: Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort:

Table 6-R shows the actual 3-year average death rate for the two Whatcom County population cohorts. It shows that the age 65 and older cohort has a lower average death rate than the statewide average while the age cohort under age 65 have a higher death rate than the statewide average. Table 6-E shows that carrying out the two calculations yields admissions to hospice that are 4% lower than expected. This absolute difference is of concern but the DOH Hospice Need Methodology does take into account whether admissions are lower or higher than expected and adjusts capacity accordingly for the later steps.

Table 6: Whatcom County Average and Projected Deaths by Age Cohort

	2016 - 2018 Average Deaths	3 -Year Average Death Rate	2016-2018 Projected Hospice Patients
Population age 65 and older for Whatcom County	1,311	61.56%	807
Population under age 65 for Whatcom County	364	27.89%	102

Table 6-R: Whatcom County Average and Projected Deaths by Age Cohort

	2016 - 2018 Whatcom Average Deaths	3 -Year Whatcom Average Death Rate	Actual Hospice Patients
Population age 65 and older for Whatcom County	1,311	57.16%	749
Population under age 65 for Whatcom County	364	34.62%	126

Table 6-E: Comparison of Table 6 and Revised Table 6-R

	Calculated	Actual	% Difference
2016 - 2018 Annual Average Hospice Patients Age 65 and Older	807	749	93%
2016 - 2018 Annual Average Hospice Patients Under Age 65	102	126	124%
Total Hospice Patients	909	875	96%

A comparison of Table 6 and Revised Table 6 shows that there is a 4% difference in the Whatcom County Hospice Capacity due to differences in the percentage of patients who select hospice to assist in the dying process. **There is no reason to adopt any change in Step 3 of the methodology even though there are differences between projected and actual hospice patient admissions.** The Need Methodology recognizes this disparity in hospice rates between expected and actual hospice utilization rates and uses the **ACTUAL** three year average of patients reported by hospices within each service area, rather than the **PROJECTED** three year average of patients served in each service area later in **Step 5.**

STEP 4: Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this use rate to determine the potential volume of hospice use by the projected population by the two age cohorts identified in Step 1, (a)(i) and (ii) of this subsection using OFM data:

No change required.

STEP 5: Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity:

Change Required

Step 5 shows the 3-year hospice capacity based on the 2016 – 2018 average number of *actual* patients. However, the only Whatcom County service area hospice has an average number of days per patient (average length of stay or ALOS) in 2018 of 55.7 days while the expected capacity by rule is the CMS average length of stay for all hospices in Washington State which is 60.13 days per patient.[8] The Revised Step 5 reduces actual hospice capacity in Whatcom County that is available for Whatcom County residents by 20% to reflect the **actual average length of stay that Whatcom County residents need for parity within Washington State.**

[8] **Berg Data Solutions**, LLC calculated the ALOS for Whatcom County Medicare patients in a conservative manner that is similar to the CMS methodology. The state survey ALOS for Whatcom hospice in 2018 was 48 days for the entire population.

Table 8: Potential Whatcom County Hospice Volume, 2019-2021 By Age Group

2019	2020	2021	Current Capacity Admits	N.A.	2019	2020	2021
Forecast Admits	Forecast Admits	Forecast Admits		N.A.	Unmet Need Admits	Unmet Need Admits	Unmet Need (Admits
986	1,026	1,060	875	N.A.	111	151	185

Table 8-R-E: Adjustment to Current Capacity Adjustment Factor Calculation

	CMS 2018 Washington ALOS	Whatcom Hospice 2018 Survey ALOS	% of Hospice Need Adjustment Factor
2018 Hospice Average Length of Stay	60.13	55.7	92.63%

Technical Note: Table 8-R-E calculates the scale of the adjustment factor for ALOS that must be applied to the ACTUAL CAPACITY admits to apply the remaining steps in the Need formula to calculate 2019 to 2021 capacity. The alternate approach ideally would directly adjust EXISTING Whatcom admits multiplied by EXISTING Whatcom ALOS of 55.7 days to obtain Existing capacity. However, this approach would not allow for comparison of Step results between the published DOH Need Methodology and the revision for Whatcom County.

Table 8-R: Potential Whatcom County Hospice Volume Adjusted for Actual Capacity

2019	2020	2021	Current Capacity Admits	Lower ALOS Capacity Adjustment Factor: 92.63%	2019	2020	2021
Forecast Admits	Forecast Admits	Forecast Admits	N.A.	Forecast Capacity Adjusted Admits	Unmet Need Admits	Unmet Need Admits	Unmet Need (Admits
986	1,026	1,060	N.A.	811	175	215	249

STEP 6: Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years:

Change Required.

In Step 5, Whatcom County 3-year hospice capacity was adjusted to reflect the near 20% lower length of stay capacity for hospice services. This same adjustment is carried through to Table 9. Table 9 provides the unmet need for both admissions and patient days in Whatcom County. The Revised Table 6-R adjusts Unmet Need Admits that were calculated in Revised Table 5-R.

Table 9: Whatcom County Admissions & Patient Days Unmet Need, 2019-2021

2019 Unmet Need Admits	2020 Unmet Need Admits	2021 Unmet Need Admits	Multiply Admits by 60.13 Days (ALOS) to Calculate Days	2019 Unmet Need Days	2020 Unmet Need Days	2021 Unmet Need Days
111	150	185	60.13	6,681	9,016	11,111

Revised Table 9-R: Whatcom County Adj. Admissions & Patient Days Unmet Need, 2019-2021

2019 Unmet Need Admits	2020 Unmet Need Admits	2021 Unmet Need Admits	Multiply Admits by 60.13 Days (ALOS) to Calculate Days	2019 Unmet Need Days	2020 Unmet Need Days	2021 Unmet Need Days
288	328	362	60.13	10,552	12,957	15,002

STEP 7: Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC:

Change Required

Table 10 provides the unmet need based on Average Daily Census in Whatcom County. As noted below, absent additional hospice capacity, the Planning Area will experience unmet ADC of 59 by the target year 2021. Table 9 must be revised to reflect the adjustments in Unmet Need Admits and Unmet Need Days resulting from the Whatcom County capacity adjustment in Steps 5 and 6.

Table 10: Whatcom County Unmet Need Based on ADC, 2019-2021

2019 Unmet Need Days	2020 Unmet Need Days	2021 Unmet Need Days	Divide Unmet Need Days by 365 Days to Calculate Average Daily Census	2019 Unmet Need ADC	2020 Unmet Need Days ADC	2021 Unmet Need Days ADC
6,681	9,016	11,111	365	18.30	24.70	30.44

Revised Table 10-R: Whatcom County Revised Unmet Need Based on ADC, 2019-2021

2019 Unmet Need Days	2020 Unmet Need Days	2021 Unmet Need Days	Divide Unmet Need Days by 365 Days to Calculate Average Daily Census	2019 Unmet Need Days	2020 Unmet Need Days	2021 Unmet Need Days
10,552	12,957	15,002	365	28.9	35.5	41.1

STEP 8: Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five:

Change Required

Table 10 needs to be revised to reflect the unmet need that was based on the 20% lower patient day utilization in Whatcom County based on the revisions to Need calculated in Steps 5, 6 and 7. Please see Table9-R , which provides the unmet need for Hospice Agencies in Whatcom County. As noted, absent additional hospice capacity, the Planning Area will experience numeric need for .87 agencies by the target year of 2020.

Table 11: Whatcom County Unmet Need for Hospice Agencies, 2020

2021 ADC (Unmet)	Agencies Needed in 2021
30.4	0.87

Revised Table 11-R: Whatcom County Revised Unmet Need for Hospice Agencies, 2020

Revised 2021 ADC (Unmet)	Agencies Needed in 2021
41.1	1.2

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

Hospice provides care, comfort, and support for people nearing the end of life, wherever they reside. With a focus on quality of life, hospice addresses the needs of the whole person, from managing pain and symptoms to providing emotional, social, and spiritual support.

Given hospice care is primarily provided in a home setting, proximity to local hospice providers is an important factor. The Department's hospice need methodology establishes that, without an expansion of services in the Planning Area, Whatcom County residents will have insufficient access to hospice care and the associated benefits.

The negative impact and consequences of unmet hospice needs is best described by listing the benefits as defined by the triple aim of better health, better healthcare and control of health care costs of hospice that are not available to those 249 Snohomish County hospice-eligible residents whose hospice need is unmet.

Better Health

Longer lives

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

Hospice care available at home

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

There are respite options for caregivers

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

Social work and bereavement support

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

Better Healthcare

Personalized and coordinated care plan

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

Reduced hospitalizations and fewer emergency room services

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

Reduced rehospitalization from skilled nursing facilities

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

Coordination of care can affect the patient and bereaved family members experience of the hospice patients care experience

The need to control pain appropriately and address bereavement issues early are two aspects of caring for the terminal patient wherein family members experience significant stress . But under the direction of the Medicare hospice interdisciplinary team, these are required aspects of care included in every patient's plan of care. A 2007 study assessing length of stay and a perception that hospice care referral was too late found that bereaved family members reported that the hospice patient was referred too late when they perceived the patient had insufficient pain control and bereavement issues were not satisfactorily addressed. ***Washington State, with one of the lowest lengths of stay nationally, was one of the 5 states with the highest response that hospice referral was too late!*** Appendix 25 documents the high use of emergency room services for pain control for patients who are not receiving hospice services.

Control of Healthcare Costs

Reduced out of pocket expense for patients and their families

Prescription medications are one of the biggest areas of cost savings for hospice patients. Hospice covers the cost of all medications for pain and comfort management related to the terminal illness. Rental costs of durable medical equipment – hospital beds, wheelchairs, walkers, wound dressings and catheters – are included as part of the paid-by-hospice coverage. Without hospice, the patient would need to pay for this equipment or would need to pay a Medicare rental copayment after submitting a doctor's approval for the equipment.

A previously cited study provides an example of total costs which are partially borne by the patient and health plan. The Survival and Cost-Effectiveness of Hospice Care for Metastatic Melanoma Patients study focused on patients 65 years of age and older with metastatic melanoma who died between 2000 and 2009. The study found that patients with four or more days of hospice care had longer survival rates and incurred lower end-of-life costs. Patients with four or more days of hospice care incurred average costs of $14,594, compared to the groups who received one to three days of care, and no hospice care at all ($22,647 and $28,923 respectively).[9]

Reduced total costs of care

In regard to total costs of care as they relate to managing healthcare costs as part of Washington's Triple Aim, Providence Health and Services dba Providence Hospice in its recently approved hospice application in Clark County (CN19-44) calculated that Based on Medicare claims data, a savings of over $99 million across Washington State payers could have save nearly $99 million annually if all Medicare beneficiaries who died in 2017 without hospice instead benefited from five weeks of hospice (35 days ALOS) (See Exhibit 7 below). Of course, the savings would be much greater if Washington hospice patients received 88.6 days of hospice care[10], which was the 2017 national ALOS.

Exhibit 7: Providence CN 19-44 Hospice Cost Savings Analysis[11]

From CN 19-44 Table 26. 2017 WA State Hospice Analysis

Estimated Patients without Hospice			
Resident Deaths	46,324		
Hospice Deaths	21,071		
Deaths without Hospice	25,253		
Payment Reduction Estimate			
Weeks with Hospice	**Average Payment**	**Deaths without Hospice**	**Est. Total Payments**
0	$36,944	25,253	$932,951,942
5	$32,999	25,253	$833,330,793
Reduced Payments if patients had 5 weeks of hospice			$99,621,149

Source: CMS Hospice State Profile -- Washington State 2017

[9] *Op cit.* Jinhai Huo, PhD, MD, MP *et al* ("Survival and Cost-Effectiveness of Hospice Care for Metastatic Melanoma Patients", Am Journal Managed Care.
[10] MedPac Report to the Congress: Medicare Payment Policy | March 2019. Page 319
[11] CN 19-44. Providence Health and Services Hospice Application. Page 53

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

Eden has been providing home health services in Whatcom County since 2014 and also operates a skilled nursing facility (SNF) and EmpRes Home Care. With this experience has local knowledge for developing referral relationships within Whatcom County. Eden understands each patient and family is special. For this reason, Eden tailors its team approach to the specific needs of each patient and family. Hospice services are provided in the patient's home, no matter where that home is located. It may be a private residence, an assisted living community, an adult care home, or a residential or intermediate care community. The proposed hospice will provide care to Medicare and Medicaid eligible patients as well as all other patients, regardless of the source or availability of payment for care.

The National Academy of Science, delves into cultural issues in the article "*Dying in America Improving Quality and Honoring Individual Preferences Near the End of Life*":

> "Patients' backgrounds, culture, ethnicity, and race influence their perceptions about life, illness, suffering, dying, and death and the meaning they ascribe to these events. These perceptions in turn affect preferences for the kinds of care people want, how much they want to know about their situation and choices, whether and how they want to make treatment choices, whom they want to make those choices if they cannot, and the role of the family in the entire process In the coming years, rapid growth in the proportion of U.S. elderly that are members of racial/ethnic minority groups will challenge clinicians to communicate more effectively with people of many cultural traditions. It is vital, that clinicians be aware of common differences in perception among racial, ethnic, and cultural groups so that at the very least, they can ask the right probing questions and have a firmer basis for individualized understanding of patients and their families. As noted above, although there are many differences among individual perspectives and actions within groups, the *general* pattern in minority populations is one of a lack of advance care planning and a preference for more intensive treatments; poorer communication with clinicians is part of this pattern. Although patients and families may not follow clinicians' advice and recommendations, "avoiding such communication increases the likelihood of poor end-of life decision making".[12]

There are at least eight special populations that Eden will focus on developing culturally competent outreach services. These populations will include the following: (1) Residents seeking a non-religiously affiliated, secular hospice provider, (2) Native American tribe members; (3) Federally Qualified Health Center patients, (4) Rural residents, (5) Ethnic diversity populations , (6) Home Health patients and (7) SNF patients and Home Care clients and (8) Veterans.

Secular Hospice: As noted throughout the CoN application, Whatcom County with only one hospice provider choice has a significant access barrier that is not faced by the other eleven urban counties with county populations of 100,000 or more residents. **This access barrier is heightened by the fact that a strict internal institutional structure under Catholic Church auspices forbids PeaceHealth to honor or support Washington State's Death with Dignity statutes**. **Presently, the residents of Whatcom County who face terminal illness and need hospice, also have the right to be informed and have access to Washington State's Death with Dignity end-of-life option.** Whether a hospice is religiously based or secular, patients and

[12] Committee on Approaching Death: Addressing Key End-of-Life Issues, Institute of Medicine of the National Academies, pg 142

their families have many concerns about the myriad end-of-life decisions (including loss of control). Presently in Whatcom, all end-of-life decisions options are not fully discussed. The barrier is also heightened further in regard to secular or religious/ governance since only 29% of Whatcom County residents report religious affiliation compared with 35% of the State population. This access barrier can be substantially lowered by having a choice of each, one religious/sectarian and one non-sectarian/secular hospice.[13]

Native American Access: The Lummi Nation Tribe provides services including a health clinic to approximately 6,000 residents in Whatcom County as well as the Nooksack Indian Tribe that operates an ambulatory care clinic in Deming for its 2,000 members. Other tribes including the Samish and Semiahmoo tribes also provide health services to Whatcom County Native American residents. Together services are provided to over 3% of the Whatcom County population who identify themselves as American Indian and Alaska Native in origin as well as other individuals in the County and the surrounding area.

Federally Qualified Health Center: Unity Care NW is a Federally Qualified Health Center Care that has enrolled over 5,000 low and moderate income individuals into healthcare programs in the last 3 years. It is opening a rural clinic in North Whatcom County that when fully operational will serve approximately 9,500 rural residents**.**

R**ural Residents Outreach:** As noted, Eden will carry on outreach services through contacts with organizations such as Unity Care NW and the Nooksack Indian Tribe. EmpRes/Eden have experience on the ground with home health services in working with advanced tele-health/virtual care technology platforms that can be of great value in establishing early referrals into the Eden Hospice program or Whatcom Hospice based on patient choice.

Ethnic Diversity Populations: Ethnically diverse populations require culturally competent and respectful outreach to increase the knowledge and acceptance of hospice services that are designed to meet each ethnic cohorts' expectations. Eden Hospice at Whatcom County will build on its 7 years of relationships in the community to establish effective outreach. The Demographic Profile of Whatcom below provides the 2017 Demographic profile for Whatcom County prepared by the Employment Security Department for Washington State.

Demographic Profile of Whatcom County[14]

	Whatcom County	Washington state
Population by age, 2017		
Under 5 years old	5.5%	6.2%
Under 18 years old	19.5%	22.2%
65 years and older	16.9%	15.1%
Females, 2017	50.5%	50.0%
Race/ethnicity, 2017		
White	86.7%	79.5%
Black	1.2%	4.2%
American Indian, Alaskan Native	3.3%	1.9%
Asian, Native Hawaiian, other Pacific Islander	4.8%	9.7%
Hispanic or Latino, any race	9.4%	12.7%

[13] *Op cit.* See footnote 5 for data source
[14] https://esd.wa.gov/labormarketinfo/county-profiles/whatcom

Home Health: EmpRes (Eden) Home Health currently refers 32 Medicare patients to hospice services. Current wait times approach two weeks until enrollment in hospice as PeaceHealth often first refers patients to home health until a hospice enrollment can take place.

Veterans Services: American Fact Finder reports that Whatcom County had 13,517 veterans as of 2017. The Eden Hospice team will meet with the Whatcom County Veterans Advisory Committee.

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

Not Applicable. Eden Hospice at Whatcom County is not an existing facility.

<u>Please provide utilization forecasts for the following, for each county proposing to serve:</u>

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

If our requested project is approved, we anticipate beginning services in Whatcom County in January 2021. Therefore, the first full year of operation will be 2021. Volume forecasts are provided in Appendix 21.

Table 12: Eden Hospice at Whatcom County Utilization Forecast, 2021 – 2024

	2021	2022	2023
Unduplicated patients	81	180	276
Average L.O.S.	60.2	61.2	61.2
Median L.O.S.[15]	18	18	18
ADC	13.4	30.2	46.3

4. **Please provide a forecasted breakdown of patient diagnoses.**

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

[15] The median length of stay is consistent with MedPac findings. Median length of stay is not used in the pro forma.

Table 13: Eden Hospice at Whatcom County Provisional Diagnostic Mix , 2021 – 2024

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

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

The methodology and assumptions used to develop the utilization forecasts presented in Table 9 include the following:

The Project (Whatcom County Forecast, "Project")

- Given the high unmet need (ADC of 41) projected by 2021 in Whatcom County, the Project-related utilization is projected to reach capacity (ADC) by the third full year of operation (2023). A moderate ramp-up is assumed in prior years.
- Patient days are calculated by multiplying the ADC by 365.
- Average length of stay (ALOS) is set to start at the Washington statewide average (60.2 days) ramping up to 61.2 days
- Patient counts are calculated by dividing patient days by the ALOS.

7. Median LOS is estimated to be in the same ratio as in 2022, the first full year of operation**s** **Provide detailed information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "compete" with the applicant.**

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

The existing providers of hospice services in Whatcom County include the following:

- Whatcom Hospice (PeaceHealth)

Through examination and modification of the Initial DOH 2019-2020 Hospice Numeric Need Methodology to revise the **expected** capacity metric to the **actual** capacity metric for Whatcom Hospice (see Exhibit 1), Eden can confirm that there is significantly higher forecasted need than current capacity in Whatcom County. Potential volume (admissions) in Whatcom County projected to be 986 in 2019, 1,026 in 2020, and 1,060 in 2021. Current 2018 admits as shown

in revised Table 3-A - R are 4% below expected levels and length of hospice stay in 2018 is 20% below the statewide average.

Adjusting **actual** capacity as measured by average daily census (actual 2018 admits multiplied by actual 2018 Medicare length of stay results in capacity being approximately 24% below expected capacity for such a well-established hospice – admits being 4% below expected admits and length of stay being 20% below CMS computed statewide average length of stay for Washington patients).

As noted in Revised Table 3A which is a comparison of the Actual number of Whatcom Hospice patients and the Expected number of Whatcom Hospice patients demonstrates that in 2018, Whatcom admits were 4% below the expected admits to hospice. While this deviation is of concern, the DOH Need Methodology accounts for this in determining capacity, it does not account for the very low hospice length of stay for Whatcom Hospice patients which when adjusted results in Need dramatically higher than the 35 patient average daily census Unmet Need metric when the **actual** capacity metric is corrected in the methodology. While the DOH methodology accounts for the lower number of patients served, it does not take into account the very low length of stay for Whatcom Hospice patients.

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

Please see the answer to question 7.a above. As noted in that response, the adjusted DOH Need methodology, there is a 2021 Unmet Hospice Need of for a 41 average daily census in 2021 (See Step 8, Table 10-R, Page 33. In addition there is the *a priori* need for a choice of at least 2 hospice agencies in all counties in Washington State but certainly in metropolitan counties and beyond question in counties with a county population that exceeds 100,000 persons since Whatcom County is the only County with a population vastly exceeding 100,000 persons without at least two hospice agencies.

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

The Project (Whatcom County Forecast, "Project")

- Given the high unmet need (ADC of 41) projected by 2021 in Whatcom County, the Project-related utilization is projected to reach capacity (ADC) by the third full year of operation (2024). A moderate ramp-up is assumed in prior years.
- Patient days are calculated by multiplying the ADC by 365.
- Average length of stay (ALOS) is set to start at the Washington statewide average (60.2 days) ramping up to 61.2 days
- Patient counts are calculated by dividing patient days by the ALOS.

Median LOS is estimated to be approximately 18 days across the forecast period.

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

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

The existing providers of hospice services in Whatcom County include the following:

- Whatcom Hospice (PeaceHealth)

Through examination and modification of the Initial DOH 2019-2020 Hospice Numeric Need Methodology to revise the **expected** capacity metric to the **actual** capacity metric for Whatcom Hospice (see Exhibit 1), Eden can confirm that there is significantly higher forecasted need than current capacity in Whatcom County. Potential volume (admissions) in Whatcom County are projected at 986 in 2019, 1,026 in 2020, and 1,060 in 2021. Current 2018 admits as shown in revised Table 3-A - R are 4% below expected levels and length of hospice stay in 2018 is 20% below the statewide average.

Adjusting **actual** capacity as measured by average daily census (actual 2018 admits multiplied by actual 2018 Medicare length of stay results in capacity being approximately 24% below expected capacity for such a well-established hospice – admits being 4% below expected admits and length of stay being 20% below CMS computed statewide average length of stay for Washington patients as previously discussed.

As noted in Revised Table 3A which is a comparison of the Actual number of Whatcom Hospice patients and the Expected number of Whatcom Hospice patients demonstrates that in 2018, Whatcom admits were 4% below the expected admits to hospice. While this deviation is of concern, the DOH Need Methodology accounts for this in determining capacity, it does not account for the very low hospice length of stay for Whatcom Hospice patients which when adjusted results in Need dramatically higher than the 35 patient average daily census Unmet Need metric when the **actual** capacity metric is corrected in the methodology. While the DOH methodology accounts for the lower number of patients served, it does not take into account the very low length of stay for Whatcom Hospice patients.

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

Please see the answer to question 7.a above. As noted in that response, the adjusted DOH Need methodology, there is a 2021 Unmet Hospice Need for an ADC of 41 (See Step 8, Table 10-R, Page 33). In addition there is the *a priori* need for a choice of at least 2 hospice agencies in all counties in Washington State but certainly in metropolitan counties and beyond question in counties with a county population that exceeds 100,000 persons since Whatcom County is the only County with a population vastly exceeding 100,000 persons without at least two hospice agencies.

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

The proposed Eden Hospice project will reach an ADC of **46.3** in 2022, the third full year of operation. While the existing hospice agency in Whatcom County is well-established, it is not able to meet current need in the County. Whatcom Hospice shows many signs of not being able to meet the capacity needs of the Whatcom County population. Here are several important metrics that document that Whatcom Hospice is **capacity limited that is unable to expand capacity rapidly enough to come close to meeting hospice Unmet Need:**

1) Whatcom Hospice Admissions per 1,000 Deaths at 557 admissions per 1,000 deaths, is below the national average of 588 admissions per 1,000 Deaths
2) An analysis of average length of stay for Whatcom County hospice patients shows that Whatcom Hospice has the 5th lowest hospice ALOS;
3) The percentage of Whatcom County hospice-eligible patients receiving hospice services is 4% below the expected statewide average;
4) The decreasing percentage of direct (same day) direct hospital discharges of hospice-eligible patient into hospice resulting in a 3-year trend of increasing wait times from 2015 to 2018 of the percentage of direct discharges into hospice shows a hospice system unable to expand capacity to meet hospice patient need.
5) Hospice appropriate patients that are transferred from home health are admitted much slower to hospice than hospital discharges. On the 6th day after discharge 12% of the patients have not been admitted to hospice. This trend has continued for many years.
6) Many patient, qualified for hospice, are referred to home health prior to enrollment in hospice delaying hospice for extended periods when there is not hospice capacity.
7) Visit Hours per Patient Day – Whatcom Hospice 2015 – 2018. ***The amount of time spent with patients has declined by 18% from 2015 to 2018 at Whatcom Hospice***.

Exhibit 1 shows that Whatcom Hospice Admissions per 1,000 Deaths at 557 admissions per 1,000 deaths is below the national average of 588 admissions per 1,000 Deaths for the Medicare population as calculated by **Berg Data Solutions**, LLC. An examination of the 3-year data from 2015 – 2018 shows no real change in admissions over the period. The 5% difference in admission rates does confirm the Washington State DOH methodology Step 3 - A Analysis of Expected versus Actual Admissions difference of 4%.

Exhibit 2 shows that the Whatcom Hospice has one of the lowest average length of stay among hospices in Washington State, 55.7 days and Washington State hospices do not compare favorably on length of stay on a national average level which is 84 days.[16]

Exhibit 3 shows that only 66% of patients discharged from hospitals are discharged directly (same day) into Whatcom Hospice compared to a national average of 79%.

Exhibit 4 shows that the percentage of direct transfer (same day) of hospital patients to hospice has declined steadily over the 2015 – 2018 time period by 14%. Now only 66% of hospital inpatient discharges of hospice-eligible patients in Whatcom County are transferred directly to

[16] The CMS statewide average length of stay calculation treats all patients as new patients on Day 1 of a calendar year and assumes discharge for all patients on the last day of a calendar year which results in some duplicate counts of hospice patient admits and a modestly shorter length of stay than measuring unduplicated patients than the Medicare 55.7 ALOS for 2018 for Washington State hospice patients calculated by **Berg Data Solutions**, LLC

hospice services.

Exhibit 5 shows that hospice appropriate patients that are transferred from home health are admitted much slower to hospice than hospital discharges. On the 6th day after discharge 12% of the patients have not been admitted to hospice. This trend has continued for many years.

Exhibit 6 shows that hospice staff visit hours per day has declined by 18% from 2015 to 2018. This is a further sign of capacity stress with the continued alarming trend in lower nursing hours per patient day.

Since there is future net need for a hospice agency, there is no duplication of services. This application has documented the following:

- Whatcom County is the only Washington State County with a population of 100,000 or greater that does not have a choice of at least two hospices serving the county service area.
- Whatcom County has hospice admits that are 4% below the calculated admission expectation for 2018 and a length of stay in hospice that is at least 20% lower than the CMS calculated average length of stay for Whatcom Medicare patients.
- The existing hospice capacity is strained because the percentage of direct admits from St. Joseph to Whatcom Hospice has declined by 14% from 2015 – 2018 to 66% compared to a national average of 79%.
- The existing hospice capacity is strained in Whatcom County has a 12% of home health patients waiting 6 days or longer to be enrolled in hospice.
- The existing hospice capacity is strained in Whatcom County. Staff visit hours per day has declined by 18% from 2015 to 2018.
- As a community-based, non-sectarian hospice agency, Eden Hospice will actively support patients pursuing their "death with dignity" options as available under Washington law. As part of this effort, Eden will reach out to End of Life Washington for their advice and support in policy development, staff training and in locating needed resources.

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

Please see Appendices 14, 15, 16, for copies of Eden Hospice at Whatcom County policies relating to admissions, charity care and patient referral policy.

In carrying out active outreach Eden Hospice will carry out the following actions:

- Develop policies tailored to the end of life needs of Patients with Special Communications Needs (including hearing disabilities, language & cultural requirements).

- Maintain a housing resource availability data base to use when Eden Hospice is referred terminally ill persons who are homeless or have unstable housing situations, the medical social worker will then connect with local resources to locate housing options specific to their needs.

- Address the current general unmet need. As documented by the Department of

Health's, capacity modified hospice need methodology, at least 249 Whatcom County patients will go without needed hospice care in 2021. These are individuals made vulnerable by virtue of their end-of-life status and are precisely the patients that Eden hospice is designed to serve.

- As noted in our response to **Section Question 2. Define the types of patients that are expected to be served by the project (page 37)** Eden will focus culturally competent outreach efforts to eight special population-based cohorts using our 7-year local knowledge of the community to meet specific needs of these cohorts for hospice care .

- In affirmation of our commitment to veterans, Eden Hospice at Whatcom County will enroll in the We Honor Veterans program, a partnership between the National Hospice and the Palliative Care Association and the Veterans Administration.

- Nationally, the majority of hospice patients are very elderly women. Eden will provide additional Medicare hospice care and outreach in Whatcom County with supporting home care and home health resources which address the needs of this group. And, compared to the average population, the group of elderly persons – especially women – who are living on fixed incomes have a higher percentage of low-income persons.

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

- Eden Whatcom Hospice will develop relationships with veterans' groups and providers, e.g., The Whatcom County Veterans Advisory Committee, of their medical care in tailoring its hospice services to the needs of this large and growing population in the service area.

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

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

Please see Appendices 14,15, 16 for copies of Eden Hospice at Whatcom County policies relating to admissions, charity care and patient referral policy.

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

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

This question is not applicable.

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

This question is not applicable.

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

This question is not applicable.

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

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

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

This question is not applicable, as there are no capital costs for this project.

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

This question is not applicable, as there are no capital costs for this project.

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

Please see Appendix 22 which includes the pro forma forecast showing operating revenue and expenses for the first three full years of operations. There is no impact on capital costs, as no capital is required for this project.

Hospice care has been shown to be cost-effective and is documented to reduce end-of-life costs without sacrificing quality of care. Research literature supports the cost-effectiveness of hospice care. In one study, researchers analyzed the association of hospice use with survival and healthcare costs among patients diagnosed with metastatic melanoma. The researchers found that patients with four or more days of hospice care had longer survival rates and incurred lower end-of-life costs. The patients with four or more days of hospice incurred on average costs of $14,594, compared to the groups who received one to three days of care, and no hospice care at all ($22,647 and $28,923, respectively).[10]

In a more recent study, researchers simulated the impact of increased hospice use among Medicare beneficiaries with poor-prognosis cancer on overall Medicare spending. The study identified 18,165 fee-for-service Medicare beneficiaries who died in 2011 with a poor-prognosis cancer diagnosis, and then matched them to similar patients who did not receive hospice services. Using a regression model to estimate the difference in weekly costs, the study estimated an annual national cost savings between $316 million and

[10] *Survival and Cost-Effectiveness of Hospice Care for Metastatic Melanoma Patients,* The American Journal of Managed Care, Volume 20, Number 5, May 2014.

$2.43 billion with increased hospice use. Under realistic scenarios of expanded hospice use for Medicare beneficiaries with poor-prognosis cancer, the program could save $1.79 billion annually.[11] While the study was limited to poor-prognosis cancer patients, they are the largest single group who receives hospice care. Based on current research and experience, Eden expects the project will contribute to overall lower end-of-life costs resulting in overall lower charges for health services.

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

Please see Appendix 12 which includes a pro forma forecast showing operating revenue and expenses for the first three full years of operations.

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

Not applicable, there is no capital expenditure.

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

As represented by EmpRes Healthcare Management, LLC, the members of Eden Hospice at Whatcom County, LLC will make capital contributions sufficient to support the start-up cash flow requirements of the expansion into Whatcom County. The source of the funds is from cash generated through operations of the members of EmpRes Healthcare Management, LLC backed up by a $40 million line of credit commitment, secured by accounts receivable, with MidCap Financial.

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

This question is not applicable, as there is no financing for this project.

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

Please see Appendix 12 which includes a pro forma forecast for expense and revenue statements for the first three full years of operation.

Please see Appendix 12 for a balance sheet for the first three years of operations.

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

This question is not applicable, as there are no capital expenditures for this project.

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

Please see Table 14, which provides the expected payer source mix for the project. The payer mix is modeled to remain the same for the first three years of operation. The projected payer mix is based on the assumptions in other similar counties in Washington State including Clark County, Clallam County and Snohomish County

Table 14: Eden Whatcom Hospice Expected Payer Mix Percent

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

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

Please see Appendix 13 for the revenue and expense statement for the EmpRes Hospice, LLC Pro Forma. In addition, please see Appendix 28a & 28b for 2016 - 2018 audited financial statements for EmpRes Healthcare Group, Inc.

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

Please note that EmpRes Healthcare Group, Inc or EmpRes Hospice, LLC do not hold cash flow statements at the facility level, and EmpRes does not routinely use facility level cash flow statements as part of its financial analysis when evaluating new business ventures

In addition, please see Appendix 28a and 28b for EmpRes Healthcare Group, Inc audited financials covering the last three complete years.

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

Appendix 28 provides the audited balance sheets for the last three full years of operation that are available.

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

This question is not applicable to hospice providers, as charges for services provided by Medicare certified agencies are set by Medicare based on a *fixed per diem rate*. This fixed per diem rate is based on factors such as local wage index, length of stay, and level of care.

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

This question is not applicable to hospice providers, as charges for services provided by Medicare certified agencies are set by Medicare based on a *fixed per diem rate*. This fixed per diem rate is based on factors such as local wage index, length of stay, and level of care. Please see Appendix 22.

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

Appendix 22 provides the addition of FTEs with salaries and benefits for each employee class over the first three complete years.

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

As represented by EmpRes Healthcare Management, LLC, the members of Eden Hospice at Whatcom County, LLC will make capital contributions sufficient to support the start-up cash flow requirements of the expansion into Whatcom County. The source of the funds is from cash generated through operations of the members of EmpRes Healthcare Management, LLC backed up by a $40 million line of credit commitment, secured by accounts receivable, with MidCap Financial.

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

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

Please see Appendix 22 for the Eden Hospice at Whatcom County projected number of FTEs for the proposed project.

2. **Please provide your staff to patient ratio.**

Table 15 provides Eden Hospice at Whatcom County staff to patient ratios.

Table 15: Eden Hospice at Whatcom County Staff / Patient Ratio

Type of Staff	Eden Hospice at Whatcom County
	Staff / Patient Ratio
Skilled Nursing (RN & LPN)	1:10
Physical Therapist	Contract only
Occupational Therapist	Contract only
Medical Social Worker	1.3
Speech Therapist	Contract only
Home Health / Hospice Aide	1:10
Chaplain	1:4

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

Eden evaluated applications that had been approved in the 2018 and 2019 cycles in preparing staffing ratios. Table 16 provides comparative data based on a review of staffing tables and assumptions in the certificate of need applications that were evaluated

Table 16: Comparative Staff : Patient Ratios on Recently Approved Hospice Agencies

Type of Staff	Olympic Medical Center 2019 CoN	Providence 2018 CoN	Envision 2019 Snohomish	Inspiring 2019 Snohomish
	Staff / Patient Ratio	Staff / Patient Ratio	Staff / Patient Ratio	Staff / Patient Ratio
Skilled Nursing (RN & LPN)	1: 10	1:11	1:10	1:8
Physical Therapist	Contract only	Contract only	Contract only	Contract only
Occupational Therapist	Contract only	Contract only	Contract only	Contract only
Medical Social Worker	1:35	1:25	1:35	1:03
Speech Therapist	Contract only	Contract only	Contract only	Contract only
Home Health / Hospice Aide	1:10	1:15	1:10	1:8
Chaplain	Contract per Visit	1:50	1:37	1:30

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

Hospice services have been proven to reduce the demand for inpatient hospital services and the nursing and other ancillary staff needed to support hospital inpatients. As a result, hospice in general reduces the demand for hospital-based nursing staff by reducing hospital length of stay and reducing readmissions to acute care hospitals.

As a large multi-state organization, EmpRes and Eden have employees, visibility and contacts across numerous job markets. Specific to Whatcom County, EmpRes currently operates both a home health agency and a skilled nursing facility in Whatcom County so it has local knowledge and established relationships within Whatcom County for recruiting staff.

Eden Hospice at Whatcom County is an employee owned agency. This is an added recruitment advantage in several important aspects of staffing, recruitment and retention:

- EmpRes maintains a recruitment office to systematically recruit for employees (see Appendix 18).

- Staff mobility within and between labor markets supports recruitment and enhances overall retention efforts for employees stay in the EmpRes and Eden organizations (see Appendix 18).

- As an employee-owned organization, EmpRes and Eden experience lower turn-over rates than many other health care providers.

- Co-location of Eden Hospice with EmpRes Home Health of Bellingham will reduce the need for new employees particularly in the start-up years.

- The EmpRes commitment to Employees/Residents reflected in the company name is also reflected in management efforts to prioritize employees and residents as core to any success again reducing turnover and making EmpRes an attractive employer.

- EmpRes maintains an Employee Referral bonus program (see Appendix 18).

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

Appendix18 provides the training plan.

6. **Describe your methods for assessing customer satisfaction and quality improvement**

Please see Appendix 19 for the Eden Hospice at Whatcom County Quality Assurance Performance Improvement (QAPI) Policy and Plan.

The primary goals of the organizational Quality Assurance Performance Improvement (QAPI) Plan are to continually and systematically plan, design, measure, assess, and improve performance of organization-wide key functions and processes relative to patient care, treatment, and services.

Element 1. D. vii. Addresses the methods for assessing customer satisfaction and quality improvement.

CAHPS and Quality Results

1. To achieve this goal, the plan strives to:
    a. Incorporate quality planning throughout the organization.
    b. Collect data to monitor performance.
    c. Provide a systematic mechanism for the organization's appropriate individuals, departments, and professions to function collaboratively in their Quality Assurance Performance Improvement (QAPI) efforts providing feedback and learning throughout the Agency.
    d. Provide for an organization-wide program that assures the Agency designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses, and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of patients and their families, staff, and others. Process design contains the following focus elements:
        i. Consistency with the organization's mission, vision, values, goals, and objectives and plans.
        ii. Meets the needs of individuals served, staff, and others.
        iii. Fosters the safety of patients and the quality of care, treatment, and services.
        iv. Supports a culture of safety and quality.
        v. Use of clinically sound and current data sources (e.g. use of practice/clinical guidelines, information from relevant literature and clinical standards).
        vi. Is based upon best practices as evidenced by accrediting bodies.
        vii. Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this organization.

        viii. Utilizes reports generated from OASIS data, including the following OASIS reports:

            - Outcome-Based Quality Monitoring (OBQM) Potentially Avoidable Events Report and Patient Listing.
            - Outcome-Based Quality Improvement (OBQI) Outcome Report.
            - Error Summary Report.
            - Utilizes the results of Quality Assurance Performance Improvement (QAPI), patient safety and risk reduction activities.
            - Management of change and Quality Assurance Performance Improvement (QAPI) supports both safety and quality through the Agency.

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

The intended hours of operation will be from 8:00 a.m.-5:00 p.m. daily for regular office hours, with 24/7 access to nursing, including nursing visits.

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

EmpRes has been a Whatcom County healthcare provider for 7 years. Its home-health agency, homecare agency, and skilled nursing facility is well established and provides existing ancillary and support services. The existing ancillary and support services include but are not limited to the following:

- **Occupational Therapy, Physical Therapy, and Speech Therapy:** EmpRes Home Health agency currently have these resources in place.

The relationships demonstrate that Eden Hospice at Whatcom County has the capabilities to meet the service demands for the project. Once the project is approved, Eden Hospice will work to make any necessary adjustments or amendments to the agreements in order to provide the full spectrum of hospice services in Whatcom County.

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

As an established provider in the community, Eden Hospice already works closely with local hospitals, physicians, and other providers to ensure continuity of care while avoiding fragmentation of care. EmpRes will leverage its existing relationships, both inside and outside of Whatcom County, and wherever necessary build additional relationships as needed to ensure a full spectrum of care.

Current relationships include but are not limited to the following:

- **Hospital:** Eden Hospice will establish an agreement with PeaceHealth to make available inpatient services and Whatcom Hospice House available to hospice patients.
- **Respite Care:** Eden Hospice will work with Evergreen at Bellingham, LLC and other SNFs in Whatcom County and surrounding counties.
- **Long Term Care facilities:** Eden Hospice will work with Evergreen at Bellingham, LLC and other SNFs in Whatcom County and surrounding counties.
- **Pharmacy Benefit Manager:** EmpRes has an agreement with
- **Home Medical Equipment and Specialty Pharmacy Services**
- **Oncology Cancer Center:** Eden Hospice will develop strong working relationships with PeaceHealth St. Joseph Cancer Center programs.
- **Primary Care Clinics:** Eden Hospice will develop additional relationships with primary care clinics including the clinics identified in this certificate of need application.

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

There are no such convictions or denial or revocation of licenses, so this question is not applicable.

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

Eden has no other hospice operating in Washington State.

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

Eden Hospice at Whatcom County, LLC is wholly owned by EmpRes Healthcare Group, Inc. EmpRes is a 100% employee-owned organization with well-established roots in Whatcom County. It currently has approximately 78 entities in Washington State and regionally including nursing homes, assisted living facilities, home health agencies, home care agencies and Medicare certified agencies. In 2014, EmpRes Healthcare Group acquired an existing home health agency in Whatcom County renaming the agency as EmpRes Home Health of Bellingham, LLC. EmpRes also operates Eden Home Care of Whatcom County, LLC and Evergreen at Bellingham, a 122-bed post acute care and long-term care skilled nursing home.

EmpRes operates 2 hospices, in Arizona and Nevada. It does not operate any hospice agencies within Washington State. EmpRes has seven years experience in providing home health, skilled nursing or home care services in Whatcom County and has established strong relationships.

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

Eden Home Health does not have any existing hospice agencies in Washington State.

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

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

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

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

· **Capital costs;**

· **Staffing impact.**

Eden Hospice at Whatcom County, LLC is requesting CN approval to operate a Medicare certified and Medicaid eligible hospice agency in Whatcom County. The hospice agency will be co-located with the EmpRes Home Health of Whatcom County, LLC agency.

As a certificate of need rules requirement, Eden Hospice evaluated the following alternatives: (1) status quo: "do nothing or postpone action," (2) develop the proposed project: and request CN approval for a hospice agency, (3) develop a joint venture with a community partner to collaborate with at least one other party to operate a hospice agency.

The first two alternatives are clearly understood but additional comments on the third alternative, a "joint venture" is helpful given the definition of "joint venture" which is:

> "A joint venture is created with a specific project in mind and generally dissolves once the project has been completed. Members of the joint venture are exposed to full legal liability. A joint venture is treated like a partnership for federal income tax purposes."[17]

As used in this analysis, the project is a "home health agency" which is ongoing until one of the parties wishes to withdraw per the terms of the joint venture legal agreement. Our use of the "joint venture" term would also include collaborations among two or more parties that would be covered by a formal contract or by a written agreement.

The three alternatives were evaluated using the following decision criteria: (1) access to hospice services; (2) health outcomes, (3) quality of care; (4)health care cost control for patients and for payers (5) operating efficiency; and Impact on the existing hospice agency. Each alternative identifies advantages and disadvantages. Based on the above decision criteria and the analyses of each criteria covered in Tables 18 -23, the requested project — seek CN approval to operate a Medicare certified and Medicaid eligible hospice agency — is the best option.

[17] USLegal.com definition

Table 18. Alternative Analysis: Access to Hospice Services

Advantages/Disadvantages	
The Provisional Unmet Need in the 2019 methodology identified a 2012 unmet need of a 30 patient ADC. Hospice applications that meet all of the other provisions of the four criteria if there is a population that is not receiving hospice services. The 2019 methodology when adjusted for lower than expected Whatcom Hospice admissions and a lower than expected ALOS yielded a 2019 unmet need of a 42 ADC. An analysis of 7 capacity related metrics documents that the Whatcom Hospice is unable to provide sufficient capacity that are barriers to access and can lead to increased healthcare costs for patients and payers.	
1) Status Quo: Do nothing or postpone action	There is no advantage to maintaining the status quo in terms of improving access. In 2018, the State methodology yielded a 2020 unmet need that rounded to a 35 ADC. Admits were higher but ALOS was substantially Lower. hospice ALOS or lower admits increase healthcare costs. Lower admits deny hospice-eligible patients the benefits of hospice care.
2) Requested Project: CN approval – to operate a hospice agency	The requested project reduces current and future access barriers identified in the Whatcom County Planning Area. It adds choice as well as a non-sectarian agency that should ease real and perceived "patient-family control of the end of life experience" related to the "Death with Dignity" statute. Admits and ALOS should increase because delays in enrollment will be sharply reduced and Eden will open new outreach channels for patients to enroll in hospice.
3) Develop a joint venture or collaboration with a community agency	In regard to access, the purpose of developing a joint venture would be to increase admits for patients by opening new outreach channels. A collaboration that would facilitate outreach in North Whatcom County would be an example of a joint venture or collaboration that could be considered. Given time constraints, this organizational form could be implemented at any time if it was advantageous, which would occur after a CoN approval.
Conclusion: The status quo is clearly not advantageous for the community from an access standpoint given the unique lack of hospice choice in a metropolitan county and the alarming metrics around lower than expected admits, and hospice ALOS as well as delays in enrollment in hospice both from hospital and home health transfers. In regard to a joint venture or collaboration, it could be implemented at any time when there was an opportunity, but it would be based on approving a new hospice agency first. Given the very limited timeframe and the effort to create a collaboration, a CoN needs to come first.	

Table 19. Alternative Analysis: Improved Health Outcome Hospice

Advantages/Disadvantages	
The literature points to an ideal ALOS of 6 months. Studies cited in this application document that patients with terminal diagnoses with a longer progression of illness (the ALOS is 88 days but the median ALOS is 18 days), live longer with reduced hospitalizations and use of the emergency room if they are enrolled in hospice.	
1) Status Quo: Do nothing or postpone action	There is no advantage to maintaining the status quo in terms of improving health outcomes. In 2018, the State methodology yielded a 2020 unmet need that rounded to a 35 ADC. Admits were higher, but ALOS was substantially lower. Hospice ALOS or lower admits increase healthcare costs. Lower admits deny hospice-eligible patients the benefits of hospice care. If patients delay enrollment or do not enroll and die without hospice, they will likely have a shorter and painful death experience.
2) Requested Project: CN approval – to operate a hospice agency	The requested project reduces current and future access barriers identified in the Whatcom County Planning Area. ALOS should increase because delays in enrollment will be sharply reduced. Eden will open new outreach channels for patients to enroll in hospice. A greater percentage of the hospice eligible population enrolling in hospice and longer ALOS will extend the lives of dying patients as well as reduce their discomfort.
3) Develop a joint venture or collaboration with a community agency	If a collaboration facilitated outreach in North Whatcom County and facilitated earlier enrollment as well as the percentage of enrolled hospice-eligible patients, then a joint venture could be considered. This organizational form could be implemented at any time if it was advantageous but generally after a CoN was approved.
Conclusion: The status quo is clearly not advantageous for the community from a health outcome standpoint given the alarming metrics around lower than expected admits and hospice ALOS as well as delays in enrollment in hospice both from hospital and home health transfers. In regard to a joint venture or collaboration, it could be implemented at any time when there was an opportunity, but it would be based on approving a new hospice agency. Given the very limited timeframe and the effort to create a collaboration, a CoN needs to come first.	

Table 20. Alternative Analysis: Quality of Care

Advantages/Disadvantages	
The literature points to an ideal ALOS of 6 months. Studies cited in this application document that patients with terminal diagnoses with a longer progression of illness (the ALOS is 88 days but the median ALOS is 18 days), live longer with reduced hospitalizations and use of the emergency room if they are enrolled in hospice. In addition to technical metrics, the care experience is also a quality metric. When patients and families are queried about the care experience, they often attribute quality of care issues as an issue of "not being on hospice long enough." The literature on this point seems to be that dissatisfaction with hospice services is more related to elements of care rather than length of stay.[18]	
1) Status Quo: Do nothing or postpone action	There is no advantage to maintaining the status quo in terms of improving. Metrics such as persistent and in some cases growing delays in enrollment to hospice both from the hospital and from home health agencies and the trend of reduced care minutes per patient for the Whatcom Hospice are the kind of metrics that can detract from the patient and family care experience. As noted earlier, these metrics seem to be related to capacity constraints for the Whatcom Hospice.
2) Requested Project: CN approval – to operate a hospice agency	The requested project should increase ALOS and should reduce delays in enrollment. These two factors alone should improve the care experience for the patient and family. Ideally minutes of hospice care per day will also increase to national average rates.
3) Develop a joint venture or collaboration with a community agency	If a joint venture or collaboration increased ALOS then the care experience should improve. A North Whatcom County collaboration could also reduce delays in enrollment and support more timely provision of care services in the rural area. This organizational form could be implemented at any time if it was advantageous but after a CoN was approved.
Conclusion: The status quo is clearly not advantageous for the community from health quality of care standpoint given the metrics around delays in enrollment in hospice both from hospital and home health transfers. In regard to a joint venture or collaboration, it could be implemented at any time when there was an opportunity, but it would be based on approving a new hospice agency. Given the very limited timeframe and the effort to create a collaboration, a CoN needs to come first.	

[18] Joan M. Teno, MD *et al.* Timing of Referral to Hospice and Quality of Care: Length of Stay and Bereaved Family Members' Perceptions of the Timing of Hospice Referral, Journal of Pain and Symptom Management Aug. 2007 pp 120, 123

Table 21. Alternative Analysis: Healthcare Cost Control – Patient and Payer

The literature points to an ideal ALOS of 6 months. Studies cited in this application document that patients with terminal diagnoses with a longer progression of illness (the ALOS is 88 days but the median ALOS is 18 days), live longer with reduced hospitalizations and use of the emergency room if they are enrolled in hospice. A Providence Hospice financial analysis in the approved CN 19-44 calculated a potential statewide savings of $99 million if all hospice eligible patients received 35 days of hospice care in short if admits and ALOS increased.[19] A melanoma study found that patients who received 4 or more hospice days had average costs of $14,594, compared to the groups who received one to three days of care, or no hospice care at all ($22,647 and $28,923 respectively.[20]	
1) Status Quo: Do nothing or postpone action	There is no advantage t**o** maintaining the status quo in terms of reducing patient or payer healthcare costs. In 2018, the State methodology yielded a 2020 unmet need that rounded to a 35 ADC. Admits were higher but ALOS was substantially. Lower hospice ALOS or lower admits increase healthcare costs. Lower admits deny hospice-eligible patients the benefits of hospice care.
2) Requested Project: CN approval – to operate a hospice agency	The requested project increases admits and ALOS should increase because delays in enrollment will be sharply reduced and Eden will open new outreach channels for patients to enroll in hospice. A higher percentage of hospice-eligible patients enrolling in hospice along with a longer ALOS for hospice care will reduce healthcare costs for both patients and payers.
3) Develop a joint venture or collaboration with a community agency	If a collaboration facilitated outreach and more admits in North Whatcom County and facilitated earlier enrollment as well as the percentage of enrolled hospice-eligible patients then a joint venture could be considered. Given the cost reductions associated with setting up a new hospice for Eden, operating costs are not a major driver. This organizational form could be implemented at any time if it was advantageous.
Conclusion: The status quo is clearly not advantageous for the community from a healthcare cost control standpoint given the lower than expected admits and hospice ALOS as well as delays in enrollment in hospice both from hospital and home health transfers. The requested project is advantageous. In regard to a joint venture or collaboration, it could be implemented at any time when there was an opportunity, but it would be based on approving a new hospice agency. Given the very limited timeframe and the effort to create a collaboration, a CoN needs to come first.	

[19] *Op cit.* See footnote 10 for details and narrative on page 35.
[20] *Op cit.* See footnote 3 for details and narrative on page 9.

Table 22. Alternative Analysis: Operating Efficiencies

Advantages/Disadvantages	
There are distinct advantages to having Eden Hospice co-locate with EmpRes Home Health of Whatcom County; there will be no additional capital expenditure and utilities costs can be allocated to two programs rather than one program' Given that the Eden agency will be co0located with a 4-county home health agency, there will be economies of scale. In addition, the expense of developing multiple ancillary contracts can be avoided. Finally, co-locating should improve enrollment of hospice-eligible home health patients into hospice should be facilitated (easier and reduced wait times).	
1) Status Quo: Do nothing or postpone action	There is no advantage to maintaining the status quo in terms of operating efficiencies. In fact, Eden Hospice breakeven costs should be reduced with no capital expenditure and with a reduction in utilities and rent.
2) Requested Project: CN approval – to operate a hospice agency	Eden Hospice breakeven costs should be reduced with no capital expenditure and with a reduction in utilities and rent.
3) Develop a joint venture or collaboration with a community agency	There are more limited operating efficiencies related to a joint venture or collaboration facilitated outreach in North Whatcom County. The principal benefit would be potentially shortened response time for patient care. However, most of the staff are field-based rather than office-based, so operating efficiencies are generally more limited. While joint ventures and collaborations can improve quality and continuity of care, they generally consume greater administrative time by both joint venture partners and often fail due to corporate culture issues.
Conclusion: The status quo is clearly not advantageous for the community. Joint ventures and collaborations are generally less efficient in terms of management time use. The key to a successful collaboration or joint venture would be if there were a dramatic increase in volume, improvement in continuity of care or risk reduction. Since EmpRes is a relatively large enterprise related to the financial risk of a relatively small community agency, the financial risk is low compared to the management efforts surrounding a joint venture.	

Table 23. Alternative Analysis: Impact on Whatcom Hospice

Advantages/Disadvantages	
As noted in this application, Whatcom Hospice is under capacity stress resulting in shorter lengths of stay and limited outreach as shown by admissions. Eden being co-located with a 4-county home health agency can operate with great economies of scale without large patient volumes that could affect Whatcom Hospice and additional staffing is minimized due to the economies of scale. This addition of capacity should reduce future capacity stress for Whatcom Hospice while not reducing current volumes. This will give Whatcom Hospice an opportunity to catch up with their current volume of patients.	
1) Status Quo: Do nothing or postpone action	The status quo shows the Whatcom Hospice is under capacity stress. Delays in enrollment into hospice from home health and from hospitals is increasing; admits and ALOS of hospice care are below state and national averages and visit hours per patient day are below the national average and have declined by 18% from 2015 through 2018. It cannot meet the Eden projected hospice need leaving **populations underserved.**
2) Requested Project: CN approval – to operate a hospice agency	Addition of the Eden Hospice will not reduce the capacity of the Whatcom Hospice. Most Eden Hospice patients will be generated by new outreach channels and simply by choice – choice that is afforded residents in other metropolitan areas. In addition, delays in enrollment from hospitals and home health agencies will be reduced or eliminated increasing ALOS. Patients who now delay or reject enrollment over real or perceived "loss of control" issues surrounding the "Death with Dignity" restrictions for Whatcom Hospice will have an alternative to no hospice care; increased patients in the SNF and home health outreach channels will be generated. As an additional benefit, Whatcom Hospice can increase its visit hours of care per hospice day.
3) Develop a joint venture or collaboration with a community agency	Joint ventures and collaboration if implemented by Eden Hospice would occur after the opening of the hospice and would have minimal to no effect on Whatcom Hospice. The purpose of a collaboration would be to increase access to special populations such as rural residents in Whatcom County. These enrollments would primarily represent new enrollments rather than replacement enrollments at Whatcom Hospice. The net result is that Whatcom Hospice would not see a reduced utilization but community residents would experience improved access and ALOS for hospice services.
Conclusion: The status quo is clearly not advantageous for the community. EmpRes has decided to first establish the Eden Hospice since a joint venture is not required to capitalize the project or to reduce risk given that Eden will co-locate its hospice with the EmpRes home health agency. If a collaborative relationship formed it would more likely be a limited contract rather than a joint venture partnership.	

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

Low hospice lengths of stay in Washington and Whatcom County, plus 2017 revisions to CMS payment formulas for hospice care, substantially reduce the potential for exceeding Medicare cost caps.

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

First, *a priori,* the Eden Hospice will provide a non-sectarian choice for hospice services that is available in every other Washington State metropolitan county with a population over 100,000 persons.

Hospice promotes efficiency as it shifts care from expensive hospital settings to lower cost, home-based settings. For patients who choose hospice, they forgo more expensive curative treatments and seek the best possible care experience focused on personalized goals, pain and symptom alleviation, and comfort through end of life. The analysis prepared by Providence in its approved CoN that was based on Medicare claims data, demonstrated the cost-effectiveness of hospice care and estimated savings of over $99 million across Washington State if all Medicare beneficiaries who died in 2017 without hospice instead benefited from five weeks of hospice.[21] In this new choice of hospice environment, more patients will be enrolled in hospice care and enrolled more rapidly. The evidence presented in this application documents that health care costs related to emergency room visits and hospital admissions can be reduced by providing palliative care in the hospice setting.

The Eden Hospice project will co-locate with the EmpRes home health agency. This co-location approach will not only eliminate capital costs and reduce operating overhead, but it will improve continuity of care and facilitate rapid enrollment of hospice and skilled nursing facility patients based on existing referral relationships established by EmpRes home health. In addition, Eden Home Health will reach out to 8 special population cohorts to increase hospice awareness and enrollment (see page 36).

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

This project eliminates all capital costs.

[21] *Op cit* .See footnote 10 and Exhibit 7, page 35.

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

This question is not applicable, as there is no planned construction or renovation for this project.

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 2

LETTER OF INTENT

eden HEALTH HOSPICE 100% Employee Owned

Eden Hospice at Whatcom County, LLC

316 E McLeod Rd., Ste. 101, Bellingham, WA 98226 | Phone: 360-734-5410 | Fax: 360-816-1652

December 27, 2019

Nancy Tyson, Executive Director
Washington State Department of Health
Health Facilities and Certificate of Need
111 Israel Rd., SE
Tumwater, WA 98501

Re: Eden Hospice at Whatcom County, LLC Letter of Intent to Operate a Medicare Certified and Medicaid Eligible Hospice Agency

Dear Ms. Tyson:

This letter of intent is issued on behalf of Eden Hospice at Whatcom County, LLC. Eden Hospice at Whatcom County, LLC in accordance with WAC 246-310-080, intends to operate a Medicare certified and Medicaid Eligible Hospice Agency to serve residents of Whatcom County.

1. **Description of proposed service**
   EmpRes Healthcare Group, Inc., through Eden Hospice at Whatcom County, LLC requests certificate of need approval to operate a Hospice Agency in Whatcom County.

2. **Estimated cost of the project**
   There are no capital costs associated with the proposed project.

3. **Identification of the service area**
   Eden Hospice at Whatcom County, LLC will provide services in the Whatcom planning area, as identified in WAG 246-310-290 (3).

Please address all correspondence to:
Jamie Brown, Vice President of Home Services
EmpRes Healthcare / Eden Health
4601 NE 77th Ave., Ste. 300,
Vancouver, WA 98662

Thank you for your attention.

Sincerely,

By: EmpRes Healthcare Management, LLC, its Manager
By: Michael J. Miller, CFO and Assistant Manager

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 3

CERTIFICATE OF FORMATION/LEGAL STRUCTURE OF EDEN HOSPICE AT WHATCOM COUNTY, LLC

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, KIM WYMAN, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

EDEN HOSPICE AT WHATCOM COUNTY, LLC

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

Effective Date: 01/03/2020
UBI Number: 604 561 430

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

Kim Wyman, Secretary of State

Date Issued: 01/03/2020

Office of the Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 01/03/2020
Effective Date: 01/03/2020
UBI #: 604 561 430

CERTIFICATE OF FORMATION

UBI NUMBER

UBI Number:
604 561 430

BUSINESS NAME

Business Name
EDEN HOSPICE AT WHATCOM COUNTY, LLC

REGISTERED AGENT

Registered Agent Name	Street Address	Mailing Address
C T CORPORATION SYSTEM	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES

REGISTERED AGENT CONSENT

Customer provided Registered Agent consent? - **Yes**

DURATION

Duration:
PERPETUAL

EFFECTIVE DATE

Effective Date:
01/03/2020

OTHER PROVISIONS

Other Provisions:

PRINCIPAL OFFICE

Phone:

Email:
LEGAL@EMPRES.COM

Street Address:
316 E MCLEOD RD STE 1 AND STE 8, BELLINGHAM, WA, 98226, UNITED STATES

Mailing Address:
4601 NE 77TH AVE, STE 300, VANCOUVER, WA, 98662, UNITED STATES

EXECUTOR

Title	Executor Type	Entity Name	First Name	Last Name	Address
EXECUTOR	INDIVIDUAL		TINA M.	NICKOLAS	4601 NE 77TH AVE, SUITE 300, VANCOUVER, WA, 98662-6736, UNITED STATES

RETURN ADDRESS FOR THIS FILING

Attention:
LEGAL DEPT

Email:
LEGAL@EMPRES.COM

Address:
4601 NE 77TH AVE STE 300, VANCOUVER, WA, 98662-6736, UNITED STATES

UPLOAD ADDITIONAL DOCUMENTS

Name	Document Type
No Value Found.	

UPLOADED DOCUMENTS

Document Type	Source	Created By	Created Date
No Value Found.			

EMAIL OPT-IN

☐ I hereby opt into receiving all notifications from the Secretary of State for this entity via email only. I acknowledge that I will no longer receive paper notifications.

AUTHORIZED PERSON - STAFF CONSOLE

☑ Document is signed.

Person Type:
ENTITY

First Name:
MICHAEL

Last Name:
MILLER, CFO AND ASSISTANT MANAGER

Entity Name:
EMPRES HEALTHCARE MANAGEMENT, LLC

Title:
MANAGER

Office of the Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 01/03/2020
Effective Date: 01/03/2020
UBI #: 604 561 430

INITIAL REPORT

UBI NUMBER

UBI Number:
604 561 430

BUSINESS NAME

Business Name
EDEN HOSPICE AT WHATCOM COUNTY, LLC

REGISTERED AGENT

Registered Agent Name	Street Address	Mailing Address
C T CORPORATION SYSTEM	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES

REGISTERED AGENT CONSENT

Customer provided Registered Agent consent? - **Yes**

EFFECTIVE DATE

Effective Date:
01/03/2020

OTHER PROVISIONS

Other Provisions:

PRINCIPAL OFFICE

Phone:

Email:
LEGAL@EMPRES.COM

Street Address:
316 E MCLEOD RD STE 1 AND STE 8, BELLINGHAM, WA, 98226, UNITED STATES

Mailing Address:
4601 NE 77TH AVE, STE 300, VANCOUVER, WA, 98662, UNITED STATES

GOVERNORS

Title	Governor Type	Entity Name	First Name	Last Name
GOVERNOR	ENTITY	EMPRES HEALTHCARE MANAGMENT, LLC		
GOVERNOR	INDIVIDUAL		BRENT	WEIL
GOVERNOR	INDIVIDUAL		MICHAEL	MILLER
GOVERNOR	INDIVIDUAL		JONATHON	ALLRED

NATURE OF BUSINESS

Nature of Business:
HEALTH CARE, SOCIAL ASSISTANCE & SERVICE ORGANIZATION

RETURN ADDRESS FOR THIS FILING

Attention:
LEGAL DEPT

Email:
LEGAL@EMPRES.COM

Address:
4601 NE 77TH AVE STE 300, VANCOUVER, WA, 98662-6736, UNITED STATES

UPLOAD ADDITIONAL DOCUMENTS

Name	Document Type
No Value Found.	

UPLOADED DOCUMENTS

Document Type	Source	Created By	Created Date
No Value Found.			

EMAIL OPT-IN

☐ I hereby opt into receiving all notifications from the Secretary of State for this entity via email only. I acknowledge that I will no longer receive paper notifications.

AUTHORIZED PERSON - STAFF CONSOLE

☑ Document is signed.

Person Type:
ENTITY

First Name:
MICHAEL

Last Name:
MILLER, CFO AND ASSISTANT MANAGER

Entity Name:
EMPRES HEALTHCARE MANAGEMENT, LLC

Title:

MANAGER

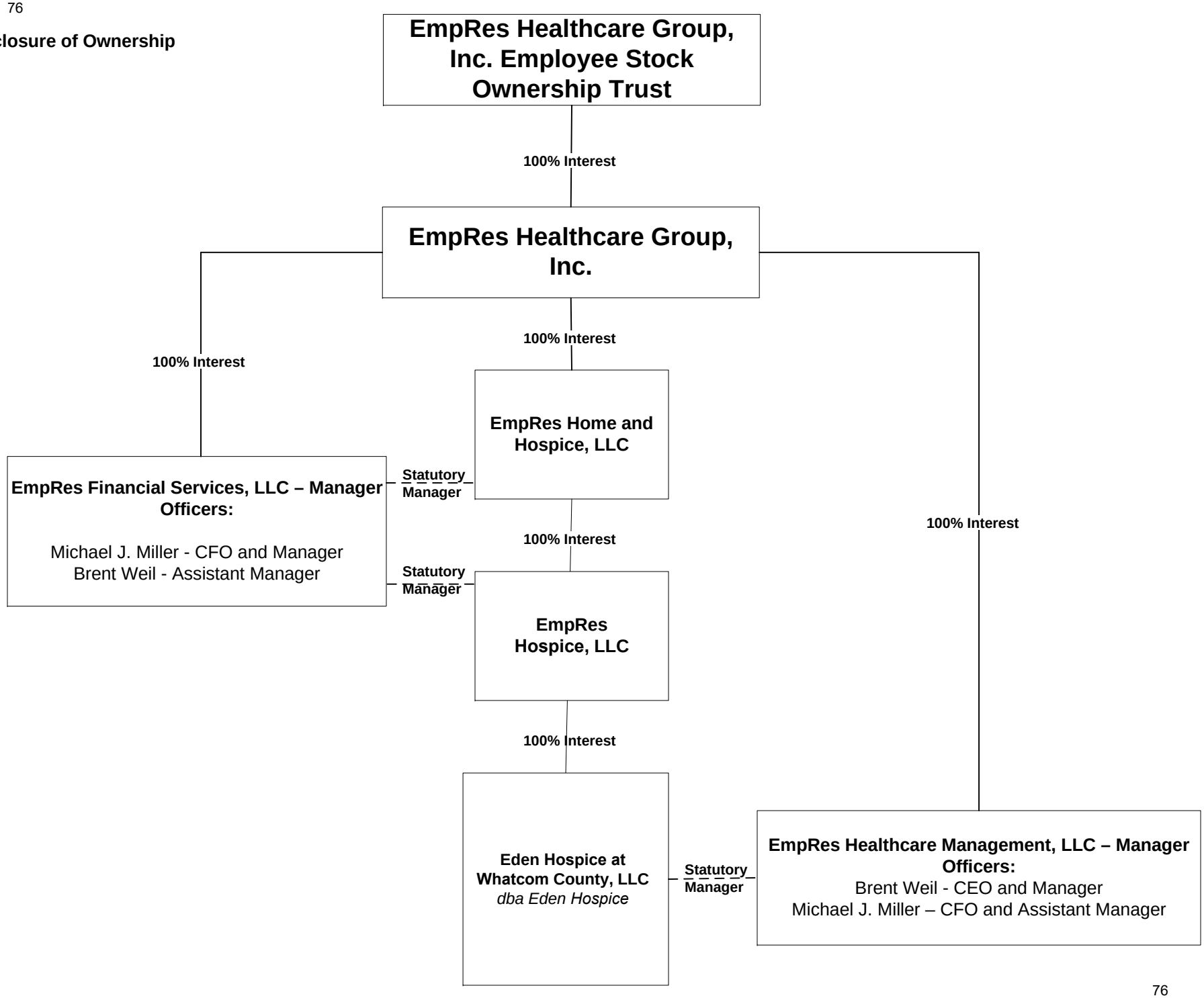
Eden Hospice at Whatcom County, LLC

Certificate of Need Application

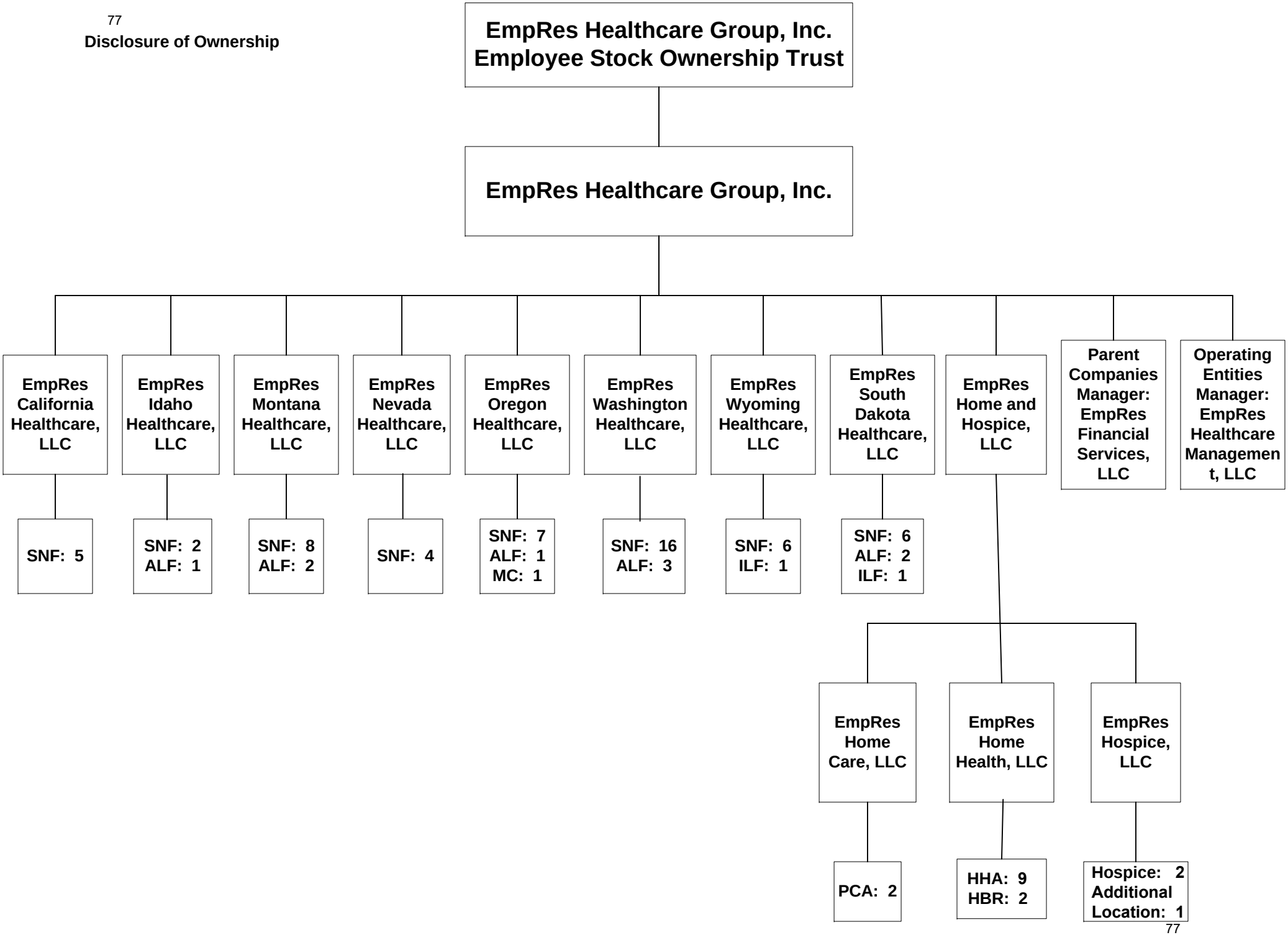
APPENDIX 4

ORGANIZATIONAL STRUCTURE OF EMPRES

Disclosure of Ownership



Disclosure of Ownership



Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 5

LETTER OF FINANCIAL COMMITMENT

EmpRes
HEALTHCARE MANAGEMENT
100% Employee Owned

VIA FEDERAL EXPRESS OVERNIGHT

January 28, 2020

Nancy Tyson, Executive Director
Health Facilities and Certificate of Need
Washington State Department of Health
111 Israel Rd., S.E.
Tumwater, WA 98501

RE: Eden Hospice at Whatcom County, LLC dba Eden Hospice

Dear Ms. Tyson:

The Certificate of Need Program's application for a Medicare-certified home health agency asks for a financial letter of commitment.

The members of Eden Hospice at Whatcom County, LLC have committed the necessary working capital to finance the establishment and operation of the proposed Medicare-certified hospice agency in Whatcom County.

On receipt of the Washington Certificate of Need, the members of Eden Hospice at Whatcom County, LLC will contribute sufficient funds currently estimated at approximately $100,000 to the working capital account of Eden Hospice at Whatcom County, LLC.

Sincerely,

Michael J. Miller
Chief Financial Officer
EmpRes Healthcare Management, LLC

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

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

APPLICATION FOR CERTIFICATE OF NEED
HOSPICE PROJECTS
(excludes amendments)

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

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

Signature and Title of Responsible Officer: EmpRes Healthcare Management, LLC, as Manager of Applicant, by Michael Miller, CFO  **Date: 01/28/2020**	**Person To Whom Questions Regarding This Application Should Be Directed:** Jamie Brown, Vice President Eden Health/EmpRes Home Services **Telephone Number:** 360-798-8298
Legal Name of Applicant: Eden Hospice at Whatcom County, LLC **Address of Applicant:** 4601 NE 77th Ave., Ste. 300 Vancouver, WA 98662 **Telephone Number:** 360-604-4210	**Type of Project (check all that apply):** [X] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Hospice Agency to Become Medicare Certified/Medicaid Eligible
Project Summary: Eden Hospice at Whatcom County, LLC intends to operate a Medicare certified and Medicaid eligible Hospice services to residents located in Whatcom County. **Estimated capital expenditure: $0**	

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

Department of Health
Certificate of Need Program
2725 Harrison Avenue, Suite 500
P 0 Box 47852
Olympia, Washington 98504-7852

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

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION

FOR REVIEW: TOTAL AMOUNT OF FEE ACCOMPANYING

THIS APPLICATION:

PROCESSING FEE: $21,968 0440035846

APPLICANT NAME:

DATE OF SUBMISSION: January 31, 2020

APPLICATION INFORMATION INSTRUCTIONS:

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

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

Department of Health
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501
P O Box 47852
Olympia, Washington 98504Y7852

- Please note that a **Letter of Intent** must be submitted for all projects, within a minimum of

30 days and a maximum of 6 months, prior to submission of the application. If a Letter of Intent is not received prior to application submission, the department will consider the application the Letter of Intent and no further action will be taken until the end of the 30 day Letter of Intent period.

- Please make the narrative information complete and concise. Data sources are to be cited Extensive supporting data, that tends to interrupt the narrative, should be placed in the appendix.
- DO NOT bind the application.
- Please number **ALL** pages consecutively.
- All cost projections are to be in non-inflated dollars. Use the current year dollar value for all program data and projections. **DO NOT** inflate these dollar amounts.
- Capital expenditures should not include contingencies. Certificate of Need statutes and regulations allow a 12 percent or $50,000.00 *(whichever is greater)* margin before an amendment to an approved Certificate is required.
- All subsequent correspondence in relation to the application must be submitted with an original and one copy.

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

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 6

LEASE

SUBLEASE

This Sublease dated _____ __, 20__ is by and between EmpRes Home Health of Bellingham, LLC, a Washington limited liability company ("Sublessor"), and Eden Hospice at Whatcom County, LLC, a Washington limited liability company ("Sublessee").

RECITALS

This Sub-Sublease is made and entered into with reference to the following facts:

A. WHEREAS, on February 23, 2016, 316, LLC (“Lessor”) and EmpRes Home Health of Bellingham, LLC entered into a lease agreement (as amended, the “Lease”) for the lease of the premises located at 316 E. McLeod Road, Suite 8 and Suite 1, Bellingham, Washington.

B. WHEREAS, Sublessor desires to sublease to Sublessee and Sublessee desires to sublease the Demised Premises Identified on Exhibit A on the terms and conditions set forth below.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt, sufficiency and mutuality of which are hereby acknowledged, it is agreed as follows:

1. Term: The initial term of this Sub-Sublease shall commence on the date of receipt Sublessee’s receipt of a Certificate of Need from the State of Washington ("Commencement Date") and shall continue for a year period ("Initial Term"). Provided that Sublessee is not in default under this Sub-Sublease, term of this Sub-Sublease shall automatically continue for 3 subsequent 1-year periods (the "Renewal Terms", and together with the Initial Term, the "Term"). This Agreement may be terminated by Sublessee upon at least 30 days notice prior to the end of the Initial Term or any subsequent Renewal Term.

2. Base Rent:

2.1.1. Beginning on the Commencement Date and through the end of the Initial Term, Sublessee shall pay Sublessor the monthly amount of 434.50 (“Monthly Base Rent”). Monthly Base Rent shall be negotiated by the parties prior to the beginning of any Renewal Term.

2.2. Monthly Base Rent shall be paid in advance on the first day of each and every calendar month during the Term hereof. The Base Rent for any fractional month shall be prorated. All Base Rent hereunder shall be due and payable without diminution or offset.

2.4. All payments of money other than monthly Base Rent required to be made by Sublessee pursuant to the terms of this Sub-Sublease shall be deemed "Additional Rent."

3. Insurance:

3.1. At all times during the term of this Sub-Sublease, Sublessee shall keep and maintain, at its own cost and expense, the following policies of insurance:

3.1.1. Property Insurance provided by a Causes of Loss-Special Form. Such Insurance shall, at all times be maintained in an amount equal to the full replacement cost of the Demised Premises. Such Insurance shall, at all times, also be maintained in the full replacement cost of the Personal Property located at or used in connection with the Demised Premises. As used herein the term "full replacement cost" shall mean coverage for the actual replacement cost of the Demised Premises. The term "full replacement cost" shall also mean coverage for the actual replacement cost of the Personal Property located at or used in connection with the Demised Premises.

3.1.2. Commercial General Liability Insurance Nursing Home or Long-Term Care Professional Liability Insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate for the Sublessee and all affiliates of common ownership. Coverage may be a claims made basis.

3.1.3. If the coverage provided under Section 3.1.2 is on a claims made basis, Sublessee is responsible for purchasing extended reporting period (tail) coverage providing protection for Lessor and Sublessor for one year, and

3.1.4. Worker's compensation insurance or other similar insurance which may be required by governmental authorities or applicable legal requirements in an amount not less than the minimum required by law.

3.2. Sublessee shall provide Master Lessor and Sublessor with copies or certificates or other evidence reasonably satisfactory to Sublessor establishing that Sublessee has obtained and continues to hold the policies of insurance required under Section 3.1, above. All such policies shall be in such form and content, including, without limitation, the amount of the deductible, and shall be issued by such company or companies as are approved by Sublessor, which shall not be unreasonably withheld.

3.3. All policies of insurance required hereunder shall provide that they may not be canceled, lapse, expire, or be materially altered except with thirty (30) days prior written notice to Sublessor.

4. Indemnification:

4.1. As a material part of the consideration to Sublessor, except for the gross negligent or willful acts of Sublessor, its employees and agents and those matters covered by insurance carried by Sublessee hereunder, Sublessee hereby expressly waives any and all claims against Sublessor for damages or liability for injury to persons or property in, on or about the Demised Premises from any cause whatsoever arising after the commencement of the term of this Sub-Sublease,

4.2, Sublessee shall indemnify, defend and hold harmless Sublessor, its agents, members, employees, officers, and directors, against each and every demand, claim, assertion, damages, actions, fees, including, without limitation, reasonable attorneys' fees, court costs and other expenses, paid, incurred or suffered arising or alleged to have arisen on or after the Commencement Date or out of any act or omission of Sublessee, its agents, members, employees, officers, directors, guests, invitees or licensees, or in connection with the use or occupation of the Demised Premises, including, without limitation, injury, death or damage to Sublessee's residents resulting from negligence, or relating to Sublessee's introduction, use, or remediation of hazardous materials, as defined in below.

5. Use of Premises: The Demised Premises shall be used solely as general office space for the management of home services agency operations. No patient cares services will be conducted within the Demised Premises.

6. Sublessor Not to Maintain: Sublessor shall not be required to repair or maintain, or pay for the repair or maintenance of, the Demised Premises. Sublessor may, but shall not be obligated to, perform any repairs or maintenance which is the obligation of Sublessee under this Sub-Sublease, after giving Sublessee thirty (30) days written notice to perform the repairs or maintenance or to begin such repairs and maintenance if the work may not reasonably be completed within thirty (30) days of receipt of written notice from Sublessor.

7. Alterations:

7.1. Except in the event of an emergency, Sublessee shall not make or allow to be made, without obtaining Sublessor's prior written consent, any structural alterations or improvements to the Demised Premises or any part thereof. In the event Sublessee intends to

undertake any alterations or improvements to the Demised Premises as provided herein, Sublessee shall provide to Sublessor written notice describing the nature of the alterations or improvements, the estimated cost thereof and stating the date the work related to the alterations or improvements is scheduled to commence and end. Sublessor shall respond within thirty (30) days of receipt of Sublessee's written notice of intent to make alterations or improvements.

7.2. Sublessee shall fully pay and discharge all claims for labor and materials furnished in connection with the repair, reconstruction, remodeling or alteration of the Demised Premises, to obtain lien releases for labor or materials for which payment has been made, and to take all other reasonable steps to forestall the assertion of lien claims against the Demised Premises.

7.3. All work done in connection with the repair, reconstruction, remodeling or alteration of the Demised Premises shall be performed in compliance with all applicable laws, ordinances, rules and regulations.

7.4. The repair, reconstruction, remodeling or alteration of the Demised Premises shall be performed in a workman like manner and in accordance with all applicable laws and regulations.

7.5. No repair, reconstruction, remodeling or alteration of the Demised Premises shall be effected unless and until Sublessee has obtained all required permits and consents from all governmental entities or agencies having jurisdiction over the Demised Premises.

7.6. All alterations and improvements constructed by Sublessee upon the Demised Premises shall, upon termination of this Sub-Sublease, belong to Master Lessor.

7.7. Sublessee shall save and hold Sublessor harmless from any and all liability of any kind on account of the repair, reconstruction, remodeling or alteration of the Demised Premises by Sublessee.

7.8. Prior to commencement of any work, alteration or repair to or of the Demised Premises by anyone other than Sublessee or the employees of Sublessee, Sublessee shall post or affix notices on or to the Demised Premises of Sublessor's non-responsibility for the performance of the work, alteration or repair and any claims or liabilities which may arise

8. Licensing Requirements: Sublessee shall maintain at all times during the term hereof and any extensions or renewals hereof all governmental licenses, permits and authorizations necessary for the establishment and operation of the Demised Premises for the

purposes permitted under this Sub-Sublease.

9. Waste and Nuisance: Sublessee shall not commit, or allow to be committed, any waste upon the Demised Premises, or any public or private nuisance. Sublessee shall not use, nor allow the Demised Premises to be used, for any improper, immoral, unlawful or objectionable purpose. Sublessee shall not allow objectionable odors or excessive noise to emanate from the Demised Premises.

10. Continuous Operation: Sublessee shall at all times during the entire term of this Sub-Sublease continuously operate the Demised Premises for the purposes permitted under this Sub-Sublease, and no other, subject to casualty, condemnation and remodeling. Sublessee shall use Sublessee's reasonable efforts to operate the Demised Premises efficiently in accordance with all Laws. Sublessee shall use Sublessee's reasonable efforts to optimize the census of patients at the Demised Premises.

11. Events of Default:

11.1 The occurrence of any of the following shall be deemed to constitute an event of default on the part of Sublessee hereunder:

11.1.1 The failure to pay rent, real or personal property taxes and assessments, utilities, or premiums for insurance under this Sub-Sublease;

11.1.2 The failure to pay other monetary obligations under this Sub-Sublease within fifteen (15) days after receipt of written notice;

11.1.3 In the reasonable and good faith judgment of Sublessor, any act or omission that places in jeopardy the continued licensing and/or certification of the facilities at the Demised Premises as then currently licensed, and/or its certification as either a Medicare or Medicaid provider, or that causes harm or embarrassment to the reputation and good will of the Demised Premises in the community if, within twenty-four (24) hours after written notice thereof from Sublessor to Sublessee, Sublessee shall not have either (i) cured such failure, or (ii) obtained an injunction or other order preventing revocation or suspension of licensing and/or decertification of the facilities at the Demised Premises by virtue of such failure or alleged failure, or (iii) provided Sublessor with assurances satisfactory to Sublessor in Sublessor's sole discretion that the facilities at the Demised Premises will not be subject to license suspension or revocation and/or decertification as a result of such failure or alleged failure;

11.1.4 The failure to perform or comply with any other term or provision of

this Sub-Sublease within fifteen (15) days after written notice of default, except for defaults that have longer cure periods under the Master Lease in which cure the cure periods and standards of the Master Lease shall apply;

11.1.5 An assignment by Sublessee of its property for the benefit of creditors;

11.1.6 The appointment of a receiver, trustee or liquidator for Sublessee, or any of the property of Sublessee, who or which is not discharged within ninety (90) days;

11.1.7 The levy of a writ of attachment against this Sub-Sublease which is not discharged within sixty (60) days;

11.1.8 Sublessee or any assignee of this Sub-Sublease files a voluntary petition under the federal Bankruptcy Act or of the law of any state, to be adjudicated a bankrupt or for any arrangement or other debtor's relief, or any such petition is filed against Sublessee by any other party and not dismissed within sixty (60) days after filing thereof; or

11.1.9 Any financial statements provided to Sublessor by Sublessee during the term of this Sub-Sublease are known by Sublessee to be materially false or misleading when given.

11.1.10 Any action taken by Sublessee that causes a default under the Master Lease and is not cured within the applicable time periods under the Master Lease.

11.2 In the event of the occurrence of any event of default mentioned in this Section 11, Sublessor shall have the right, at its election, by written notice to Sublessee, in addition to all other remedies, to terminate this Sub-Sublease.

12. Sublessor's Recovery From Sublessee: Upon termination of this Sub-Sublease by Sublessor, Sublessor shall be entitled to all remedies available under law.

13. No Waiver: No waiver by Sublessor of any breach of the covenants, conditions or agreements of this Sub-Sublease shall be construed to be a waiver of any succeeding breach of the same or of any other covenants, condition or agreement hereof.

14. Damage by Fire or Other Casualty:

14.1 In the event of a fire, earthquake or other casualty causing damage or destruction of the Demised Premises, subject to force majeure and the provisions of the Master Lease Sublessee shall promptly commence and diligently complete the repair or reconstruction of the Demised Premises to the condition that existed prior to such damage or destruction. The net insurance proceeds shall be used for the repair or reconstruction of the

Demised Premises. Sublessor shall execute all documents reasonably necessary to make the net insurance proceeds available to Sublessee to repair or rebuild the Demised Premises.

14.2 Subject to the provisions of the Master Lease, at the election of Sublessor, fire and extended peril insurance proceeds shall not be payable to Sublessee but shall instead be deposited in escrow with a bank or other federally-insured financial institution selected by Sublessor on terms and in accordance with procedures reasonably satisfactory to Sublessor and Sublessee, with funds released during the course and at completion of the repair or reconstruction, upon completion of the repair or reconstruction, and receipt by such third party escrowee of lien waivers from the contractors, subcontractors, and suppliers relating to the work completed.

14.3 Subject to the terms of the Master Lease, if there remains any surplus of insurance proceeds after the completion of the repair or reconstruction of the Demised Premises, such surplus shall belong to and be paid to Sublessee.

14.4 In any event during any time that Sublessee is unable to use and occupy the Demised Premises or any portion thereof as a result of damage or destruction occurring without fault of Sublessee, or as a result of any repairs thereof, the rent hereunder shall be abated to the extent, and only to the extent, of the proceeds of Sublessee's business interruption insurance made available to Sublessor or Master Lessor.

14.5 Sublessor shall have no liability whatsoever with respect to any goods, fixtures, equipment or other personal property of Sublessee, nor shall Sublessor have any liability for loss of revenues or income resulting from fire or other casualty.

15. Condemnation:

15.1 If during the term of this Sub-Sublease, the whole of the Demised Premises is taken or condemned by any competent public or quasi-public authority this Sub-Sublease shall terminate. If during the term of this Sub-Sublease, there is a partial taking the consequences of that taking shall be governed by Section 16 of the Lease.

15.2 Except as provided by the Master Lease all compensation upon any taking or condemnation of the Demised Premises shall belong to Master Lessor, except that Sublessee shall receive any compensation separately awarded for relocation, plus any sum separately awarded to compensate Sublessee for the value of any of Sublessee's personal property taken by condemnor.

15.3 Except as provided above, this Sub-Sublease shall not terminate and shall

remain in full force and effect in the event of a taking or condemnation of the Demised Premises, or any portion thereof; provided, however, that the Base Rent hereunder shall be adjusted for the remainder of the term of this Sub-Sublease in the same manner as the Base Rent is adjusted in the Master Lease.

16. Assigning and Subletting:

16.1 Sublessee may not assign this Sub-Sublease or any portion of the term hereof, or sublet the Demised Premises, or any portion thereof.

17. Covenants Against Liens: Except as expressly provided in this Sub-Sublease, Sublessee shall not, during the term hereof, suffer or permit any lien, including, without limitation, any tax, mechanic's or judgment lien or conditional sales agreement, to be attached to or upon the Demised Premises or any part thereof, including but not limited to Sublessor's personal property, by reason of any act or omission on the part of Sublessee, and hereby agrees to save and hold harmless Sublessor from or against any such lien or claim of lien.

18. Attornment And Subordination: Sublessee acknowledges and agrees that its rights under this Sub-Sublease are subject and subordinate to the term of the Lease, and to all amendments, renewals and extensions thereof, and to the matters to which the Lease is or shall be subject or subordinate and that in the event of termination of the Lease as a result of a default by Sublessor or reentry or dispossession of Sublessor as the tenant thereunder by Lessor, Lessor may, at its option, take over all of the right, title and interest of Sublessor, as sublessor under this Sub-Sublease and in such event provided Sublessee has not committed an event of default and no event has occurred which with the passage of time or giving of notice or both would constitute an event of default, Sublessee shall attorn to Lessor pursuant to the then executory provisions of this Sub-Sublease and Lessor shall not disturb Sublessee's quiet possession of the Demised Premises nor deprive Sublessee of any of its rights under the Sublease. In the event Sublessee receives a written Notice from the Lessor or Lessor's assignees, if any, stating that Sublessor is in default under the Lease, Sublessee shall thereafter be obligated to pay all Rent accruing under this Sub-Sublease directly to the party giving such Notice, or as such party may direct. All Rent received from Sublessee by Master Lessor or Lessor's assignees, if any, as the case may be, shall be credited against the amounts owing by Sublessor under the Lease.

19. Relationship of Parties: Nothing contained in this Sub-Sublease shall be deemed to constitute Sublessor and Sublessee as partners or joint venturers, or any other relationship

other than that of lessor and lessee.

20. Further Assurances: Sublessor and Sublessee shall execute such further documents and instruments as shall be necessary or appropriate to carry out the provisions of this Sub-Sublease. Sublessee shall execute such further documents and instruments and take such further action as is necessary to transition the operation of the Demised Premises back to Sublessor or Sublessor's designated agent upon the expiration or termination of this Sub-Sublease without interruption or discontinuation of the services being provided at the Demised Premises.

21. Estoppel Certificates: Sublessor and Sublessee shall, within ten (10) days after written request from the other, execute and deliver to the other, in recordable form, a certificate stating that this Sub-Sublease is unmodified and in full force and effect, or in full force and effect as modified, and stating the modifications, and that the other party is not in default hereunder, or is in default and specifying the nature and extent of the alleged default. Failure to deliver the certificate within said ten (10) days shall be conclusive upon the party to whom the request has been given that this Sub-Sublease is in full force and effect and has not been modified except as may be represented by the requesting party and that the requesting party is not in default hereunder.

22. Notices:

22.1 All notices or other documents required or permitted to be given hereunder shall be personally delivered, sent by private overnight courier, or sent by registered or certified mail, postage prepaid, return receipt requested.

22.2 Notices sent by registered or certified mail shall be deemed received the third business day after posting and notices sent by private overnight courier shall be deemed received the first business day after delivering the same to the private overnight courier during regular business hours.

23.3 Sublessor and Sublessee may change their addresses and/or telephone numbers for purposes of this Sub-Sublease upon written notice.

24. Quiet Enjoyment: Provided that Sublessee is not in default under this Sub-Sublease beyond all applicable cure periods, Sublessor shall not interfere with the peaceful and quiet occupation and enjoyment of the Demised Premises by Sublessee or Sublessee's permitted assignees, sublessees, or residents.

25. Authority: Sublessee shall deliver to Sublessor upon execution of this Sub-

Sublease a certified copy of a resolution of its board of directors or members, as applicable, authorizing the execution of this Sub-Sublease and naming the person(s) who is/are authorized to execute this Sub-Sublease on its behalf.

26. Intentionally Omitted.

27. Applicable Law: This Sub-Sublease shall be governed by, and construed in accordance with, the laws of the State of Washington.

28. Headings: The descriptive headings used in this Sub-Sublease are for convenience only and shall not control or affect the meaning or construction of any of its provisions.

29. Attorneys' Fees: If Sublessor or Sublessee brings any action to interpret or enforce this Sub-Sublease, or for damages for any alleged breach hereof, the prevailing party in any such action or arbitration shall be entitled to reasonable attorneys' fees as awarded by the court in addition to all other recoverable damages and costs.

30. Definitions: As used in this Sub-Sublease, following terms are defined as follows:

30.1 The term "days" shall refer to calendar days unless otherwise specified.

30.4 The term "hazardous materials" as used in this Sub-Sublease shall mean any substance, material, or waste which has been or becomes regulated by any local governmental authority, the State of California, or the United States government, including, but not limited to, "petroleum" as defined in 42 U.S.C. Section 6991(8), asbestos, lead paint, polychlorinated biphenyls, designated as a "hazardous substance" pursuant to Section 311 or listed pursuant to Section 307 of the Clean Water Act, defined as a "hazardous waste" pursuant to Section 1004 of the Resource Conservation and Recovery Act, defined as a "hazardous substance" pursuant to Section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act, or defined as "underground storage tank" under 42 U.S.C. Section 6991.

31. Severability: In the event any part or provision of this Sub-Sublease shall be determined to be invalid or unenforceable under the laws of the State of California, the remaining portion of this Sub-Sublease shall, nevertheless, continue in full force and effect.

32. Time: Time is of the essence of each and every provision of this Sub-Sublease.

33. Counterparts: This Sub-Sublease may be executed in any number of counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same agreement.

IN WITNESS WHEREOF, Sublessor and Sublessee have executed this Sub-Sublease the day and year first above written.

Sublessor:

EmpRes Home Health of Bellingham, LLC

_____
by EmpRes Healthcare Management, LLC, Manager
by Michael J. Miller, CFO

Sublessee:

Eden Hospice at Whatcom County, LLC

_____
by EmpRes Healthcare Management, LLC, Manager
by Michael J. Miller, CFO

Lessor Consent:

Lessor hereby consents to the sublease of the Demised Premises as provided in this Sublease:

316, LLC

By: _____

Name: _____

Title: _____

Dane: _____

Exhibit "A"

Floor Plan

CBA Form No. LA
Addendum/Amendment to Leases
Rev. 5/07
Page 1 of 1

4/12/16 ADDENDUM/AMENDMENT TO CBA LEASES

The following is part of the Commercial Lease Agreement dated **February 23, 2016**,
Between **316 LLC** ("Landlord")
And **EmpRes Home Health of Bellingham, LLC** ("Tenant")
regarding the lease of the property known as **316 E McLeod Rd, Bellingham, WA 98226-6491**
(the "Premises").

IT IS AGREED BETWEEN THE LANDLORD AND TENANT AS FOLLOWS:

The sales tax ($6506.73) for the improvement will be added to the base rent of the lease. It will be spread out over 23 equal payments of $271.11 plus one final payment of $271.20.

Base rent 4331.04 + Improvement $3116.25 + Tax $271.11 = $7718.40 base rent per month for 23 months and one month for $7718.49.

Triple nets will have to be added to the total base monthly rent.

After the improvements and taxes are paid in full the rent schedule will follow the rent rider.

AGENT (COMPANY): **Keller Williams Western Realty** By: _____

ALL OTHER TERMS AND CONDITIONS of said Agreement remain unchanged.

INITIALS:
Tenant/Lessee _____ DATE 4-18-16
Tenant/Lessee _____ DATE _____

Landlord/Lessor _____ DATE _____
Landlord/Lessor _____ DATE _____

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)

THIS LEASE AGREEMENT (the "Lease") is entered into and effective as of February 23, 2016 (date), between 316 LLC ("Landlord"), and EmpRes Home Health of Bellingham, LLC (Tenant"). Landlord and Tenant agree as follows:

1. LEASE SUMMARY.

a. **Leased Premises.** The leased commercial real estate i) consists of an agreed area of approximately 5495 rentable square feet and is outlined on the floor plan attached as Exhibit A (the "Premises"); ii) is located on the land legally described on attached Exhibit B; and iii) is commonly known as 316 E. McLeod Road, Suite 8 and Suite 1, Bellingham WA (suite number and address). The Premises do not include, and Landlord reserves, the exterior walls and roof of the building in which the Premises are located (the "Building"), the land beneath the Building, the pipes and ducts, conduits, wires, fixtures, and equipment above the suspended ceiling; and the structural elements of the Building. The Building, the land upon which it is situated, all other improvements located on such land, and all common areas appurtenant to the Building are referred to as the "Property." The Building and all other buildings on the Property as of the date of this Lease consist of an agreed area of 15101 rentable square feet.

b. **Lease Commencement Date.** The term of this Lease shall be for a period of 26.677 months and shall commence on May 10, 2016 or such earlier or later date as provided in Section 3 (the "Commencement Date").

c. **Lease Termination Date.** The term of this Lease shall terminate at midnight on June 30, 2018 or such earlier or later date as provided in Section 3 (the "Termination Date"). Tenant shall have no right or option to extend this Lease, unless otherwise set forth in a rider attached to this Lease (e.g., Option to Extend Rider, CBA Form OR).

d. **Base Rent.** The base monthly rent shall be (check one): ☐ $_____, or ☒ according to the Rent Rider attached hereto ("Base Rent"). Rent shall be payable at Landlord's address shown in Section 1(h) below, or such other place designated in writing by Landlord.

e. **Prepaid Rent.** Upon execution of this Lease, Tenant shall deliver to Landlord the sum of $6,050.16 as prepaid rent, to be applied to the Rent due for months Aug 10, 2016 through Aug 31, 2016 of the Lease.

f. **Security Deposit.** Upon execution of this Lease, Tenant shall deliver to Landlord the sum of $4,331.04 to be held as a security deposit pursuant to Section 5 below. The security deposit shall be in the form of (check one): ☒ cash, or ☐ letter of credit according to the Letter of Credit Rider (CBA Form LCR) attached hereto.

g. **Permitted Use.** The Premises shall be used only for Business Office

and for no other purpose without the prior written consent of Landlord (the "Permitted Use").

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h. Notice and Payment Addresses.

Landlord: 316 LLC
4186 Stoney Brook Lane
Bellingham, WA 98229
Fax No.:
Email: ~~annecantrell@cbbcainc.com~~ annecantrell@gmail.com 3/8/16

Tenant: EmpRes Home Health of Bellingham, LLC

Fax No.:
Email:

i. Tenant's Pro Rata Share. Landlord and Tenant agree that Tenant's Pro Rata Share is 35.000 %, based on the ratio of the agreed rentable area of the Premises to the agreed rentable area of the Building and all other buildings on the Property as of the date of this Lease. Any adjustment to the Premises' or Building's rentable floor area measurements will be reflected in an adjustment to Tenant's Base Rent or Pro Rata Share.

2. PREMISES.

a. Lease of Premises. Landlord leases to Tenant, and Tenant leases from Landlord, the Premises upon the terms specified in this Lease.

b. Acceptance of Premises. Except as specified elsewhere in this Lease, Landlord makes no representations or warranties to Tenant regarding the Premises, including the structural condition of the Premises or the condition of all mechanical, electrical, and other systems on the Premises. Except for any tenant improvements to be completed by Landlord as described on attached Exhibit C (the "Landlord's Work"), Tenant shall be responsible for performing any work necessary to bring the Premises into a condition satisfactory to Tenant. By signing this Lease, Tenant acknowledges that it has had an adequate opportunity to investigate the Premises; acknowledges responsibility for making any corrections, alterations and repairs to the Premises (other than the Landlord's Work); and acknowledges that the time needed to complete any such items shall not delay the Commencement Date.

c. Tenant Improvements. Attached Exhibit C sets forth all Landlord's Work, if any, and all tenant improvements to be completed by Tenant (the "Tenant's Work"), if any, that will be performed on the Premises. Responsibility for design, payment and performance of all such work shall be as set forth on attached Exhibit C. If Tenant fails to notify Landlord of any defects in the Landlord's Work within thirty (30) days of delivery of possession to Tenant, Tenant shall be deemed to have accepted the Premises in their then condition. If Tenant discovers any major defects in the Landlord's Work during this 30-day period that would prevent Tenant from using the Premises for the Permitted Use, Tenant shall notify Landlord and the Commencement Date shall be delayed until after Landlord has notified Tenant that Landlord has corrected the major defects and Tenant has had five (5) days to inspect and approve the Premises. The Commencement Date shall not be delayed if Tenant's inspection reveals minor defects in the Landlord's Work that will not prevent Tenant from using the Premises for the Permitted Use. Tenant shall prepare a punch list of all minor defects in Landlord's Work and provide the punch list to Landlord, which Landlord shall promptly correct.

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(Multi-Tenant Triple Net (NNN) Lease)
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3. **TERM.** The term of this Lease shall commence on the Commencement Date specified in Section 1, or on such earlier or later date as may be specified by notice delivered by Landlord to Tenant advising Tenant that the Premises are ready for possession and specifying the Commencement Date, which shall not be less than _____ days (thirty (30) days if not filled in) following the date of such notice.

   a. **Early Possession.** If Landlord permits Tenant to possess and occupy the Premises prior to the Commencement Date specified in Section 1, then such early occupancy shall not advance the Commencement Date or the Termination Date set forth in Section 1, but otherwise all terms and conditions of this Lease shall nevertheless apply during the period of early occupancy before the Commencement Date.

   b. **Delayed Possession.** Landlord shall act diligently to make the Premises available to Tenant; provided, however, neither Landlord nor any agent or employee of Landlord shall be liable for any damage or loss due to Landlord's inability or failure to deliver possession of the Premises to Tenant as provided in this Lease. If possession is delayed, the Commencement Date set forth in Section 1 shall also be delayed. In addition, the Termination Date set forth in Section 1 shall be modified so that the length of the Lease term remains the same. If Landlord does not deliver possession of the Premises to Tenant within _____ days (sixty (60) days if not filled in) after the Commencement Date specified in Section 1, Tenant may elect to cancel this Lease by giving written notice to Landlord within ten (10) days after such time period ends. If Tenant gives such notice of cancellation, the Lease shall be cancelled, all prepaid rent and security deposits shall be refunded to Tenant, and neither Landlord nor Tenant shall have any further obligations to the other. The first "Lease year" shall commence on the Commencement Date and shall end on the date which is twelve (12) months from the end of the month in which the Commencement Date occurs. Each successive Lease year during the initial term and any extension terms shall be twelve (12) months, commencing on the first day following the end of the preceding Lease year. To the extent that the tenant improvements are not completed in time for the Tenant to occupy or take possession of the Premises on the Commencement Date due to the failure of Tenant to fulfill any of its obligations under this Lease, the Lease shall nevertheless commence on the Commencement Date set forth in Section 1.

4. **RENT.**

   a. **Payment of Rent.** Tenant shall pay Landlord without notice, demand, deduction or offset, in lawful money of the United States, the monthly Base Rent stated in Section 1 in advance on or before the first day of each month during the Lease term beginning on (check one): ☒ the Commencement Date, or ☐ _____ (If no date specified, then on the Commencement Date), and shall also pay any other additional payments due to Landlord ("Additional Rent"), including Operating Costs (collectively the "Rent") when required under this Lease. Payments for any partial month at the beginning or end of the Lease shall be prorated. All payments due to Landlord under this Lease, including late fees and interest, shall also constitute Additional Rent, and upon failure of Tenant to pay any such costs, charges or expenses, Landlord shall have the same rights and remedies as otherwise provided in this Lease for the failure of Tenant to pay rent.

   b. **Triple Net Lease.** This Lease is what is commonly called a "Net, Net, Net" or "triple-net" Lease, which means that, except as otherwise expressly provided herein, Landlord shall receive all Base Rent free and clear of any and all other impositions, taxes, liens, charges or expenses of any nature whatsoever in connection with the ownership and operation of the Premises. In addition to Base Rent, Tenant shall pay to the parties respectively entitled thereto, or satisfy directly, all Additional Rent and other impositions, insurance premiums, repair and maintenance charges, and any other charges, costs, obligations, liabilities, requirements, and expenses, including without limitation the Operating Costs described in Section 8, which arise with regard to the Premises or may be contemplated under any other provision of the Lease during its term, except for costs and expenses expressly made the obligation of Landlord in this Lease.

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c. **Late Charges; Default Interest.** If any sums payable by Tenant to Landlord under this Lease are not received within five (5) business days after their due date, Tenant shall pay Landlord an amount equal to[1] the greater of $100 or five percent (5%) of the delinquent amount for the cost of collecting and handling such late payment in addition to the amount due and as Additional Rent. All delinquent sums payable by Tenant to Landlord and not paid within five (5) business days after their due date shall, at Landlord's [2] option, bear interest at the rate of fifteen percent (15%) per annum, or the highest rate of interest allowable by law, whichever is less (the "Default Rate"). Interest on all delinquent amounts shall be calculated from the original due date to the date of payment.

d. **Less Than Full Payment.** Landlord's acceptance of less than the full amount of any payment due from Tenant shall not be deemed an accord and satisfaction or compromise of such payment unless Landlord specifically consents in writing to payment of such lesser sum as an accord and satisfaction or compromise of the amount which Landlord claims. Any portion that remains to be paid by Tenant shall be subject to the late charges and default interest provisions of this Section 4.

5. **SECURITY DEPOSIT.** Upon execution of this Lease, Tenant shall deliver to Landlord the security deposit specified in Section 1 above. Landlord's obligations with respect to the security deposit are those of a debtor and not of a trustee, and Landlord may commingle the security deposit with its other funds. If Tenant breaches any covenant or condition of this Lease, including but not limited to the payment of Rent, Landlord may apply all or any part of the security deposit to the payment of any sum in default and any damage suffered by Landlord as a result of Tenant's breach. Tenant acknowledges, however, that the security deposit shall not be considered as a measure of Tenant's damages in case of default by Tenant, and any payment to Landlord from the security deposit shall not be construed as a payment of liquidated damages for Tenant's default. If Landlord applies the security deposit as contemplated by this Section, Tenant shall, within ~~five (5)~~ [3] days after written demand therefore by Landlord, deposit with Landlord the amount so applied. If Tenant complies with all of the covenants and conditions of this Lease throughout the Lease term, the security deposit shall be repaid to Tenant without interest within thirty (30) days after the surrender of the Premises by Tenant in the condition required hereunder by Section 13 of this Lease.

6. **USES.** The Premises shall be used only for the Permitted Use specified in Section 1 above, and for no other business or purpose without the prior written consent of Landlord. No act shall be done on or around the Premises that is unlawful or that will increase the existing rate of insurance on the Premises, the Building, or the Property, or cause the cancellation of any insurance on the Premises, the Building, or the Property. Tenant shall not commit or allow to be committed any waste upon the Premises, or any public or private nuisance. Tenant shall not do or permit anything to be done on the Premises, the Building, or the Property which will obstruct or interfere with the rights of other tenants or occupants of the Property, or their employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees or to injure or annoy such persons.

7. **COMPLIANCE WITH LAWS.** Tenant shall not cause or permit the Premises to be used in any way which violates any law, ordinance, or governmental regulation or order. Landlord represents to Tenant that, as of the Commencement Date, to Landlord's knowledge, but without duty of investigation, and with the exception of any Tenant's Work, the Premises comply with all applicable laws, rules, regulations, or orders, including without limitation, the Americans With Disabilities Act, if applicable, and Landlord shall be responsible to promptly cure at its sole cost any noncompliance which existed on the Commencement Date. Tenant shall be responsible for complying with all laws applicable to the Premises as a result of the Permitted Use, and Tenant shall be responsible for making any changes or alterations as may be required by law, rule, regulation, or order for Tenant's Permitted Use at its sole cost and expense. Otherwise, if changes or alterations are required by law, rule, regulation, or order unrelated to the Permitted Use, Landlord shall make changes and alterations at its expense.

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8. OPERATING COSTS.

a. Definition. As used herein, "Operating Costs" shall mean all costs of operating, maintaining and repairing the Premises, the Building, and the Property, determined in accordance with generally accepted accounting principles, and including without limitation the following: all taxes and assessments (including, but not limited to, real and personal property taxes and assessments, local improvement district assessments and other special purpose assessments, and taxes on rent or gross receipts); insurance premiums paid by Landlord and (to the extent used) deductibles for insurance applicable to the Property; water, sewer and all other utility charges (other than utilities separately metered and paid directly by Tenant or other tenants); janitorial and all other cleaning services; refuse and trash removal; supplies, materials, tools, and equipment used in the operation, repair, and maintenance of the Property; refurbishing and repainting; carpet replacement; to the extent serving areas other than just the Premises, heating, ventilation and air conditioning ("HVAC") service and repair and replacement of HVAC when necessary; elevator service and repair and replacement of elevators when necessary; pest control; lighting systems, fire detection and security services; landscape maintenance; management (fees and/or personnel costs); parking lot, road, sidewalk and driveway patching, resurfacing and maintenance; snow and ice removal; repair, maintenance, and, where reasonably required, replacement of signage; amortization of capital improvements as Landlord may in the future install to comply with governmental regulations and rules or undertaken in good faith with a reasonable expectation of reducing operating costs (the useful life of which shall be a reasonable period of time as determined by Landlord); costs of legal services (except those incurred directly relating to a particular occupant of the Building); and accounting services, labor, supplies, materials and tools. Landlord and Tenant agree that if the Building is not ninety percent (90%) occupied during any calendar year (including the Base Year, if applicable), on a monthly average, then those portions of the Operating Costs that are driven by occupancy rates, as reasonably determined by Landlord, shall be increased to reflect the Operating Costs of the Building as though it were ninety percent (90%) occupied and Tenant's Pro Rata Share of Operating Costs shall be based upon Operating Costs as so adjusted. Operating Costs shall not include: Landlord's income tax or general corporate overhead; depreciation on the Building or equipment therein; loan payments; real estate broker's commissions; capital improvements to or major repairs of the Building shell (i.e., the Building structure, exterior walls, roof, and structural floors and foundations), except as described above; or any costs regarding the operation, maintenance and repair of the Premises, the Building, or the Property paid directly by Tenant or other tenants in the Building, or otherwise reimbursed to Landlord. If Tenant is renting a pad separate from any other structures on the Property for which Landlord separately furnishes the services described in this paragraph, then the term "Operating Costs" shall not include those costs of operating, repairing, and maintaining the enclosed mall which can be separately allocated to the tenants of the other structures. Operating Costs which cannot be separately allocated to the tenants of other structures may include but are not limited to: insurance premiums; taxes and assessments; management (fees and/or personnel costs); exterior lighting; parking lot, road, sidewalk and driveway patching, resurfacing and maintenance; snow and ice removal; and costs of legal services and accounting services.

b. Type of Payment. Options one and two below address the manner in which Operating Costs are paid under this Lease. To select the pure triple net option, check option 1. To select the base year option, check option 2.

☒ **OPTION ONE: TRIPLE NET.** As additional Rent, Tenant shall pay to Landlord on the first of each month with payment of Tenant's base Rent one-twelfth ~~of~~ Tenant's Pro Rata Share of Operating Costs. (4)

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☐ **OPTION TWO: BASE YEAR.** The Base Rent paid by Tenant under this Lease includes Tenant's Pro Rata Share of Operating Costs for the calendar year in which the Commencement Date occurs (the "Base Year"). As additional Rent, Tenant shall pay to Landlord on the first day of each month commencing on the first day of the first year after the Commencement Date, with Tenant's payment of Base Rent, one-twelfth of the amount, if any, by which Tenant's Pro Rata Share of Operating Costs exceeds Tenant's annualized Pro Rata Share of Operating Costs for the Base Year.

c. **Method of Payment.** Tenant shall pay to Landlord Operating Costs pursuant to the following procedure:

(i) Landlord shall provide to Tenant, at or before the Commencement Date, a good faith estimate of annual Operating Costs for the calendar year in which the Commencement Date occurs. Landlord shall also provide to Tenant, as soon as possible following the first day of each succeeding calendar year, a good faith estimate of Tenant's annual Pro Rata Share of Operating Costs for the then-current year.

(ii) Each estimate of Tenant's annual Pro Rata Share of Operating Costs determined by Landlord, as described above, shall be divided into twelve (12) equal monthly installments. If Tenant pays Operating Costs under Option One, Tenant shall pay to Landlord such monthly installment of Operating Costs with each monthly payment of Base Rent. If Tenant pays Operating Costs under Option Two, Tenant shall pay to Landlord with each monthly payment of Base Rent the amount, if any, by which such monthly installments of Operating Costs exceed one twelfth of Tenant's annualized Pro Rata Share of Operating Costs for the Base Year. In the event the estimated amount of Tenant's Pro Rata Share of Operating Costs has not yet been determined for any calendar year, Tenant shall pay the monthly installment in the estimated amount determined for the preceding calendar year until the estimate for the current calendar year has been provided to Tenant. When the estimate for the current calendar year is received, Tenant shall then pay any shortfall or receive a credit for any surplus for the preceding months of the current calendar year and shall, thereafter, make the monthly installment payments in accordance with the current estimate.

(iii) As soon as reasonably possible following the end of each calendar year of the Lease term, Landlord shall determine and provide to Tenant a statement (the "Operating Costs Statement") setting forth the amount of Operating Costs actually incurred and the amount of Tenant's Pro Rata Share of Operating Costs actually payable by Tenant with respect to such calendar year. In the event the amount of Tenant's Pro Rata Share of Operating Costs exceeds the sum of the monthly installments actually paid by Tenant for such calendar year, Tenant shall pay to Landlord the difference within thirty (30) days following receipt of the Operating Costs Statement. In the event the sum of the monthly installments actually paid by Tenant for such calendar year exceeds the amount of Tenant's Pro Rata Share of Operating Costs actually due and owing, the difference shall be applied as a credit to Tenant's future Pro Rata Share of Operating Costs payable by Tenant pursuant to this Section, or if the term has expired, the excess shall be refunded to Tenant within thirty (30) days after delivery of such Operating Costs Statement.

(iv) Should Tenant dispute any amount shown on the Operating Costs Statement, Tenant may audit Landlord's books and records for the calendar year covered by such Operating Costs Statement upon written notice to Landlord given within ninety (90) days after Tenant's receipt of such Operating Costs Statement. If Tenant fails to provide notice of dispute within such ninety (90) day period, the Operating Costs Statement shall be final and conclusive. Any audit conducted by Tenant shall be completed within sixty (60) days after Tenant's request therefor. In the event the amount of Tenant's Pro Rata Share of Operating Costs exceeds the sum of the monthly installments actually paid by Tenant for such

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calendar year, Tenant shall pay to Landlord the difference within thirty (30) days following completion of the audit. In the event the sum of the monthly installments actually paid by Tenant for such calendar year exceeds the amount of Tenant's Pro Rata Share of Operating Costs actually due and owing, the difference shall be applied as a credit to Tenant's future Pro Rata Share of Operating Costs payable by Tenant pursuant to this Section, or if the term has expired, the excess shall be refunded to Tenant within thirty (30) days after completion of the audit. Landlord and Tenant shall cooperate as may be reasonably necessary in order to facilitate the timely completion of any audit. Nothing in this section shall in any manner modify Tenant's obligations to make payments as and when provided under this Lease.

9. **UTILITIES AND SERVICES.** Landlord shall provide the Premises the following services, the cost of which shall be included in the Operating Costs, to the extent not separately metered to the Premises: water and electricity for the Premises seven (7) days per week, twenty-four (24) hours per day, and HVAC from 8 a.m. to 9 p.m. Monday through Friday; 8 a.m. to 5 p.m. on Saturday; and 8 a.m. to 5 p.m. on Sunday. Landlord shall provide janitorial service to the Premises and Building five (5) nights each week, exclusive of holidays, the cost of which shall also be included in Operating Costs. HVAC services will also be provided by Landlord to the Premises during additional hours on reasonable notice to Landlord, at Tenant's sole cost and expense, at an hourly rate reasonably established by Landlord from time to time and payable by Tenant, as and when billed, as Additional Rent. Notwithstanding the foregoing, if Tenant's use of the Premises incurs utility service charges which are above those usual and customary for the Permitted Use, Landlord reserves the right to require Tenant to pay a reasonable additional charge for such usage. Landlord shall not be liable for any loss, injury or damage to person or property caused by or resulting from any variation, interruption, or failure of utilities due to any cause whatsoever, and Rent shall not abate as a result thereof.

   Tenant shall furnish all other utilities (including, but not limited to, telephone, internet, and cable service if available) and other services which Tenant requires with respect to the Premises, and shall pay, at Tenant's sole expense, the cost of all utilities separately metered to the Premises, and of all other utilities and other services which Tenant requires with respect to the Premises, except those to be provided by Landlord and included in Operating Expenses as described above.

10. **TAXES.** Tenant shall pay all taxes, assessments, liens and license fees ("Taxes") levied, assessed or imposed by any authority having the direct or indirect power to tax or assess any such liens, related to or required by Tenant's use of the Premises as well as all Taxes on Tenant's personal property located on the Premises. Landlord shall pay all taxes and assessments with respect to the Property, including any taxes resulting from a reassessment of the Building or the Property due to a change of ownership or otherwise, all of which shall be included in Operating Costs and subject to partial reimbursement by Tenant as set forth in Section 8.

11. **COMMON AREAS.**

   a. **Definition.** The term "Common Areas" means all areas, facilities and building systems that are provided and designated from time to time by Landlord for the general non-exclusive use and convenience of Tenant with other tenants and which are not leased or held for the exclusive use of a particular tenant. To the extent that such areas and facilities exist within the Property, Common Areas include hallways, entryways, stairs, elevators, driveways, walkways, terraces, docks, loading areas, restrooms, trash facilities, parking areas and garages, roadways, pedestrian sidewalks, landscaped areas, security areas, lobby or mall areas, common heating, ventilating and air conditioning systems, common electrical service, equipment and facilities, and common mechanical systems, equipment and facilities. Tenant shall comply

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with reasonable rules and regulations concerning the use of the Common Areas adopted by Landlord from time to time. Without advance notice to Tenant and without any liability to Tenant, Landlord may change the size, use, or nature of any Common Areas, erect improvements on the Common Areas or convert any portion of the Common Areas to the exclusive use of Landlord or selected tenants, so long as Tenant is not thereby deprived of the substantial benefit of the Premises. Landlord reserves the use of exterior walls and the roof, and the right to install, maintain, use, repair and replace pipes, ducts, conduits, and wires leading through the Premises in areas which will not materially interfere with Tenant's use thereof.

b. **Use of the Common Areas.** Tenant shall have the non-exclusive right, in common with such other tenants to whom Landlord has granted or may grant such rights, to use the Common Areas. Tenant shall abide by rules and regulations adopted by Landlord from time to time and shall use its best efforts to cause its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees to comply with those rules and regulations, and not interfere with the use of Common Areas by others.

c. **Maintenance of Common Areas.** Landlord shall maintain the Common Areas in good order, condition and repair. This maintenance cost shall be an Operating Cost chargeable to Tenant pursuant to Section 8. In performing such maintenance, Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises.

12. **ALTERATIONS.** Tenant may make alterations, additions or improvements to the Premises, including any Tenant Work identified on attached Exhibit C (the "Alterations"), only with the prior written consent of Landlord, which, with respect to Alterations not affecting the structural components of the Premises or utility systems therein, shall not be unreasonably withheld, conditioned, or delayed. Landlord shall have thirty (30) days in which to respond to Tenant's request for any Alterations so long as such request includes the name of Tenant's contractors and reasonably detailed plans and specifications therefor. The term "Alterations" shall not include the installation of shelves, movable partitions, Tenant's equipment, and trade fixtures that may be performed without damaging existing improvements or the structural integrity of the Premises, the Building, or the Property, and Landlord's consent shall not be required for Tenant's installation or removal of those items. Tenant shall perform all work at Tenant's expense and in compliance with all applicable laws and shall complete all Alterations in accordance with plans and specifications approved by Landlord, using contractors approved by Landlord, and in a manner so as not to unreasonably interfere with other tenants. Tenant shall pay, when due, or furnish a bond for payment (as set forth in Section 20) all claims for labor or materials furnished to or for Tenant at or for use in the Premises, which claims are or may be secured by any mechanics' or materialmens' liens against the Premises or the Property or any interest therein. Tenant shall remove all Alterations at the end of the Lease term unless Landlord conditioned its consent upon Tenant leaving a specified Alteration at the Premises, in which case Tenant shall not remove such Alteration, and it shall become Landlord's property. Tenant shall immediately repair any damage to the Premises caused by removal of Alterations.

13. **REPAIRS AND MAINTENANCE; SURRENDER.** Tenant shall, at its sole expense, maintain the entire Premises in good condition and promptly make all non-structural repairs and replacements necessary to keep the Premises safe and in good condition, including all HVAC components and other utilities and systems to the extent exclusively serving the Premises. Landlord shall maintain and repair the Building structure, foundation, subfloor, exterior walls, roof structure and surface, and HVAC components and other utilities and systems serving more than just the Premises, and the Common Areas, the costs of which shall be included as an Operating Cost. Tenant shall not damage any demising wall or disturb the structural integrity of the Premises, the Building, or the Property and shall promptly repair any damage or injury done to any such demising walls or structural elements caused by Tenant or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. Notwithstanding anything in this Section to the contrary,

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Tenant shall not be responsible for any repairs to the Premises made necessary by the negligence or willful misconduct of Landlord or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees therein. If Tenant fails to perform Tenant's obligations under this Section, Landlord may at Landlord's option enter upon the Premises after ten (10) days' prior notice to Tenant and put the same in good order, condition and repair and the cost thereof together with interest thereon at the default rate set forth in Section 4 shall be due and payable as additional rent to Landlord together with Tenant's next installment of Base Rent. Upon expiration of the Lease term, whether by lapse of time or otherwise, Tenant shall promptly and peacefully surrender the Premises, together with all keys, to Landlord in as good condition as when received by Tenant from Landlord or as thereafter improved, reasonable wear and tear and insured casualty excepted.

14. **ACCESS AND RIGHT OF ENTRY.** After twenty-four (24) hours' notice from Landlord (except in cases of emergency, when no notice shall be required), Tenant shall permit Landlord and its agents, employees and contractors to enter the Premises at all reasonable times to make repairs, inspections, alterations or improvements, provided that Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises. This Section shall not impose any repair or other obligation upon Landlord not expressly stated elsewhere in this Lease. After reasonable notice to Tenant, Landlord shall have the right to enter the Premises for the purpose of (a) showing the Premises to prospective purchasers or lenders at any time, and to prospective tenants within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term; and (b) posting "for lease" signs within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term.

15. **SIGNAGE.** Tenant shall obtain Landlord's written consent as to size, location, materials, method of attachment, and appearance, before installing any signs upon the Premises. Tenant shall install any approved signage at Tenant's sole expense and in compliance with all applicable laws. Tenant shall not damage or deface the Premises in installing or removing signage and shall repair any injury or damage to the Premises caused by such installation or removal.

16. **DESTRUCTION OR CONDEMNATION.**

a. **Damage and Repair.** If the Premises or the portion of the Building or the Property necessary for Tenant's occupancy are partially damaged but not rendered untenantable, by fire or other insured casualty, then Landlord shall diligently restore the Premises and the portion of the Property necessary for Tenant's occupancy to the extent required below and this Lease shall not terminate. Tenant may, however, terminate the Lease if Landlord is unable to restore the Premises within ~~six (6) months~~ of the casualty (5) event by giving twenty (20) days written notice of termination.

The Premises or the portion of the Building or the Property necessary for Tenant's occupancy shall not be deemed untenantable if twenty-five percent (25%) or less of each of those areas are damaged. If insurance proceeds are not available or are not sufficient to pay the entire cost of restoring the Premises, or if Landlord's lender does not permit all or any part of the insurance proceeds to be applied toward restoration, then Landlord may elect to terminate this Lease and keep the insurance proceeds, by notifying Tenant within sixty (60) days of the date of such casualty.

If the Premises, the portion of the Building or the Property necessary for Tenant's occupancy, or fifty percent (50%) or more of the rentable area of the Property are entirely destroyed, or partially damaged and rendered untenantable, by fire or other casualty, Landlord may, at its option: (a) terminate this Lease as provided herein, or (b) restore the Premises and the portion of the Property necessary for Tenant's occupancy to their previous condition to the extent required below; provided, however, if such casualty event occurs during the last six (6) months of the Lease term (after considering any option to extend the

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term timely exercised by Tenant) then either Tenant or Landlord may elect to terminate the Lease. If, within sixty (60) days after receipt by Landlord from Tenant of written notice that Tenant deems the Premises or the portion of the Property necessary for Tenant's occupancy untenantable, Landlord fails to notify Tenant of its election to restore those areas, or if Landlord is unable to restore those areas within ~~six (6) months~~ of the date of the casualty event, then Tenant may elect to terminate the Lease upon twenty (20) days' notice to Landlord unless Landlord, within such twenty (20) day period, notifies Tenant that it will in fact restore the Premises or actually completes such restoration work to the extent required below, as applicable. (e)

If Landlord restores the Premises or the Property under this Section, Landlord shall proceed with reasonable diligence to complete the work, and the Rent shall be abated in the same proportion as the untenantable portion of the Premises bears to the whole Premises, provided that there shall be a Rent abatement only if the damage or destruction of the Premises or the Property did not result from, or was not contributed to directly or indirectly by the act, fault or neglect of Tenant, or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. No damages, compensation or claim shall be payable by Landlord for inconvenience, loss of business or annoyance directly, incidentally or consequentially arising from any repair or restoration of any portion of the Premises or the Property. Landlord shall have no obligation to carry insurance of any kind for the protection of Tenant; any alterations or improvements paid for by Tenant; any Tenant's Work identified in Exhibit C (regardless of who may have completed them); Tenant's furniture; or on any fixtures, equipment, improvements or appurtenances of Tenant under this Lease, and Landlord's restoration obligations hereunder shall not include any obligation to repair any damage thereto or replace the same.

b. **Condemnation.** If the Premises, the portion of the Building or the Property necessary for Tenant's occupancy, or 50% or more of the rentable area of the Property are made untenantable by eminent domain, or conveyed under a threat of condemnation, this Lease shall terminate at the option of either Landlord or Tenant as of the earlier of the date title vests in the condemning authority or the condemning authority first has possession of the Premises or the portion of the Property taken by the condemning authority. All Rents and other payments shall be paid to that date.

If the condemning authority takes a portion of the Premises or of the Building or the Property necessary for Tenant's occupancy that does not render them untenantable, then this Lease shall continue in full force and effect and the Rent shall be equitably reduced based on the proportion by which the floor area of any structures is reduced. The reduction in Rent shall be effective on the earlier of the date the condemning authority first has possession of such portion or title vests in the condemning authority. The Premises or the portion of the Building or the Property necessary for Tenant's occupancy shall not be deemed untenantable if twenty-five percent (25%) or less of each of those areas are condemned. Landlord shall be entitled to the entire award from the condemning authority attributable to the value of the Premises or the Building or the Property and Tenant shall make no claim for the value of its leasehold. Tenant shall be permitted to make a separate claim against the condemning authority for moving expenses if Tenant may terminate the Lease under this Section, provided that in no event shall Tenant's claim reduce Landlord's award.

17. INSURANCE.

a. **Tenant's Liability Insurance.** During the Lease term, Tenant shall pay for and maintain commercial general liability insurance with broad form property damage and contractual liability endorsements. This policy shall name Landlord, its property manager (if any), and other parties designated by Landlord as additional insureds using an endorsement form acceptable to Landlord, and shall insure Tenant's activities

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and those of Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees with respect to the Premises against loss, damage or liability for personal injury or bodily injury (including death) or loss or damage to property with a combined single limit of not less than $2,000,000, and a deductible of not more than ~~$10,000~~. Tenant's insurance will be (7) primary and noncontributory with any liability insurance carried by Landlord. Landlord may also require Tenant to obtain and maintain business income coverage for at least six (6) months, business auto liability coverage, and, if applicable to Tenant's Permitted Use, liquor liability insurance and/or warehouseman's coverage.

b. **Tenant's Property Insurance.** During the Lease term, Tenant shall pay for and maintain special form clauses of loss coverage property insurance (with coverage for earthquake if required by Landlord's lender and, if the Premises are situated in a flood plain, flood damage) for all of Tenant's personal property, fixtures and equipment in the amount of their full replacement value, with a deductible of not more than $10,000.

c. **Miscellaneous.** Tenant's insurance required under this Section shall be with companies rated A-/VII or better in Best's Insurance Guide, and which are admitted in the State in which the Premises are located. No insurance policy shall be cancelled or reduced in coverage and each such policy shall provide that it is not subject to cancellation or a reduction in coverage except after thirty (30) days prior written notice to Landlord. Tenant shall deliver to Landlord upon commencement of the Lease and from time to time thereafter, copies of the insurance policies or evidence of insurance and copies of endorsements required by this Section. In no event shall the limits of such policies be considered as limiting the liability of Tenant under this Lease. If Tenant fails to acquire or maintain any insurance or provide any policy or evidence of insurance required by this Section, and such failure continues for three (3) days after notice from Landlord, Landlord may, but shall not be required to, obtain such insurance for Landlord's benefit and Tenant shall reimburse Landlord for the costs of such insurance upon demand. Such amounts shall be Additional Rent payable by Tenant hereunder and in the event of non-payment thereof, Landlord shall have the same rights and remedies with respect to such non-payment as it has with respect to any other non-payment of Rent hereunder.

d. **Landlord's Insurance.** Landlord shall carry special form clauses of loss coverage property insurance of the Building shell and core in the amount of their full replacement value, liability insurance with respect to the Common Areas, and such other insurance of such types and amounts as Landlord, in its discretion, shall deem reasonably appropriate. The cost of any such insurance shall be included in the Operating Costs, and if such insurance is provided by a "blanket policy" insuring other parties or locations in addition to the Building, then only the portion of the premiums allocable to the Building and Property shall be included in the Operating Costs.

e. **Waiver of Subrogation.** Landlord and Tenant hereby release each other and any other tenant, their agents or employees, from responsibility for, and waive their entire claim of recovery for any loss or damage arising from any cause covered by property insurance required to be carried or otherwise carried by each of them. Each party shall provide notice to the property insurance carrier or carriers of this mutual waiver of subrogation, and shall cause its respective property insurance carriers to waive all rights of subrogation against the other. This waiver shall not apply to the extent of the deductible amounts to any such property policies or to the extent of liabilities exceeding the limits of such policies.

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18. INDEMNIFICATION.

a. **Indemnification by Tenant.** Tenant shall defend, indemnify, and hold Landlord and its property manager (if any) harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Tenant or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the Premises or the Property, or arising from any breach of this Lease by Tenant. Tenant shall use legal counsel reasonably acceptable to Landlord in defense of any action within Tenant's defense obligation.

b. **Indemnification by Landlord.** Landlord shall defend, indemnify and hold Tenant harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Landlord or Landlord's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the Premises or the Property, or arising from any breach of this Lease by Landlord. Landlord shall use legal counsel reasonably acceptable to Tenant in defense of any action within Landlord's defense obligation.

c. **Waiver of Immunity.** Landlord and Tenant each specifically and expressly waive any immunity that each may be granted under the Washington State Industrial Insurance Act, Title 51 RCW. Neither party's indemnity obligations under this Lease shall be limited by any limitation on the amount or type of damages, compensation, or benefits payable to or for any third party under the Worker Compensation Acts, Disability Benefit Acts or other employee benefit acts.

d. **Exemption of Landlord from Liability.** Except to the extent of claims arising out of Landlord's gross negligence or intentional misconduct, Landlord shall not be liable for injury to Tenant's business or assets or any loss of income therefrom or for damage to any property of Tenant or of its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, or any other person in or about the Premises or the Property.

e. **Survival.** The provisions of this Section 18 shall survive expiration or termination of this Lease.

19. ASSIGNMENT AND SUBLETTING. Tenant shall not assign, sublet, mortgage, encumber or otherwise transfer any interest in this Lease (collectively referred to as a "Transfer") or any part of the Premises, without first obtaining Landlord's written consent, which shall not be unreasonably withheld, conditioned, or delayed. No Transfer shall relieve Tenant of any liability under this Lease notwithstanding Landlord's consent to such Transfer. Consent to any Transfer shall not operate as a waiver of the necessity for Landlord's consent to any subsequent Transfer. In connection with each request for consent to a Transfer, Tenant shall pay the reasonable cost of processing same, including attorneys' fees, upon demand of Landlord, up to a maximum of $1,250.

If Tenant is a partnership, limited liability company, corporation, or other entity, any transfer of this Lease by merger, consolidation, redemption or liquidation, or any change in the ownership of, or power to vote, which singularly or collectively represents a majority of the beneficial interest in Tenant, shall constitute a Transfer under this Section.

As a condition to Landlord's approval, if given, any potential assignee or sublessee otherwise approved by Landlord shall assume all obligations of Tenant under this Lease and shall be jointly and severally liable with Tenant and any guarantor, if required, for the payment of Rent and performance of all terms of this Lease. In connection with any Transfer, Tenant shall provide Landlord with copies of all assignments, subleases and assumption agreement or documents.

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20. LIENS. Tenant shall not subject the Landlord's assets to any liens or claims of lien. Tenant shall keep the Premises free from any liens created by or through Tenant. Tenant shall indemnify and hold Landlord harmless from liability for any such liens including, without limitation, liens arising from any Alterations. If a lien is filed against the Premises by any person claiming by, through or under Tenant, Tenant shall, within ten (10) days after Landlord's demand, at Tenant's expense, either remove the lien or furnish to Landlord a bond in form and amount and issued by a surety satisfactory to Landlord, indemnifying Landlord and the Premises against all liabilities, costs and expenses, including attorneys' fees, which Landlord could reasonably incur as a result of such lien.

21. DEFAULT. The following occurrences shall each constitute a default by Tenant (an "Event of Default"):

a. **Failure To Pay.** Failure by Tenant to pay any sum, including Rent, due under this Lease following ~~five (5)~~ (8) days' notice from Landlord of the failure to pay.

b. **Vacation/Abandonment.** Vacation by Tenant of the Premises (defined as an absence for at least fifteen (15) consecutive days without prior notice to Landlord), or abandonment by Tenant of the Premises (defined as an absence of five (5) days or more while Tenant is in breach of some other term of this Lease). Tenant's vacation or abandonment of the Premises shall not be subject to any notice or right to cure.

c. **Insolvency.** Tenant's insolvency or bankruptcy (whether voluntary or involuntary); or appointment of a receiver, assignee or other liquidating officer for Tenant's business; provided, however, that in the event of any involuntary bankruptcy or other insolvency proceeding, the existence of such proceeding shall constitute an Event of Default only if such proceeding is not dismissed or vacated within sixty (60) days after its institution or commencement.

d. **Levy or Execution.** The taking of Tenant's interest in this Lease or the Premises, or any part thereof, by execution or other process of law directed against Tenant, or attachment of Tenant's interest in this Lease by any creditor of Tenant, if such attachment is not discharged within fifteen (15) days after being levied.

e. **Other Non-Monetary Defaults.** The breach by Tenant of any agreement, term or covenant of this Lease other than one requiring the payment of money and not otherwise enumerated in this Section or elsewhere in this Lease, which breach continues for a period of thirty (30) days after notice by Landlord to Tenant of the breach.

f. **Failure to Take Possession.** Failure by Tenant to take possession of the Premises on the Commencement Date or failure by Tenant to commence any Tenant improvement in a timely fashion.

Landlord shall not be in default unless Landlord fails to perform obligations required of Landlord within a reasonable time, but in no event less than thirty (30) days after notice by Tenant to Landlord. If Landlord fails to cure any such default within the allotted time, Tenant's sole remedy shall be to seek actual money damages (but not consequential or punitive damages) for loss arising from Landlord's failure to discharge its obligations under this Lease. Nothing herein contained shall relieve Landlord from its duty to perform of any of its obligations to the standard prescribed in this Lease.

Any notice periods granted herein shall be deemed to run concurrently with and not in addition to any default notice periods required by law.

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22. REMEDIES. Landlord shall have the following remedies upon an Event of Default. Landlord's rights and remedies under this Lease shall be cumulative, and none shall exclude any other right or remedy allowed by law.

a. **Termination of Lease.** Landlord may terminate Tenant's interest under the Lease, but no act by Landlord other than notice of termination from Landlord to Tenant shall terminate this Lease. The Lease shall terminate on the date specified in the notice of termination. Upon termination of this Lease, Tenant will remain liable to Landlord for damages in an amount equal to the Rent and other sums that would have been owing by Tenant under this Lease for the balance of the Lease term, less the net proceeds, if any, of any reletting of the Premises by Landlord subsequent to the termination, after deducting all of Landlord's Reletting Expenses (as defined below). Landlord shall be entitled to either collect damages from Tenant monthly on the days on which rent or other amounts would have been payable under the Lease, or alternatively, Landlord may accelerate Tenant's obligations under the Lease and recover from Tenant: (i) unpaid rent which had been earned at the time of termination; (ii) the amount by which the unpaid rent which would have been earned after termination until the time of award exceeds the amount of rent loss that Tenant proves could reasonably have been avoided; (iii) the amount by which the unpaid rent for the balance of the term of the Lease after the time of award exceeds the amount of rent loss that Tenant proves could reasonably be avoided (discounting such amount by the discount rate of the Federal Reserve Bank of San Francisco at the time of the award, plus 1%); and (iv) any other amount necessary to compensate Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under the Lease, or which in the ordinary course would be likely to result from the Event of Default, including without limitation Reletting Expenses described below.

b. **Re-Entry and Reletting.** Landlord may continue this Lease in full force and effect, and without demand or notice, re-enter and take possession of the Premises or any part thereof, expel the Tenant from the Premises and anyone claiming through or under the Tenant, and remove the personal property of either. Landlord may relet the Premises, or any part of them, in Landlord's ~~or Tenant's~~ name for the account of (3) Tenant, for such period of time and at such other terms and conditions as Landlord, in its discretion, may determine. Landlord may collect and receive the rents for the Premises. To the fullest extent permitted by law, the proceeds of any reletting shall be applied: first, to pay Landlord all Reletting Expenses (defined below); second, to pay any indebtedness of Tenant to Landlord other than rent; third, to the rent due and unpaid hereunder; and fourth, the residue, if any, shall be held by Landlord and applied in payment of other or future obligations of Tenant to Landlord as the same may become due and payable, and Tenant shall not be entitled to receive any portion of such revenue. Re-entry or taking possession of the Premises by Landlord under this Section shall not be construed as an election on Landlord's part to terminate this Lease, unless a notice of termination is given to Tenant. Landlord reserves the right following any re-entry or reletting, or both, under this Section to exercise its right to terminate the Lease. Tenant will pay Landlord the Rent and other sums which would be payable under this Lease if repossession had not occurred, less the net proceeds, if any, after reletting the Premises and after deducting Landlord's Reletting Expenses. "Reletting Expenses" is defined to include all expenses incurred by Landlord in connection with reletting the Premises, including without limitation, all repossession costs, brokerage commissions and costs for securing new tenants, attorneys' fees, remodeling and repair costs, costs for removing persons or property, costs for storing Tenant's property and equipment, and costs of tenant improvements and rent concessions granted by Landlord to any new Tenant, prorated over the life of the new lease.

c. **Waiver of Redemption Rights.** Tenant, for itself, and on behalf of any and all persons claiming through or under Tenant, including creditors of all kinds, hereby waives and surrenders all rights and privileges which they may have under any present or future law, to redeem the Premises or to have a continuance of this Lease for the Lease term, or any extension thereof.

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d. **Nonpayment of Additional Rent.** All costs which Tenant is obligated to pay to Landlord pursuant to this Lease shall in the event of nonpayment be treated as if they were payments of Rent, and Landlord shall have the same rights it has with respect to nonpayment of Rent.

e. **Failure to Remove Property.** If Tenant fails to remove any of its property from the Premises at Landlord's request following an uncured Event of Default, Landlord may, at its option, remove and store the property at Tenant's expense and risk. If Tenant does not pay the storage cost within ~~five (5)~~ days of (10) Landlord's request, Landlord may, at its option, have any or ~~all of such property~~ sold at public or private (11) sale (and Landlord may become a purchaser at such sale), in such manner as Landlord deems proper, without notice to Tenant. Landlord shall apply the proceeds of such sale: (i) to the expense of such sale, including reasonable attorneys' fees actually incurred; (ii) to the payment of the costs or charges for storing such property; (iii) to the payment of any other sums of money which may then be or thereafter become due Landlord from Tenant under any of the terms hereof; and (iv) the balance, if any, to Tenant. Nothing in this Section shall limit Landlord's right to sell Tenant's personal property as permitted by law or to foreclose Landlord's lien for unpaid rent.

23. **MORTGAGE SUBORDINATION AND ATTORNMENT.** This Lease shall automatically be subordinate to any mortgage or deed of trust created by Landlord which is now existing or hereafter placed upon the Premises including any advances, interest, modifications, renewals, replacements or extensions ("Landlord's Mortgage"). Tenant shall attorn to the holder of any Landlord's Mortgage or any party acquiring the Premises at any sale or other proceeding under any Landlord's Mortgage provided the acquiring party assumes the obligations of Landlord under this Lease. Tenant shall promptly and in no event later than fifteen (15) days after request execute, acknowledge and deliver documents which the holder of any Landlord's Mortgage may reasonably require as further evidence of this subordination and attornment. Notwithstanding the foregoing, Tenant's obligations under this Section to subordinate in the future are conditioned on the holder of each Landlord's Mortgage and each party acquiring the Premises at any sale or other proceeding under any such Landlord's Mortgage not disturbing Tenant's occupancy and other rights under this Lease, so long as no uncured Event of Default by Tenant exists.

24. **NON-WAIVER.** Landlord's waiver of any breach of any provision contained in this Lease shall not be deemed to be a waiver of the same provision for subsequent acts of Tenant. The acceptance by Landlord of Rent or other amounts due by Tenant hereunder shall not be deemed to be a waiver of any previous breach by Tenant.

25. **HOLDOVER.** If Tenant shall, without the written consent of Landlord, remain in possession of the Premises and fail to return them to Landlord after the expiration or termination of this Lease, the tenancy shall be a holdover tenancy and shall be on a month-to-month basis, which may be terminated according to Washington law. During such tenancy, Tenant agrees to pay to Landlord 150% of the rate of rental last payable under this Lease, unless a different rate is agreed upon by Landlord. All other terms of the Lease shall remain in effect. Tenant acknowledges and agrees that this Section does not grant any right to Tenant to holdover, and that Tenant may also be liable to Landlord for any and all damages or expenses which Landlord may have to incur as a result of Tenant's holdover.

26. **NOTICES.** All notices under this Lease shall be in writing and effective (i) when delivered in person or via overnight courier to the other party, (ii) three (3) days after being sent by registered or certified mail to the other party at the address set forth in Section 1; or (iii) upon confirmed transmission by facsimile to the other party at the facsimile numbers set forth in Section 1. The addresses for notices and payment of rent set forth in Section 1 may be modified by either party only by written notice delivered in conformance with this Section.

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27. **COSTS AND ATTORNEYS' FEES.** If Tenant or Landlord engage the services of an attorney to collect monies due or to bring any action for any relief against the other, declaratory or otherwise, arising out of this Lease, including any suit by Landlord for the recovery of Rent or other payments, or possession of the Premises, the losing party shall pay the prevailing party a reasonable sum for attorneys' fees in such action, whether in mediation or arbitration, at trial, on appeal, or in any bankruptcy proceeding.

28. **ESTOPPEL CERTIFICATES.** Tenant shall, from time to time, upon written request of Landlord, execute, acknowledge and deliver to Landlord or its designee a written statement specifying the following, subject to any modifications necessary to make such statements true and complete: (i) the total rentable square footage of the Premises; (ii) the date the Lease term commenced and the date it expires; (iii) the amount of minimum monthly Rent and the date to which such Rent has been paid; (iv) that this Lease is in full force and effect and has not been assigned, modified, supplemented or amended in any way; (v) that this Lease represents the entire agreement between the parties; (vi) that all obligations under this Lease to be performed by either party have been satisfied; (vii) that there are no existing claims, defenses or offsets which the Tenant has against the enforcement of this Lease by Landlord; (viii) the amount of Rent, if any, that Tenant paid in advance; (ix) the amount of security that Tenant deposited with Landlord; (x) if Tenant has sublet all or a portion of the Premises or assigned its interest in the Lease and to whom; (xi) if Tenant has any option to extend the Lease or option to purchase the Premises; and (xii) such other factual matters concerning the Lease or the Premises as Landlord may reasonably request. Tenant acknowledges and agrees that any statement delivered pursuant to this Section may be relied upon by a prospective purchaser of Landlord's interest or assignee of any mortgage or new mortgagee of Landlord's interest in the Premises. If Tenant shall fail to respond within ten (10) days to Landlord's request for the statement required by this Section, Landlord may provide the statement and Tenant shall be deemed to have admitted the accuracy of the information provided by Landlord.

29. **TRANSFER OF LANDLORD'S INTEREST.** This Lease shall be assignable by Landlord without the consent of Tenant. In the event of any transfer or transfers of Landlord's interest in the Premises, other than a transfer for collateral purposes only, upon the assumption of this Lease by the transferee, Landlord shall be automatically relieved of obligations and liabilities accruing from and after the date of such transfer, including any liability for any retained security deposit or prepaid rent, for which the transferee shall be liable, and Tenant shall attorn to the transferee.

30. **LANDLORD'S LIABILITY.** Anything in this Lease to the contrary notwithstanding, covenants, undertakings and agreements herein made on the part of Landlord are made and intended not as personal covenants, undertakings and agreements for the purpose of binding Landlord personally or the assets of Landlord but are made and intended for the purpose of binding only the Landlord's interest in the Premises, as the same may from time to time be encumbered. In no event shall Landlord or its partners, shareholders, or members, as the case may be, ever be personally liable hereunder.

31. **RIGHT TO PERFORM.** If Tenant shall fail to timely pay any sum or perform any other act on its part to be performed hereunder, Landlord may make any such payment or perform any such other act on Tenant's behalf. Tenant shall, within ~~ten (10) days~~ of demand, reimburse Landlord for its expenses incurred in making [12] such payment or performance. Landlord shall (in addition to any other right or remedy of Landlord provided by law) have the same rights and remedies in the event of the nonpayment of sums due under this Section as in the case of default by Tenant in the payment of Rent.

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32. **HAZARDOUS MATERIAL.** As used herein, the term "Hazardous Material" means any hazardous, dangerous, toxic or harmful substance, material or waste including biomedical waste which is or becomes regulated by any local governmental authority, the State of Washington or the United States Government, due to its potential harm to the health, safety or welfare of humans or the environment. Landlord represents and warrants to Tenant that, to Landlord's knowledge without duty of investigation, there is no Hazardous Material on, in, or under the Premises as of the Commencement Date except as may otherwise have been disclosed to Tenant in writing before the execution of this Lease. If there is any Hazardous Material on, in, or under the Premises as of the Commencement Date which has been or thereafter becomes unlawfully released through no fault of Tenant, then Landlord shall indemnify, defend and hold Tenant harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including without limitation sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees, incurred or suffered by Tenant either during or after the Lease term as the result of such contamination.

Tenant shall not cause or permit any Hazardous Material to be brought upon, kept, or used in or about, or disposed of on the Premises or the Property by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, except with Landlord's prior consent and then only upon strict compliance with all applicable federal, state and local laws, regulations, codes and ordinances. If Tenant breaches the obligations stated in the preceding sentence, then Tenant shall indemnify, defend and hold Landlord harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including, without limitation, diminution in the value of the Premises or the Property; damages for the loss or restriction on use of rentable or usable space or of any amenity of the Premises or the Property, or elsewhere; damages arising from any adverse impact on marketing of space at the Premises or the Property; and sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees incurred or suffered by Landlord either during or after the Lease term. These indemnifications by Landlord and Tenant include, without limitation, costs incurred in connection with any investigation of site conditions or any clean-up, remedial, removal or restoration work, whether or not required by any federal, state or local governmental agency or political subdivision, because of Hazardous Material present in the Premises, or in soil or ground water on or under the Premises. Tenant shall immediately notify Landlord of any inquiry, investigation or notice that Tenant may receive from any third party regarding the actual or suspected presence of Hazardous Material on the Premises.

Without limiting the foregoing, if the presence of any Hazardous Material brought upon, kept or used in or about the Premises or the Property by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, results in any unlawful release of any Hazardous Materials on the Premises or the Property, Tenant shall promptly take all actions, at its sole expense, as are necessary to return the Premises or the Property to the condition existing prior to the release of any such Hazardous Material; provided that Landlord's approval of such actions shall first be obtained, which approval may be withheld at Landlord's sole discretion. The provisions of this Section 32 shall survive expiration or termination of this Lease.

33. **QUIET ENJOYMENT.** So long as Tenant pays the Rent and performs all of its obligations in this Lease, Tenant's possession of the Premises will not be disturbed by Landlord or anyone claiming by, through or under Landlord.

34. **MERGER.** The voluntary or other surrender of this Lease by Tenant, or a mutual cancellation thereof, shall not work a merger and shall, at the option of Landlord, terminate all or any existing subtenancies or may, at the option of Landlord, operate as an assignment to Landlord of any or all of such subtenancies.

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35. GENERAL.

a. **Heirs and Assigns.** This Lease shall apply to and be binding upon Landlord and Tenant and their respective heirs, executors, administrators, successors and assigns.

b. **Brokers' Fees.** Tenant represents and warrants to Landlord that except for Tenant's Broker, if any, described and disclosed in Section 37 of this Lease, it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Landlord against any loss, cost, liability or expense incurred by Landlord as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Tenant. Landlord represents and warrants to Tenant that except for Landlord's Broker, if any, described and disclosed in Section 37 of this Lease, it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Tenant against any loss, cost, liability or expense incurred by Tenant as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Landlord.

c. **Entire Agreement.** This Lease contains all of the covenants and agreements between Landlord and Tenant relating to the Premises. No prior or contemporaneous agreements or understandings pertaining to the Lease shall be valid or of any force or effect and the covenants and agreements of this Lease shall not be altered, modified or amended except in writing, signed by Landlord and Tenant.

d. **Severability.** Any provision of this Lease which shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision of this Lease.

e. **Force Majeure.** Time periods for either party's performance under any provisions of this Lease (excluding payment of Rent) shall be extended for periods of time during which the party's performance is prevented due to circumstances beyond such party's control, including without limitation, fires, floods, earthquakes, lockouts, strikes, embargoes, governmental regulations, acts of God, public enemy, war or other strife.

f. **Governing Law.** This Lease shall be governed by and construed in accordance with the laws of the State of Washington.

g. **Memorandum of Lease.** Neither this Lease nor any memorandum or "short form" thereof shall be recorded without Landlord's prior consent.

h. **Submission of Lease Form Not an Offer.** One party's submission of this Lease to the other for review shall not constitute an offer to lease the Premises. This Lease shall not become effective and binding upon Landlord and Tenant until it has been fully signed by both of them.

i. **No Light, Air or View Easement.** Tenant has not been granted an easement or other right for light, air or view to or from the Premises. Any diminution or shutting off of light, air or view by any structure which may be erected on or adjacent to the Building shall in no way effect this Lease or the obligations of Tenant hereunder or impose any liability on Landlord.

j. **Authority of Parties.** Each party signing this Lease represents and warrants to the other that it has the authority to enter into this Lease, that the execution and delivery of this Lease has been duly authorized, and that upon such execution and delivery, this Lease shall be binding upon and enforceable against the party on signing.

k. **Time.** "Day" as used herein means a calendar day and "business day" means any day on which commercial banks are generally open for business in the state where the Premises are situated. Any period of time which would otherwise end on a non-business day shall be extended to the next following business day. Time is of the essence of this Lease.

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)
(Continued)

36. EXHIBITS AND RIDERS. The following exhibits and riders are made a part of this Lease, and the terms thereof shall control over any inconsistent provision in the sections of this Lease:

- ✓ Exhibit A Floor Plan/Outline of the Premises
- Exhibit B Legal Description of the Property
- ✓ Exhibit C Tenant Improvement Schedule

CHECK THE BOX FOR ANY OF THE FOLLOWING THAT WILL APPLY. CAPITALIZED TERMS USED IN THE RIDERS SHALL HAVE THE MEANING GIVEN TO THEM IN THE LEASE.

- [X] Rent Rider ☒ Addendum
- [ ] Arbitration Rider
- [ ] Letter of Credit Rider
- [ ] Guaranty of Tenant's Lease Obligations Rider
- [X] Parking Rider
- [X] ~~Option to Extend Rider~~
- [ ] Rules and Regulations

JOWP 3/8/16 QC 2.26.16 JOWP

37. AGENCY DISCLOSURE. At the signing of this Lease, Landlord is represented by **Courtland Booze, Keller Williams Western Realty**
(Insert both the name of the Broker and the Firm as licensed) (the "Landlord's Broker"), and Tenant is represented by **Courtland Booze, Keller Williams Western Realty**
(Insert both the name of the Broker and the Firm as licensed) (the "Tenant's Broker").

This Agency Disclosure creates an agency relationship between Landlord, Landlord's Broker (if any such person is disclosed), and any managing brokers who supervise Landlord's Broker's performance (collectively the "Supervising Brokers"). In addition, this Agency Disclosure creates an agency relationship between Tenant, Tenant's Broker (if any such person is disclosed), and any managing brokers who supervise Tenant's Broker's performance (also collectively the "Supervising Brokers"). If Tenant's Broker and Landlord's Broker are different real estate licensees affiliated with the same Firm, then both Tenant and Landlord confirm their consent to that Firm and both Tenant's and Landlord's Supervising Brokers acting as dual agents. If Tenant's Broker and Landlord's Broker are the same real estate licensee who represents both parties, then both Landlord and Tenant acknowledge that the Broker, his or her Supervising Brokers, and his or her Firm are acting as dual agents and hereby consent to such dual agency. If Tenants' Broker, Landlord's Broker, their Supervising Brokers, or their Firm are dual agents, Landlord and Tenant consent to Tenant's Broker, Landlord's Broker and their Firm being compensated based on a percentage of the rent or as otherwise disclosed on the attached addendum. Neither Tenant's Broker, Landlord's Broker nor either of their Firms are receiving compensation from more than one party to this transaction unless otherwise disclosed on an attached addendum, in which case Landlord and Tenant consent to such compensation. Landlord and Tenant confirm receipt of the pamphlet entitled "The Law of Real Estate Agency."

38. COMMISSION AGREEMENT. If Landlord has not entered into a listing agreement (or other compensation agreement with Landlord's Broker), Landlord agrees to pay a commission to Landlord's Broker (as identified in the Agency Disclosure paragraph above) as follows:

- [ ] $_____
- [ ] _____% of the gross rent payable pursuant to the Lease
- [ ] $_____ per square foot of the Premises
- [X] Other **Per Listing Agreement**

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)
(Continued)

Landlord's Broker ☐ shall ☒ shall not (shall not if not filled in) be entitled to a commission upon the extension by Tenant of the Lease term pursuant to any right reserved to Tenant under the Lease calculated ☐ as provided above or ☐ as follows _____ (if no box is checked, as provided above). Landlord's Broker ☐ shall ☒ shall not (shall not if not filled in) be entitled to a commission upon any expansion of the Premises pursuant to any right reserved to Tenant under the Lease, calculated ☐ as provided above or ☐ as follows _____ (if no box is checked, as provided above).

Any commission shall be earned upon execution of this Lease, and paid one-half upon execution of the Lease and one-half upon occupancy of the Premises by Tenant. Landlord's Broker shall pay to Tenant's Broker (as identified in the Agency Disclosure paragraph above) the amount stated in a separate agreement between them or, if there is no agreement, $_____ or _____% (complete only one) of any commission paid to Landlord's Broker, within five (5) days after receipt by Landlord's Broker.

If any other lease or sale is entered into between Landlord and Tenant pursuant to a right reserved to Tenant under the Lease, Landlord ☐ shall ☒ shall not (shall not if not filled in) pay an additional commission according to any commission agreement or, in the absence of one, according to the commission schedule of Landlord's Broker in effect as of the execution of this Lease. Landlord's successor shall be obligated to pay any unpaid commissions upon any transfer of this Lease and any such transfer shall not release the transferor from liability to pay such commissions.

39. BROKER PROVISIONS.

LANDLORD'S BROKER, TENANT'S BROKER AND THEIR FIRMS HAVE MADE NO REPRESENTATIONS OR WARRANTIES CONCERNING THE PREMISES; THE MEANING OF THE TERMS AND CONDITIONS OF THIS LEASE; LANDLORD'S OR TENANT'S FINANCIAL STANDING; ZONING OR COMPLIANCE OF THE PREMISES WITH APPLICABLE LAWS; SERVICE OR CAPACITY OF UTILITIES; OPERATING COSTS; OR HAZARDOUS MATERIALS. LANDLORD AND TENANT ARE EACH ADVISED TO SEEK INDEPENDENT LEGAL ADVICE ON THESE AND OTHER MATTERS ARISING UNDER THIS LEASE.

IN WITNESS WHEREOF, this Lease has been executed the date and year first above written.

316 LLC
LANDLORD 316 LLC

Anne Cantrell
LANDLORD

BY Anne Cantrell 2-16-2016

ITS: Managing Member

Dale L. Patterson
TENANT EmpRes Home Health of Bellingham, LLC
by EmpRes Healthcare Management, LLC,
Manager
by Dale Patterson, CEO

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)
(Continued)

STATE OF WASHINGTON
COUNTY OF Clark
ss.

I certify that I know or have satisfactory evidence that Dale L. Patterson is the person who appeared before me and said person acknowledged that he signed this instrument, on oath stated that he was authorized to execute the instrument and acknowledged it as the _____ of _____ to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 24th day of February, 2016.

Notary Public
State of Washington
TINA M NICKOLAS
My Commission Expires
November 20, 2018

Tina M Nickolas
(Signature of Notary)

Tina M. Nickolas
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington
Residing at Battle Ground, Clark County, WA

My appointment expires November 20, 2018

STATE OF WASHINGTON
COUNTY OF Whatcom
ss.

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me and said person acknowledged that _____ signed this instrument, on oath stated that _____ was authorized to execute the instrument and acknowledged it as the _____ of _____ to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this _____ day of _____, _____.

_____
(Signature of Notary)

_____
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington
Residing at _____

My appointment expires _____

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)
(Continued)

STATE OF WASHINGTON)
) ss.
COUNTY OF Whatcom)

I certify that I know or have satisfactory evidence that Anne Cantrell is the person who appeared before me and said person acknowledged that she signed this instrument, on oath stated that she was authorized to execute the instrument and acknowledged it as the managing member of 316 LLC to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 26th day of February, 2016

JOANN K. STEIDL NOTARY PUBLIC COMMISSION EXPIRES 04-09-2016 STATE OF WASHINGTON

Joann K Steidl
(Signature of Notary)

Joann K Steidl
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington
Residing at Bellingham

My appointment expires 4-9-16

STATE OF WASHINGTON)
) ss.
COUNTY OF Whatcom)

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me and said person acknowledged that _____ signed this instrument, on oath stated that _____ was authorized to execute the instrument and acknowledged it as the _____ of _____ to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this _____ day of _____, _____,

_____
(Signature of Notary)

_____
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington
Residing at _____

My appointment expires _____

ADDENDUM

PROPERTY: 316 E McLeod Rd, Bellingham, WA 98226-6491

1) Page 4, Item "c"
10 Days
2) Page 4, Item "c"
10 Days
3) Page 4, Item "5"
10 Days
4) Page 5, Item "b"
per month of
5) Page 9, Item "16a"
30 Days
6) Page 10, Item "16a"
60 Days
7) Page 11, Item "17a"
$25000.00

8) Page 13, Item "21a"
15 Days
9) Page 14, Item "22b"
Remove "or Tenant's"
10) Page 15, Item "22e"
30 Days
11) Page 15, Item "22e"
with the exception of business and client records and any documentation or information which would be considered Protection Health Information under HIPAA
12) Page 16, Item "31"
30 days for the first two months

Date: 2.26.16

Signature 316 LLC

Date:

Signature

Date: 2/24/16

Signature EmpRes Home Health of Bellingham, LLC
by EmpRes Healthcare Management, LLC,
Manager
by Dale Patterson, CEO

Addendum

CBA Form RR
Rent Rider
Rev. 1/2011
Page 1 of 1

RENT RIDER

This Rent Rider ("Rider") is made part of the Lease Agreement dated February 23, 2016, (the "Lease") between 316 LLC ("Landlord") and EmpRes Home Health of Bellingham, LLC ("Tenant") concerning the space commonly known as _____ (the "Premises"), located at the property commonly known as 316 E McLeod Rd, Bellingham, WA 98226-6491 (the "Property").

☒ **1. BASE MONTHLY RENT SCHEDULE.** Tenant shall pay Landlord base monthly rent during the Lease Term according to the following schedule:

Lease Year (Stated in Years or Months)	Base Monthly Rent Amount
5/10/2016 to 8/1/2016	$ 2,610 JDVP
Additional rent for the first 24 months	$ 3,116.25
8/1/2016 to 7/31/2017	$ 4331.04 plus NNN
8/1/2017 to 7/31/2018	$ 4331.04 plus NNN
8/1/2018 to 7/31/2019 optional	$ 4331.04 plus NNN
	$
	$
	$
	$
	$

DC 2.26.16

☐ **2. ~~CONSUMER PRICE INDEX ADJUSTMENT ON BASE MONTHLY RENT.~~** ~~The base monthly rent shall be increased on the first day of the second year of the Lease and on the first day of each year of the Lease thereafter (each, an "Adjustment Date") during the term of this Lease (but not during any extension term(s) unless specifically set forth elsewhere in the Lease or another Rider attached thereto). The increase shall be determined in accordance with the increase in the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (all items for the geographical statistical area in which the Premises is located on the basis of 1982-1984 equals 100) (the "Index"). The base monthly rent payable immediately prior to the applicable adjustment date shall be increased by the percentage that the Index published for the date nearest preceding the applicable Adjustment Date has increased over the Index published for the date nearest preceding the first day of the Lease Year from which the adjustment is being measured. Upon the calculation of each increase, Landlord shall notify Tenant of the new base monthly rent payable hereunder. Within twenty (20) days of the date of Landlord's notice, Tenant shall pay to Landlord the amount of any deficiency in Rent paid by Tenant for the period following the subject Adjustment Date, and shall thereafter pay the increased Rent until receiving the next notice of increase from Landlord. If the components of the Index are materially changed after the Commencement Date, or if the Index is discontinued during the Lease term, Landlord shall notify Tenant of a substitute published index which, in Landlord's reasonable discretion, approximates the Index, and shall use the substitute index to make subsequent adjustments in base monthly rent. In no event shall base monthly rent be decreased pursuant to this Rider.~~

INITIALS: LANDLORD DC DATE _____ TENANT JDVP DATE 2/24/16

LANDLORD _____ DATE _____ TENANT _____ DATE _____

CBA Form PR
Parking Rider
Rev. 1/2011
Page 1 of 1

PARKING RIDER

This Parking Rider (the "Rider") is made part of the lease agreement dated February 23, 2016, (the "Lease") between 316 LLC ("Landlord") and EmpRes Home Health of Bellingham, LLC ("Tenant") concerning the leased space commonly known as _____ (the "Premises"), located at the property commonly known as 316 E McLeod Rd, Bellingham, WA 98226-6491 (the "Property").

1. **Tenant's Parking Rights.** Tenant's right to park on the Property shall be as follows (check one):

   ☐ Tenant shall be entitled to use parking stalls on the Property or other designated parking area on a (check one) ☐ reserved ☐ unreserved (unreserved, if neither box checked) basis at the prevailing monthly rate established by Landlord from time to time. Tenant shall comply with the reasonable rules and regulations which Landlord or its parking operator may adopt from time to time for the safe and orderly operation of the parking areas.

   ☒ **Free Parking.** Tenant shall be entitled to share parking with Landlord's other tenants in the designated parking areas at no charge. Tenant shall be responsible for ensuring compliance with the terms of the Lease, this Rider, and any reasonable rules and regulations adopted by Landlord from time to time for the safe and orderly sharing of parking.

   ☐ **No Parking.** The Lease does not include parking on the Property, and Tenant shall park off the Property at Tenant's own expense.

2. **Tenant.** For purpose of this Rider only, the term "Tenant" shall include Tenant and Tenant's employees, officers, contractors, licensees, agents, and invitees, except as follows:
   as assigned
   Tenant is entitled to park ~~anywhere~~ on the property incompliance with ADU restrictions. Tenant is guaranteed its pro rata share of spaces which is 15, based on their percentage of space assigned on lease. Landlord ~~will assign~~ has assigned allotted spaces ~~if tenant notifies Landlord of their need for assigned spaces~~. $25 unit 101.
   Upper parking lot for clients/visitors only.

DPP ac
3/8/16 2.26.16

INITIALS: LANDLORD _____ DATE 2.26.16 TENANT DPP DATE 2/24/16
LANDLORD _____ DATE _____ TENANT _____ DATE _____

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)
(Continued)

EXHIBIT A
[Outline of the Premises]

See attachment 1, two pages

EXHIBIT A

CBA

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)
(Continued)

EXHIBIT B
[Legal Description of the Property]

DKC ac 2.25.2016

LEGAL DESCRIPTION FOR PARCEL # 380318094137
PER DEED RECORDED UNDER AUDITOR'S FILE NO. 2110102716

Legal: Unit A, McLeod Commercial Condominium, as per the declaration recorded at Auditor's File No. 2080602858, records of Whatcom County, Washington.

Situate in Whatcom County, Washington

LEGAL DESCRIPTION FOR PARCEL # 380318092320
PER DEED RECORDED UNDER AUDITOR'S FILE NO. 2080602961

Unit B, McLeod Commercial Condominium, as per the Declaration recorded at Auditor's File No. 2080602857, Records of Whatcom County, Washington.

EXHIBIT B

LEASE AGREEMENT
(Multi-Tenant Triple Net (NNN) Lease)
(Continued)

EXHIBIT C
[Tenant Improvement Schedule]

1. **Tenant Improvements to be Completed by Landlord**

Landlord will pay up to $74,790.00 for tenant improvements. Landlord will spread the cost of the improvements evenly over 24 months. Tenant rent will increase $3116.25 per month for 24 months starting with the month of August 2016.
Base rent $4331.04 + Improvement $3116.25 + NNN = $7447.29 + NNN for 24 months.
The base lease only runs for twenty three months. If the tenant doesn't renew there will be a balloon payment of $10,563.54 for the last month of the lease. Base rent $4331.04 + Improvement $6232.50 = $10,563.54.

2. **Tenant Improvements to be Completed by Tenant**

See attachment 2, eight pages.

Page 1 Exhibit "C"

AC

2.26.16

THE FRANKLIN CORPORATION
General Contractors | Project Consultants

December 30, 2015

Nicole Thompson
nthompson@edenhh.com

Corky Booze
corkycwr@gmail.com

Re: Deductions and Cost Breakouts per Site Meeting
316 E. McLeod Road, Bellingham, WA 98226

The following are those items discussed today during our walk through:

I.)	Original base bid price	= $ 77,024.00	
II.)	Deduct for demising wall at main floor manager's office	= $ (2,234.00)	
III.)	Revised base price	= $ 74,790.00	Plus W.S.S.T.
IV.)	Breakout price for reception office #3 which is included in base price above	= $ 5,435.00	Plus W.S.S.T.
V.)	Cost for a (1) ton Mitsubishi split system for the IT room in basement, add to base price	= $ 7,100.00	Plus W.S.S.T.

Please let me know if you have any other questions and have a great New Year's holiday.

Best regards,

Myles P. Donnelly
The Franklin Corporation
President
FRANKC*099BQ

MAIL: 6459 PORTAL WAY, FERNDALE WA 98248
EMAIL: info@thefranklincorporation.com
PHONE: (360) 384-6200
FAX: (360) 384-6201

page 2 Exhibit "C"

THE FRANKLIN CORPORATION
General Contractors | Project Consultants

December 24, 2015

Nicole Thompson
nthompson@edenhh.com

Corky Booze
corkycwr@gmail.com

Re: Tenant Improvement
316 E. McLeod Road, Bellingham, WA 98226

The Franklin Corporation proposes to furnish all labor, materials, equipment, architectural plans, and required permits to complete the following "Scope of Work" for a total cost of:

$77,024.00 (Seventy-Seven Thousand and Twenty-Four Dollars & 00/100) Plus W.S.S.T.

Alternate Add Item: Install (1) Mitsubishi (3) Ton Split System for the proposed I.T. Room. Unit to be wall mounted with the compressor installed on grade, adjacent to the electrical service gear.

Add = $10,945 plus W.S.S.T.

Please review our proposal carefully and then we can meet at your convenience to walk the site.

We appreciate the opportunity to be of service and would enjoy working with you on your project.

Best regards,

Myles P. Donnelly
The Franklin Corporation
President
FRANKC*099BQ

Attachments 1.) Scope of Work, pages 1-4 of 4.
2.) T.F.C. Floor Plans for work areas, pages 1-2 of 2.

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EMAIL: info@thefranklincorporation.com
PHONE: (360) 384-6200
FAX: (360) 384-6201

Page 3 Exhibit "C"

THE FRANKLIN CORPORATION
General Contractors | Project Consultants

December 23, 2015

Eden Home Health
Scope of Work

Reception & Office #3

I.) Demolition:
- A.) Demo 12 l.f. of cabinetry.
- B.) Demo double hung entry door.
- C.) Demo carpet in new office #3.
- D.) Cut and patch for electrical wiring as needed.

II.) New Walls:
- A.) Frame new 17 l.f. wall full height with 5/8" GWB both sides.
- B.) Frame infill wall at removed entry door with 5/8" GWB both sides; texture to match existing.

III.) Doors & Trim:
- A.) (1) New $3^0 7^0$ x $1^3/_4$" solid core maple door and jamb with full relite and reused entry hardware; clear pre-finish.
- B.) (1) New $3^0 7^0$ x $1^3/_4$" solid core maple door and jamb per above for new office #3.
- C.) Maple casing to match existing.
- D.) Infill 1/2 x 6 painting wood base as needed and at new walls.

IV.) Electrical:
- A.) Move existing reception cabinet power and data wiring to side wall.
- B.) Add (1) white "pillow" light and switch for new reception area.
- C.) Re-switch (2) existing white "pillow" lights at new office #3.
- D.) Add illuminated exit lights, (2) total, above doors in and out of reception area.

V.) Floor Coverings:
- A.) Install new mid-range priced 24"x 24" carpet tile in new office #3.
- B.) Install transitions to existing flooring at new entry door and door to office #3.

VI.) Painting:
- A.) Paint all new drywall areas with (1) coat primer and (2) coats finish latex.
- B.) Repaint patched/repaired areas to near change in plane or surface.

Manager's Office Area

I.) Demolition:
- A.) Remove carpet tile as needed for (2) new floor plugs with data ports.
- B.) Cut and patch for electrical as needed.

II.) New Walls:
- A.) Frame 33 l.f. of new walls full height with 5/8" GWB on both sides to form offices #1 & #2.

MAIL: 6459 PORTAL WAY, FERNDALE WA 98248
EMAIL: info@thefranklincorporation.com
PHONE: (360) 384-6200
FAX: (360) 384-6201

Page 4 Exhibit "C"

III.) Doors & Trim:
- A.) (2) New $3^0 7^0$ x $1^3/_4$" solid core oak doors and clear hemlock painted jambs, full glass lites, and locking lever hardware; pre-finished clear on door.
- B.) Paint grade 1 x 3 painted casing to match existing.
- C.) Paint grade 1/2 x 6 base trim to match existing.

IV.) Electrical:
- A.) Add (1) new "pillow" light at office #2 switched with existing lights.
- B.) Relocate (1) 4 gang data port at east wall to be inside of office #2.
- C.) Add (2) combination floor boxes with power and data ports in recessed receptacles, covered with existing carpet tile to match existing. These are to be located in open work area south of offices #1 & #2.
- D.) We provide pipes and boxes for data wiring but install no wire and make no terminations.

V.) H.V.A.C.:
- A.) There is no return air duct distribution so no R/A run to manager's office #2 is included.

VI.) Floor Coverings: None

VII.) Painting:
- A.) Paint all new drywall with (1) coat primer and (2) coats finished latex.
- B.) Paint (2) door jambs with (2) coats satin latex.
- C.) Paint casing and base with (2) coats satin latex.

Basement Area

I.) Demolition:
- A.) Remove existing carpet and base from stairs, existing office areas #4, #5, and #6.
- B.) Remove metal work bench approximately 11' long.
- C.) Remove overhead door 10' x 10'.
- D.) Remove hollow metal man door and jamb.
- E.) Remove all miscellaneous non-functional wall attachments and overhead braces.
- F.) Cut and patch for subcontractors as needed.
- G.) Remove door and jamb entering new office areas #4 & #5.

II.) New Walls:
- A.) Frame 31 l.f. of new walls full height with 5/8" GWB both sides to create offices #4 & #5.
- B.) Frame 21 l.f. of new walls to 10' AFF with 5/8" GWB both sides to create new breakroom.
- C.) Infill area at removed overhead door to accommodate new 4060 window, and stucco exterior finish.
- D.) Reframe existing man door at removed hollow metal door to accommodate new aluminum storefront door.

III.) Doors & Trim:
- A.) (3) New $3^0 7^0$ x $1^3/_4$" solid core birch doors and hemlock jambs, prefinished clear at offices #4, #5, and breakroom.
- B.) (3) Lever passage latch sets.
- C.) Prefinished clear hemlock, prefinished casing.
- D.) Line and case new $4^0 6^0$ window surround with clear, prefinished hemlock.
- E.) Line and case new $3^0 7^0$ storefront man door with clear, prefinished hemlock.

F.) Install new clear hemlock "Breadloaf" style handrail at stairs; approximately 7 l.f. mounted on wall brackets.
G.) Install 1 x 6 paint grade trim and cap board at exposed concrete foundation wall.
H.) Case and line opening at offices #4 and #5 with paint grade trim.

IV.) Electrical:
A.) Lighting:
1.) Install new 2 x 4 parabolic drop in fixtures in new acoustic grid system in offices #4 and #5 (center non soffited areas) new breakroom, and entire "Bullpen" area to include over I.T. room.
2.) Make recessed can lights at existing hand lid soffit in office #5 & #6 openable. Recessed cans controlled by one switch.
3.) Install emergency exit lighting at new storefront door as required by code.
B.) Heating:
1.) Confirm baseboard heaters in offices #4, #5, #5 are operable (additional costs will be incurred if heaters are found to be inoperable).
2.) Lower and rewire as needed to electrical space heaters which are existing and wall mounted (additional costs will be incurred if heaters are found to be inoperable).
C.) General:
1.) Safe off any open receptacles.
2.) Relocate plugs, switches, and data ports as needed to accommodate new walls.

V.) Acoustic Ceiling Systems:
A.) Install new 2x4 white grid and Armstrong random fissure tiles in non soffit area of office #4 and #5, entire "Bullpen" area, and breakroom.
B.) Replace damaged tile in office #6.

VI.) Insulation:
A.) Install R-11 unfaced sound batts above all new acoustic ceiling areas.
B.) Install R-11 unfaced sound batts at all new framed walls.
C.) Install R-21 faced batts at exterior wall infill area.

VII.) Painting:
A.) All new GWB to receive (1) coat primer and (2) coats finish latex.
B.) Patch and repair existing walls to a passable level of appearance (not new condition); spot prime.
C.) Repaint all existing surfaces as needed.
D.) Paint MDF base-of-wall trim at exterior concrete walls.
E.) Paint existing repaired stucco area at exterior wall as needed.

VIII.) Stucco:
A.) Repair/infill area at removed overhead and man door; texture to match existing as close as possible.
B.) Color coat to match existing as close as possible.

IX.) Floor Coverings:
A.) Install mid-range 24"x 24" carpet tile in all designated areas per attached floor plan to include (5) stairs and risers. (Installed allowance of $3.25/s.f.)
B.) Install commercial grade sheet vinyl with welded seams in breakroom. (Installed allowance of $3.00/s.f.).

Page 6 Exhibit "C"

C.) Install 4" rubber base at all newly carpeted areas.

General Conditions

I.) Project management / Supervision
II.) Daily cleanup / General labor
III.) Architectural services
IV.) Permits and fees as required for building, electrical and mechanical
V.) Small tools, supplies, and fuel
VI.) Temporary lighting
VII.) Scaffolding / Equipment rentals
VIII.) Disposal fees
IX.) Final janitorial cleaning

Exclusions/Conditions

I.) Work not covered in this "Scope of Work."
II.) Correction of non code compliant existing conditions not specifically covered by this "Scope of Work."
III.) Work due to plan check corrections by City of Bellingham or other agencies having jurisdiction.
IV.) Testing for, removal and/or disposal of hazardous materials.
V.) Off hours work; work is assumed to be done during normal hours of 7:00am to 6:00pm.
VI.) Architectural services required above and beyond the requirements of this "Scope of Work."
VII.) Security systems or data wiring.

End

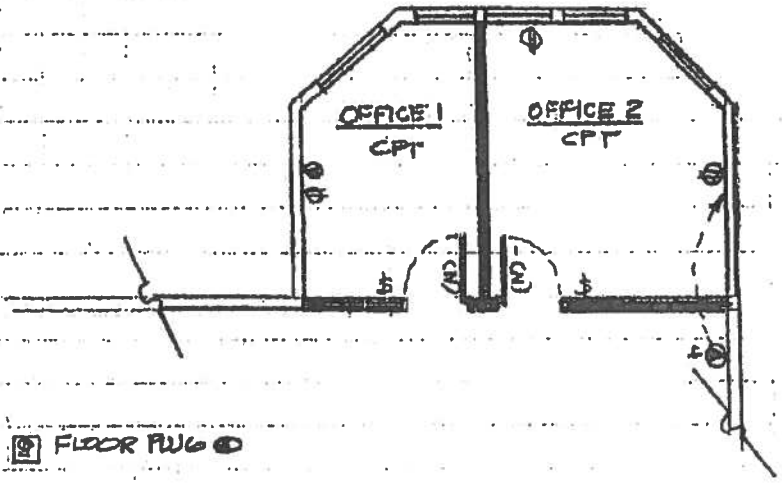
Page 7 Exhibit "C"

THE FRANKLIN CORPORATION
GENERAL CONTRACTORS & PROJECT CONSULTANTS
(360) 384-6200 • Fax: (360) 384-6201

PROJECT _____
SUBJECT MANAGER / RECEPTION
BY _____ DATE _____ PAGE ____ OF ____

MANAGERS OFFICE

SCALE: 1/8" = 1'

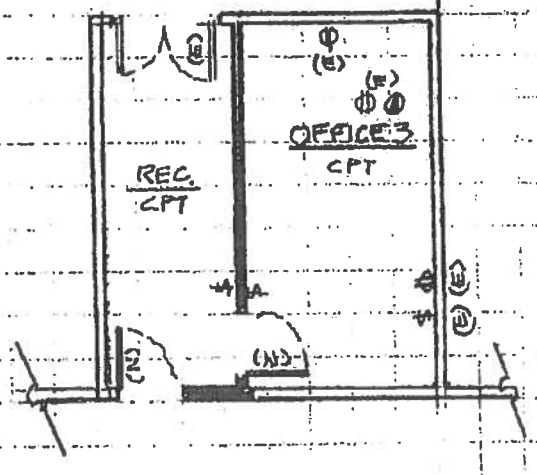


FLOOR PLUG

FLOOR PLUG

RECEPTION / OFFICE

SCALE: 1/8" = 1'



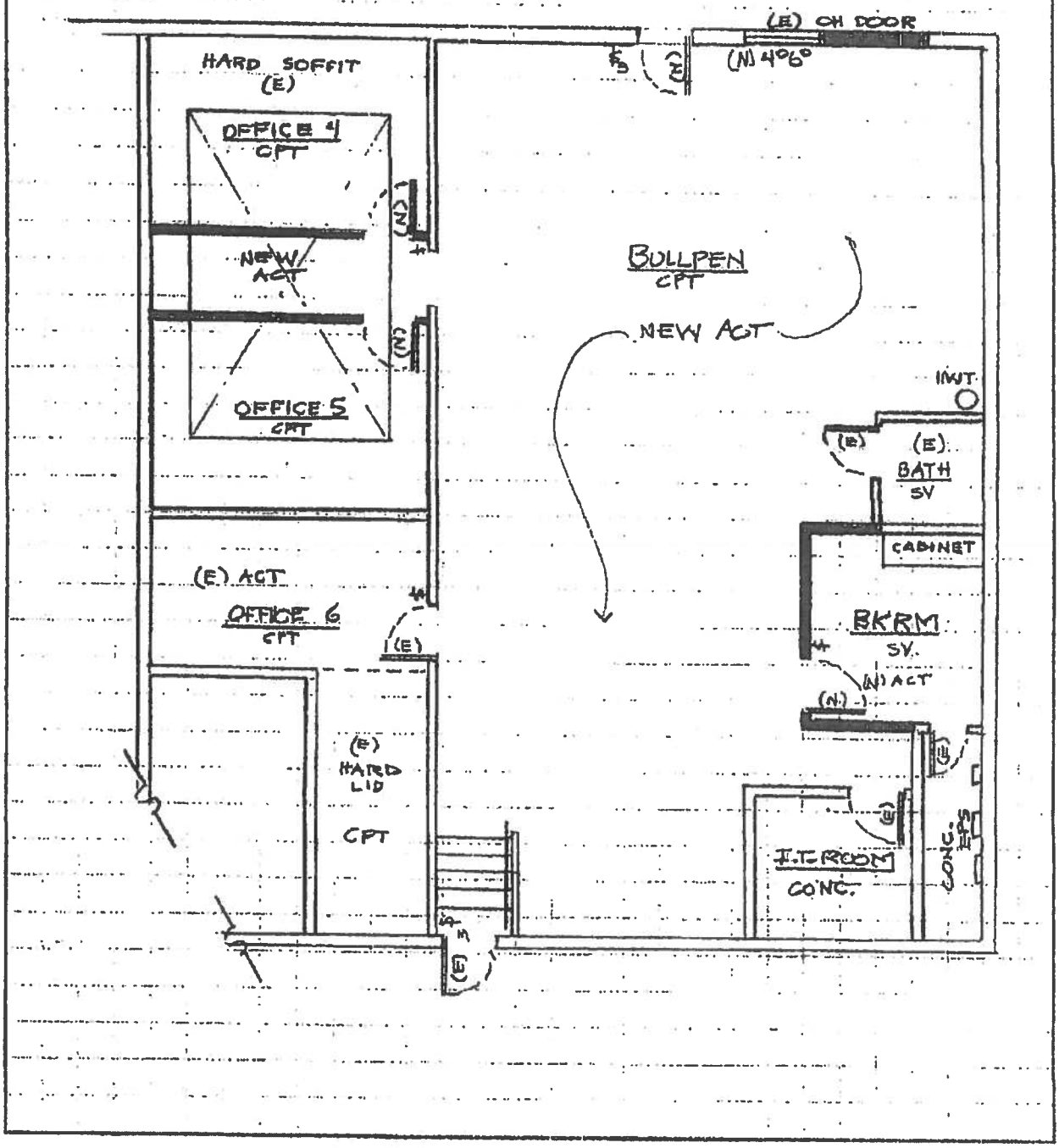
Page 8 Exhibit "C"

THE FRANKLIN CORPORATION
GENERAL CONTRACTORS & PROJECT CONSULTANTS
(360) 384-6200 • Fax: (360) 384-6201

PROJECT EDEN HEALTH CARE
SUBJECT BASEMENT LEVEL
BY MPD DATE 12/21 PAGE 1 OF

BASEMENT LEVEL

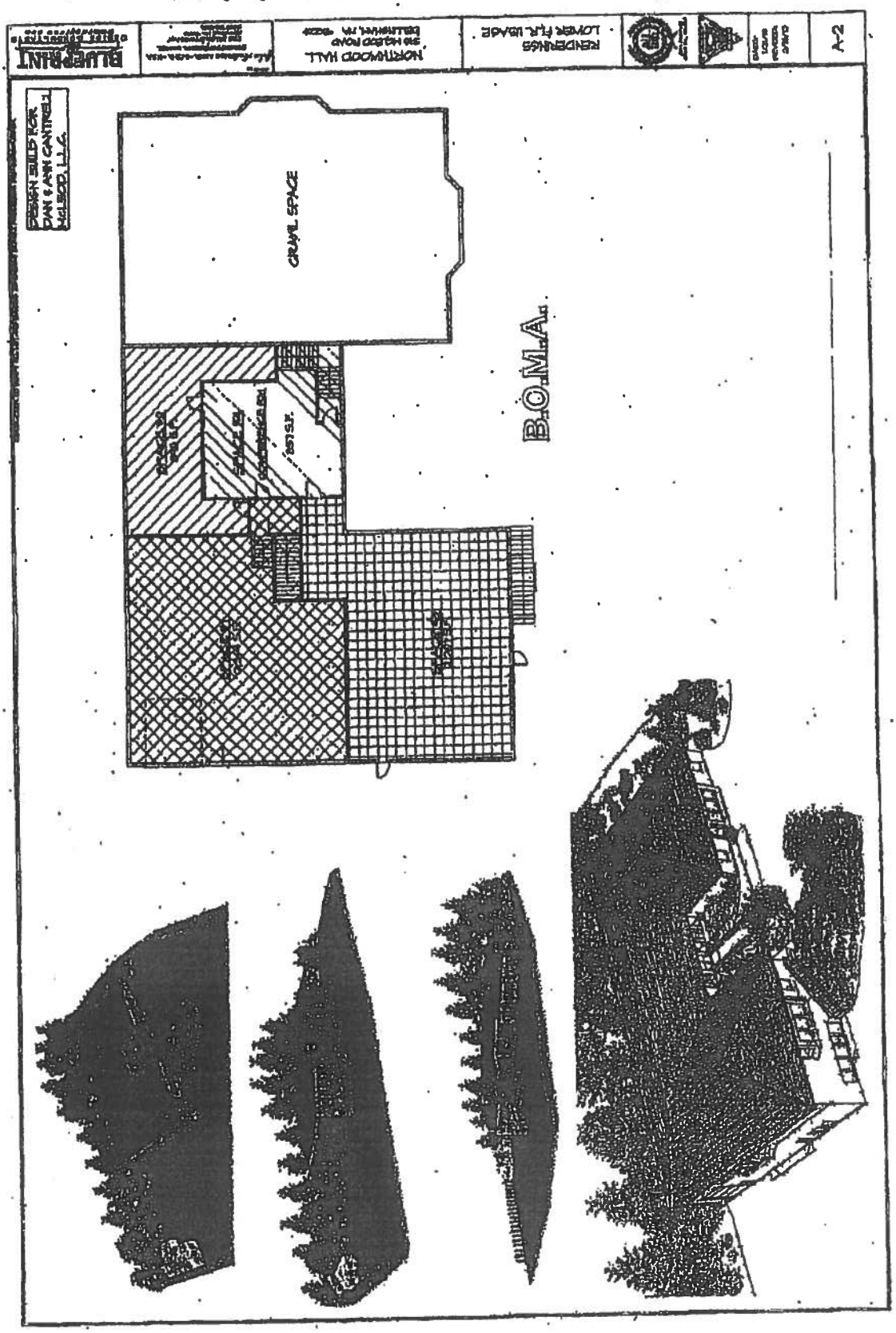
SCALE: 1/8"=1'



ATTACHMENT 1

AC 3.16.16

Exhibit pg 1 of 2



ATTACHMENT 1

AC
2.26.14

Exhibit A pg 2 of 2

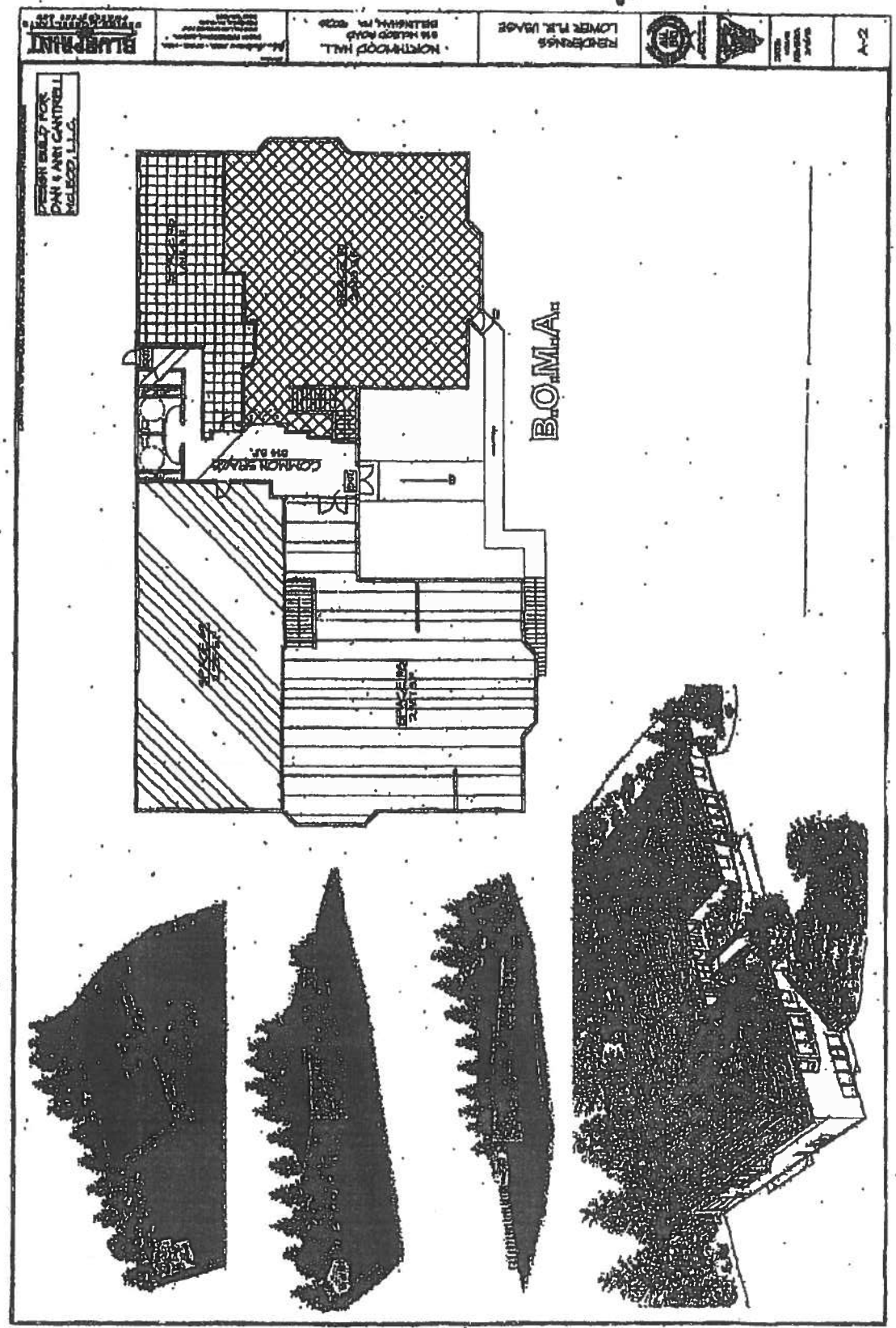


EXHIBIT A

Compass Washington
503 Westlake Ave N
Seattle, WA 98109
Phone: 206-330-0314

Form: LA
Lease Addendum
Rev 5/2007
Page 1 of 1

ADDENDUM/AMENDMENT TO CBA LEASES

CBA Text Disclaimer: Text deleted by licensee indicated by strike.

The following is part of the Commercial Lease Agreement dated Feb 23,2016 ,

Between 316 LLC ("Landlord")

And EmpRes Health of Bellingham ("Tenant")

regarding the lease of the Property known as: 316 E McLeod Rd, Bellingham WA

IT IS AGREED BETWEEN THE LANDLORD AND TENANT AS FOLLOWS: Tenant agrees to extend Lease as follows :

8/1/2019 to 7/31/2020 .	$4460.94 plus NNN
8/1/2020 to 7/31/2021 .	$4594.76 plus NNN
8/1/2021 to 7/31/2022 .	$4732.82 plus NNN
8/1/2022 to 7/31/ 2023 .	$4874.78 plus NNN
8/1/2023 to 7/31/2024 .	$5020.24 plus NNN

AGENT (COMPANY): Compass By: AnneCantrell

ALL OTHER TERMS AND CONDITIONS of said Agreement remain unchanged.

INITIALS:
Landlord/Lessor: JC 316LLC Date Jan.24/2020 Tenant/Lessee: _____ Date _____

Landlord/Lessor: _____ Date _____ Tenant/Lessee: _____ Date _____

CBA Form No. LA
Addendum/Amendment to Leases
Rev. 5/07
Page 1 of 1

Extension ADDENDUM/AMENDMENT TO CBA LEASES

The following is part of the Commercial Lease Agreement dated February 23, 2016.
Between 316 LLC ("Landlord")
And EmpRes Health of Bellingham ("Tenant")
regarding the lease of the property known as 316 E McLeod Rd, Bellingham, WA 98226-6491
(the "Premises").

IT IS AGREED BETWEEN THE LANDLORD AND TENANT AS FOLLOWS:

Tenant agrees to extend lease as follows :

8/1/2018 to 7/31/2019	**$4331.04 plus NNN**
8/1/2019 to 7/31/2020	**$4460.94 plus NNN**
8/1/2021 to 7/31/2021	**$4594.76 plus NNN**

The lease of Suite **108** between Landlord and Tenant was terminated May **31, 2017.**

AGENT (COMPANY): ~~CB Bain~~ 316 LLC By:

ALL OTHER TERMS AND CONDITIONS of said Agreement remain unchanged.

INITIALS:
Tenant/Lessee _____ DATE 5/25/18
Tenant/Lessee _____ DATE _____

Landlord/Lessor _____ [ac] DATE 06/07/2018
Landlord/Lessor _____ DATE _____

Caldwell Banker Bain, 3610 Meridian Bellingham WA 98226 Phone (360)734-3410 Fax (360)734-6879 EmpRes Home Health
Anne Cantrell

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 7

Realities of End-of-life Issues Confronted – Whatcom Watch Online

Whatcom Watch Online
A community forum on government, environmental issues and media

Realities of End-of-life Issues Confronted

by Robert A. Duke

Healthcare Providers and Public in Landmark Meeting on End-of-Life Issues

Artwork by Hilary Cole

"Rumors and Realities" was an apt title for the Jan. 17, 2018, standing-room-only public meeting about dying in Whatcom County.

Community rumors were rife that PeaceHealth's St. Joseph Medical Center's Catholic orientation subordinates patient's end-of-life care directives to its religious ideology. The realities are that civil laws and poor healthcare record access dictate more about end-of-life issues than do any other factors.

A first-time-ever panel representing St. Joseph Medical Center and End-of-Life Washington attempted to address these factors at Moles Community Center in Bellingham for an audience of 120. The results were a mix of successes and failures, but all agreed this unprecedented start was itself the greatest success.

Marie Eaton, director of the Palliative Care Institute at Western Washington University, and Sandy Stork, founder of Bellingham's branch of the international group Death Café, made this meeting possible. The panel responding to questions consisted of three representing St. Joseph's: Gurpreet Dhillon, director of Palliative, Cancer and Hospice Care; Jodi Newcomer, nurse manager of Whatcom Hospice; Ross Fewing, director of Mission and Ethics; and Sally McLaughlin represented End of Life Washington.

Organizers

In their roles with Death Café and Palliative Care, Sandy and Marie have been addressing the same community audience, which has continually voiced concerns over PeaceHealth's compliance with end-of-life choices, especially involving St. Joseph Medical Center. Whether grounded in facts or not, the pair reached out in late 2017 to PeaceHealth's Gurpreet Dhillon and Jodi Newcomer to put together the Rumors and Realities event.

Moderator Eaton opened the two-hour meeting by saying its goal was to ". . .unpack what's possible and what's not possible," and then read a prepared question. Each panelist in turn responded to the question, and when Eaton voiced the next question, a man in the audience raised his hand and said the first question hadn't yet been answered. An approving murmur swept the room.

And so, the meeting went, with audience questions intermixed with more pre-submitted questions. The moderator recognized audience members desiring to comment on various points of the discussion, and others who told fragments of their personal stories. Approximately a dozen questions were asked and answered, about 10 minutes per question.

Sample Audience Questions

Audience: Can patients in local hospice be administered end-of-life drugs?
Panel: No. We don't want to abandon you, but we'll help you find a facility that can help. PeaceHealth will not prescribe or administer end-of-life drugs but will discuss options and refer you to facilities that will.

Audience: With Alzheimer's, are you able to honor end-of-life requests, even if (the patient) can't speak it?
Panel: There's no clear answer to that right now. The basic issue is competency to make an informed decision.

Audience: Who advocates for people who are less literate?
Panel: The hospital's patient advocate.

Audience: How does PeaceHealth handle death by Voluntary Stopping of Eating and Drinking (VSED), and what are the issues of the ethics of care and legal requirements?
Panel: That's very difficult. If a VSED patient says, 'I'm thirsty', even if he's delirious, the nurse or provider MUST give a drink. The same goes for food.

After about the first 30 minutes, I'd say the audience and panelists had reconciled themselves to what they were both up against – that emergency situations can be dicey — and concluded to make the best of it. Several audience questions could have been answered from published information, and the panelists addressed the impact of legal constraints, complexities of the healthcare system, and the responsibilities of patients, families and caregivers to help make the system work.

Success or Failure

Was the PeaceHealth: Rumors and Realities a success or a failure? Yes!

That the two groups met for two hours was success itself. In particular, moderator Eaton and co-host Stork each has her own success list.

Eaton's List

1. I was glad that panelists Ross Fewing and Jodi Newcomer clarified that, although PeaceHealth will not prescribe or administer Death With Dignity (DWD) drugs, it does not have a gag order on its staff. I was particularly interested to learn that, according to Newcomer, hospice presents DWD as an option on its patient intake forms.

2. I also appreciated hearing from panelist Sally McLaughlin (from End-Of-Life Washington) that only four hospitals in Washington allow on-premise participation in DWD, indicating PeaceHealth is not as far out of the mainstream as some might think.

3. Panelists addressed details about the challenges healthcare institutions face and clarified the difficulties facing supporters of VSED.

4. To honor advance directives at PeaceHealth, there is a "tab" now in your medical chart indicating where your advance directive and/or POLST documents are located, but there remain identified challenges for healthcare providers to actually obtain them.

Stork's List

1. There was affirmation that people want opportunities to ask the questions directly and address the issues they have about the policies of patient care at PeaceHealth facilities.

2. Besides the turnout for the event, I thought the degree of audience engagement was great.

3. Many of the questions I had hoped would be asked were asked (not that there couldn't have been more questions.).

4. The discussion stimulated meaningful conversations among the panelists about "where do we go from here."

Catholic Hospitals vs. Hospitals

The question of Catholic religious bias affecting end-of-life care at St. Joseph's remains unanswered, because it was never explicitly addressed. I think the "Catholic" question is a relic from the Reformation. Much of the history of hospitals is the history of religion – all religions.

I thought the internet's Huffington Post article titled 'Catholic' Hospitals vs. Hospitals, by Dr. Andrew Agwunobi of Cambodia said it best: "I also happen to be Catholic, which I hasten to clarify is about as important to this topic as being Cambodian."

The earliest hospitals were Egyptian temples dedicated to various gods and deities where the sick went seeking relief. This system of religion = care for the sick progressed through Greek and Roman civilizations and into Europe, and is a staple concept of Christianity and other world religions.

Here's a representative list of U.S. hospitals with religious affiliations:

Catholic Hospitals include St. Francis, John's, Joseph's, Luke's, Mary's, Thomas', Theodore's, and Vincent's. There's also New York Presbyterian Hospital, Barnes—Jewish Hospital, Wake Forest Baptist Medical Center, and Lutheran, Methodist and Adventist Hospitals.

There also may be good reason for seeking a religion-based hospital. An Aug. 17, 2017, Huffington Post article titled Religious Hospitals Better? Study Says Catholic and Church-Run Hospitals More Efficient, Provide Superior Care by Daniel Burke, who wrote, "If you are looking to justify your preference for a Catholic hospital, here's your excuse."

Historically, Catholic hospitals followed Catholic dictates largely because they were staffed by Catholic nuns until 1960. In the 1960s, the population of nuns nosedived, forcing Catholic hospitals to become more secular. It therefore seems safe to put aside the Catholic conspiracy theory and look for more likely causes to the problem of getting advance directives recognized and acted upon.

A Clue

The cause of the perceived problem with honoring patient end-of-life directives at St. Joseph Medical Center may have been pinpointed by panelist Gurpreet Dhillon's opening remarks to the audience, when he asked, "How many of you have an advanced care directive?"

Most hands went up, and he said, "We're working on how to make more reliability, so this information can get to the right person when you get (to the hospital). We're working on the culture to get that done." (Emphasis added.)

In response came the shouted question, “Can I be guaranteed?” to which Dhillon responded, “I can’t guarantee it. We’re working on making it more reliable.”

The problem, it seems, is not Catholicism but the issue of disorganized and mismanaged corporate healthcare manifested by the lack of compatible, accessible and fully implemented “electronic healthcare records” (EHR). The last published WA State Health Department count of Whatcom EHRs was 30, most of which cannot communicate with each other. By contrast, the state of Oregon has mandated that only one EHR be in effect. No other reliable destination that is universally accessible to every healthcare provider attending you at the end of your life is available in 2018. (For an in-depth look at EHR in Whatcom County see the Whatcom Watch October/November 2014 issue of my column Whatcom: Chronic & Acute article Patient Portal: A Magic Gateway to Healthcare Reform.)

I came away from the Rumors and Realities event with the astonishing realization that the public was by the show of hands further ahead in adopting end-of-life directives than is the healthcare system as represented by PeaceHealth and St. Joseph Medical Center.

Failure

I confess to attending the event and anticipating failure.

The panel mostly provided anecdotal information laced with complaints about the complexity of end-of-life matters and underscored by frequent apologies. Their message was often that providers were doing their best, and responsibility for end-of-life decisions and care rested with family, spouses and friends of the patient. There was little specific talk about the roles of clinicians or hospital administrators in end-of-life.

I had witnessed the whole St. Joseph Medical Center end-of-life process with the death of my wife from brain cancer in 2011. We had all of our paper work in order, and I witnessed advance directive medical decisions being made. Doctors must make such decisions, at any time of the day or night, regardless of whom else might be present. Time and tide, the adage says, wait for no man, but neither does death.

From knowledge I acquired as a member of the PeaceHealth Patient Advisory Board, the most likely person to be in charge of a patient at any time in the hospital is a physician designated as the “hospitalist.” My question to the panel was to name the medical person most likely to be making advance directive end-of-life decisions for St. Joseph patients? Initially there was no answer given, but late in the event, a physician responsible for end-of-life decisions had been publicly identified. For this, I had a personal reason to consider Rumors and Realities a success.

Hope and Trust

From my experience as my wife’s sole caregiver for the 18 months she lived coupled with my ongoing experience as a patient, I learned how much patients and caregivers subsist on hope and trust: hope for treatment and perhaps a cure, and trust that it will be provided.

It’s not about success or failure, it’s about ongoing hope and trust. I believe the Jan. 17, 2018 PeaceHealth: Rumors and Realities meeting was a success by initiating dialogue about end-of-life concerns that gave the standing-room-only crowd some hope the hospital is aware of and will work to address these issues widespread in our community.

Robert A. Duke is author of "Waking Up Dying: Caregiving When There Is No Tomorrow," he lives in Bellingham. His email: boshduke@gmail.com

Bookmark the permalink.

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 8

UPDATED FACILITIES LIST

Legal Name	DBA
OPERATING ENTITIES	
ARIZONA	
Eden Hospice at Sierra Vista, LLC	Eden Hospice
Eden Home Health of Sierra Vista, LLC	Eden Home Health
Eden Home Health of Safford, LLC	Eden Home Health of Safford
Eden Hospice at Cochise County, LLC	Eden Hospice in Chochise
CALIFORNIA	
Evergreen at Petaluma, L.L.C.	EmpRes Post Acute Rehabilitation
Evergreen at Salinas, L.L.C.	Katherine Healthcare
Evergreen at Tracy, L.L.C.	New Hope Post Acute Care
Evergreen at Heartwood Avenue, L.L.C.	Heartwood Avenue Healthcare
Evergreen at Springs Road, L.L.C.	Springs Road Healthcare
Eden Home Health of Elk Grove, LLC	Eden Home Health
IDAHO	
EmpRes at Idaho Falls, LLC	Teton Post Acute Care and Rehabilitation
Lewiston Royal Plaza Care, LLC	Royal Plaza Health and Rehabilitation
Lewiston Royal Plaza Retirement, LLC	Royal Plaza Retirement Center
Eden Home Health of Idaho Falls, LLC	Eden Home Health
Eden Home Health of Sandpoint, LLC	Eden Home Health
MONTANA	
Evergreen at Polson, L.L.C.	Polson Health and Rehabilitation Center

Legal Name	DBA
Evergreen at Hot Springs, L.L.C.	Hot Springs Health and Rehabilitation Center
Evergreen at Missoula, L.L.C.	Missoula Health and Rehabilitation Center
Evergreen at Laurel, L.L.C.	Laurel Health and Rehabilitation Center
Evergreen at Livingston, L.L.C.	Livingston Health and Rehabilitation Center
EmpRes at Lewistown, LLC	Central Montana Nursing & Rehabilitation Center
EmpRes at Shelby, LLC	Marias Care Center
EmpRes at Billings, LLC	Aspen Meadows Health and Rehabilitation Center
Aspen Meadows Assisted Living, LLC	Aspen Meadows Assisted Living
NEVADA	
Evergreen at Pahrump, L.L.C.	Pahrump Health and Rehabilitation Center
Evergreen at Carson City, L.L.C.	Ormsby Post Acute Rehab
Evergreen at Mountain View, L.L.C.	Mountain View Health and Rehabilitation Center
Evergreen at Gardnerville, L.L.C.	Gardnerville Health and Rehabilitation Center
EmpRes Personal Care Nevada, LLC	Eden Home Care
Quality Health Care Corporation	Eden Home Health
Eden Hospice at Carson City, LLC	Eden Hospice
OREGON	
Evergreen Oregon Healthcare Mountain Vista, L.L.C.	LaGrande Post Acute Rehab
Evergreen Oregon Healthcare Independence, L.L.C.	Independence Health and Rehabilitation Center
Evergreen Oregon Healthcare Tualatin, L.L.C.	EmpRes Hillsboro Health and Rehabilitation Center

Legal Name	DBA
Evergreen Oregon Healthcare Orchards Rehabilitation, L.L.C.	Milton Freewater Health and Rehabilitation Center
Evergreen Oregon Healthcare Orchards Retirement, L.L.C.	Cascade Valley Assisted Living and Memory Care Cascade Valley Assisted Living Cascade Valley Memory Care
Evergreen Oregon Healthcare Valley Vista, L.L.C.	The Dalles Health and Rehabilitation Center
Evergreen Oregon Healthcare Portland, L.L.C.	Portland Health and Rehabilitation Center
Evergreen Oregon Healthcare Salem, L.L.C.	Windsor Health and Rehabilitation Center
SOUTH DAKOTA	
EmpRes at Mitchell, LLC	Firesteel Healthcare Center
EmpRes at Rapid City, LLC	Fountain Springs Healthcare Center
Rapid City Assisted Living, LLC	Fountain Springs Assisted Living
Sturgis Assisted Living, LLC	Aspen Grove Assisted Living
EmpRes at Garretson, LLC	Palisade Healthcare Center
EmpRes at Woonsocket, LLC	Prairie View Healthcare Center
EmpRes at Flandreau, LLC	Riverview Healthcare Center
Flandreau Independent Living, LLC	Riverview Care Center
EmpRes at Britton, LLC	Wheatcrest Hills Healthcare Center
WASHINGTON	
Evergreen Washington Healthcare Frontier, L.L.C.	Frontier Rehabilitation and Extended Care
Evergreen Washington Healthcare Americana, L.L.C.	Americana Health and Rehabilitation Center
Evergreen Washington Healthcare Whitman, L.L.C.	Whitman Health and Rehabilitation Center
Evergreen Washington Healthcare Seattle, L.L.C.	Seattle Medical Post Acute Care
Evergreen Washington Healthcare Enumclaw, L.L.C.	Enumclaw Health and Rehabilitation Center
Evergreen Washington Healthcare Auburn, L.L.C.	Canterbury House

Legal Name	DBA
Evergreen at Shelton, L.L.C.	Shelton Health and Rehabilitation Center
Evergreen at Bellingham, L.L.C.	North Cascades Health and Rehabilitation Center
Evergreen at Tacoma, L.L.C.	Alaska Gardens Health and Rehabilitation Center
EmpRes at Alderwood, LLC	Alderwood Park Health and Rehabilitation
EmpRes Highland Care, LLC	Highland Health and Rehabilitation
EmpRes at Snohomish, LLC	Snohomish Health and Rehabilitation
Spokane Royal Park Care, LLC	Royal Park Health and Rehabilitation
Spokane Royal Park Retirement, LLC	Royal Park Retirement Center
EmpRes at Colville, LLC	Buena Vista Healthcare
Fort Vancouver Post Acute, LLC	Fort Vancouver Healthcare Fort Vancouver Post Acute
Fort Vancouver Assisted Living, LLC	Fort Vancouver Assisted Living
EmpRes at Auburn, LLC	Advanced Post Acute
EmpRes Home Health of Bellingham, LLC	Eden Home Health
EmpRes Home Care of Bellingham, LLC	Eden Home Care
Eden Home Health of King County, LLC	Eden Home Health
Eden Home Health of Clark County, LLC	Eden Home Health
Eden Home Health of Spokane County, LLC	Eden Home Health

Legal Name	DBA
WYOMING	
EmpRes at Rock Springs, LLC	Sage View Care Center
EmpRes at Cheyenne, LLC	Granite Rehabilitation and Wellness
EmpRes at Rawlins, LLC	Rawlins Rehabilitation and Wellness
EmpRes at Riverton, LLC	Wind River Rehabilitation and Wellness
EmpRes at Thermopolis, LLC	Thermopolis Rehabilitation and Wellness
EmpRes at Casper, LLC	Shepherd of the Valley Rehabilitation and Wellness
Casper Independent Living, LLC	Maurice Griffith Manor Care

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 9

MEDICAL DIRECTOR CONTRACT

Medical Director Independent Contractor Agreement

THIS MEDICAL DIRECTOR INDEPENDENT CONTRACTOR AGREEMENT ("Agreement") is between Eden Hospice at Whatcom County, LLC d/b/a Eden Hospice ("AGENCY") and Dr. Gilson R. Girotto, DO, ("PROVIDER"). In consideration of the mutual promises set forth below in the body of this Agreement, the parties agree as follows:

1. TERM

The term of this Agreement shall commence on the date PROVIDER is licensed as a state certified hospice agency and shall continue for a period of one year thereafter, with automatic one-year renewals. AGENCY may terminate the use of PROVIDER's services at any time, for any reason, upon 30 days advance written notice to PROVIDER, and without further obligations to PROVIDER except for payment due for services performed by PROVIDER prior to the contract termination date. PROVIDER may also terminate the contract at any time, for any reason, upon 30 days advance written notice to AGENCY; provided that PROVIDER agrees to continue to perform the agreed upon services for the 30 days leading up to the contract termination date. This Agreement may be terminated immediately upon the determination that any of the representations made by either party under this Agreement are false.

2. PROVIDER SERVICES

PROVIDER agrees to provide medical director services ("Services") to AGENCY's clients in accordance with all applicable requirements of federal, state or local laws, rules and/or regulations to include official interpretations of those requirements by the entities charged with implementing and enforcing them, including but not limited to the requirements of 42 C.F.R. § 418.102 and applicable CMS guidance regarding the same. PROVIDER will perform its services in accordance with accepted professional standards of practice and, in accordance with 42 C.F.R. 418.64, use only qualified duly licensed, certified or registered health care professionals in the performance of these services. PROVIDER understands and agrees that this Agreement is subject to the right of AGENCY clients, clients' insurers or payors and clients' physicians to choose services from another provider.

PROVIDER agrees to be responsible for (1) implementation of client care policies, and (2) the coordination of medical care at AGENCY.

With respect to the implementation of client care policies, PROVIDER agrees to provide clinical guidance and oversight regarding the implementation of client care policies, which includes collaborating with the AGENCY to help develop, implement and evaluate client care policies and procedures that reflect current standards of practice. "Client care policies and procedures" is further defined as the AGENCY's goals, directives and governing Statements that direct the delivery of care and services to clients. Client care procedures describe the processes by which the AGENCY provides care to clients that are consistent with current standards of practice and AGENCY policies.

With respect to the coordination of medical care, PROVIDER shares responsibility with the AGENCY for assuring AGENCY is providing appropriate care as required, which involves

(1) providing oversight and supervision of physician services and medical care of clients, and (2) helping the AGENCY identify, evaluate, and address/resolve medical and clinical issues that affect client care, medical care or qualify of life, or are related to the provision of services by physicians and other health care practitioners. PROVIDER agrees to consult with clients or their attending physicians as needed to ensure adequate care is being provided. PROVIDER will attend client care conferences and advise AGENCY on pertinent ethical and clinical issues. PROVIDER will participate in utilization reviews of AGENCY services and participate in periodic, random reviews of records for AGENCY client services.

PROVIDER shall abide by applicable AGENCY policies and procedures to contractors, respond to AGENCY's requests for services in a timely manner, and provide accurate and timely documentation to AGENCY of services provided to AGENCY's clients. PROVIDER will provide clinical input and guidance, as required, in AGENCY's hiring of and clinical evaluation of AGENCY's Director of Nursing Services or AGENCY's clinical evaluation of other health care personnel as requested. PROVIDER will also provide clinical input and guidance into other quality monitoring programs established by AGENCY, which may include periodic attendance at the AGENCY's Continuous Quality Improvement Committee and Care Planning Committee meetings.

PROVIDER shall act as AGENCY's medical representative in the community (including medical staff, referring physicians, hospitals and community and professional organizations) and be familiar with policies and programs of public health agencies that may affect client care management. PROVIDER shall communicate with federal, state and county agencies regarding AGENCY programs.

PROVIDER shall participate as a member of AGENCY's OIG Compliance Committee.

PROVIDER shall participate in clinical education programs at the AGENCY, including the in-service clinical education of AGENCY personnel and continuing client/family and community education.

PROVIDER and AGENCY understand and agree that, while PROVIDER may also serve as an attending physician to clients of the AGENCY, PROVIDER's roles and functions as a Medical Director under this Agreement are separate from PROVIDER's roles and functions as an attending physician, which involves primary responsibility for the medical care of individual clients.

3. COMPENSATION

INVOICE FOR WORK PROVIDED PAYABLE NET 30. PROVIDER will be paid for Services on a monthly basis at the rate of $200.00 per hour which will be billed at ¼ hour increments rounded up to the closest ¼ hour. All payments will be made net 30 days of receipt of an invoice for Services provided under this Agreement. Invoices shall indicate services rendered and the time expended to provide said services during the preceding month in accordance with the rates and fees set forth above, as well as sufficient documentation in support of the services provided. Payment of PROVIDER is conditioned on PROVIDER complying with all material provisions of this Agreement, providing an acceptable quality of service consistent with the requirements of all applicable federal and state requirements, and providing the AGENCY accurate and complete documentation of such services.

The parties warrant and acknowledge that the above rate of compensation constitutes fair market value for PROVIDER's services and is consistent with PROVIDER's customary services, if any.

Any and all professional service fees or retainers due to PROVIDER in his or her capacity as an attending physician or any fees owed to PROVIDER associated with any visitations, examinations or consultations to clients of AGENCY shall be the complete and sole responsibility of PROVIDER and not of AGENCY.

4. CIVIL RIGHTS

PROVIDER shall comply with Title VI and VII of the Civil Rights Act of 1964, Sections 503 and 504 of the Rehabilitation Act of 1973, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services and any other applicable agencies issued pursuant to these Acts.

5. RECORDS

5.1 AGENCY and PROVIDER will each prepare and maintain complete and detailed clinical records concerning AGENCY's clients receiving Services under this Agreement, in accordance with prudent record-keeping procedures and as required by applicable federal and state laws, regulations and program guidelines. Each clinical record shall completely, timely and accurately document all services provided to, and events concerning, each patient (including evaluations, treatments, and progress notes) (collectively, "Clinical Records") and will remain confidential. The Clinical Records, records relating to billing and payment and other records relating to this Agreement shall be retained by AGENCY and PROVIDER for 8 years from the date said service was provided.

5.2 To the extent the value or services furnished under this Agreement, or a subcontract of this Agreement, exceed $10,000 over a 12-month period, PROVIDER will make available to the Secretary of the Department of Health and Human Services, the Comptroller General, or their authorized representatives, a copy of this Agreement and such books, documents and records that are necessary to certify the nature and extent of the costs incurred by AGENCY under this Agreement for a period of four years after the furnishing of such services. PROVIDER agrees to notify AGENCY within 3 days of the nature and scope of any request for access and to provide, or make available, copies of any books, records or documents proposed to be provided. Any disclosure under this paragraph shall not be construed as a waiver of any other legal rights to which such party may be entitled.

6. QUALIFICATIONS

6.1 AGENCY represents and warrants that it is duly licensed and certified. PROVIDER represents and warrants that it has, and will maintain at all times throughout the term of this Agreement, all the necessary qualifications, certifications and/or licenses required by applicable federal, state and local laws and regulations to provide the Services covered by this Agreement. PROVIDER will provide AGENCY with a copy of its license in effect on the effective date of this Agreement and at each successive renewal. PROVIDER shall provide notice of any changes in certifications or licensing within 15 days.

6.2 PROVIDER agrees that it shall be responsible for conducting criminal background checks on those of its employees it assigns to AGENCY, including all costs relating to conducting such investigations and testing. PROVIDER further agrees that it shall not assign any of its employees to AGENCY who have been convicted of the following crimes: theft, sexually deviant behavior, assault and/or battery, abuse of the elderly, children or vulnerable individuals or other criminal conviction related to the services being provided to the AGENCY. PROVIDER further agrees that it shall not assign any of its employees to AGENCY who are determined (after appropriate alcohol and drug testing if necessary) to be engaged in the possession, distribution, dispensation, manufacture, sale or use of alcohol or illegal drugs in the workplace (whether that workplace is the AGENCY or elsewhere). For purposes of this Agreement, the term “illegal drugs” includes the abuse or misuse of prescription medication and the use or abuse of medical and/or recreational marijuana.

6.3 .PROVIDER acknowledges and agrees that investigations into criminal backgrounds (a) will cover the previous seven years, (b) shall be conducted in accordance with applicable state and federal law, and (c) must be based on information provided by the appropriate state or local law enforcement agency if so required by applicable state law.

6.4 Each party represents and warrants that it is currently eligible for Medicare and Medicaid participation and not subject to any sanction or exclusion. The Parties agree to regularly verify such status of themselves and their employees and immediately disclose any actual or threatened federal, state or local investigations or imposed sanctions of any kind, in progress or initiated subsequent to the date of entering into this Agreement. Each party further represents and warrants that it has not been sanctioned under any applicable state or federal fraud and abuse statutes, including exclusion from any state or federal health care program. If, during the term of this Agreement, either party, any parent company of either party, or any officer, director or owner of either party, receives such a sanction or notice of a proposed sanction and the period of its duration within 15 days. Each party reserves the right to terminate the Agreement immediately upon receipt of notice that the other party, has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation. Each party agrees to indemnify and hold the other harmless from any and all liability, loss or expenses incurred directly or indirectly as a result of such sanctions or investigations against the indemnifying party.

7. INSURANCE AND INDEMNITY

7.1 PROVIDER shall arrange and maintain in full force and effect at all times during the term of this Agreement malpractice insurance with a carrier reasonably satisfactory to AGENCY in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate. Such insurance shall cover the professional medical services provided by PROVIDER in private practice, and, PROVIDER’S Services as Medical Director pursuant to this Agreement. PROVIDER represents and warrants that such insurance is in effect on the date of execution of this Agreement and shall remain in effect during the term of this Agreement. The policy shall provide that AGENCY shall be given not less than 30 days prior written notice of any reduction in coverage or any cancellation of the policy. In addition, PROVIDER shall notify AGENCY of any lapse in coverage. Prior to the commencement of this Agreement and at least 10 days prior to the expiration of any then effective policy, PROVIDER

shall provide AGENCY with satisfactory written evidence of the coverage required by this paragraph.

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

7.3 PROVIDER agrees to save, indemnify and hold harmless AGENCY from and against any and all losses, malpractice actions, claims, suits, damages, liabilities and expenses based upon, arising out of or attributable to the negligent performance or non-performance of their respective obligations under this Agreement.

8. EQUIPMENT AND SUPPLIES

PROVIDER is expected to use its own equipment and/or supplies whenever feasible. When PROVIDER uses equipment and/or supplies provided by AGENCY, PROVIDER shall use such equipment and supplies properly and is solely responsible for injuries or damages resulting from any misuse. In addition, PROVIDER shall notify AGENCY in writing whenever equipment or supplies provided by AGENCY and used by PROVIDER for providing Services need repair or replacement. When PROVIDER uses its own equipment and/or supplies, PROVIDER agrees to save, indemnify and hold AGENCY harmless of and from the use, misuse or failure of such equipment or supplies. The parties shall maintain their equipment and/or supplies in good operating condition and repair and in accordance with manufacturer's recommendations and all applicable federal, state and local laws.

9. MASTER LIST

Pursuant to 42 CFR 411.357(d)(1)(ii) a master list of contracts which reflects all arrangements and/or agreements between AGENCY and PROVIDER or PROVIDER's immediate family members, to the extent any such arrangements or agreements exists, is provided by PROVIDER to AGENCY and maintained by AGENCY.

10. INDEPENDENT CONTRACTOR

This Agreement does not constitute a hiring of PROVIDER as an employee of AGENCY. It is the parties' intention that PROVIDER shall be an independent contractor and not AGENCY's employee. PROVIDER shall retain discretion and judgment regarding the manner and means of providing Services to AGENCY subject to all applicable laws, regulations and AGENCY's policies. AGENCY assumes professional and administrative responsibility for the services rendered only to the extent that AGENCY will assure itself that (1) PROVIDER is qualified by education and/or experience to render the services contracted for; and (2) PROVIDER is satisfying the obligations set forth herein in a timely manner. This Agreement shall not be construed as a partnership, and AGENCY shall not be liable for any obligations incurred by PROVIDER.

The parties hereto agree that payments to be made by AGENCY to PROVIDER are for services as an independent contractor. AGENCY shall not make any deduction from the fees to be paid PROVIDER including, but not limited to, social security, withholding taxes, business taxes, unemployment insurance, and other such deductions. PROVIDER assumes full responsibility, on an independent contractor basis, for all such taxes, contributions, and assessments and for worker's compensation insurance, agrees to indemnify AGENCY with respect thereto and agrees to meet all requirements with enforcement of any relevant state or federal act or regulation. PROVIDER agrees to obtain and maintain any and all business licenses as may be required under any applicable federal or state laws for independent contractors or consultants and to provide AGENCY with proof of same immediately upon request.

PROVIDER acknowledges that since he is not an employee of the Company, the Company will not provide health insurance or any other fringe benefit of any kind to PROVIDER.

11. CONFIDENTIALITY

PROVIDER agrees to respect and abide by all federal, state and local laws pertaining to confidentiality and disclosure with regard to all information and records obtained or reviewed in the course of providing services to AGENCY and/or its clients.

12. ATTORNEY'S FEES

If suit is brought to enforce any of the terms or conditions of this Agreement, the prevailing party shall be entitled to recover such sums as the court may fix as costs and reasonable attorney's fees, in addition to any other relief to which it may be entitled.

13. NOTICES

Any notice required to be provided to any party to this Agreement shall be in writing and shall be considered effective three (3) days after the date of deposit with the United States Postal Service by certified or registered mail, first class postage prepaid, return receipt requested.

14. NON-ASSIGNABILITY

Neither this Agreement nor any of the Services or obligations of PROVIDER hereunder shall be assigned or delegated by PROVIDER without prior written consent of AGENCY.

15. WASHINGTON LAW AND VENUE

This Agreement shall be governed by the laws of the State of Washington. If any suit or action is filed by any party to enforce or interpret this Agreement, venue shall be in the federal or state courts of Clark County, Washington.

16. COMPLETE AGREEMENT

This Agreement and the accompanying Business Associate Agreement supersedes all previous agreements, oral or written, between the parties and embodies the complete Agreement between the parties. This Agreement may only be amended or modified by written agreement signed by both parties.

17. COMPLIANCE CERTIFICATION

PROVIDER acknowledges AGENCY's Corporate Compliance Program and receipt of AGENCY's Code of Conduct. PROVIDER represents and warrants that each of its employees who provide patient care to Federal health care program beneficiaries at AGENCY shall read and review AGENCY's Code of Conduct prior to commencement of services under this Agreement. PROVIDER agrees to obtain and retain a signed certification from its employees that they have received, read and understand AGENCY's Code of Conduct and agree to abide by the requirements of AGENCY's Corporate Compliance Program. Such certification shall be obtained prior to commencement of services under this Agreement, shall be maintained by PROVIDER and shall be made available for review by AGENCY or AGENCY's agents upon reasonable request.

18. COMPENSATION NOT BASED ON REFERRALS

The parties acknowledge that none of the benefits granted to PROVIDER under this Agreement or in relation to the performance of services hereunder is conditioned on any requirement that PROVIDER make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the AGENCY or the affiliates of the AGENCY by common ownership. The parties further acknowledge that, except as may otherwise be provided in this Agreement, PROVIDER is not restricted from establishing staff privileges at, referring any services to, or otherwise generating any business for any other entity of PROVIDER'S choosing.

IN WITNESS WHEREOF, the parties by their duly authorized representatives have entered into thus Agreement s of the date first above written.

AGENCY by its Manager, EmpRes Healthcare Management, LLC,	PROVIDER
By: _____	By: _____
Name: Michael Miller	Name: _____
Title: CFO	Title: _____
Date: _____	Date: _____
	UPIN #: _____

REQUIRED DOCUMENTS FOR CONTRACT COMPLETION
Copy of Liability/Malpractice Insurance - $1M / $3M Liability Limits
Office Address and Phone Number

Copy of Current State of Practice License;
PROVIDER-signed Business Associate Agreement

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 10

MEDICAL DIRECTOR JOB DESCRIPTION

JOB TITLE: Medical Director
REPORTS TO: Administration, Board of Directors
SUPERVISES:

AGENCY NAME:
DISTRIBUTION CODE: N/A
FSLA STATUS:

JOB SUMMARY

The Medical Director provides overall management of medical care of Agency patients and makes sure provision of Hospice services reflects Eden philosophy and standards. The Medical Director adheres to all federal, state, and local rules and regulations, as well as accrediting organization standards. He or she works in conjunction with the patient's attending physician and provides direct patient care. The Medical Director establishes relationships with the medical community in order to increase awareness and provide education about hospice and palliative care, and participates in the Agency's performance improvement program.

Note: Medical staff is privileged and credentialed according to the rules and regulations of the specific Agency. The medical staff of each Agency is responsible for peer review activities to promote continuous improvement of the quality of patient care provided by the medical staff in all departments of the Agency. See Eden's M*edical Staff Bylaws and Rules and Regulations* to define these processes.

ESSENTIAL FUNCTIONS

1. Directs and coordinates medical care for the Agency.
2. Participates in administrative decision making and establishes policies, procedures, and guidelines designed to provide adequate, comprehensive care.
3. Communicates with patients' attending physicians and other healthcare providers regarding the Agency's policies, procedures, and standards.
4. Develops and implements rules, regulations, and policies that govern the attending physicians that admit patients to the Agency, in conjunction with the administration.
5. Monitors the clinical practice of the attending physicians; may intervene as needed on the patient's behalf.
6. Assists in developing procedures for the emergency treatment of patients. May assume care of the patient if the attending physician is not available or the patient does not have an attending physician.
7. Assists with the development of policies and procedures for the admission, transfer, or discharge of patients to other facilities when necessary.
8. Participates in patient comprehensive care planning.
9. Participates in the development and implementation of educational programs for nursing and other healthcare professionals of the Agency.
10. Provides clear, concise documentation in medical record as it relates to reimbursement guidelines and Agency policy and procedure.
11. Reviews and evaluates incident reports and identifies hazards to health and safety to provide a safe and sanitary environment for patients. Makes relevant recommendations to Administration.
12. Helps create environment that optimizes patient safety and reduces the likelihood of medical/health care errors.
13. Supports and maintains a culture of safety and quality.
14. Advocates on behalf of the patient to meet the patient's medical and psychosocial needs.

15. Develops, revises, and implements policies and procedures for patient care, infection prevention and control, performance improvement, and patient rights.
16. Establishes performance improvement monitoring programs and standards to make sure the Agency maintains accreditation, licensing, and quality patient care.
17. Monitors and evaluates the quality and appropriateness of medical services as an integral part of the overall performance improvement program.
18. Treats patients and their families with respect and dignity.
19. Identifies and addresses psychosocial needs of patients and their families.
20. Demonstrates extensive knowledge of hospice and palliative care.
21. Demonstrates knowledge of current pain management protocols.
22. Effectively and consistently communicates administrative directives to physicians and staff and encourages interactive meetings and discussions.
23. Presents periodic reports reflecting the medical services of the Agency and such special reports as may be required by the Board.
24. Develops educational classes for healthcare professionals and the community regarding hospice and palliative care.
25. Acts as the Agency's medical representative in the community.
26. Provides direct patient medical care:
    - **a.** Approves Patient Admittance
    - **b.** Confirms Patient Diagnosis and Prognosis
    - **c.** Recertifies Patients for Each Benefit Period
    - **d.** Pain Management
    - **e.** Symptom Management
    - **f.** Palliative Care
    - **g.** Inpatient Rounds
    - **h.** Home Visits
    - **i.** On Call
    - **j.** Prescribes Medications and Other Regulated Medical Devices

PROFESSIONAL REQUIREMENTS

1. Adheres to dress code; appearance is neat and clean.
2. Reports to work on time and as scheduled.
3. Wears identification while on duty.
4. Attends annual review and departmental inservices, as appropriate.
5. Represents the organization in a positive and professional manner.
6. Completes quarterly/annual education requirements.
7. Maintains regulatory requirements, including federal, state, local regulations, and accrediting organization standards.
8. Maintains patient confidentiality.
9. Works at maintaining a good rapport and a cooperative working relationship with physicians, departments, and staff.
10. Attends committee, QAPI, management meetings, and other required meetings as appropriate.
11. Adheres to payroll, billing, and documentation policies and procedures.

12. Guarantees compliance with policies and procedures regarding operations, fire safety, emergency management, grievance and concerns, adverse events, incident reporting and infection prevention and control.
13. Complies with organizational policies regarding ethical business practices.
14. Demonstrates effective time management and organizational skills.
15. Communicates the mission, ethics, and goals of the organization.

KNOWLEDGE, SKILLS, AND ABILITIES

1. Understands regulations/standards applicable to Hospice.
2. Thorough knowledge and understanding of the functions of a Hospice Agency.
3. Demonstrates knowledge of the dying patient and pain control measures.
4. Exhibits genuine interest in and compassion for patients and families dealing with end-of-life issues.
5. Understands hospice philosophy and issues of death and dying.
6. Ability to be flexible, organized, and function under stressful situations
7. Able to communicate effectively in English, both verbally and in writing.
8. Excellent interpersonal skills.
9. Excellent writing and presentation skills.
10. Knowledge of general modalities and scope of practice within the state of Agency operation.
11. Candidate should be self-directed and can work in the field with minimum supervision.
12. A valid driver's license, reliable auto, and current auto insurance.
13. Basic computer knowledge.

EDUCATION AND EXPERIENCE

1. Doctorate in Medicine or Osteopathy.
2. Currently licensed to practice medicine in the state of employment.
3. Current Board Certification in specialty area. Board certified by the American Academy of Hospice and Palliative Medicine preferred.
4. Drug Enforcement Administration Registration.
5. Presentation of Certificate of Insurance.
6. Experience in hospice and palliative care required.
7. Administrative experience preferred.

REPORTING RELATIONSHIPS

1. This position reports directly to Administration and the Board of Directors.

WORKING CONDITIONS

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job.

1. Ability to work under stress and in emergency situations.
2. Ability to work under conditions requiring sitting, standing, walking, reaching, pushing, pulling, and grasping with potential exposure to communicable diseases.

PHYSICAL DEMANDS ANALYSIS

See attached Physical Demands Analysis, if applicable.

SIGNATURES

I have read and reviewed this job description and fully understand the requirements set forth therein. I am able to perform the essential functions of this job with or without reasonable accommodation. I agree to perform the tasks outlined in this job description in a safe manner and in accordance with the company's established processes.

Employee Signature	***Date***
Supervisor Signature	***Date***

JOB TITLE: Medical Director
REPORTS TO: Administrator, Board of Directors
SUPERVISES:

AGENCY NAME:
DISTRIBUTION CODE: N/A
FSLA STATUS:

PHYSICAL DEMANDS

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of this position.

On-the-job time is spent in the following physical activities:

Standing: Remaining on one's feet in an upright position at a workstation without moving about.
LEVEL: Matted/even surface (linoleum, carpet, mats)
TIME: 3.00 hours per day
REPETITION: Occasionally

Sitting: Remaining in the seated position.
LEVEL: Casual, flexible, discretionary position.
TIME: 2.00 hours per day
REPETITION: Occasionally

Walking: Moving about on foot.
LEVEL: Casual, discretionary movement on matted/even surface (linoleum, carpet, mats). TIME: 3.00 hours per day
REPETITION: Frequently

Lifting: Raising or lowering an object from one level to another.
LEVEL: Medium, 50lbs maximum, frequent lifting/carrying 25lbs or less.
TIME: 1.00 hours per day
REPETITION: Occasionally

Bending: Moving the body downward and forward by bending the spine at the waist.
LEVEL: Moderate bend (45 degrees).
TIME: 2.00 hours per day
REPETITION: Occasionally

Reaching: Extending the hands and arms in any direction.
LEVEL: Dominant hand and arm.
TIME: 4.00 hours per day
REPETITION: Frequently

LEVEL: Both hands and arms.
TIME: 2.00 hours per day
REPETITION: Occasionally

Handling: Seizing, holding, grasping, turning, or otherwise working with the hand or hands (with or without significant weight resistance).
LEVEL: Dominant hand and arm.
TIME: 4.00 hours per day
REPETITION: Frequently

LEVEL: Both hands and arms.
TIME: 4.50 hours per day
REPETITION: Frequently

Fingering: Picking and pinching or otherwise working with the fingers primarily.
LEVEL: Dominant hand.
TIME: 4.00 hours per day
REPETITION: Frequently

LEVEL: Both hands.
TIME: 2.50 hours per day
REPETITION: Occasionally

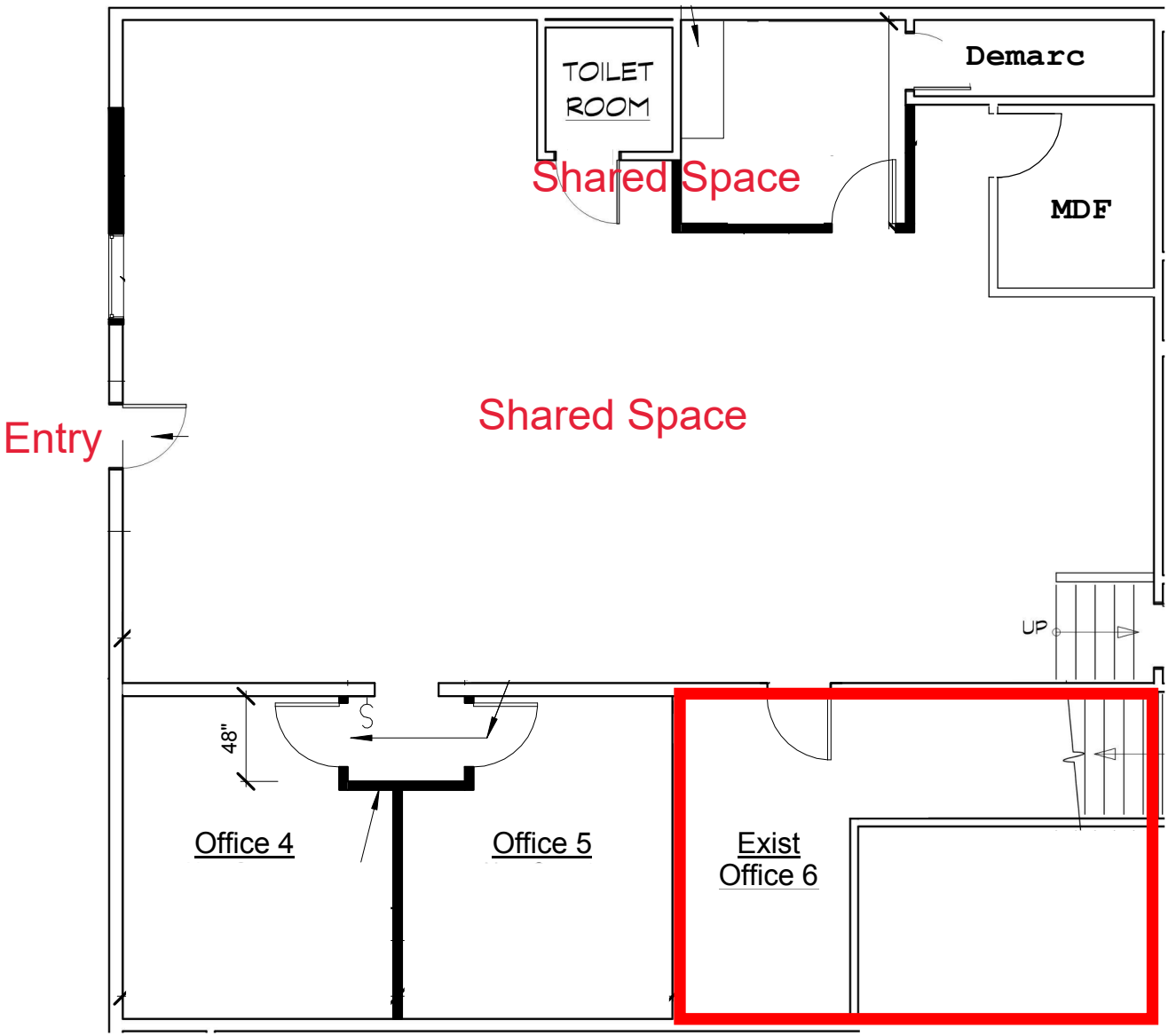
Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 11

SINGLE LINE DRAWINGS OF HOSPICE – HOME HEALTH CO-LOCATION

Eden Hospice of Whatcom County, LLC



Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 12

EDEN HOSPICE AT WHATCOM COUNTY PRO FORMA

Projected Statement of Operations
Eden Hospice at Whatcom County, LLC

CENSUS	2021	2022	2023
Patient Days	4,875	11,019	16,888
Average Daily Census	**13.36**	**30.19**	**46.27**
REVENUE			
Medicare	822,511	1,859,177	2,849,471
Medicaid	93,286	210,861	323,177
Commercial/Other	46,719	105,601	161,850
TOTAL GROSS REVENUE	**962,515**	**2,175,639**	**3,334,498**
Deductions from Revenue			
Contractual Allowances	(16,450)	(37,184)	(56,989)
Bad Debt	(9,625)	(21,756)	(33,345)
Charity Care Adj	(14,438)	(32,635)	(50,017)
TOTAL NET REVENUE	**922,002**	**2,084,064**	**3,194,146**
DIRECT CARE EXPENSE			
Ancillary Expenses			
Pharmacy Expense	24,374	55,094	84,440
Lab Expense	585	1,322	2,027
Xray Expense	390	882	1,351
Ambulance/Transportation Expense	1,950	4,408	6,755
DME Expense	25,593	57,849	88,662
TOTAL ANCILLARY EXPENSES	**52,891**	**119,554**	**183,235**
Home Services Expense			
Mileage Expense	40,558	91,677	140,508
Medical Supplies	9,750	22,038	33,776
RN Expense	97,229	219,773	336,835
Hospice Aide Expense	50,003	113,026	173,229
Spiritual Counselor Expense	58,240	58,240	101,920
QA Nurse Expense	40,000	40,000	40,000
GIP Expense	21,071	47,629	72,998
Respite Expense	9,289	20,997	32,181
SNF Room & Board Expense	13,975	31,590	48,416
Social Services Expense	30,558	69,071	105,862
Payroll Taxes & Benefits	99,309	166,533	275,459
TOTAL HOME SERVICES EXPENSE	**469,982**	**880,572**	**1,361,186**
Contract Labor			
Medical Director	34,124	77,132	118,216
Physical Therapy	244	551	844
Occupational Therapy	146	331	507
Speech Therapy	244	551	844
Dietary Consulting	439	992	1,520
TOTAL CONTRACT LABOR	**35,196**	**79,556**	**121,932**
TOTAL DIRECT CARE EXPENSES	**558,070**	**1,079,683**	**1,666,352**
A&G EXPENSE			
Administrative Compensation			
Administrator	65,000	65,000	65,000
Director of Patient Care Services	55,000	55,000	55,000
Clinical Manager	-	-	63,750

Projected Statement of Operations
Eden Hospice at Whatcom County, LLC

Business Office Manager	30,000	30,000	30,000
Clinical Support Specialist	37,440	37,440	74,880
Volunteer/Bereavement Coord	-	-	41,600
Community Liaison	65,000	65,000	130,000
Payroll Taxes & Benefits	75,732	75,732	138,069
TOTAL ADMIN COMP EXPENSES	**328,172**	**328,172**	**598,299**
Administrative Expenses			
Contract Services	11,052	11,052	11,052
Office Supplies	4,200	4,800	4,800
Recruiting	4,800	4,800	4,800
Telephone/Internet	8,512	17,728	26,532
Licenses/Permits	1,642	1,642	1,642
Business Taxes	17,518	39,597	60,689
Bank Fees	1,383	3,126	4,791
Office Cleaning	5,250	5,250	5,250
Marketing Expense	7,200	7,200	7,200
TOTAL	**61,557**	**95,196**	**126,756**
TOTAL A&G EXPENSE	**389,729**	**423,368**	**725,055**
INSURANCE EXPENSE	6,915	15,630	23,956
TOTAL OPERATING EXPENSES	**954,714**	**1,518,681**	**2,415,363**
MANAGEMENT FEES	46,100	104,203	159,707
BUILDING LEASE	5,214	5,214	5,214
EBITDA	**(84,026)**	**455,967**	**613,862**
TOTAL DEPRECIATION & AMORTIZATIC	-	-	-
INTEREST EXPENSE	-	-	-
TOTAL NON OPERATING EXPENSES	**51,314**	**109,417**	**164,921**
TOTAL EXPENSES	**1,006,028**	**1,628,098**	**2,580,285**
NET INCOME (LOSS)	**(84,026)**	**455,967**	**613,862**

Balance Sheet
Eden Hospice at Whatcom County, LLC

ASSETS	2021	2022	2023
Current Assets			
Cash & Cash Equivalents	136,381	385,576	561,510
Accounts Receivable (net)	76,834	173,672	266,179
Prepaid Expenses	-	-	-
Total Current Assets	**213,214**	**559,248**	**827,689**
Property and Equipment			
Fixed Assets	-	-	-
Accumulated Depreciation	-	-	-
Total Property and Equipment	**-**	**-**	**-**
Other Assets			
Intangibles	-	-	-
Loan Fees	-	-	-
Accumulated Amortization	-	-	-
Total Other Assets	**-**	**-**	**-**
TOTAL ASSETS	**213,214**	**559,248**	**827,689**
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	12,570	24,750	36,338
Accrued Payroll & Related Payables	31,003	45,270	73,838
Notes Payable	-	-	-
Current Portion LT Debt	-	-	-
Total Current Liabilities	**43,573**	**70,021**	**110,176**
Long-Term Liabilities			
Long-Term Note Payable	-	-	-
Less: Current Portion of LTD	-	-	-
Total Long-Term Liabilities	**-**	**-**	**-**
TOTAL LIABILITIES	**43,573**	**70,021**	**110,176**
Capital	100,000		
Retained Earnings	-	(84,026)	371,941
Shareholder Equity	-	-	-
Net Income	(84,026)	455,967	613,862
Total Capital	**15,974**	**371,941**	**985,803**
TOTAL LIABILITIES AND CAPITAL	**59,547**	**441,962**	**1,095,979**

PER PATIENT DAY RATES	Medicare	Medicaid	Commercial	**Average**	
Routine Home Care 0-60	222.42	222.70	177.94	**207.69**	Per day
Routine Home Care 61+	175.78	176.01	140.62	**164.14**	Per day
Respite Care	501.00	527.36	400.80	**476.39**	Per day
General Inpatient Care	1,157.81	1,157.81	926.25	**1,080.62**	Per day
Continuous Care	66.50	66.52	53.20	**62.07**	Per hour
SNF R&B RATES	**Highland**	**Alderwood**	**N Cascades**		
2019-2020	211.86	234.90	241.30	**229.35**	Per day

Cash Flow
Eden Hospice at Whatcom County, LLC

Cash Flows from Operating Activities	**2021**	**2022**	**2023**
Net Income	(84,026)	455,967	613,862
Adjustments to reconcile net income to cash provided by operations			
Accumulated Depreciation & Amortization	-	-	-
Accounts Receivable	76,834	(96,839)	(92,507)
Prepaid Expenses	-	-	-
Accounts Payable	12,570	12,180	11,588
Payroll Related Expense	31,003	14,268	28,568
Current Portion of LT Debt	-	-	-
Line of Credit & Short Term Debt	-	-	-
	120,406	**(70,390)**	**(52,351)**
Net Cash Provided by Operations	36,381	385,576	561,510
Cash Flows from investing activities used for:			
Capital Equipment & Furniture	-	-	-
Sale of Fixed Assets	-	-	-
Intangibles & Other Assets	-	-	-
Net Cash Used in Investing	**-**	**-**	**-**
Cash Flows from financing activities			
Proceeds From:			
Note Payable Increase	-	-	-
Capital Contributions	100,000	-	-
Used For:			
Note Payable Repayment	-	-	-
Note Payable Shareholder	-	-	-
Less: Current Portion of LTD	-	-	-
Dividends	-	-	-
Net Cash Used in Financing	**100,000**	**-**	**-**
Net Increase/(Decrease) in Cash	**136,381**	**385,576**	**561,510**

SUMMARY			
Cash Balance at End of Period	136,381	521,957	1,083,467
Cash Balance at Beg of Period	-	136,381	521,957
Net Increase/(Decrease) in Cash	**136,381**	**385,576**	**561,510**

Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 13

EDEN HOSPICE AT WHATCOM COUNTY PRO FORMA WITH AND WITHOUT EDEN HOSPICE AT WHATCOM COUNTY

Projected Statement of Operations
EXISTING HOSPICE OPERATIONS 3 YEAR HISTORICAL

	2017	2018	2019
TOTAL GROSS REVENUE	**3,493,043**	**4,751,449**	**6,454,531**
TOTAL NET REVENUE	**3,442,004**	**4,656,503**	**6,341,272**
TOTAL EXPENSES	**3,063,631**	**4,035,188**	**5,701,665**
NET INCOME (LOSS)	**378,373**	**621,315**	**639,607**

Projected Statement of Operations
EXISTING HOSPICE OPERATION WITHOUT EDEN HOSPICE AT WHATCOM COUNTY, LLC

	2021	2022	2023
TOTAL GROSS REVENUE	**6,961,526**	**7,100,757**	**7,242,772**
TOTAL NET REVENUE	**6,683,065**	**6,816,726**	**6,953,061**
TOTAL EXPENSES	**6,203,758**	**6,327,883**	**6,454,390**
NET INCOME (LOSS)	**479,307**	**488,843**	**498,671**

Projected Statement of Operations
EXISTING HOSPICE OPERATION PLUS EDEN HOSPICE AT WHATCOM COUNTY, LLC

	2021	2022	2023
TOTAL GROSS REVENUE	**7,924,041**	**9,276,395**	**10,577,270**
TOTAL NET REVENUE	**7,605,067**	**8,900,791**	**10,147,207**
TOTAL EXPENSES	**7,209,786**	**7,955,981**	**9,034,674**
NET INCOME (LOSS)	**395,281**	**944,810**	**1,112,533**

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APPENDIX 14

ADMISSION PROCESS POLICY

INTAKE/REFFERAL POLICY

PURPOSE:

- The Hospice intake process is an important first step in a potential hospice patient's experience, to guarantee the Agency can provide applicable care, treatment, and services to the patient.

POLICY:

1. The Agency's intake process functions 24 hours a day, seven days a week.

2. This process strives to enable same day admissions.

PROCEDURE:

1. Intake receives referrals by way of multiple referral methods including:
   - **a.** Telephone
   - **b.** Facsimile
   - **c.** Written Order
   - **d.** E-mail
   - **e.** Direct Contact

2. Intake referral sources:
   - **a.** Physicians of medicine, osteopathy, podiatry, dental surgery, psychiatrists, or dentists.
   - **b.** Office staff representing the physician.
   - **c.** Discharge planners from inpatient and/or outpatient services.
   - **d.** Social Service agencies.
   - **e.** Individual patients, their family members, or caregiver(s).
   - **f.** Case managers and/or insurance company representatives.
   - **g.** Other home health or hospice organizations.

3. Intake during scheduled working hours:
   - **a.** Clinical or office staff may obtain referral information, requesting patient demographics, diagnosis, services needed, the name of the physician, hospitalization, etc.
   - **b.** The Director of Patient Care Services, Clinical Manager, or designee decides whether the patient meets the eligibility criteria.
   - **c.** Patient insurance is verified and authorization is received as appropriate. Ongoing authorization is obtained as required. Payment Method: Eden Hospice accepts most private healthcare insurance (please refer to the Agency brochure for further details), Medicare, and Medicaid.
   - **d.** If the referral call is not from a physician, staff contacts the physician to confirm service needs, medications, and to obtain verbal orders for an evaluation and admission visit.
   - **e.** Referrals containing verbal orders are given to the designated professional for verification and documentation of verbal orders.

f. Staff may ask for verification of physician certification.
g. Staff contacts patient, family, or caregiver to schedule an initial meeting to assess the patient for admission into the Agency and provide information on the Agency's services and program.

4. Patients are accepted by the Hospice Medical Director for care and services based on eligibility criteria listed below:
a. The care and services required by the patient are consistent with the Agency's mission, scope of service, and availability of services to meet patient's needs.
b. The patient resides within the geographical area served by the Agency.
c. The patient has adequate support at the place of residence.
d. The patient is certified as being terminally ill as required by payer source.
e. There is a reasonable expectation that the patient's care and service needs can be met adequately in his/her residence.

5. If it is determined that the Agency cannot reasonably accommodate the patient's needs, or if the patient does not meet the admission criteria, the patient/family/ referral source is notified and provided with information about other providers and referrals are made when appropriate.

6. The hospice maintains a record of referrals.

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APPENDIX 15

ADMISSION CRITERIA POLICY

ADMISSION POLICY

PURPOSE:

- To keep acceptance of patients consistent with Eden Hospice' mission and scope of services based on the reasonable expectation that the patient's care and service needs can be appropriately and safely met in the patient's place of residence.

POLICY:

1. The Agency admits a patient on the recommendation of the Hospice Medical Director in consultation with/with input from the patient's attending physician.

2. The Hospice Medical Director considers the following information when reaching a decision to certify that a patient is terminally ill:
   - **a.** Diagnosis of the terminal condition of the patient.
   - **b.** Other health conditions whether related or unrelated to the terminal condition.
   - **c.** Current clinically relevant information supporting diagnoses.

3. Patients with a terminal illness are accepted by the clinical supervisor or designee for care and services who meet the eligibility criteria listed below:
   - **a.** The patient is under the care of a physician. The patient's physician orders and approves care by the Agency. The physician is willing to sign or get another physician to sign the death certificate upon the patient's death. The physician discusses the patient's resuscitation status with the patient, family, or caregiver.
   - **b.** The patient identifies a family member, a caregiver, or a legal representative who agrees to be a primary support care person. Terminally ill patients (who are currently independent in activities of daily living) without an identified support person require the development of a specific plan for the future need of a primary support person. Staff discuss and plan for this at time of admission.
   - **c.** The patient has a life-threatening illness with a life expectancy of six months or less, as determined by the attending physician and Hospice Medical Director.
   - **d.** The patient wants hospice services and is aware of his/her diagnosis and prognosis.
   - **e.** The focus of the care wanted is palliative versus curative.
   - **f.** The patient, family, or caregiver agrees to participate in the plan of care and signs the *Hospice Consent Form*.
   - **g.** The patient, family, or caregiver understands and agrees that the Agency primarily provides care at home.
   - **h.** The physical facilities and equipment in the patient's home are adequate for safe and effective care.
   - **i.** The patient resides within the Agency's geographical area.

j. Hospice does not base eligibility for participation on the patient's race, color, creed, sex, age, disability (mental or physical), communicable disease, or place of national origin.
k. The patient meets the eligibility criteria for Medicare, Medicaid, or private Hospice benefit.
l. In order to be eligible to elect hospice care under Medicare, the patient is:
  i. Entitled to Part A of Medicare, *and*
  ii. Certified as being terminally ill.
m. The Agency accepts patients based on their care needs. The Agency considers the adequacy and suitability of staff and the resources required to provide the service. A reasonable expectation exists that the Agency can adequately take care of the patient at home.
n. The Agency accepts patients based on a patient's ability to pay for hospice services, either through state or federal assistance programs, private insurance, or personal assets.
o. The Agency reserves the right to refuse patients who do not meet the admission criteria and refers patients to other resources.
p. For Medicare patients, the physician is willing to provide a face-to-face encounter and the required written orders for care and/or services.
q. Payment Method: Eden Home Health accepts most private healthcare insurance (please refer to the Agency brochure for further details), Medicare, and Medicaid.

4. If it is determined that the Agency cannot reasonably accommodate the patient's needs, or if the patient does not meet the admission criteria, the patient/family/ referral source is notified and provided with information about other providers.

PROCEDURE:

1. Referral information provided by family, caregiver, and healthcare clinicians from other facilities, other agencies, and physicians' offices may help in the determination of eligibility for admission. If the patient's physician does not make the request for service, the Agency consults with the physician before the assessment visit.

2. Assignment of appropriate staff to conduct the initial assessment.

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APPENDIX 16

CHARITY CARE POLICY

CHARITY CARE POLICY

POLICY:

1. Patients may be eligible for charity care at the time of admission to Eden Hospice or during the period when they receive hospice services, consistent with the Income Guidelines set out below.

2. Admitted Patients can appeal charity care determinations according to the Patient Concerns and Grievances policy.

3. Eligibility for charity care under this policy is at all times contingent upon the patient's cooperation with the application process, including the timely submission of all information that Eden Hospice deems necessary or appropriate to enable it to make a charity care determination.

4. Patients' eligibility for free or discounted care is based on household income and family size as identified in Exhibit 1, which is updated annually, and is based on eligible services.

Income Level of 200% or less -- 100% discount level
Income Level of 201% to 300% -- 75% discount level
Income Level of 301% to 400% -- 50% discount level

EXHIBIT 1

National Federal Poverty Guidelines 2019

Household Size	100% - 199%	200%	300%	400%
1	$12,490	$24,980	$37,470	$49,960
2	$16,910	$33,820	$50,730	$67,640
3	$21,330	$42,660	$63,990	$85,320
4	$25,750	$51,500	$77,250	$103,000
5	$30,170	$60,340	$90,510	$120,680
6	$34,590	$69,180	$103,770	$138,360
7	$39,010	$78,020	$117,030	$156,040
8	$43,430	$86,860	$130,290	$173,720
9	$47,850	$95,700	$143,550	$191,400
10	$52,270	$104,540	$156,810	$209,080

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APPENDIX 17

VOLUNTEER SERVICES POLICY

VOLUNTEER SERVICES POLICY

PURPOSE:

- The Agency has qualified volunteers to help meet the patient's needs and to follow the interdisciplinary plan of care.

POLICY:

1. The Agency has volunteer services under the direction of the Agency's Volunteer Department. The Volunteer coordinator is the coordinator of volunteers providing Hospice services.
2. The Agency uses volunteers to provide assistance with ancillary and office activities, as well as indirect patient care services, and/or to help patients and families with household chores, shopping, transportation, and companionship.
3. Volunteers may work in a variety of capacities, including:
    a. Patient care volunteers provide emotional support and practical assistance that enhance the comfort and quality of life for patients/families/caregivers. These services include being available for companionship, listening, simply "being there," and preparing meals.
    b. Bereavement volunteers provide anticipatory counseling and bereavement support to families and caregivers.
    c. Errands and transportation volunteers offer a type of practical support often needed by Hospice patients, families, and caregivers. These duties may include picking up needed prescriptions or supplies or grocery shopping.
    d. Office volunteers lend their services working in Hospice's office. These activities may include assembling information packets, filing, photocopying, and assisting with mailings.
4. Volunteers who are qualified to provide professional services must meet standards associated with their specialty area. If licensure or registration is required by the state, the volunteer is licensed or registered.
5. The Agency documents and maintains a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals five percent (5%) of the total patient care hours of paid Agency employees and contract staff.
    a. Expansion of care and services achieved through the use of volunteers, including the types of services and the time worked, is recorded.

PROCEDURE:

1. The Volunteer Coordinator arranges for volunteers to provide support to the patient, family, or caregiver according to the Interdisciplinary Plan of Care.
2. The Agency documents active and ongoing efforts to recruit and retain volunteers.
    a. Documentation includes evidence such as advertisements in local newspapers, bulletins, or flyers.

3. Volunteers work under the supervision of an Agency staff member.
4. Required volunteer training is consistent with the specific tasks performed.
5. Volunteers receive orientation before being assigned to a patient/family in the following areas:
    a. The duties and responsibilities of the volunteer position.
    b. To whom the volunteer reports.
    c. The person(s) to contact if assistance is needed and instructions regarding the performance of their duties and responsibilities.
    d. Hospice goals, services, and philosophy.
    e. Confidentiality and protection of the patient's and family's rights.
    f. Documentation.
    g. Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death, and bereavement.
    h. Procedures followed in an emergency, or following the death of the patient.
    i. Infection prevention and control (e.g. hand hygiene).
6. Attendance at orientation and inservices is maintained in the volunteer's Human Resources file.
7. Volunteers document their activities on the Volunteer Progress Note and submit this documentation for the patient's clinical records.
8. The Agency documents the cost savings achieved through the use of volunteers, specifically identifying the positions which are occupied by volunteers, and collect the work time spent by the volunteers occupying those positions.
    a. The Volunteer Coordinator estimates the dollar costs which Agency would have incurred if paid Agency staff occupied the identified positions.
9. The Volunteer Coordinator develops, implements, and evaluates the volunteer services program regularly and at least annually.

VOLUNTEER HOURS:

1. Volunteers submit their documentation for services and time to the Volunteer Coordinator on a weekly basis.
2. The Volunteer Coordinator composes and analyzes the data monthly.
3. Monthly and annual statistical reports determine the percentage of services given by volunteers in relationship to the other disciplines.
4. Based on the reports, the Volunteer Coordinator determines the cost savings achieved through the use of Hospice volunteers.
5. Reports are submitted to the Executive Director as requested and at least on an annual basis.

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APPENDIX 18

EMPLOYEE RECRUITMENT, TRAINING AND DEVELOPMENT POLICY

RECRUITMENT POLICY

PURPOSE:

- Eden Health believes that hiring qualified individuals to fill positions at the company contributes to the overall strategic success of the organization. Each employee, while employed, is hired to make significant contributions to Eden Health.

HIRING PROCESS AND PROCEDURES:

1. Personnel requisitions must be completed to fill Eden Health positions. Requisitions must be initiated by the department supervisor/manager and forwarded to the Eden Health Recruiting Department. This is done by the completion of the *New Open Position Form.* Once completed, the form is forwarded to the recruiting department via email.

2. Personnel requisitions should indicate the following:
    a. Date, Eden Location, and Agency number
    b. Discipline if applicable
    c. Position title
    d. Position's hours/shifts
    e. Hourly rate/Salary/Per visit
    f. Territory Coverage (specific)
    g. Hiring manager and names of interviewers
    h. Any additional information about the posting/position that will assist the recruiter

JOB POSTINGS:

1. All regular exempt and nonexempt job openings are posted on the Eden Health website within 24 hours of receipt of the submitted *New Open Position form*. The job posting will also be advertised automatically on various applicable job posting websites. Jobs will remain posted until the position(s) is filled.

2. Positions are advertised externally based on need and budget requirements.

3. The Recruiting Department is responsible for placing all recruitment advertising.

4. Unless otherwise noted by the supervisor/manager who submits the New Open Position form, all jobs will be posted on the Eden Health website as well as various applicable job posting websites.

RECRUITMENT:

1. The Recruiting Department reviews all applicants. The applicants that best fit the open position are contacted by the recruiter and screened for a possible interview. The interview is then scheduled with the manager if the applicant passes the screening.

2. After three (3) weeks of the initial job posting, the recruiting team re-evaluates the position if no candidates have applied and partners with the supervisor/manager for plan of action. Adjustments are made accordingly to obtain candidates for the position.

ACTIONS BY AGENCY:

1. Upon completion of the interview by the Agency, the interviewer is to make contact with the recruiter within 24 hours of the interview to give some feedback on how the interview and provide thoughts on next steps.

JOB OFFER MADE TO APPLICANT:

1. Upon receipt of written approval from the hiring manager/supervisor, the Recruiting Department will make an initial verbal offer to the applicant. The recruiter will also advise the applicant that once the background information form is completed, the recruiter will then follow up with a formal offer letter. The offer letter will be drafted to note that employment is contingent upon satisfactory completion of reference checks, motor vehicle and criminal background checks. The Recruiting Department will establish a start date in coordination with the Agency and the applicant.

2. The Recruiting Department is responsible to notify applicants who are not selected for positions at Eden Health.

INTERNAL TRANSFERS:

1. Employees who have been in their current position for at least one year may apply for internal job openings. This requirement may be waived with the consent of the employee's manager.

2. Employees must complete the Internal Job Opening Request Form. The form must be completed and submitted to the Recruiting Department within one week after the job is posted.

3. All applicants for a posted vacancy will be considered on the basis of their qualifications and ability to perform the job successfully. Internal candidates who are not selected will be notified by the Recruiting Department.

EMPLOYEE REFERRALS:

1. Employees are eligible for a referral bonus if they have referred an applicant that is hired for a full time position. The referral bonus will vary depending on the position and this will be outlined in the Referral Bonus program on the Eden Health website. The employee is to complete the Referral form provided on our website and submit the form prior to the applicant having an interview. In addition, the applicant should specify on the Eden Health application, the referring Eden employee's name. The Eden Health employee will then be eligible for the referral bonus once the applicant is hired in a full time position and has worked for a minimum of 90 days.

REFERENCE CHECKS, CRIMINAL BACKGROUND CHECKS, AND FINAL DOCUMENTS FORWARDED TO AGENCY:

1. The Recruiting Department will submit a request for a background check and will check references for all hired candidates.

2. Once the Recruiting Department has the following documents for the candidate:
   - **a.** New Hire Approval
   - **b.** Completed Application
   - **c.** Completed Background Check
   - **d.** Completed Motor Vehicle Check
   - **e.** Resume
   - **f.** Completed Reference checks
   - **g.** Signed Offer Letter

3. The Recruiting Department will then scan all the documents and forward them via email to the BOM (Business Office Manager) located at the Agency.

CONTINUING EDUCATION PROGRAMS POLICY

PURPOSE:

- To provide planned ongoing educational activities for Eden Hospice employees that:
  - Develop and enhance employees' skills.
  - Broaden and increase employee's knowledge base.
  - Maintain and improve staff competency.

POLICY:

1. This Agency provides educational programs appropriate to the staff's patient care, treatment, and services responsibilities specific to the needs of the patient population served, and as required by applicable laws, regulations, and standards.

2. Educational programs are provided to those staff members whose responsibilities have changed.

3. Hospice Aides receive a minimum of 12 hours of inservice training every 12 months. Inservice training may occur when an aide is furnishing care to a patient under the supervision of an RN.

4. Staff are evaluated annually and as needed to identify educational needs.

5. Patient care, treatment, and services staff are required to attend or produce evidence of having attended the appropriate number of continuing education programs required by law and regulation to maintain currency of licensure and/or certification.

6. Supervisors are encouraged to attend on-going education programs to improve their supervisory skills.

7. An annual educational program is planned and implemented based on identified staff needs and regulatory requirements including, but limited to:

- Emergency/disaster training
- How to handle complaints/grievances
- Infection control training
- Cultural diversity
- Communication barriers
- Ethics training
- Workplace (OSHA), patient safety and components of HSP7-2A.01
- Methods for coping with work related issues of grief, loss, and change
- Patient Right and Responsibilities
- Compliance Program
- Pain and symptom management

Safety training:

- Body mechanics
- Fire
- Evacuation

- Security
- Office Equipment
- Environmental hazards
- In-home safety
- Personal safety techniques

8. Non-direct care personnel have a minimum of 8 hours of on-going education per year. Direct care personnel have a minimum of 12 hours of on-going education during each 12-month period.

9. Hospice administration retains the right to designate other inservice programs as mandatory programs.

INSERVICE RESPONSIBILITIES:

1. Each department manager is responsible for providing current and factual information to his/her employees regarding performance of their job duties. New processes, procedures, or policies governing such duties are conveyed to the employees in a manner that is understandable and reasonable to those involved. Records of such programs are retained as described in this policy.

2. The administration provides up-to-date and factual information to employees regarding policies, procedures, and benefits. In most cases, policies and procedures are conveyed to department managers who convey such information to their employees.

PROCEDURE - INSERVICE ATTENDANCE:

1. Mandatory Inservice Meetings: Those meetings which have been determined necessary for employees within a particular department or group of common interest are considered to be mandatory. Mandatory attendance is at the discretion of the department manager with approval of the Executive Director/Administrator.

a. Mandatory meetings are generally those which provide vital and necessary information to the employees involved, and attendance is requested with prior notice to those required to attend. Employees receive their regular rate of pay for attendance at mandatory meetings, unless their attendance is not specifically requested. If attendance at a mandatory meeting involve overtime for an employee during that work week, specific approval from the department manager is required if an alternate attendance time cannot be arranged.

2. Voluntary Inservice Meetings: Those meetings for which attendance is not deemed necessary and vital to a particular department or group of common interest are considered voluntary. Attendance at voluntary meetings is at the discretion of the employee, based on his/her interest in the subject being presented.

3. Credit for Attendance at Inservice Programs:

a. In order to receive appropriate attendance credit, participants:

i. Attend the entire program.

ii. Sign the attendance sheet.
iii. Complete an evaluation form.

4. Continuing Education Credits:
   a. Programs for which continuing education credits are offered are advertised as such.
   b. The number of credit hours is listed with the program information.
   c. In order to receive appropriate continuing education credits and a certificate, participants:
      i. Attend the entire program.
      ii. Sign the attendance sheet.
      iii. Complete an evaluation form.

5. Internal Scheduling of Inservice Programs:
   a. Equipment and Supplies: Audiovisual and other inservice equipment is maintained by the Education Department. Those who desire use of this equipment submit a written request as early in advance as possible.
      i. Supplies necessary for inservice programs are the responsibility of the individual conducting the program. Prior administrative approval is required for expenditures made for inservice program supplies.
   b. Meeting Room Availability: Meeting rooms are reserved in advance as early as possible through administration.

6. Record Keeping for Education Programs:
   a. Records of education programs are maintained in a central location (e.g. Education Department, Hospice Clinical Nurse Manager, or administration). Proper record keeping contains the following information:
      i. Names and signatures of employees who attended the program.
      ii. Title of the program, name of the individual conducting the program, dates, and times the program was conducted, and the location of the program.
      iii. A description of the content of the program, its relation to the department and/or employees, and voluntary/mandatory status of the program.
   b. Results of education program evaluation are compiled and summarized by the Education Department.
   c. Summary reports are evaluated monthly to determine the quality and appropriateness of the education provided and to develop and/or modify future educational programs.
   d. Summary reports of educational activities and the results of program evaluations are submitted to the Performance Improvement Committee quarterly.
   e. Education records for individual employees are considered valid on either a card made for that employee showing dates and subjects of programs attended, or on a written form or other sheet of paper containing such information placed in the employee's personnel file.

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APPENDIX 19

QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) POLICY

PURPOSE:

1. The Agency's Quality Assurance Performance Improvement (QAPI) plan is designed to:
    - **a.** Delineate expectations and plan and manage processes to measure, assess, and improve Eden Hospice's Agency's governance, management, clinical, and support activities.
    - **b.** Promote positive patient outcomes through the application of optimal patient care, treatment, and services based on clinically sound principles and current knowledge.
    - **c.** Identify, on an ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment, and services.
    - **d.** Evaluate, monitor, improve, and resolve areas of concern.

2. The Quality Assurance Performance Improvement (QAPI) plan, established by the senior management of the organization in collaboration with staff members and the Performance Improvement Committee, with the support and approval of the Governing Body, is comprehensive in scope and provides a vehicle to monitor patient care, treatment, and services with the goal of identifying and resolving processes, functions, and services that may adversely impact patient care, treatment, and services, while striving to continuously facilitate positive patient outcomes.

POLICY:

1. The Hospice Agency develops implements and maintains an ongoing, effective, data driven Quality Assurance Performance Improvement (QAPI) program.

2. The Governing Body guarantees the following;
    - **a.** The program reflects the complexity of its organization and services.
    - **b.** Involves all Hospice agency services (including those under contract or arrangement).
    - **c.** Focuses on indicators related to improved outcomes including;
        - **i.** Use of emergency care services,
        - **ii.** Hospital admissions and readmissions,
        - **iii.** Takes actions that address the performance across the spectrum of care,
        - **iv.** Prevention and re-education of medical errors.

3. Eden Hospice's Quality Assurance Performance Improvement (QAPI) plan is evaluated at least annually and revised as necessary.

4. The Quality Assurance Performance Improvement (QAPI) activities are planned in a collaborative, interdisciplinary manner throughout the organization.

5. In keeping with the organization's mission of providing quality, cost-effective patient care, treatment, and services, the Quality Assurance Performance Improvement (QAPI) plan allows for a systematic, coordinated, and continuous approach to improving performance, focusing upon the process and functions that address these principles.

GOALS:

1. The primary goals of the organizational Quality Assurance Performance Improvement (QAPI) Plan are to continually and systematically plan, design, measure, assess, and improve performance of organization-wide key functions and processes relative to patient care, treatment, and services.

2. To achieve this goal, the plan strives to:
    - **a.** Incorporate quality planning throughout the organization.
    - **b.** Collect data to monitor performance.
    - **c.** Provide a systematic mechanism for the organization's appropriate individuals, departments, and professions to function collaboratively in their Quality Assurance Performance Improvement (QAPI) efforts providing feedback and learning throughout the Agency.
    - **d.** Provide for an organization-wide program that assures the Agency designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses, and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of patients and their families, staff, and others. Process design contains the following focus elements:
        - **i.** Consistency with the organization's mission, vision, values, goals, and objectives and plans.
        - **ii.** Meets the needs of individuals served, staff, and others.
        - **iii.** Fosters the safety of patients and the quality of care, treatment, and services.
        - **iv.** Supports a culture of safety and quality.
        - **v.** Use of clinically sound and current data sources (e.g. use of practice/clinical guidelines, information from relevant literature and clinical standards).
        - **vi.** Is based upon best practices as evidenced by accrediting bodies.
        - **vii.** Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this organization.
        - **viii.** Utilizes reports generated from OASIS data, including the following OASIS reports:
            - Outcome-Based Quality Monitoring (OBQM) Potentially Avoidable Events Report and Patient Listing.
            - Outcome-Based Quality Improvement (OBQI) Outcome Report.
            - Error Summary Report.

ix. Utilizes the results of Quality Assurance Performance Improvement (QAPI), patient safety and risk reduction activities.
x. Management of change and Quality Assurance Performance Improvement (QAPI) supports both safety and quality through the Agency.

e. The organization incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions, or services.
f. Assure that the improvement process is organization-wide, monitoring, assessing, and evaluating the quality and appropriateness of patient care, treatment, and services, patient safety practices, and clinical performance to resolve identified problems and improve performance.
g. Appropriate reporting of information to the Governing Body to provide the leaders with the information they need in fulfilling their responsibility for the quality of patient care, treatment, and services, and safety is a required mandate of this plan.

3. Necessary information is communicated among departments/services when opportunities to improve patient care, treatment, and/or services and patient/staff safety practices impact more than one department/service.

4. The status of identified problems is monitored to assure improvement or resolution.

5. Information from departments/services and the findings of discrete Quality Assurance Performance Improvement (QAPI) activities are analyzed to detect trends, patterns of performance, or potential problems that may impact more than one department/service.

6. The objectives, scope, organization, and mechanisms for overseeing the effectiveness of monitoring, assessing, evaluation, and problem-solving activities in the Quality Assurance Performance Improvement (QAPI) program are evaluated at least annually and revised as necessary.

7. Important key aspects of care to the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences of deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, or those tending to produce problems for patients, their families, or staff.

8. Internal structures can adapt to changes in the environment.

SCOPE OF ACTIVITIES:

1. Eden Hospice measures, analyzes, and tracks quality indicators to enable the agency to assess processes of care, services, and operations.

2. The scope of the organizational Quality Assurance Performance Improvement (QAPI) program includes an overall assessment of the efficacy of Quality Assurance Performance Improvement (QAPI) activities with a focus on continually improving care, treatment, and services, and patient and staff safety practices.

3. The Hospice agency's performance improvement activities must;
    a. Focus on high risk, high volume, or problem-prone areas;
    b. Consider incidence, prevalence, and severity of problems in those areas;
    c. Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.
4. Performance activities must track adverse patient events, analyze their causes, and implement preventative actions.
5. Assessment of the performance of the following patient care and organizational functions may include but not limited to:
    a. Environment of Care.
    b. Emergency Management, including:
    c. Review of the annual emergency management planning reviews.
    d. Review of emergency response exercises.
    e. Review of response to actual emergencies.
    f. Human Resources.
    g. Infection Prevention and Control.
    h. Information Management.
    i. Leadership.
    j. Medication Management.
    k. Provision of Care, Treatment, and Services.
    l. Performance Improvement.
    m. Record of Care, Treatment, and Services.
    n. Rights and Responsibilities of the Individual.
    o. Waived Testing.

PERFORMANCE IMPROVEMENT PROJECTS:

1. Hospice Agencies must conduct performance improvement projects.
2. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the Hospice Agencies services and operations.
3. The Hospice Agency must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measureable progress achieved on these projects.

ORGANIZATION:

1. To achieve fulfillment of the objectives, goals, and scope of the organizational Quality Assurance Performance Improvement (QAPI) plan, the organizational structure of the program is designed to facilitate an effective system of monitoring, assessment, and evaluation of the care, treatment, and services provided within the Agency.
    a. The Governing Body is ultimately responsible for the quality of patient care, treatment, and services provided.
        i. The Governing Body requires staff, through the Performance Improvement Committee and Administration, to implement and report

on the activities and the mechanisms for monitoring, assessing, and evaluating patient safety practices and the quality of patient care, treatment, and services, for identifying and resolving problems and for identifying opportunities to improve patient care, treatment, and services or performance throughout the organization. This process addresses those departments/disciplines that have a direct or indirect effect on patient care, treatment, and services, including management and administrative functions.

ii. The Governing Body, through the VP of Hospice and Hospice, Director of Clinical Service, and the Agency Administrator/Executive Director, provide for resources and support systems for the Quality Assurance Performance Improvement (QAPI) functions and risk management functions related to patient care, treatment, and services and safety.

b. The governing body is responsible for guaranteeing;

i. The ongoing program for quality improvement and patient safety is defined, implemented, and maintained.

ii. The Hospice Agency wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improved actions are evaluated for effectiveness.

iii. That clear expectations for patient safety are established, implemented, and maintained.

iv. That any findings of fraud or waste are appropriately addressed

ANNUAL EVALUATION AND APPROVAL:

1. The organizational Quality Assurance Performance Improvement (QAPI) program is evaluated for effectiveness at least annually and revised as necessary to assure appropriateness of the approach to planning processes of improvement: setting priorities for improvement; assessing performance systematically; using statistically valid methods; implementing improvement activities on the basis of assessment; and sustaining achieved improvements.

CONFIDENTIALITY:

1. Information related to Quality Assurance Performance Improvement (QAPI) activities in accordance with this plan is confidential.

a. Confidential information may include, but is not limited to, staff committee meetings, Quality Assurance Performance Improvement (QAPI) Executive Report, electronic data gathering and reporting, medical record reviews, and untoward incident reporting.

b. Some information may be disseminated on a “need to know basis” as required by agencies such as federal review agencies, regulatory bodies, or another organization with a proven “need to know basis” as approved by the Agency’s Administration and/or the Governing Body.

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

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

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.
WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Hospice admissions ages 0-64	
Year	Admissions
2016	3,768
2017	3,757
2018	4,114
average:	**3,880**

Deaths ages 0-64	
Year	Deaths
2016	13,557
2017	14,113
2018	14,055
average:	**13,908**

Use Rates	
0-64	27.89%
65+	61.56%

Hospice admissions ages 65+	
Year	Admissions
2016	24,738
2017	26,365
2018	26,951
average:	**26,018**

Deaths ages 65+	
Year	Deaths
2016	41,104
2017	42,918
2018	42,773
average:	**42,265**

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

0-64				
County	2016	2017	2018	2016-2018 Average Deaths
Adams	34	38	28	**33**
Asotin	50	49	52	**50**
Benton	352	385	331	**356**
Chelan	123	124	130	**126**
Clallam	172	180	191	**181**
Clark	781	883	874	**846**
Columbia	12	19	6	**12**
Cowlitz	290	351	300	**314**
Douglas	56	71	51	**59**
Ferry	20	30	28	**26**
Franklin	115	133	145	**131**
Garfield	4	6	5	**5**
Grant	191	203	195	**196**
Grays Harbor	233	238	227	**233**
Island	134	166	135	**145**
Jefferson	69	69	64	**67**
King	3,204	3,256	3,264	**3,241**
Kitsap	518	485	515	**506**
Kittitas	59	91	68	**73**
Klickitat	50	63	58	**57**
Lewis	194	210	227	**210**
Lincoln	26	20	25	**24**
Mason	164	169	158	**164**
Okanogan	110	119	103	**111**
Pacific	59	88	64	**70**
Pend Oreille	35	34	43	**37**
Pierce	1,883	1,936	1,964	**1,928**
San Juan	36	18	19	**24**
Skagit	248	271	231	**250**
Skamania	39	16	27	**27**
Snohomish	1,440	1,483	1,533	**1,485**
Spokane	1,168	1,147	1,177	**1,164**
Stevens	103	96	113	**104**
Thurston	485	530	554	**523**
Wahkiakum	10	3	13	**9**
Walla Walla	123	123	110	**119**
Whatcom	365	367	360	**364**
Whitman	42	57	66	**55**
Yakima	560	586	601	**582**

65+				
County	2016	2017	2018	2016-2018 Average Deaths
Adams	92	78	72	**81**
Asotin	192	190	214	**199**
Benton	1,075	1,081	1,125	**1,094**
Chelan	535	556	573	**555**
Clallam	762	842	871	**825**
Clark	2,589	2,579	2,767	**2,645**
Columbia	48	116	43	**69**
Cowlitz	863	917	840	**873**
Douglas	227	232	255	**238**
Ferry	64	60	55	**60**
Franklin	242	284	278	**268**
Garfield	20	17	30	**22**
Grant	479	509	524	**504**
Grays Harbor	606	622	647	**625**
Island	565	630	675	**623**
Jefferson	293	308	336	**312**
King	9,766	10,039	9,917	**9,907**
Kitsap	1,704	1,780	1,713	**1,732**
Kittitas	243	237	239	**240**
Klickitat	145	151	158	**151**
Lewis	676	721	730	**709**
Lincoln	102	105	94	**100**
Mason	494	550	526	**523**
Okanogan	303	350	332	**328**
Pacific	222	262	279	**254**
Pend Oreille	120	133	130	**128**
Pierce	4,751	5,019	4,926	**4,899**
San Juan	126	115	114	**118**
Skagit	979	1,007	1,001	**996**
Skamania	64	65	56	**62**
Snohomish	3,857	4,118	4,055	**4,010**
Spokane	3,356	3,527	3,556	**3,480**
Stevens	336	376	373	**362**
Thurston	1,661	1,768	1,823	**1,751**
Wahkiakum	39	37	33	**36**
Walla Walla	485	501	445	**477**
Whatcom	1,353	1,329	1,252	**1,311**
Whitman	212	236	199	**216**
Yakima	1,458	1,471	1,517	**1,482**

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

0-64		
County	2016-2018 Average Deaths	Projected Patients: 27.90% of Deaths
Adams	33	9
Asotin	50	14
Benton	356	99
Chelan	126	35
Clallam	181	50
Clark	846	236
Columbia	12	3
Cowlitz	314	87
Douglas	59	17
Ferry	26	7
Franklin	131	37
Garfield	5	1
Grant	196	55
Grays Harbor	233	65
Island	145	40
Jefferson	67	19
King	3,241	904
Kitsap	506	141
Kittitas	73	20
Klickitat	57	16
Lewis	210	59
Lincoln	24	7
Mason	164	46
Okanogan	111	31
Pacific	70	20
Pend Oreille	37	10
Pierce	1,928	538
San Juan	24	7
Skagit	250	70
Skamania	27	8
Snohomish	1,485	414
Spokane	1,164	325
Stevens	104	29
Thurston	523	146
Wahkiakum	9	2
Walla Walla	119	33
Whatcom	364	102
Whitman	55	15
Yakima	582	162

65+		
County	2016-2018 Average Deaths	Projected Patients: 61.56% of Deaths
Adams	81	50
Asotin	199	122
Benton	1,094	673
Chelan	555	341
Clallam	825	508
Clark	2,645	1,628
Columbia	69	42
Cowlitz	873	538
Douglas	238	147
Ferry	60	37
Franklin	268	165
Garfield	22	14
Grant	504	310
Grays Harbor	625	385
Island	623	384
Jefferson	312	192
King	9,907	6,099
Kitsap	1,732	1,066
Kittitas	240	148
Klickitat	151	93
Lewis	709	436
Lincoln	100	62
Mason	523	322
Okanogan	328	202
Pacific	254	157
Pend Oreille	128	79
Pierce	4,899	3,016
San Juan	118	73
Skagit	996	613
Skamania	62	38
Snohomish	4,010	2,469
Spokane	3,480	2,142
Stevens	362	223
Thurston	1,751	1,078
Wahkiakum	36	22
Walla Walla	477	294
Whatcom	1,311	807
Whitman	216	133
Yakima	1,482	912

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

0-64								
County	Projected Patients	2016-2018 Average Population	2019 projected population	2020 projected population	2021 projected population	2019 potential volume	2020 potential volume	2021 potential volume
Adams	**9**	**17,899**	18,160	18,291	18,456	9	10	10
Asotin	**14**	**16,842**	16,715	16,652	16,596	14	14	14
Benton	**99**	**165,123**	167,984	169,415	171,026	101	102	103
Chelan	**35**	**61,755**	62,227	62,463	62,512	35	35	35
Clallam	**50**	**52,605**	52,494	52,439	52,233	50	50	50
Clark	**236**	**399,287**	411,278	417,273	421,901	243	247	249
Columbia	**3**	**2,905**	2,822	2,780	2,745	3	3	3
Cowlitz	**87**	**85,617**	85,817	85,917	85,843	88	88	88
Douglas	**17**	**34,335**	35,130	35,527	35,803	17	17	17
Ferry	**7**	**5,731**	5,628	5,577	5,541	7	7	7
Franklin	**37**	**83,832**	88,012	90,102	92,443	38	39	40
Garfield	**1**	**1,623**	1,581	1,560	1,541	1	1	1
Grant	**55**	**83,784**	86,033	87,158	88,240	56	57	58
Grays Harbor	**65**	**58,246**	57,387	56,958	56,679	64	63	63
Island	**40**	**62,814**	63,114	63,264	63,280	41	41	41
Jefferson	**19**	**20,670**	20,705	20,722	20,636	19	19	19
King	**904**	**1,841,848**	1,885,115	1,906,749	1,918,470	925	936	942
Kitsap	**141**	**215,543**	218,538	220,035	220,614	143	144	144
Kittitas	**20**	**37,330**	38,453	39,015	39,286	21	21	21
Klickitat	**16**	**15,955**	15,702	15,575	15,439	16	16	15
Lewis	**59**	**62,097**	62,700	63,001	63,164	59	60	60
Lincoln	**7**	**7,982**	7,864	7,805	7,751	7	6	6
Mason	**46**	**49,652**	50,632	51,122	51,397	47	47	47
Okanogan	**31**	**32,726**	32,364	32,183	32,087	31	30	30
Pacific	**20**	**14,830**	14,545	14,403	14,322	19	19	19
Pend Oreille	**10**	**9,952**	9,859	9,812	9,769	10	10	10
Pierce	**538**	**738,738**	756,339	765,139	769,918	551	557	560
San Juan	**7**	**11,084**	10,863	10,753	10,730	7	7	7
Skagit	**70**	**99,346**	100,807	101,537	101,887	71	71	72
Skamania	**8**	**9,260**	9,248	9,242	9,223	8	8	8
Snohomish	**414**	**683,800**	705,787	716,781	721,527	428	434	437
Spokane	**325**	**418,875**	423,256	425,447	426,740	328	330	331
Stevens	**29**	**34,343**	34,109	33,992	33,917	29	29	29
Thurston	**146**	**231,571**	238,190	241,500	243,867	150	152	154
Wahkiakum	**2**	**2,612**	2,498	2,441	2,405	2	2	2
Walla Walla	**33**	**50,328**	50,763	50,981	51,028	33	34	34
Whatcom	**102**	**180,629**	185,418	187,812	189,267	104	106	106
Whitman	**15**	**43,051**	43,222	43,308	43,315	15	15	15
Yakima	**162**	**219,328**	222,774	224,497	225,822	165	166	167

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

65+								
County	Projected Patients	2016-2018 Average Population	2019 projected population	2020 projected population	2021 projected population	2019 potential volume	2020 potential volume	2021 potential volume
Adams	**50**	**2,000**	2,227	2,341	2,383	55	58	59
Asotin	**122**	**5,426**	5,812	6,005	6,175	131	135	139
Benton	**673**	**28,657**	30,986	32,150	33,373	728	755	784
Chelan	**341**	**14,811**	15,876	16,408	17,052	366	378	393
Clallam	**508**	**20,867**	21,800	22,267	22,901	531	542	557
Clark	**1628**	**71,564**	78,605	82,125	85,686	1,788	1,869	1,950
Columbia	**42**	**1,169**	1,236	1,269	1,287	45	46	47
Cowlitz	**538**	**20,505**	22,148	22,969	23,719	581	602	622
Douglas	**147**	**7,213**	7,976	8,358	8,666	162	170	176
Ferry	**37**	**2,022**	2,168	2,241	2,289	39	41	42
Franklin	**165**	**8,343**	9,188	9,610	10,083	182	190	199
Garfield	**14**	**620**	645	658	669	14	15	15
Grant	**310**	**13,628**	14,861	15,477	16,071	338	352	366
Grays Harbor	**385**	**15,064**	16,123	16,653	17,133	412	425	438
Island	**384**	**19,163**	20,239	20,777	21,412	405	416	429
Jefferson	**192**	**10,916**	11,588	11,924	12,323	204	210	217
King	**6099**	**282,395**	310,572	324,660	337,771	6,707	7,012	7,295
Kitsap	**1066**	**49,743**	53,833	55,878	58,185	1,154	1,198	1,247
Kittitas	**148**	**7,055**	7,647	7,943	8,266	160	166	173
Klickitat	**93**	**5,310**	5,829	6,088	6,268	102	107	110
Lewis	**436**	**15,987**	16,808	17,219	17,697	459	470	483
Lincoln	**62**	**2,755**	2,891	2,959	3,039	65	66	68
Mason	**322**	**14,717**	15,905	16,499	17,167	348	361	376
Okanogan	**202**	**9,624**	10,475	10,901	11,210	220	229	235
Pacific	**157**	**6,421**	6,747	6,910	7,035	165	168	172
Pend Oreille	**79**	**3,560**	3,925	4,107	4,239	87	91	94
Pierce	**3016**	**119,836**	130,688	136,114	142,422	3,289	3,425	3,584
San Juan	**73**	**5,322**	5,768	5,991	6,174	79	82	85
Skagit	**613**	**25,308**	27,881	29,168	30,314	675	706	734
Skamania	**38**	**2,414**	2,670	2,798	2,923	42	44	46
Snohomish	**2469**	**107,560**	119,333	125,219	131,978	2,739	2,874	3,029
Spokane	**2142**	**80,834**	87,852	91,361	94,670	2,328	2,421	2,509
Stevens	**223**	**10,407**	11,360	11,837	12,214	243	253	261
Thurston	**1078**	**46,608**	50,757	52,832	54,900	1,174	1,222	1,269
Wahkiakum	**22**	**1,379**	1,503	1,565	1,580	24	25	26
Walla Walla	**294**	**10,881**	11,006	11,068	11,350	297	299	306
Whatcom	**807**	**37,426**	40,902	42,640	44,217	882	920	954
Whitman	**133**	**4,948**	5,526	5,815	6,008	148	156	161
Yakima	**912**	**35,809**	37,530	38,391	39,475	956	978	1,006

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

County	2019 potential volume	2020 potential volume	2021 potential volume	Current Capacity	2019 Admits (Unmet)	2020 Admits (Unmet)	2021 Admits (Unmet)
Adams	65	68	69	**35.00**	30	33	34
Asotin	145	149	153	**92.00**	53	57	61
Benton	829	857	887	**949.00**	(120)	(92)	(62)
Chelan	401	414	429	**374.33**	27	39	54
Clallam	581	592	607	**229.50**	351	363	378
Clark	2,032	2,115	2,199	**2,229.00**	(197)	(114)	(30)
Columbia	48	49	50	**20.33**	28	29	30
Cowlitz	668	690	710	**758.67**	(90)	(69)	(49)
Douglas	179	187	193	**138.33**	41	49	55
Ferry	47	48	49	**33.33**	13	14	15
Franklin	220	229	240	**149.33**	71	80	90
Garfield	16	16	16	**2.67**	13	13	13
Grant	395	409	424	**261.00**	134	148	163
Grays Harbor	476	489	501	**303.00**	173	186	198
Island	446	457	470	**337.33**	109	119	132
Jefferson	223	229	236	**164.00**	59	65	72
King	7,633	7,948	8,237	**7,668.17**	(35)	280	568
Kitsap	1,297	1,342	1,392	**1,177.00**	120	165	215
Kittitas	181	187	194	**143.00**	38	44	51
Klickitat	118	122	125	**224.00**	(106)	(102)	(99)
Lewis	518	530	543	**705.33**	(187)	(176)	(163)
Lincoln	71	73	75	**27.33**	44	45	47
Mason	395	408	423	**216.67**	178	192	206
Okanogan	251	259	266	**167.67**	83	92	98
Pacific	184	188	190	**107.33**	76	80	83
Pend Oreille	97	101	104	**63.67**	33	37	40
Pierce	3,839	3,982	4,144	**3,782.33**	57	200	362
San Juan	86	89	91	**79.67**	6	9	11
Skagit	746	778	806	**686.00**	60	92	120
Skamania	50	52	54	**32.00**	18	20	22
Snohomish	3,166	3,308	3,466	**2,975.00**	191	333	491
Spokane	2,656	2,751	2,839	**2,684.83**	(29)	66	155
Stevens	272	282	290	**145.67**	126	136	144
Thurston	1,324	1,374	1,423	**1,176.67**	147	197	246
Wahkiakum	27	28	28	**5.67**	21	22	22
Walla Walla	330	332	340	**296.67**	34	36	43
Whatcom	986	1,025	1,060	**875.33**	111	150	185
Whitman	164	171	177	**246.17**	(82)	(75)	(70)
Yakima	1,121	1,144	1,173	**1,163.67**	(43)	(19)	9

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

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	**2019 Admits (Unmet)**	**2020 Admits (Unmet)**	**2021 Admits (Unmet)**	**Statewide ALOS**	**2019 Patient Days (unmet)**	**2020 Patient Days (unmet)**	**2021 Patient Days (unmet)**
Adams	30	33	34	**60.13**	1,788	1,962	2,029
Asotin	53	57	61	**60.13**	3,182	3,441	3,668
Benton	(120)	(92)	(62)	**60.13**	(7,216)	(5,519)	(3,733)
Chelan	27	39	54	**60.13**	1,622	2,368	3,262
Clallam	351	363	378	**60.13**	21,133	21,813	22,728
Clark	(197)	(114)	(30)	**60.13**	(11,876)	(6,847)	(1,811)
Columbia	28	29	30	**60.13**	1,679	1,749	1,785
Cowlitz	(90)	(69)	(49)	**60.13**	(5,429)	(4,128)	(2,949)
Douglas	41	49	55	**60.13**	2,442	2,920	3,304
Ferry	13	14	15	**60.13**	792	868	918
Franklin	71	80	90	**60.13**	4,252	4,809	5,433
Garfield	13	13	13	**60.13**	782	797	811
Grant	134	148	163	**60.13**	8,031	8,919	9,775
Grays Harbor	173	186	198	**60.13**	10,387	11,171	11,889
Island	109	119	132	**60.13**	6,529	7,182	7,948
Jefferson	59	65	72	**60.13**	3,543	3,900	4,317
King	(35)	280	568	**60.13**	(2,127)	16,807	34,179
Kitsap	120	165	215	**60.13**	7,228	9,924	12,921
Kittitas	38	44	51	**60.13**	2,272	2,663	3,077
Klickitat	(106)	(102)	(99)	**60.13**	(6,380)	(6,114)	(5,932)
Lewis	(187)	(176)	(163)	**60.13**	(11,257)	(10,566)	(9,773)
Lincoln	44	45	47	**60.13**	2,645	2,733	2,839
Mason	178	192	206	**60.13**	10,707	11,516	12,411
Okanogan	83	92	98	**60.13**	4,982	5,510	5,894
Pacific	76	80	83	**60.13**	4,595	4,823	4,999
Pend Oreille	33	37	40	**60.13**	2,002	2,241	2,414
Pierce	57	200	362	**60.13**	3,419	12,015	21,768
San Juan	6	9	11	**60.13**	357	537	687
Skagit	60	92	120	**60.13**	3,608	5,513	7,197
Skamania	18	20	22	**60.13**	1,058	1,179	1,296
Snohomish	191	333	491	**60.13**	11,506	20,029	29,529
Spokane	(29)	66	155	**60.13**	(1,727)	3,966	9,299
Stevens	126	136	144	**60.13**	7,587	8,194	8,676
Thurston	147	197	246	**60.13**	8,841	11,851	14,815
Wahkiakum	21	22	22	**60.13**	1,264	1,322	1,335
Walla Walla	34	36	43	**60.13**	2,027	2,137	2,597
Whatcom	111	150	185	**60.13**	6,681	9,016	11,111
Whitman	(82)	(75)	(70)	**60.13**	(4,961)	(4,493)	(4,181)
Yakima	(43)	(19)	9	**60.13**	(2,556)	(1,161)	558

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

				Step 7 (Patient Days / 365) = Unmet ADC		
County	**2019 Patient Days (unmet)**	**2020 Patient Days (unmet)**	**2021 Patient Days (unmet)**	**2019 ADC (unmet)**	**2020 ADC (unmet)**	**2021 ADC (unmet)**
Adams	1,788	1,962	2,029	5	5	6
Asotin	3,182	3,441	3,668	9	9	10
Benton	(7,216)	(5,519)	(3,733)	(20)	(15)	(10)
Chelan	1,622	2,368	3,262	4	6	9
Clallam	21,133	21,813	22,728	58	60	62
Clark	(11,876)	(6,847)	(1,811)	(33)	(19)	(5)
Columbia	1,679	1,749	1,785	5	5	5
Cowlitz	(5,429)	(4,128)	(2,949)	(15)	(11)	(8)
Douglas	2,442	2,920	3,304	7	8	9
Ferry	792	868	918	2	2	3
Franklin	4,252	4,809	5,433	12	13	15
Garfield	782	797	811	2	2	2
Grant	8,031	8,919	9,775	22	24	27
Grays Harbor	10,387	11,171	11,889	28	31	33
Island	6,529	7,182	7,948	18	20	22
Jefferson	3,543	3,900	4,317	10	11	12
King	(2,127)	16,807	34,179	(6)	46	94
Kitsap	7,228	9,924	12,921	20	27	35
Kittitas	2,272	2,663	3,077	6	7	8
Klickitat	(6,380)	(6,114)	(5,932)	(17)	(17)	(16)
Lewis	(11,257)	(10,566)	(9,773)	(31)	(29)	(27)
Lincoln	2,645	2,733	2,839	7	7	8
Mason	10,707	11,516	12,411	29	32	34
Okanogan	4,982	5,510	5,894	14	15	16
Pacific	4,595	4,823	4,999	13	13	14
Pend Oreille	2,002	2,241	2,414	5	6	7
Pierce	3,419	12,015	21,768	9	33	60
San Juan	357	537	687	1	1	2
Skagit	3,608	5,513	7,197	10	15	20
Skamania	1,058	1,179	1,296	3	3	4
Snohomish	11,506	20,029	29,529	32	55	81
Spokane	(1,727)	3,966	9,299	(5)	11	25
Stevens	7,587	8,194	8,676	21	22	24
Thurston	8,841	11,851	14,815	24	32	41
Wahkiakum	1,264	1,322	1,335	3	4	4
Walla Walla	2,027	2,137	2,597	6	6	7
Whatcom	6,681	9,016	11,111	18	25	30
Whitman	(4,961)	(4,493)	(4,181)	(14)	(12)	(11)
Yakima	(2,556)	(1,161)	558	(7)	(3)	2

Highlighted counties have pending applications from the 2018 concurrent review. If you are interested in applying in one of these counties, please contact the CN program for more information.

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

Application Year

Step 7 (Patient Days / 365) = Unmet ADC				Step 8 - Numeric Need	
County	2019 ADC (unmet)	2020 ADC (unmet)	2021 ADC (unmet)	Numeric Need?	Agencies Needed?
Adams	5	5	6	FALSE	FALSE
Asotin	9	9	10	FALSE	FALSE
Benton	(20)	(15)	(10)	FALSE	FALSE
Chelan	4	6	9	FALSE	FALSE
Clallam	58	60	62	TRUE	1.78
Clark	(33)	(19)	(5)	FALSE	FALSE
Columbia	5	5	5	FALSE	FALSE
Cowlitz	(15)	(11)	(8)	FALSE	FALSE
Douglas	7	8	9	FALSE	FALSE
Ferry	2	2	3	FALSE	FALSE
Franklin	12	13	15	FALSE	FALSE
Garfield	2	2	2	FALSE	FALSE
Grant	22	24	27	FALSE	FALSE
Grays Harbor	28	31	33	FALSE	FALSE
Island	18	20	22	FALSE	FALSE
Jefferson	10	11	12	FALSE	FALSE
King	(6)	46	94	TRUE	2.68
Kitsap	20	27	35	TRUE	1.01
Kittitas	6	7	8	FALSE	FALSE
Klickitat	(17)	(17)	(16)	FALSE	FALSE
Lewis	(31)	(29)	(27)	FALSE	FALSE
Lincoln	7	7	8	FALSE	FALSE
Mason	29	32	34	FALSE	FALSE
Okanogan	14	15	16	FALSE	FALSE
Pacific	13	13	14	FALSE	FALSE
Pend Oreille	5	6	7	FALSE	FALSE
Pierce	9	33	60	TRUE	1.70
San Juan	1	1	2	FALSE	FALSE
Skagit	10	15	20	FALSE	FALSE
Skamania	3	3	4	FALSE	FALSE
Snohomish	32	55	81	TRUE	2.31
Spokane	(5)	11	25	FALSE	FALSE
Stevens	21	22	24	FALSE	FALSE
Thurston	24	32	41	TRUE	1.16
Wahkiakum	3	4	4	FALSE	FALSE
Walla Walla	6	6	7	FALSE	FALSE
Whatcom	18	25	30	FALSE	FALSE
Whitman	(14)	(12)	(11)	FALSE	FALSE
Yakima	(7)	(3)	2	FALSE	FALSE

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

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

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	2016	2017	2018
Adams	6	4	6
Asotin	10	7	6
Benton	106	110	118
Chelan	35	44	34
Clallam	6	14	16
Clark	310	282	336
Columbia	0	1	1
Cowlitz	105	124	107
Douglas	19	19	10
Ferry	3	7	6
Franklin	16	15	30
Garfield	0	1	1
Grant	42	44	41
Grays Harbor	66	72	35
Island	32	35	38
Jefferson	15	14	21
King	906	862	1,009
Kitsap	132	104	180
Kittitas	20	46	15
Klickitat	30	17	10
Lewis	53	45	56
Lincoln	4	3	7
Mason	18	34	14
Okanogan	35	34	21
Pacific	15	17	13
Pend Oreille	11	8	8
Pierce	453	419	543
San Juan	11	3	6
Skagit	62	61	48
Skamania	14	4	2
Snohomish	366	339	422
Spokane	367	397	400
Stevens	13	25	30
Thurston	132	144	114
Wahkiakum	0	1	2
Walla Walla	45	45	24
Whatcom	122	139	117
Whitman	9	29	19
Yakima	179	188	248
Grand Total	**3,768**	**3,757**	**4,114**

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	2016	2017	2018
Adams	25	30	34
Asotin	47	85	121
Benton	751	875	887
Chelan	305	319	386
Clallam	110	143	187
Clark	1,737	1,898	2,124
Columbia	19	17	23
Cowlitz	645	695	600
Douglas	102	129	136
Ferry	18	37	29
Franklin	110	122	155
Garfield	3	1	2
Grant	179	216	261
Grays Harbor	264	292	180
Island	195	364	348
Jefferson	120	167	155
King	6,510	6,739	6,359
Kitsap	938	1,156	1,021
Kittitas	79	134	135
Klickitat	72	82	81
Lewis	378	420	1,164
Lincoln	17	22	29
Mason	191	232	161
Okanogan	133	132	148
Pacific	99	106	72
Pend Oreille	56	55	53
Pierce	3,401	3,356	3,175
San Juan	70	70	79
Skagit	591	616	680
Skamania	35	21	20
Snohomish	2,228	2,084	2,636
Spokane	2,176	2,467	2,248
Stevens	120	128	121
Thurston	880	899	936
Wahkiakum	5	4	5
Walla Walla	273	276	227
Whatcom	712	766	770
Whitman	207	248	227
Yakima	937	962	977
Grand Total	**24,738**	**26,365**	**26,951**

Total Admissions by County - Not Adjusted for New Approvals

Column1	Total 201	Total 201	Total 201	Average
Adams	31	34	40	**35.00**
Asotin	57	92	127	**92.00**
Benton	857	985	1,005	**949.00**
Chelan	340	363	420	**374.33**
Clallam	116	157	203	**158.67**
Clark	2,047	2,180	2,460	**2,229.00**
Columbia	19	18	24	**20.33**
Cowlitz	750	819	707	**758.67**
Douglas	121	148	146	**138.33**
Ferry	21	44	35	**33.33**
Franklin	126	137	185	**149.33**
Garfield	3	2	3	**2.67**
Grant	221	260	302	**261.00**
Grays Harbor	330	364	215	**303.00**
Island	227	399	386	**337.33**
Jefferson	135	181	176	**164.00**
King	7,416	7,601	7,368	**7,461.67**
Kitsap	1,070	1,260	1,201	**1,177.00**
Kittitas	99	180	150	**143.00**
Klickitat	102	99	91	**97.33**
Lewis	431	465	1,220	**705.33**
Lincoln	21	25	36	**27.33**
Mason	209	266	175	**216.67**
Okanogan	168	166	169	**167.67**
Pacific	114	123	85	**107.33**
Pend Oreille	67	63	61	**63.67**
Pierce	3,854	3,775	3,718	**3,782.33**
San Juan	81	73	85	**79.67**
Skagit	653	677	728	**686.00**
Skamania	49	25	22	**32.00**
Snohomish	2,594	2,423	3,058	**2,691.67**
Spokane	2,543	2,864	2,648	**2,684.83**
Stevens	133	153	151	**145.67**
Thurston	1,012	1,043	1,050	**1,035.00**
Wahkiakum	5	5	7	**5.67**
Walla Walla	318	321	251	**296.67**
Whatcom	834	905	887	**875.33**
Whitman	216	277	246	**246.17**
Yakima	1,116	1,150	1,225	**1,163.67**

Total Admissions by County - Adjusted for New Approvals

Adjusted Cells Highlighted in YELLOW

Column1	Total 201	Total 201	Total 201	Average
Adams	31	34	40	**35.00**
Asotin	57	92	127	**92.00**
Benton	857	985	1,005	**949.00**
Chelan	340	363	420	**374.33**
Clallam	116	157	416	**229.50**
Clark	2,047	2,180	2,460	**2,229.00**
Columbia	19	18	24	**20.33**
Cowlitz	750	819	707	**758.67**
Douglas	121	148	146	**138.33**
Ferry	21	44	35	**33.33**
Franklin	126	137	185	**149.33**
Garfield	3	2	3	**2.67**
Grant	221	260	302	**261.00**
Grays Harbor	330	364	215	**303.00**
Island	227	399	386	**337.33**
Jefferson	135	181	176	**164.00**
King	7,629	7,796	7,581	**7,668.17**
Kitsap	1,070	1,260	1,201	**1,177.00**
Kittitas	99	180	150	**143.00**
Klickitat	102	291	280	**224.00**
Lewis	431	465	1,220	**705.33**
Lincoln	21	25	36	**27.33**
Mason	209	266	175	**216.67**
Okanogan	168	166	169	**167.67**
Pacific	114	123	85	**107.33**
Pend Oreille	67	63	61	**63.67**
Pierce	3,854	3,775	3,718	**3,782.33**
San Juan	81	73	85	**79.67**
Skagit	653	677	728	**686.00**
Skamania	49	25	22	**32.00**
Snohomish	2,594	2,423	3,908	**2,975.00**
Spokane	2,543	2,864	2,648	**2,684.83**
Stevens	133	153	151	**145.67**
Thurston	1,012	1,043	1,475	**1,176.67**
Wahkiakum	5	5	7	**5.67**
Walla Walla	318	321	251	**296.67**
Whatcom	834	905	887	**875.33**
Whitman	216	277	246	**246.17**
Yakima	1,116	1,150	1,225	**1,163.67**

Agencies that have operated for <3 years:

Wesley Homes Hospice - approved in 2015, operational since 2017 in King County. 2018 volumes exceed "default" - no adjustment for 2018.

Heart of Hospice - approved in August 2017. Operational since August 2017 in Klickitat County.

Envision Hospice - approved in September 2018 for Thurston County.

Continuum Care of Snohomish - approved in July 2019 for Snohomish County.
Olympic Medical Center - approved in September 2019 for Clallam County
Symbol Healthcare - approved in November 2019 for Thurston County
Heart of Hospice - approved in November 2019 for Snohomish County
Envision Hospice - approved in November 2019 for Snohomish County
Glacier Peak Healthcre - approved in November 2019 for Snohomish County

Calculation for "default values" per WAC 246-310-290(7)(b), assumption of 35 ADC, 60.13 ALOS per CMS

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/60.13 ALOS = 212.5 default admissions
212.5 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

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

	0-64			65+		
County	2016	2017	2018	2016	2017	2018
ADAMS	34	38	28	92	78	72
ASOTIN	50	49	52	192	190	214
BENTON	352	385	331	1,075	1,081	1,125
CHELAN	123	124	130	535	556	573
CLALLAM	172	180	191	762	842	871
CLARK	781	883	874	2,589	2,579	2,767
COLUMBIA	12	19	6	48	116	43
COWLITZ	290	351	300	863	917	840
DOUGLAS	56	71	51	227	232	255
FERRY	20	30	28	64	60	55
FRANKLIN	115	133	145	242	284	278
GARFIELD	4	6	5	20	17	30
GRANT	191	203	195	479	509	524
GRAYS HARBOR	233	238	227	606	622	647
ISLAND	134	166	135	565	630	675
JEFFERSON	69	69	64	293	308	336
KING	3,204	3,256	3,264	9,766	10,039	9,917
KITSAP	518	485	515	1,704	1,780	1,713
KITTITAS	59	91	68	243	237	239
KLICKITAT	50	63	58	145	151	158
LEWIS	194	210	227	676	721	730
LINCOLN	26	20	25	102	105	94
MASON	164	169	158	494	550	526
OKANOGAN	110	119	103	303	350	332
PACIFIC	59	88	64	222	262	279
PEND OREILLE	35	34	43	120	133	130
PIERCE	1,883	1,936	1,964	4,751	5,019	4,926
SAN JUAN	36	18	19	126	115	114
SKAGIT	248	271	231	979	1,007	1,001
SKAMANIA	39	16	27	64	65	56
SNOHOMISH	1,440	1,483	1,533	3,857	4,118	4,055
SPOKANE	1,168	1,147	1,177	3,356	3,527	3,556
STEVENS	103	96	113	336	376	373
THURSTON	485	530	554	1,661	1,768	1,823
WAHKIAKUM	10	3	13	39	37	33
WALLA WALLA	123	123	110	485	501	445
WHATCOM	365	367	360	1,353	1,329	1,252
WHITMAN	42	57	66	212	236	199
YAKIMA	560	586	601	1,458	1,471	1,517

Agency Name	License Number	County	Year	0-64	65+
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2016	6	25
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2016	42	176
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2016	4	16
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2016	6	110
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2016	1	6
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2016	25	229
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2016	3	52
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2016	30	240
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2016	6	88
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2016	35	305
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2016	19	97
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2016	78	364
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2016	98	583
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2016	0	5
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2016	10	47
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2016	0	3
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2016	0	7
Evergreen Health Home Care Services	IHS.FS.00000278	King	2016	292	2227
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2016	85	727
Franciscan Hospice	IHS.FS.00000287	King	2016	106	1140
Franciscan Hospice	IHS.FS.00000287	Kitsap	2016	45	486
Franciscan Hospice	IHS.FS.00000287	Pierce	2016	232	2499
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2016	0	5
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2016	0	3
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2016	35	133
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2016	24	346
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2016	66	264
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2016	15	99
Heart of Hospice	IHS.FS.00000185	Skamania	2016	9	13
Heart of Hospice	IHS.FS.00000185	Klickitat	2016	3	25
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2016	4	107
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2016	12	165
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2016	11	99
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2016	168	976
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2016	6	39
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2016	1	5
Horizon Hospice	IHS.FS.00000332	Spokane	2016	28	350
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2016	0	0
Hospice of Spokane	IHS.FS.00000337	Ferry	2016	3	18
Hospice of Spokane	IHS.FS.00000337	Lincoln	2016	0	1
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2016	11	56
Hospice of Spokane	IHS.FS.00000337	Spokane	2016	315	1620
Hospice of Spokane	IHS.FS.00000337	Stevens	2016	13	120
Hospice of Spokane	IHS.FS.00000337	Whitman	2016	0	1
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2016	13	61
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2016	11	70
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2016	62	591
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2016	7	96
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2016	14	114
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2016	64	397
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2016	1	23
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2016	0	0
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2016	38	567
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2016	23	119
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2016	39	229
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2016	6	110
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2016	24	206
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2016	9	206
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2016	20	79
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2016	5	31
Kline Galland Community Based Services	IHS.FS.60103742	King	2016	20	305
Memorial Home Care Services	IHS.FS.00000376	Yakima	2016	161	684
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2016	24	111
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2016	64	333
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2016	182	673
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2016	22	16
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2016	4	17
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2016	8	28
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2016	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2016	265	1288
Providence Hospice of Seattle	IHS.FS.00000336	King	2016	402	1814
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2016	3	7
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2016	28	149
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2016	15	139
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2016	102	640
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2016	102	644
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2016	16	110
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2016	0	19
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2016	45	273
Wesley Homes	IHS.FS.60276500	King	2016	0	0

Agency Name	License Number	County	Year	0-64	65+
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2016	122	712
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2017	4	30
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2017	44	209
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2017	3	22
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2017	14	143
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2017	1	14
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2017	17	257
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2017	8	43
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2017	39	235
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2017	11	48
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2017	44	319
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2017	18	119
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2017	67	419
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2017	116	630
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2017	1	4
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2017	7	85
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2017	1	1
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2017	0	7
Evergreen Health Home Care Services	IHS.FS.00000278	King	2017	272	2393
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2017	82	478
Franciscan Hospice	IHS.FS.00000287	King	2017	90	1115
Franciscan Hospice	IHS.FS.00000287	Kitsap	2017	64	796
Franciscan Hospice	IHS.FS.00000287	Pierce	2017	181	2242
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2017	1	10
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2017	0	7
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2017	34	132
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2017	14	375
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2017	72	292
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2017	17	106
Heart of Hospice	IHS.FS.00000185	Skamania	2017	2	11
Heart of Hospice	IHS.FS.00000185	Klickitat	2017	1	20
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2017	12	130
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2017	28	197
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2017	21	248
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2017	165	1064
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2017	7	47
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2017	0	0
Horizon Hospice	IHS.FS.00000332	Spokane	2017	35	420
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2017	0	0
Hospice of Spokane	IHS.FS.00000337	Ferry	2017	7	37
Hospice of Spokane	IHS.FS.00000337	Lincoln	2017	0	0
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2017	8	55
Hospice of Spokane	IHS.FS.00000337	Spokane	2017	340	1722
Hospice of Spokane	IHS.FS.00000337	Stevens	2017	25	128
Hospice of Spokane	IHS.FS.00000337	Whitman	2017	0	1
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2017	11	77
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2017	3	70
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2017	61	616
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2017	7	83
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2017	13	153
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2017	50	415
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2017	1	18
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2017	0	0
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2017	38	487
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2017	7	107
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2017	27	189
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2017	2	68
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2017	22	325
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2017	29	247
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2017	46	134
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2017	11	33
Kline Galland Community Based Services	IHS.FS.60103742	King	2017	13	301
Memorial Home Care Services	IHS.FS.00000376	Yakima	2017	149	717
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2017	42	149
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2017	33	253
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2017	211	925
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2017	5	29
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2017	2	10
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2017	3	32
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2017	5	14
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2017	238	1440
Providence Hospice of Seattle	IHS.FS.00000336	King	2017	387	1888
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2017	10	15
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2017	28	163
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2017	26	189
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2017	105	664
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2017	98	745
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2017	15	122
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2017	1	17
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2017	45	276

Agency Name	License Number	County	Year	0-64	65+
Wesley Homes	IHS.FS.60276500	King	2017	1	17
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2017	139	766
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2018	6	34
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2018	40	254
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2018	6	28
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2018	16	186
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2018	1	11
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2018	35	280
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2018	4	44
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2018	24	273
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2018	41	8
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2018	34	386
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2018	10	133
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2018	54	383
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2018	87	524
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2018	2	5
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2018	6	121
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2018	1	2
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2018	1	9
Evergreen Health Home Care Services	IHS.FS.00000278	King	2018	348	1989
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2018	79	690
Franciscan Hospice	IHS.FS.00000287	King	2018	102	921
Franciscan Hospice	IHS.FS.00000287	Kitsap	2018	141	693
Franciscan Hospice	IHS.FS.00000287	Pierce	2018	331	2110
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2018	0	3
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2018	1	7
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2018	21	148
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2018	37	180
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2018	35	180
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2018	13	71
Heart of Hospice	IHS.FS.00000185	Skamania	2018	0	10
Heart of Hospice	IHS.FS.00000185	Klickitat	2018	1	23
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2018	6	137
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2018	24	219
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2018	20	235
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2018	243	1305
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2018	20	76
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2018	1	1
Horizon Hospice	IHS.FS.00000332	Spokane	2018	31	389
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2018	0	0
Hospice of Spokane	IHS.FS.00000337	Ferry	2018	6	29
Hospice of Spokane	IHS.FS.00000337	Lincoln	2018	1	1
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2018	8	53
Hospice of Spokane	IHS.FS.00000337	Spokane	2018	346	1593
Hospice of Spokane	IHS.FS.00000337	Stevens	2018	30	121
Hospice of Spokane	IHS.FS.00000337	Whitman	2018	none reported	none reported
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2018	6	60
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2018	6	79
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2018	48	680
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2018	2	67
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2018	20	144
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2018	39	436
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2018	none reported	none reported
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2018	none reported	none reported
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2018	25	416
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2018	14	96
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2018	35	198
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2018	14	94
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2018	23	265.5
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2018	19	226.5
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2018	15	135
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2018	5	40
Kline Galland Community Based Services	IHS.FS.60103742	King	2018	29	368
Memorial Home Care Services	IHS.FS.00000376	Yakima	2018	183	750
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2018	32	158
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2018	25	232
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2018	177	867
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2018	4	18
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2018	1	9
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2018	11	44
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2018	none reported	none reported
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2018	316	1772
Providence Hospice of Seattle	IHS.FS.00000336	King	2018	407	1959
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2018	11	13
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2018	21	884
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2018	10	117
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2018	90	663
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2018	112	750
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2018	30	155
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2018	1	23

Agency Name	License Number	County	Year	0-64	65+
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2018	24	227
Wesley Homes	IHS.FS.60276500	King	2018	29	368
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2018	117	770
IRREGULAR-COMMUNITY HOME HEALTH & HOSPICE	IHS.FS.00000262	Pacific	2018	0	1
IRREGULAR-MULTICARE	IHS.FS.60639376	Clallam	2018	0	1

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

Eden Hospice at Whatcom County, LLC

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APPENDIX 21

EDEN HOSPICE AT WHATCOM COUNTY UTILIZATION FORECAST, 2021 - 2024

Revenue Assumptions & Staffing Summary
Eden Hospice at Whatcom County, LLC

CENSUS	2021	2022	2023
Admissions	81	180	276
Patient Days	4,875	11,019	16,888
Average Daily Census	**13.36**	**30.19**	**46.27**

PATIENT DAYS BY LEVEL OF CARE			
Routine Home Care 0-60	2,242	5,069	7,768
Routine Home Care 61+	2,535	5,730	8,782
Respite Care	49	110	169
General Inpatient Care	24	55	84
Continuous Care	24	55	84
TOTAL	**4,875**	**11,019**	**16,888**

Eden Hospice at Whatcom County, LLC

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APPENDIX 22

EDEN HOSPICE AT WHATCOM COUNTY 3 YEAR ADDITION OF FTE & PERSONNEL EXPENSE

Revenue Assumptions & Staffing Summary
Eden Hospice at Whatcom County, LLC

CENSUS	2021	2022	2023	
Admissions	81	180	276	
Patient Days	4,875	11,019	16,888	
Average Daily Census	**13.36**	**30.19**	**46.27**	
PATIENT DAYS BY LEVEL OF CARE				
Routine Home Care 0-60	2,242	5,069	7,768	
Routine Home Care 61+	2,535	5,730	8,782	
Respite Care	49	110	169	
General Inpatient Care	24	55	84	
Continuous Care	24	55	84	
TOTAL	**4,875**	**11,019**	**16,888**	
PER PATIENT DAY RATES				
Routine Home Care 0-60	207.69	207.69	207.69	Per day
Routine Home Care 61+	164.14	164.14	164.14	Per day
Respite Care	476.39	476.39	476.39	Per day
General Inpatient Care	1,080.62	1,080.62	1,080.62	Per day
Continuous Care	62.07	62.07	62.07	Per hour
GROSS REVENUE BY LEVEL OF CARE				
Routine Home Care 0-60	465,714	1,052,686	1,613,401	
Routine Home Care 61+	416,072	940,476	1,441,422	
Respite Care	23,223	52,492	80,452.28	
General Inpatient Care	26,339	59,536	91,248	
Continuous Care	31,167	70,449	107,974	
TOTAL	**962,515**	**2,175,639**	**3,334,498**	
PAYER MIX				
Medicare	85%	85%	85%	
Medicaid	10%	10%	10%	
Commercial/Other	5%	5%	5%	
TOTAL	**100%**	**100%**	**100%**	
GROSS REVENUE BY PAYER				
Medicare	822,511	1,859,177	2,849,471	
Medicaid	93,286	210,861	323,177	
Commercial/Other	46,719	105,601	161,850	
TOTAL	**962,515**	**2,175,639**	**3,334,498**	
STAFFING SUMMARY FTE				
CLINICAL OPERATIONS	**SALARY**			
QAPI Nurse	80,000	0.50	0.50	0.50 Split between HH and HOS
Registered Nurse	72,800	1.34	3.02	4.63 1 per 10 ADC
Medical Social Worker	68,640	0.45	1.01	1.54 1 per 30 ADC
Hospice Aide	37,440	1.34	3.02	4.63 1 per 10 ADC
Spiritual Care Coord	58,240	1.00	1.00	2.00 Vol/bereavement until ADC 30
TOTAL		**4.62**	**8.54**	**13.30**
ADMINISTRATIVE				
Administrator	130,000	0.50	0.50	0.50 Split between HH and HOS
Director of Patient Care	110,000	0.50	0.50	0.50 Split between HH and HOS
Clinical Manager	85,000	-	-	1.00 ADC 30
Business Office Manager	60,000	0.50	0.50	0.50 Split between HH and HOS
Clinical Support Specialist	37,440	1.00	1.00	2.00
Volunteer/Bereavement Coord	41,600	-	-	1.00
Community Liaison	65,000	1.00	1.00	2.00
TOTAL		**3.50**	**3.50**	**7.50**
TOTAL FTE'S		**8.12**	**12.04**	**20.80**

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APPENDIX 24

MELANOMA SURVIVAL AND COSTS

Survival and Cost-Effectiveness of Hospice Care for Metastatic Melanoma Patients

Jinhai Huo, PhD, MD, MPH; David R. Lairson, PhD; Xianglin L. Du, MD, PhD; Wenyaw Chan, PhD; Thomas A. Buchholz, MD; and B. Ashleigh Guadagnolo, MD, MPH

Objectives

We analyzed the association of hospice use with survival and healthcare costs among patients diagnosed with metastatic melanoma.

Methods

We used the Surveillance, Epidemiology, and End Results (SEER)-Medicare-linked databases to identify patients 65 years or older with metastatic melanoma who died between 2000 and 2009. We analyzed claims data to ascertain cancer treatment utilization and costs. Survival, end-of-life costs, and incremental cost-effectiveness ratio were evaluated using propensity score methods. Costs were analyzed from the payer perspective in 2009 dollars.

Results

Of 862 patients, 225 (26%) received no hospice care, 523 (61%) received 1 to 3 days of hospice care, and 114 (13%) received 4 or more days of hospice care. The median survival time was 6.1 months for patients with no hospice care, 6.5 months for patients enrolled in hospice for 1 to 3 days, and 10.2 months for patients enrolled for 4 or more days (P <.001). The hazard ratio for survival among patients with 4 or more days of hospice use was 0.66; 95% confidence interval, 0.54-0.81, P <.0001 in the propensity score–matched model. Patients with 4 or more days of hospice care incurred lower end-of-life costs than the comparison groups ($14,594 vs $22,647 for the 1-to-3-days hospice care, and $28,923 for patients with no hospice care; P <.0001).

Conclusions

Patients diagnosed with metastatic melanoma who enrolled in 4 or more days of hospice care had longer survival than those who had 1 to 3 days of hospice or no hospice care, and this longer overall survival was accompanied by lower end-of-life costs.

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The 5-year survival rate for patients with melanoma detected at the earliest stages is approximately 95%,[1] but falls precipitously to 15% for patients diagnosed with metastatic disease.[2] Melanoma also places a significant economic burden on society and patients.[3] The estimated annual cost of melanoma care in the United States is $249 million and the average lifetime disease-associated cost for a patient from the time of diagnosis with melanoma until death is approximately $28,210.[3] Furthermore, 40% of the annual cost is attributed to stage 4 melanoma, which includes only around 3% of melanoma patients.[3]

Since stage 4 melanoma is rarely curable, most medical treatment for these patients—including surgery, radiation therapy, chemotherapy, and biologic therapy—is prescribed with limited expectations for long-term survival, and often with palliative intent. Increasingly, hospice care has become an acceptable alternative for patients with metastatic cancer. Hospices provide the necessary care, pain management, and emotional support to provide a comfortable end-of-life experience. The use of hospice also likely results in a decrease in utilization of surgery, radiation therapy, and chemotherapy,[4] thus likely leading to a decrease in medical costs, although this has not been studied among patients with metastatic melanoma. Other investigators have shown that hospice utilization does not result in shortened survival for other terminal illnesses such as advanced lung cancer and pancreatic cancer.[5,6] However, no studies have examined whether survival is reduced when patients elect hospice care for metastatic melanoma. Our goal is to examine the associations of use of hospice care with survival and costs among patients with metastatic melanoma and to analyze the cost-effectiveness for different durations of hospice care in patients with this disease.

METHODS

Data Source and Cohort Definition

We conducted this study using data from the National Cancer Institute's Surveillance, Epidemiology, and End Re-

sults (SEER)-Medicare-linked databases. This database covers 17 geographic areas in the United States and encompasses approximately 28% of the US population.[7] The SEER registries are linked to the Medicare claims databases, which are updated biennially and include 97% of US citizens 65 years and older.[8] All available Medicare claims files were used to obtain information on treatments and costs of care. The Patient Entitlement and Diagnosis Summary File (PEDSF) contains 1 record per person linked via encrypted identifiers to a corresponding file in the SEER database and provides basic information on sociodemographic and tumor characteristics. All data were de-identified such that no protected health information could be linked to individual patients. The institutional review board from the University of Texas MD Anderson Cancer Center, Houston, Texas, and the University of Texas Health Science Center, Houston, Texas, exempted this study.

Take-Away Points

- Patients who enrolled in hospice for 4 or more days showed longer median survival than patients who did not use hospice care or who enrolled in hospice care for only 1 to 3 days after diagnosis with metastatic melanoma.
- Among patients who were enrolled in 4 or more days of hospice care, the end-of-life costs decreased by $14,680 in the model with the original cohort, and by $9576 in the model with the propensity score–matched cohort.
- The incremental cost was $29,426 per life-year gained for patients who received 4 or more days of hospice care.

We identified patients 65 years and older who were diagnosed with pathologically confirmed malignant melanoma (stage 4) between January 1, 2000, and December 31, 2009. Patients were excluded if their death year and month in the SEER data set and Medicare data sets did not match, or if their cancer diagnosis came from either an autopsy or death certificate. Patients were excluded if they did not have continuous coverage through enrollment in Medicare Part A and Part B from the date of melanoma diagnosis until death or if they had health maintenance organization coverage during this time.

Dependent Variables

Overall survival was defined as the time from diagnosis of melanoma to the patient's death due to the melanoma. The costs incurred in the last 3 months were used to estimate the incremental cost-effectiveness ratio, defined as cost per life-year gained.

Independent Variables

Independent variables in the analysis included age at diagnosis, sex, marital status, neighborhood income and education levels, geographic region, comorbidity score, and hospice density. Hospice density, defined as the number of hospice facilities available within each patient's health service area, was obtained from the Area Resource File.[9] The Charlson Comorbidity Index score was calculated from an algorithm developed by Klabunde and colleagues.[10,11] The use of hospice care was identified based on any hospice service date after the melanoma diagnosis date. Based on information relayed by hospice staff, Kris and colleagues concluded that 3 or fewer days was an insufficient amount of time for patients and hospice staff to fully communicate on the planning and implementation of hospice care, so we adopted this common classification approach whereby the number of hospice service days was categorized into 3 groups: no hospice care, 1 to 3 days of hospice care, and 4 or more days of hospice care.[6,12]

Statistical Analysis

We conducted a univariate analysis using χ^2 test. Multivariate analysis was performed with a standard of $P < .05$ to determine the significance of association of outcomes and variables. A Cox proportional hazards model controlling for potential explanatory variables was used to assess the relationship between hospice use and overall survival. All hazard ratios (HRs) were calculated with 2-sided P value and 95% confidence intervals (CIs). Survival rates were calculated from Kaplan-Meier estimation. Since all patients died within the observation window, no censored cases occurred. The generalized linear model with a gamma distribution was used for validating the outcome of the Cox model.

To minimize potential selection bias, we used propensity score–based 1:N match (1 case matched with N controls) in the survival and cost models. Since a 3-group propensity score–matching algorithm is not available, and survival for patients with no hospice care was similar to that of patients who used 1 to 3 days hospice, we combined these 2 groups into 0 to 3 days of hospice use and further matched with patients who used 4 or more days of hospice care by applying a propensity score–based 1:N match algorithm developed by Parsons.[13] In this algorithm, all the demographic variables were included in the propensity score logistic model to generate the predicted probability that is used for matching. To maximize the sample size from a 5-matching scenario (1:N, N is 1 to 5), we used a 1:5 match-optimized cohort by using an 8-to-1-digit matching algorithm.[13] In the matched cohort,

a Cox proportional hazards model stratified by matched pair evaluated the associations between 4 or more days of hospice care or 0 to 3 days of hospice care and overall survival time in months.

To conduct the economic analysis, we divided the total cost of care after diagnosis into 3 phases based on the phase-of-care approach developed by Riley and colleagues.[14] The majority of resources are typically consumed in the initial phase, when a patient's disease is diagnosed and treated, and during the final (end-of-life) phase, when extensive efforts are employed to extend the patient's life or to improve quality of life. Thus, the costs calculated from this method would follow a U-shaped pattern, with the highest costs on the 2 end points. In our study, the initial phase, which lasts an average of 3 months, was defined as the period during which medical intervention was implemented for advanced melanoma and might include the times of diagnosis, surgery, chemotherapy, and radiation therapy. The end-of-life phase is defined as the last 3 months immediately preceding death. The interim months of continuing care after the initial phase include surveillance and routine therapy costs.

We calculated the cost difference by comparing the total Medicare payments incurred by patients receiving 4 or more days of hospice care with those incurred by patients not receiving hospice care prior to death and those patients receiving 1 to 3 days of hospice care. The total cost of care for patients was calculated as the sum of reimbursements authorized by Medicare. Medicare claims reimbursements were adjusted for inflation to 2009 dollars using the Prospective Pricing Index for Part A claims and the Medicare Economic Index for Part B claims.[15] Costs were adjusted for geographic variation using the geographic adjustment factor for Part A claims and the geographic practice cost index for Part B claims.[15] These adjusting factors are acquired from direct communication with the National Cancer Institute's Health Services and Economics Branch of the Applied Research Program. These indices were matched via the state and county codes for each patient and then multiplied with the costs from each file in the database. Since the median survival time for metastatic melanoma patients is less than 1 year, discounting was not applied to cost or survival time. Costs were further analyzed in a generalized linear model with a gamma distribution controlling for patient demographic and clinical covariates.[16]

The cost-effectiveness analysis utilized the mean of costs from all 3 phases of cancer care and survival. The incremental cost-effectiveness ratio (ICER) = $(C_1 - C_2) / (E_1 - E_2) = \Delta C / \Delta E$, where C_x equals cost of group x and E_x is effectiveness at group x, with the quotient representing cost per life-year gained. In the cost-effectiveness model, a bootstrap simulation analysis was implemented to assess the statistical uncertainty. We performed an analysis with 1000 bootstrap estimates of the ICER in both the original cohort and the 1:5 matched cohort. Statistical analysis was conducted using SAS version 9.3 (SAS Institute, Inc, Cary, North Carolina).

RESULTS

Patient and Tumor Characteristics

Characteristics of the entire cohort and matched cohort as well as univariate analysis of hospice use and patient characteristics are shown in **Table 1**. Of 862 patients, 225 (26%) had no hospice care after diagnosis, 523 (61%) had 1 to 3 days of hospice care, and 114 (13%) had 4 or more days of hospice care. All covariates were evenly balanced in the matched cohort.

Overall Survival

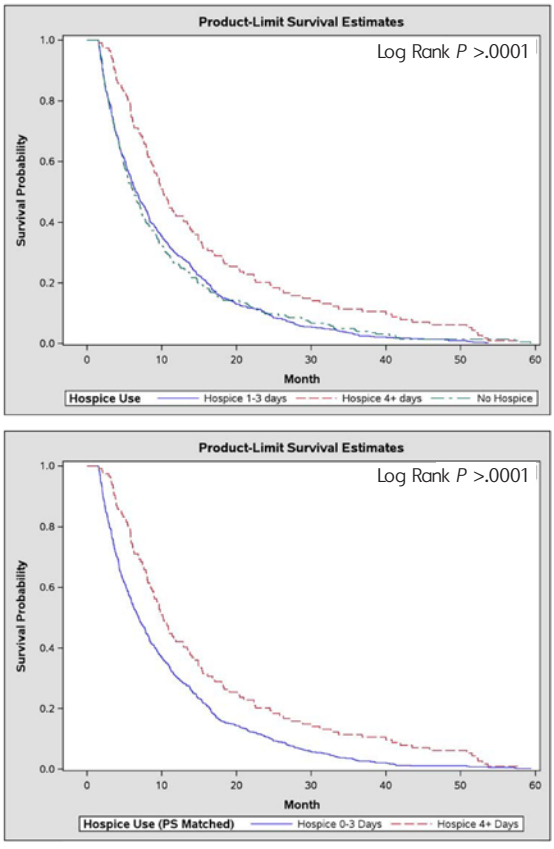
At the end of the 60-month study period, the unadjusted survival curves for the entire cohort categorized by hospice use are shown in **Figure 1A**. The median survival time was 6.1 months for patients who did not enroll in hospice, 6.5 months for patients who enrolled in hospice for 1 to 3 days, and 10.2 months for patients who enrolled in hospice for 4 or more days. The survival curves for the propensity score–matched cohort after combining the groups of patients with no hospice use or only 1 to 3 days of hospice use are shown in **Figure 1B**. The overall survival rates at all-time points for the patients enrolling in 4 or more days of hospice care were significantly better than those for the comparison group (log-rank test, P <.001).

In Cox proportional hazards models, 4 or more days of hospice care was associated with an improvement in survival when adjusting for other characteristics (**Table 2**). The estimated improvements in survival for 4 or more days of hospice use were similar in the original-cohort Cox proportional hazards model (HR, 0.63; 95% CI, 0.52-0.77, P <.0001) and propensity score–matched model (HR, 0.66; 95% CI, 0.54-0.81, P <.0001). Patients enrolled in 4 or more days of hospice care had 3.9 months longer median survival time in the unmatched cohort model (P <.0001), and 3.3 months longer median survival time in the propensity score–matched cohort model (P <.0001). The findings were similar across various models and cohorts, suggesting that the overall association between 4 or more days of hospice use and reduced mortality was not affected by statistical modeling methods.

Table 1. Univariate Analysis for the Entire Cohort

	Original Cohort				Propensity Score 1:5 Matched Cohort		
	No Hospice N (%) 225 (26.1)	Hospice Care 1-3 Days N (%) 523 (60.7)	Hospice Care 4+ Days N (%) 114 (13.2)	*P*	Hospice Care 0-3 Days N (%) 570 (83.3)	Hospice Care 4+ Days N (%) 114 (16.7)	*P*
Year of death				.10			.23
2000-2001	34 (15.1)	49 (9.4)	12 (10.5)		63 (11.1)	12 (10.5)	
2002-2003	37 (16.4)	94 (18.0)	15 (13.2)		98 (17.2)	15 (13.2)	
2004-2005	53 (23.6)	115 (22.0)	22 (19.3)		125 (21.9)	22 (19.3)	
2006-2007	47 (20.9)	124 (23.7)	39 (34.2)		136 (23.9)	39 (34.2)	
2008-2009	54 (24.0)	141 (27.0)	26 (22.8)		148 (26.0)	26 (22.8)	
Age at diagnosis				.13			.26
65-69 y	42 (18.7)	72 (13.8)	12 (10.5)		85 (14.9)	12 (10.5)	
70-74 y	52 (23.1)	122 (23.3)	26 (22.8)		138 (24.2)	26 (22.8)	
75-79 y	63 (28.0)	134 (25.6)	25 (21.9)		145 (25.4)	25 (21.9)	
≥80 y	68 (30.2)	195 (37.3)	51 (44.7)		202 (35.4)	51 (44.7)	
Gender				.69			.66
Male	158 (70.2)	356 (68.1)	75 (65.8)		387 (67.9)	75 (65.8)	
Female	67 (29.8)	167 (31.9)	39 (34.2)		183 (32.1)	39 (34.2)	
Marital status				.92			.94
Married	133 (59.1)	317 (60.6)	68 (59.7)		342 (60.0)	68 (59.7)	
Other	92 (40.9)	206 (39.4)	46 (40.4)		228 (40.0)	46 (40.4)	
Median household income				.36			.10
Lowest quartile	59 (26.2)	121 (23.1)	28 (24.6)		144 (25.3)	28 (24.6)	
2nd quartile	50 (22.2)	124 (23.7)	33 (29.0)		128 (22.5)	33 (29.0)	
3rd quartile	56 (24.9)	119 (22.8)	32 (28.1)		128 (22.5)	32 (28.1)	
Highest quartile	53 (23.6)	137 (26.2)	17 (14.9)		148 (26.0)	17 (14.9)	
Education <12 years				.32			.54
Lowest quartile	53 (23.6)	130 (24.9)	22 (19.3)		140 (24.6)	22 (19.3)	
2nd quartile	52 (23.1)	127 (24.3)	26 (22.8)		130 (22.8)	26 (22.8)	
3rd quartile	48 (21.3)	132 (25.2)	27 (23.7)		136 (23.9)	27 (23.7)	
Highest quartile	63 (28.0)	106 (20.3)	34 (29.8)		132 (23.2)	34 (29.8)	
Comorbidity scores				.96			.92
0	132 (58.7)	317 (60.6)	69 (60.5)		334 (58.6)	69 (60.5)	
1	54 (24.0)	112 (21.4)	25 (21.9)		128 (22.5)	25 (21.9)	
≥2	39 (17.3)	94 (18.0)	20 (17.5)		108 (19.0)	20 (17.5)	
Geographic region				.10			.24
West	115 (51.1)	217 (41.5)	48 (42.1)		261 (45.8)	48 (42.1)	
Northeast	51 (22.7)	142 (27.2)	22 (19.3)		142 (24.9)	22 (19.3)	
Midwest	18 (8.0)	58 (11.1)	15 (13.2)		57 (10.0)	15 (13.2)	
South	41 (18.2)	106 (20.3)	29 (25.4)		110 (19.3)	29 (25.4)	
Hospice density				.96			.93
0	31 (13.8)	58 (11.1)	14 (12.3)		68 (11.9)	14 (12.3)	
1-4	109 (48.4)	263 (50.3)	53 (46.5)		284 (49.8)	53 (46.5)	
5-9	43 (19.1)	104 (19.9)	24 (21.1)		113 (19.8)	24 (21.1)	
≥10	42 (18.7)	98 (18.7)	23 (20.2)		105 (18.4)	23 (20.2)	

■ **Figure 1.** Comparison of Survival Time Among the Patients Who Did Not Use Hospice, Who Used Hospice for 1 to 3 Days, and Who Used Hospice for 4 or More Days—Entire Cohort



A
Propensity Score 1:3 Matched Cohort
No Hospice:
Median: 6.1 months
CI: 5.27-7.3 months
Hospice Care 1-3 Days:
Median: 6.5 months
CI: 5.9-7.5 months
Hospice Care 4+ Days:
Median: 10.2 months
CI: 8.7-12.9 months

B
Log-Rank Test in Entire Cohort, *P* <.0001;
Log-Rank Test in Matched Cohort, *P* <.0001
Hospice Care 0-3 Days:
Median: 6.9 months
CI: 6.1-7.7 months
Hospice Care 4+ Days:
Median: 10.2 months
CI: 8.7-12.9 months

CI indicates confidence interval; PS, propensity score.

Cost Analysis

The mean overall costs of care from diagnosis until death for patients with metastatic melanoma was $56,266 for patients who received no hospice care, $49,411 for patients enrolled in 1 to 3 days of hospice care, and $66,022 for patients enrolled in 4 or more days of hospice care. As shown in Figure 2 (A, B, and C), patients with 4 or more days of hospice care had lower costs in the last 3 months of life than did patients from the other 2 groups (*P* <.0001, $14,594 vs $22,647 for the patients with 1-3 days of hospice care, vs $28,923 for patients with no hospice care). The end-of-life costs of care for patients with 1 to 3 days of hospice care were also lower than those of patients who received no hospice care.

Predictors of End-of-Life Cost

We found age and use of hospice care to be the only factors significantly associated with end-of-life costs. Among patients who were enrolled in 4 or more days of hospice care, the end-of-life costs decreased by $14,680 (*P* <.0001) in the model with the original cohort, and by $9576 (*P* <.0001) in the model with propensity score–matched cohort.

Cost-Effectiveness Analysis

As shown in Figure 3A, mean incremental cost was $29,426 (95% CI, $723-$63,634) per life-year gained for patients who received 4 or more days of hospice care. The incremental cost increased to $33,209 (95% CI, $12,852-$66,280) per life-year gained in the propensity score–matched cohort in Figure 3B.

DISCUSSION

We observed that patients who enrolled in hospice for 4 or more days experienced longer median survival than patients who did not use hospice care or who enrolled in hospice care for only 1 to 3 days after being diagnosed with metastatic melanoma. We performed sensitivity analyses to examine the survival time for a relatively homogeneous cohort in which we excluded patients who died within 3 months of diagnosis to eliminate those with particularly rapid pace of disease. The positive association between 4 or more days of hospice use and longer survival was similar to that for the initial study cohort.

Our results are consistent with those of previous studies showing that election of hospice care does not shorten survival after metastatic cancer diagnosis.[5,6] In a study by Connor and colleagues, patients with congestive heart failure, lung cancer, or pancreatic cancer who enrolled in hospice experienced significantly longer median overall survival than those who did not. Our findings that median survival time did not differ between patients who received no hospice care and those who only received 1 to 3 days of hospice care is consistent with results from Earle and colleagues,[17] suggesting that a short stay in hospice may not impact survival.[7,18-20]

We also found that the costs of care in the final 3 months of life were lower among patients who received 4 or more days of hospice care after metastatic melanoma

diagnosis. Other researchers have shown that patients close to the end of life who received hospice care incurred less cost than other patients.[21,22] Pyenson and colleagues analyzed Medicare claims from 1999 to 2000 and found that hospice enrollment was a significant predictor of lower costs among patients with congestive heart failure, liver cancer, and pancreatic cancer, even when controlling for age and gender.[21] The cost difference we observed between the patients receiving 4 or more days of hospice care and those who received 0 to 3 days of hospice care is consistent with that observed by Pyenson and colleagues. Furthermore, our observed incremental cost-effectiveness ratio for patients who received 4 or more days of hospice care ($29,000 per life-year gained) lies well below the current willingness-to-pay thresholds.[23]

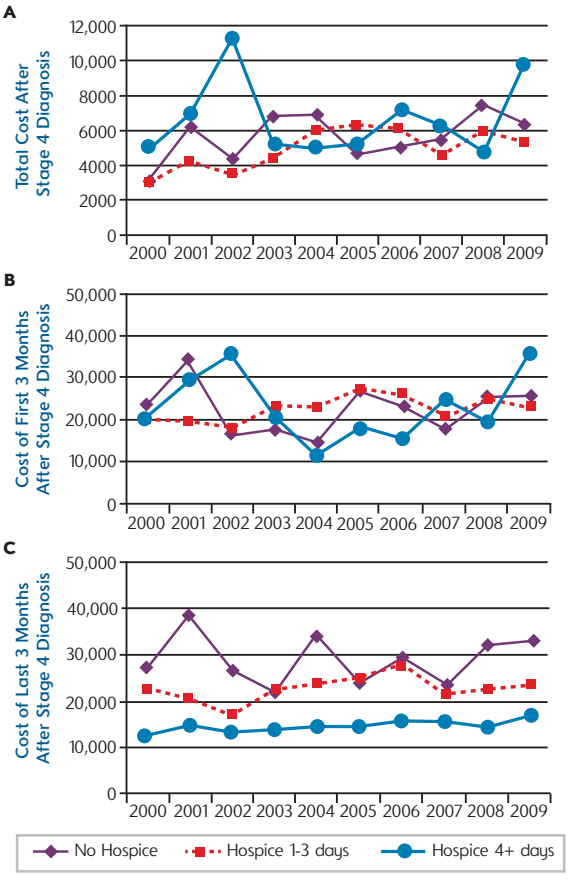
Our study has current policy relevance given that the proportion of Medicare expenditures during the last year of life has been stable for 20 years, with 26.9% to 30.6% of all Medicare expenditures occurring during that interval.[24] Furthermore, Lubitz and colleagues found that 70% of total costs of care is attributable to the consumption of healthcare resources in the last 6 months of life, with the largest percentage of this cost burden falling to Medicare (61% of costs), followed by Medicaid (10%), other payers (12%), and patients or families (paying the remaining 18% out of pocket).[24,25] Taylor and colleagues quantified the cost savings for the Medicare patients who received hospice care[26] and found the average cost savings for hospice users to be $2309 for the last year of life

Table 2. Hazard Ratios (95% CI) for Melanoma Patients and the Predictors After Propensity Score Adjustment (Cox Proportional Hazards Regression)

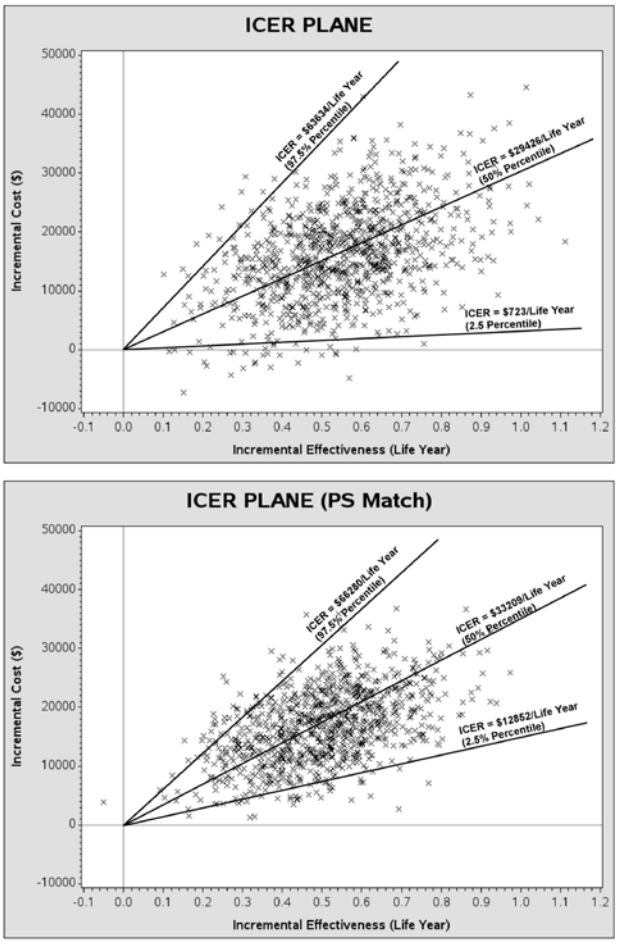
	Original Cohort (N = 862)			Propensity Score-Matched Model (N = 558)		
	HR	95% CI	*P*	HR	95% CI	*P*
End-of-Life Care						
Hospice care 0-3 days	1.00	Reference	—	1.00	Reference	—
Hospice care 4+ days	0.63	0.52-0.77	<.0001	0.66	0.54-0.81	<.0001
Year of death						
2000-2001	1.00	Reference	—			
2002-2003	0.65	0.50-0.85	<.01			
2004-2005	0.55	0.43-0.70	<.0001			
2006-2007	0.57	0.44-0.73	<.0001			
2008-2009	0.50	0.39-0.64	<.0001			
Marital status						
Other	1.00	Reference	—			
Married	0.86	0.75-0.98	0.03			

CI indicates confidence interval; HR, hazard ratio.

Figure 2. Comparison of Costs at the End of Life After Diagnosis, 3 Months After Diagnosis, and Last 3 Months Before Death, Stratified by Year and by Group (in $)



■ **Figure 3.** The Estimates of Incremental Cost-Effectiveness Ratio in the Cost-Effectiveness Plane (95% confidence interval lines are noted)



A
The incremental cost-effectiveness ratio and 95% confidence interval with original cohort.

B
The incremental cost-effectiveness ratio and 95% confidence interval with adjusted cohort.

ICER indicates incremental cost-effectiveness ratio; PS, propensity score.

compared with the costs of care for patients not receiving hospice care.[26]

Emanuel[27] challenged studies showing cost savings with hospice care, noting that several methodological issues could invalidate the findings of cost savings for hospice care, such as selection bias, different time frames for assessing costs, fewer cost components evaluated, and generalizability of the studies. Since that 1996 report, the methodology for analyzing cost implications of hospice care has improved—for instance, more medical cost data are available for evaluation compared with the 1990s, when only Medicare Part A was available. Moreover, the author concluded that the use of hospice does not increase costs and does yield better quality of life and increased autonomy at the end of life.[27]

Of the inherent limitations to the use of retrospective claims data, our study's main limitation was inability to obtain data on patient and provider preferences regarding hospice election. Another limitation is that the outcome variable examined was limited to survival time, which does not capture effects on quality of life; therefore, quality-adjusted life-years, the preferred measure in cost-effectiveness studies, cannot be estimated. This measure is of particular value for patients at the end of life. Hospice care aims to provide a better quality of life, and indeed, previous studies have shown better quality of life for patients who enroll in hospice care.[28-30] However, that the survival time of patients enrolled in hospice was longer than that of patients not electing hospice remains notable. Another consideration is that patients who survived longer might have had more opportunity to use hospice care and for longer durations than those who survived for a shorter period of time. Finally, the years encompassed by our study predate the diffusion of targeted molecular agents such as vemurafenib and ipilimumab, which have recently been shown to improve outcomes for patients with metastatic melanoma.[31] Therefore, it remains to be seen whether continued treatment with newer life-prolonging treatments such as those mentioned might mitigate the survival improvement associated with 4 or more days of hospice use observed in our study.

CONCLUSIONS

Our study showed a significantly longer median survival time for the patients diagnosed with metastatic melanoma who enrolled in 4 or more days of hospice care compared with those who had 0 to 3 days of hospice care, and this improved overall survival was accompanied by lower end-of-life costs. Our evaluation of the survival times and costs of care contributes to the understanding of the potential clinical and economic effects of hospice care on outcomes for patients with metastatic melanoma. Implications of our findings are that communication and

education regarding the benefits of hospice care should be a particular priority for patients diagnosed with metastatic melanoma.

Acknowledgments

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APPENDIX 25

HALF OF OLDER AMERICANS SEEN IN EMERGENCY DEPARTMENT IN LAST MONTH OF LIFE

THIS ARTICLE HAS BEEN CORRECTED.
See the correction in volume 31 on page 1650.

Half Of Older Americans Seen In Emergency Department In Last Month Of Life; Most Admitted To Hospital, And Many Die There

Alexander Smith, Ellen McCarthy, [...], and Kenneth Covinsky

Abstract

Emergency department use contributes to high end-of-life costs and is potentially burdensome for patients and family members. We examined emergency department use in the last months of life for patients age sixty-five or older who died while enrolled in a longitudinal study of older adults in the period 1992–2006. We found that 51 percent of the 4,158 decedents visited the emergency department in the last month of life, and 75 percent in the last six months of life. Repeat visits were common. A total of 77 percent of the patients seen in the emergency department in the last month of life were admitted to the hospital, and 68 percent of those who were admitted died there. In contrast, patients who enrolled in hospice at least one month before death rarely visited the emergency department during that period. Policies that encourage the preparation of patients and families for death and early enrollment in hospice may prevent emergency department visits at the end of life.

Emergency departments are not designed to provide end-of-life care and in many ways are poorly suited to do so. Nonetheless, they are visited with surprising frequency by severely ill patients whose deaths are approaching.(1) The often overcrowded and seemingly chaotic nature of the emergency department may add to the stress that patients and their families feel.

Most people say they prefer to receive end-of-life care at home.(2, 3) But pain, worsening symptoms, or other urgent needs may force an emergency department visit. In such cases, patients often arrive in the emergency department acutely ill, with their care plan uncertain and their families deeply anxious at the approach of a dreaded event.(1, 3, 4)

Emergency department care is expensive, and it is a major component of escalating costs of care at the end of life.(5) Most patients who are hospitalized at that point are admitted through the emergency department, and it is there that care pathways are often determined, including the balance between palliative and life-sustaining treatments.(6, 7)

We used a nationally representative data set linked to Medicare claims data to study emergency department use by older adults at the end of life. The objective of this study was to use these data to describe the prevalence and frequency of, and factors associated with, emergency department use in the last months of life, as well as care following the visit, including hospitalization and death in the hospital.

Study Data And Methods

Setting And Participants

The Health and Retirement Study was designed to examine changes in health and wealth as people age.(8) It provided a data set that enabled us to assess patient characteristics and health status as well as family-level end-of-life concerns that can be linked to dying patients' emergency department visits.

Health and Retirement Study participants are more than fifty years old and living in the community at the time of enrollment in the study, which began in 1992. Participants are interviewed every two years following enrollment. Additional participants are added every six years so that the study remains representative of the US population over fifty. Follow-up rates are very high (84–93 percent), and date of death is determined for 99 percent of participants using the National Death Index, a centralized record of death certificate information maintained by the National Center for Health Statistics.(9

The study's interviews are conducted over the phone. For participants who are age eighty or older, are too sick to be interviewed by phone, or do not have access to a phone, interviews are conducted in person. If participants are too sick or cognitively unable to complete the interview, interviews are conducted with proxies. Interviews after death are conducted with participants' next of kin. Details of the sampling frame and complex survey design are available elsewhere.(10

We linked Health and Retirement Study data to Medicare claims to ascertain emergency department use, using previously described methods.(11) Because the timing of death is often unpredictable, we examined the relationship between emergency department use and death in two directions.

For the first analysis, we included 8,338 participants age sixty-five or older who were continuously enrolled in Medicare fee-for-service Parts A and B from 1992 to 2006 and visited the emergency department. For these participants, we asked what percentage of older adults died within six months of

visiting the emergency department.

For the second analysis, we focused on the subset of 4,585 participants who died, and for whom there were 4,158 next-of-kin interviews completed with the measures necessary for our analysis. For these participants, we asked what percentage of older adults who died had visited the emergency department in the last 6 months and last month before death.

Finally, we matched each decedent participant to a Health and Retirement Study subject who was alive at the time the participant died, categorized by age group (65–74, 75–84, and 85 or older) and sex. This allowed us to compare decedents' and nondecedents' rates of emergency department use.

This study was approved by the Institutional Review Board of the University of California, San Francisco.

Measures

We used Medicare claims to measure emergency department use, hospitalization, and intensive care unit use.(12) We examined factors that might be correlated with emergency department use in the last months of life, based on our clinical experience and review of the literature. Demographic factors included age, sex, race or ethnicity, and net worth.

Clinical factors were drawn from Health and Retirement Study interviews with next of kin conducted after the subject's death. Next of kin were asked to describe the participant's clinical condition during the last three months life. Factors included the presence or absence of four chronic conditions (cancer, lung disease, stroke, and heart condition), need for help in activities of daily living, cognitive impairment, and the presence of moderate or severe pain.

Health system factors included census region, urban versus rural residence, hospice use prior to the last month of life (hereafter referred to as "early hospice use"), nursing home residence, and year of death. We examined what we categorized as "anticipatory/preparatory" factors—for example, whether the subject's next of kin reported that the death was expected or unexpected at the time it occurred and whether or not there was an advance directive.

Statistical Analysis

First, using the sample of 10,364 patients (both living and deceased), we calculated the percentage of emergency department visits by patients who died within six months of the visit.

The remainder of our analysis focused on the 4,158 decedents. We began by determining the proportion of these older people who visited the emergency department in the last six months and in the last month of life.

To understand which factors were independently associated with emergency department use by participants in the last month of life, we created a multivariable model adjusted for the demographic and clinical factors described above. The results of the multivariable logistic regression are presented as probabilities of emergency department use across different levels for each predictor of interest adjusted for age, sex, race or ethnicity, net worth, chronic conditions, physical dependency, cognitive impairment, and pain. We present time trends in emergency department use in the last month of life adjusted for variations in age of the Health and Retirement Study decedent sample across years and increasing rates of early hospice use (Appendix Exhibit 1).(11

Appendix 1
Time trends in emergency department (ED) use in the last month of life 1994 to 2006 are displayed. Sample sizes of decedents were too small in 1992 and 1993 to generate reliable estimates. Panel A: Time trends in ED use adjusted for age at death. Panel ...

We examined care patterns following emergency department visits in the last month of life. Specifically, we examined hospitalization following the emergency department visit, intensive care unit use, and location of death.

The Health and Retirement Study purposely oversamples certain key subpopulations and also carefully tracks nonresponse rates by subpopulation. To produce nationally representative statistical estimates and to attach correct standard errors to these estimates, we performed a survey-weighted analysis using weights provided by the Health and Retirement Study.(13, 14) The statistical analyses were performed using the statistical software Stata, version 10.1, and the statistical analysis software SAS, version 9.2.

Limitations

We were unable to discern the specific reason for emergency department visits. A diagnostic code for congestive heart failure, for example, is not particularly informative as to the reason for the emergency department visit, such as shortness of breath, or the reasons that led to that condition, such as difficulty contacting an outpatient provider, lack of access to medications for symptom relief, or a family that was unprepared to manage end-of-life

symptoms. Similarly, we could not definitively state that certain emergency department visits were avoidable. Finally, although our findings suggest that changes over time have been modest, the latest available Medicare claims data files are from 2006, and practice may have changed since that time.

Study Results

In this nationally representative study of older adults, 8,338 living and dead participants visited the emergency department. Of the total, 15 percent, or about one out of every seven emergency department visits, were made by a patient who died in the six months after that visit. Among the oldest participants (those over age eighty-four), the proportion was 24 percent, or about one out of four. Among the 4,158 participants who died, seventy-five percent transited through the emergency department in the last six months of life (Exhibit 2); half did so in the last month of life.

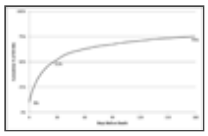


Exhibit 2

Cumulative Incidence of emergency department (ED) visits during the last 6 months of life, noting the incidence on the last day of life (9%), and the cumulative incidence at 30 days before death (51%) and 180 days before death (75%).

The rate of emergency department use in the last month of life was much higher than the rate among participants matched by age and sex to the subject who were alive at the time the subject died. In the matched group, only 4 percent visited the emergency department in a one-month time period.

Focusing on decedents, we found that the mean age of the 4,158 participants who had died was eighty-three (standard deviation eight), and 47 percent were women (Exhibit 1). Among the decedents, the burden of chronic conditions, functional dependency, and cognitive impairment was high: The mean number of chronic diseases was 1.4 (out of 4); 77 percent of patients were dependent in at least one activity of daily living, and 67 percent were in three or more (data not shown). In addition, over one-third were cognitively impaired, experienced moderate or severe pain, and resided in a nursing home (Exhibit 1). The top three primary diagnoses for emergency department visits in the last six months of life were congestive heart failure (8.0 percent of visits), pneumonia (6.6 percent), and acute stroke (4.9 percent) (see Appendix Exhibit 2 for the rest of the top ten primary diagnoses).(15

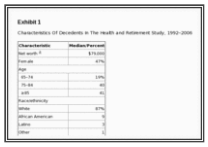
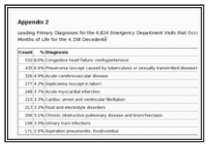


Exhibit 1

Characteristics Of Decedents In The Health and Retirement Study, 1992–2006



Appendix 2

Leading Primary Diagnoses for the 6,824 Emergency Department Visits that Occurred During the Last Six Months of Life for the 4,158 Decedents*

Routine visits were common. In fact, 41 percent of the 4,158 participants who died had made more than one visit in that time period, and 12 percent had gone to the emergency department more than once in the last month of life (data not shown).

Hospitalization also was common following an emergency department visit toward the end of life. Among the 2,157 participants who visited the emergency department in the last month of life, 77 percent were subsequently hospitalized. Of those who were hospitalized, 39 percent were admitted to an intensive care unit, and 68 percent died in the hospital (Appendix Exhibit 3).(15)

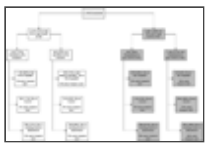


Exhibit 3

Flow diagram outlining emergency department, hospitalization, and location of death among the 4,58 patients in the Health and Retirement Study (HRS) who died between 1992 and 2006. Early hospice use indicates hospice use prior to the last month of life. ...

Early hospice use and death in the home, nursing home, or other setting outside the hospital was more common among participants who did not visit the emergency department in the last month of life (Appendix Exhibit 3).(15

Exhibit 3 shows emergency department use in the last month of life by various characteristics, after adjustment for demographic and clinical factors. For example, patients who were African American or Latino were more likely to visit the emergency department than white patients. (for a complete list of factors, see Appendix Exhibit 4).(15) After adjustment, patients who experienced moderate or severe pain were 4 percent more likely to visit the emergency department in the last month of life than patients who had less pain. Having an advance directive had little effect after adjustment. These differences were modest in comparison to those between patients who did and did not enroll in hospice early.

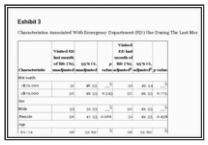


Exhibit 3

Characteristics Associated With Emergency Department (ED) Use During The Last Month Of Life, 1992–2006

The rise in emergency department use between 1994 and 2006 was marginally significant in analyses adjusted for age (p for trend = 0.048) (Appendix Exhibit 1).(15) However, when adjusting for early utilization of hospice, there was a modest increase in emergency department use over time (p for trend < 0.001), suggesting that a rise in early utilization of hospice (5 percent in 1994; 15 percent in 2006) may have blunted what would have otherwise been a greater increase in emergency department use over time (Appendix Exhibit 1).(15)

Discussion

High Rates Of Emergency Department Use

As noted above, seventy-five percent of the decedents in our study transited through the emergency department in the last six months of life, and half in the last month of life. Yet we also found substantial variation in emergency department use in the last month of life by age, race or ethnicity, illness burden, functional dependency, cognitive impairment, pain, region, year of death, and whether or not death was expected. Early enrollment in hospice was by far the strongest predictor of emergency department use or lack thereof. Specifically, emergency department use was relatively rare among people enrolled in hospice at least one month before death.

Improving The Quality Of Outpatient Care

These high rates of emergency department use in the last months of life suggest opportunities for improvement in the outpatient setting. As was the case in our sample, the last months of life for older adults are often characterized not by sudden death, but by chronic illness, pain, functional decline, and cognitive impairment.(16, 17) Many health problems and symptoms in late life are predictable, and some visits to the emergency department could potentially be avoided with access to high-quality outpatient care.(18, 19)

Most people prefer to die at home, and rates of end-of-life hospitalization are unlikely to decrease without reducing rates of emergency department use. The emergency department is seldom the best place for discussions about the goals of care.

Primary providers can plan for the eventuality of death by preparing patients and families for end-of-life symptoms, engaging in discussions about goals of care, arranging treatment that matches the patient's wishes, and documenting preferences in ways that will be accessible to emergency department providers.(20–24) To this end, recent policy initiatives, such as those passed in 2008 in California(25) and 2010 in New York(26) that require physician disclosure of prognosis, may reduce costly and potentially burdensome use of the emergency department at the end of life.

Federal Initiatives

At the federal level, legislation that would have provided reimbursement under Medicare for physicians to address end-of-life planning was stripped from national health reform amid a furor over so-called death panels. In our study, advance directives were not associated with emergency department visits after adjustment.

Advance care planning is much more than the advance directive document, however. It also includes the discussion of and planning and preparation for future events by patients, caregivers, and physicians. There is some evidence to suggest that such discussions have an effect on high-cost, high-intensity health services.(27

The Medicare hospice benefit was recently criticized for spending increases primarily caused by increases in lengths-of-stay over the past decade.(28, 29) However, these critiques do not account for the avoidance of costly acute care services by early enrollees in hospice.(29) In our study, early enrollment was associated with 80 percent less use of the emergency department in the last month of life, and dramatically reduced rates of hospitalization and of death in the hospital, compared to the rates for patients who did not enroll early. Although hospice use at the end of life has increased over the past decade, most patients enroll in hospice late, less than a month before death.(30)

Many analysts have viewed this delayed entry into hospice as a problem in the quality of end-of-life care.(30, 31) In fact, the type of care that patients receive in hospice—such as symptom control, family support, and discussion of preferences—are of benefit long before the final days of life.

The Medicare hospice benefit is available to all adults age sixty-five or older, and rising rates of early hospice use are encouraging. Yet we found that only 9 percent of the older adults in our study who died had enrolled in hospice before the last month of life. Policy initiatives should be directed toward increasing early hospice enrollment among elderly patients. Strong consideration should be given to removing from the Medicare hospice benefit the requirement of a prognosis of six months or less to live, basing eligibility and reimbursement instead on need for hospice services.(32

The Role Of Palliative Care

Part of the Affordable Care Act directs support to chronically ill elderly people in the outpatient setting, avoiding high-cost repeat emergency department visits and hospital readmissions. Potential avenues for supporting chronically ill elderly people on an outpatient basis include promoting early hospice use and mandating that inpatient and outpatient palliative care services are incorporated into accountable care organizations.(33, 34)

Palliative care is focused on improving quality of life for patients with serious illness. Its major areas of expertise include pain and symptom management and communication about goals of care. Palliative care is ideally initiated at the time of diagnosis of advanced heart disease, dementia, cancer, or other serious condisions, and can be delivered concurrently with life-prolonging care. Specialized palliative care is delivered by interdisciplinary palliative care teams.

Early enrollment in outpatient palliative care services has shown great promise in improving the quality of life for patients with serious illness, but access to these services remains limited.(19, 20, 35)Prognosis is inherently challenging, and even when prognosis is limited, some patients may elect not to enroll in hospice early. Our research suggests that many of these patients will transit through the emergency department at the end of life, and palliative care needs to be integrated into emergency services.

The majority of palliative care in emergency departments, however, is delivered not by palliative care specialists but by emergency department doctors, nurses, and social workers.(21) Hospice, in contrast, is a specific palliative service and Medicare benefit for patients with a prognosis of six months or less.

Emergency departments should be supported in their growing efforts to improve palliative care for patients, such as the well-respected Education on Palliative and End-of-Life Care Project curriculum, newly developed for training emergency medicine professionals.(36) The American Board of Emergency Medicine is one of 11 specialty boards that cosponsorspalliative medicine as a recognized subspecialty.(37)

In qualitative research, emergency providers and terminally ill patients and their caregivers suggested a change in emergency care, recognizing that the goals of patients near the end of life often do not fit well within the traditional emergency department model.(1, 3, 38, 39) Some providers suggested that emergency protocols could be modified by creating an explicit triage category of supportive care focused on symptom stabilization.

Structural barriers to change need to be overcome, including a pervading fear of litigation among emergency physicians, logistical hurdles to emergency providers rapidly coordinating home or hospice services with outpatient clinicians, and a general lack of access to palliative medicine consultation services in the emergency department, particularly at night and on weekends.(3, 39, 40)

Conclusion

Emergency department visits are common at the end of life, and a substantial minority of all visits to the emergency department by older adults are made by patients who will die within six months of the visit. For patients whose terminal trajectories are clear, we can do better in the outpatient setting.(22–24) Outpatient providers can help prepare families for the eventuality of death, including by giving them early referrals to hospice and, where available, outpatient palliative care services. Policies that require physicians to disclose a terminal prognosis and that provide reimbursement for advance care planning should be encouraged.

For other older adults, serious illness is unexpected and emergency department visits are unavoidable.(41) Therefore, emergency departments should be supported in their efforts to incorporate palliative and end-of-life care principles into their practices. Ultimately clinicians and policy makers need to work together to ensure high-quality care experiences for patients and families seen in the emergency department during a vulnerable time.

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This article has been corrected. See the correction in volume 31 on page 1650.

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APPENDIX 26

LENGTH OF STAY AND PERCEPTION OF TOO LATE REFERRAL

NHPCO *Original Article*

Timing of Referral to Hospice and Quality of Care: Length of Stay and Bereaved Family Members' Perceptions of the Timing of Hospice Referral

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Abstract

Previous research has noted that many persons are referred to hospice in the last days of life. The National Hospice and Palliative Care Organization collaborated with Brown Medical School to create the Family Evaluation of Hospice Care (FEHC) data repository. In 2005, 106,514 surveys from 631 hospices were submitted with complete data on the hospice length of stay and bereaved family member perceptions of the timing of hospice care. Of these surveys, 11.4% of family members believed that they were referred "too late" to hospice. This varied from 0 to 28.1% among the participating hospice programs with 30 or more surveys. Among those with hospice lengths of stay of less than a month, only 16.2% reported they were referred "too late." Although the bereaved family member perceptions of the quality of end-of-life care did not vary by length of stay for each of the FEHC domains, the perception of being referred "too late" was associated with more unmet needs, higher reported concerns, and lower satisfaction. Our results suggest that family members' perception of the timing of hospice referral—not the length of stay—is associated with the quality of hospice care. This perception varies substantially among the participating hospice programs. Future research is needed to understand this variation and how hospice programs are delivering high quality of care despite short length of stay. J Pain Symptom Manage 2007;34:120–125. © *2007 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words

Hospice, quality of end-of-life care, timing of referral

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Introduction

Hospice was developed to provide comprehensive services that allow dying persons to live their lives to the fullest. Originally, the concept of hospice was introduced as an ongoing program to ease suffering during the transition between life and death. Although many experts recommend a hospice stay of at least three months to provide adequate services,[1] the average length of stay is less than 60 days. In the United States, the median length of stay declined from 29 days in 1995 to 26 days in 2005, with 30% of those served by hospice dying in 7 days or less (www.nhpco.org). Short hospice stays are not desirable due to their impact on the dying persons' and the caregivers' quality of life and the quality of end-of-life care. Recent studies have shown lower satisfaction with hospice services was correlated with family members' reports of late referrals,[2] and shorter length of stay was associated with family members' reports of decreased number of services provided.[3] Furthermore, although many patients prefer to die at home,[4] patients with hospice enrollment less than 7 days are less likely to receive care at home.[5]

Over the past 10 years, the Brown Medical School Center for Gerontology and Health Care Research has collaborated with the National Hospice and Palliative Care Organization (NHPCO) to create an actionable tool to measure consumer perceptions of the quality of end-of-life care. The Family Evaluation of Hospice Care (FEHC) has been validated[6] and used in the national study of dying in the United States.[7] The survey is currently used as part of an ongoing NHPCO performance measurement program, with a web-based repository that allows hospice programs to submit their data and receive a 30-page quarterly report regarding their quality of end-of-life care.[8] As of 2006, nearly 1000 hospices are submitting their data online. The FEHC data repository allows us to examine at a national level the relationship of length of stay, perceived timing of hospice referral, and quality of end-of-life care.

Methods

Development of Survey

Based on expert opinion, a structured review of existing guidelines, and consumer focus groups, Teno and colleagues developed the FEHC.[9] The original instrument was shortened and a mode test was conducted that found the survey could be self-administered, with similar results to telephone administration. The FEHC is based on a conceptual model of patient-focused, family-centered medical care. Under this model, a health care institution provides excellent end-of-life care when it: 1) provides the desired physical comfort and emotional support; 2) supports shared decision making; 3) treats the patient with respect; 4) attends to the needs of the family for emotional support and the needed information; and 5) coordinates care effectively. Detailed information on how to calculate the problem and modified domain score is available in the paper by Connor and colleagues.[8] Although the analysis was done with full problem scores, we summarize the findings by reporting the percent of persons who report one or more concerns with the quality of care.

In this study, our goal was to examine the association of the perceptions of the quality of care with both hospice length of stay and bereaved family members' perceptions of the timing of hospice referral. For the latter, respondents were asked the following question, "In your opinion, was [PATIENT] referred to hospice too early, at the right time, or too late during the course of [HIS/HER] final illness?" Hospice length of stay was based on the bereaved family member report.

Data Collection

Brown Medical School's Center for Gerontology and Health Care Research, in collaboration with the NHPCO, developed a Web site for hospices to submit data for the repository used by this report. The Web site was piloted at Brown and then modified by the NHPCO. Participation in the FEHC survey is voluntary, although the NHPCO has encouraged all hospices nationwide to take part. Hospices or third-party vendors contact bereaved family members between one to three months after the patient's death to invite them to participate in the survey. The surveys are usually completed by paper and pencil and returned to the hospice program or a data vendor hired to compile the results. The response rate as calculated based on the one-year total number of surveys completed over the number mailed out is 45%.

Table 1
Characteristics of Decedents ($n = 106,514$ Surveys)

Characteristics	Decedents $n = 106,514$ (%)	Perceived Appropriate Timing of Referral $n = 92,899$ (%)	Perceived Late Referral $n = 12,182$ (%)
Age 85 years and older at time of patient's death	49.1	32.6	47.1
Sex			
Male	41.3	41.4	41.7
Primary illness leading to hospice admission			
Cancers—all types	42.7	43.0	39.9
Heart & circulatory disease	9.9	9.8	10.2
Lung & breathing disease	7.6	7.5	8.4
Kidney disease	2.2	2.2	2.3
Liver disease	1.6	1.6	1.5
Stroke	3.9	4.03	3.3
Dementia & Alzheimer's disease	7.8	7.7	7.8
AIDS & other infectious diseases	0.2	0.2	0.2
Frailty & decline due to old age	5.7	5.7	5.6
Other illness	4.2	4.04	5.2
Highest grade or level of school completed			
8th grade or less	8.9	9.01	8.1
Race			
American Indian or Alaskan Native	0.7	0.6	0.8
Asian or Pacific Islander	0.7	0.7	0.7
Black or African American	3.3	3.4	2.6
White	82.9	83.0	82.5
Another race or multiracial	1.6	1.2	1.4
Length of time patient received hospice services			
2 days or less	10.0	8.2	24.7
3–7 days	21.7	20.4	32.5
8–14 days	15.08	15.0	15.9
15–29 days	11.5	11.9	9.7
1–3 months	25.7	27.3	14.1
4–6 months	8.2	9.0	2.0
7–9 months	3.0	3.3	0.6
10–12 months	1.9	2.0	0.3
>1 year	2.8	3.0	0.3

Analytic Approach

For this study, we report the descriptive results and examine the association of length of stay, bereaved family member of the timing of hospice referral, and the perception of quality of end-of-life care with each of the domains of the FEHC. Because of the large number of cases, even minor differences achieve statistical significance; we set a threshold of 5% difference as being clinically relevant. For those hospices contributing 30 or more surveys to the repository, we reported the variation in bereaved family members' report that referral to hospice was "too late."

Results

Perception of Timeliness of Hospice Referral

Eighty-seven percent reported that the patient was referred at the right time, whereas 11.4% felt that hospice services were initiated "too late." Only 1.4% ($n = 1433$) reported that the patient was referred at a time too early for hospice services (Table 1). There were no statistically significant differences in perception of appropriate vs. late referrals when patients were grouped by age at time of death, sex, primary illness leading to hospice admission, education, race, or ethnicity.

Length of Stay, Perception of Being Referred "Too Late," and Perceived Quality of End-of-Life Care

Fig. 1 depicts the association between length of stay and the quality-of-care domains in the FEHC. For each domain and overall satisfaction, there is essentially a flat line, indicating the lack of an association between hospice lengths of stay and bereaved family members' perceptions of the quality of care. In contrast, bereaved family members who believed their relative was referred "too late" reported more unmet needs, higher reported number of concerns, and lower satisfaction with the quality of end-of-life care than those who indicated referral was made at the "right time" (Table 2). More family members who felt that the referral was "too late" reported unmet needs of the patient for management of pain (9.7 vs. 5.0%), dyspnea (10.0 vs. 4.1%), and emotional support (18.2 vs. 8.1%). Similarly, family members reported having greater unmet needs for their own emotional support (18.8 vs. 10.0%). More family members also felt that they were less informed about what to expect (41.4 vs. 25.2%) and about management of symptoms (17.9 vs. 9.0%). Furthermore, family members who perceived a late

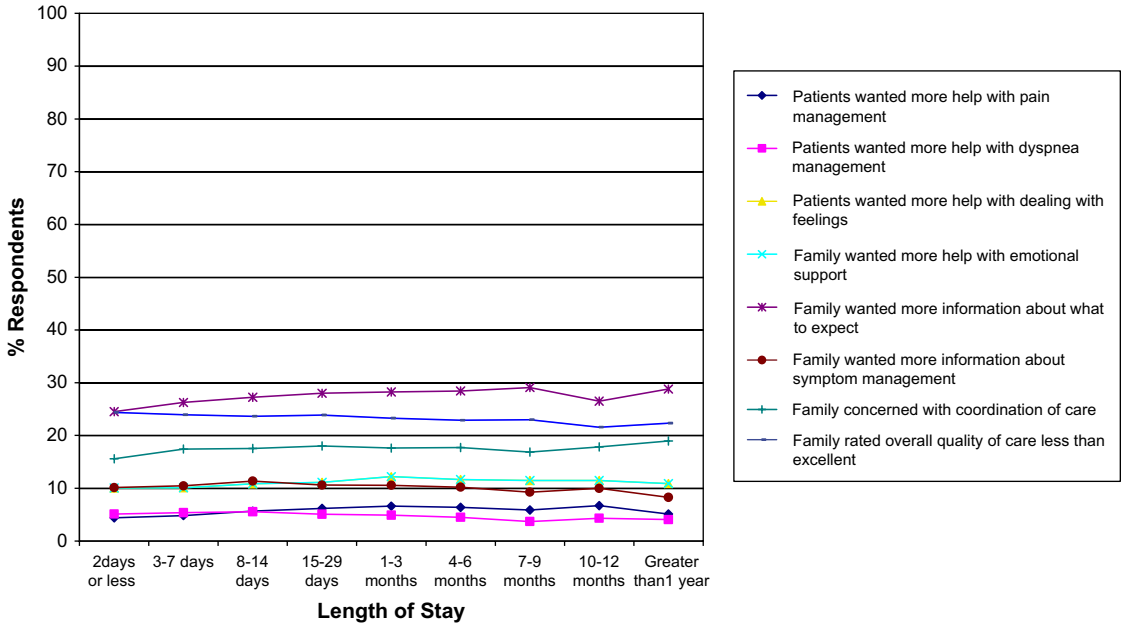

Fig. 1. Length of stay and reported hospice outcomes.

referral were more dissatisfied with the coordination of care (23.7 vs. 16.4%) and the overall quality of care (33.5 vs. 21.9%). This trend of unmet needs and greater dissatisfaction with care among those who reported referral that was "too late" was also found with reports of hospice staff not always treating the patient with respect, although the difference was less marked (5.4 vs. 2.8%).

Geographic and Hospice Variation of Perceptions of Late Referrals

Bereaved family member perceptions of being referred "too late" varied by both state and hospice program. Fig. 2 shows variation of perceptions of late referrals by a state-by-state basis, ranging from 7.8% in Vermont to 15.0% in South Carolina. Among the 521 hospices with 30 or more surveys, the variation of the

Table 2
Bereaved Family Members' Perceptions of Timing of Referral and Quality of Care

	"At the Right Time" $n = 92,899$ (%)	"Too Late" $n = 12,182$* (%)
Provide desired physical comfort and emotional support		
Patient did not receive appropriate amount of help with		
Pain	5.03	9.66
Dypsnea	4.14	9.96
Dealing with feelings	8.14	18.18
Treat dying person with respect		
Not always treating patient with respect	2.77	5.43
Attend to the needs of the family: one or more concerns with		
Emotional support	9.96	18.77
Being informed about what to expect	25.18	41.37
Being informed about symptoms	9.03	17.77
Coordination of care		
One or more concerns	16.41	23.73
Overall quality of care		
Response less than excellent	21.86	33.48

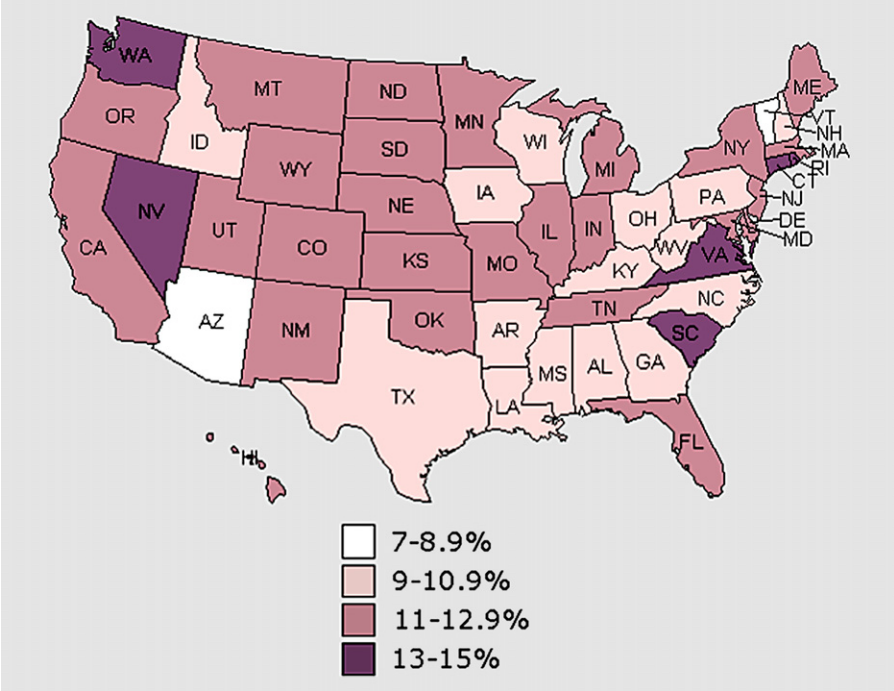

Fig. 2. Depicted is the state variation in bereaved family member response that their dying relative was referred "too late." Among the 819 participating hospices, 12,182 (11.4%) bereaved family members believe their loved one was referred "too late" to hospice services. This varied from 7.8% (VT) to 15.0% (SC).

perception of being referred "too late" ranged from 0 to 28.1% (mean 11.5%, 25th percentile 9.2, 75th percentile 14.0%).

Discussion

Slightly less than one in five bereaved family members with a hospice length of stay of less than one month stated that their family member was referred "too late" to hospice services. Unfortunately, this result raises more questions than it answers. Why aren't more bereaved family members reporting they were referred "too late" despite a short length of stay? It would appear that families need to be educated about the importance of a longer hospice length of stay. However, in some cases, an earlier hospice referral may not be possible. Waldrop et al.[10] used open-ended interviews with 59 bereaved caregivers of hospice patients who died with short lengths of stay and found that 44% were diagnosed too late and 17% refused hospice services at an earlier time point. Schockett and colleagues[2] found that about one in four cases referred "too late" to hospice may not be easily changed to access hospice at an earlier point in time, in that 13% of dying persons refused an earlier hospice referral and 10% were diagnosed at a late point in their illness. Based on these two studies, the rate of short stays that *could not* have been referred earlier to hospice varied between 23% and 61%. These two small studies suggest that it might not be possible for some dying persons to have been referred at an earlier time point.

Our data suggest that the perception of being referred "too late," rather than length of stay, is associated with greater unmet needs, more concerns, and lower satisfaction. One could hypothesize that hospice programs have become very adept at "rallying the troops" to provide excellent end-of-life care for those persons with short lengths of stay. The perception of being referred "too late" is not easily predicted by the existing sociodemographic data available in this data set. This perception of being referred "too late" varied between 0% and 28% among hospice programs with 30 or more surveys completed in 2005.

The striking variation in the perception of being referred "too late" calls for research to

understand whether hospices are using different organizational interventions to improve access to hospice services. For example, many hospices are now adopting "open access" policies to allow dying patients to receive potentially "life-prolonging treatment." This intervention potentially could improve access to hospice services, reducing bereaved family members' perceptions that their dying relatives or friends were referred "too late" to hospice services. Future research is needed to characterize this variation by hospice program in regard to whether there are different processes of care, consumer education efforts, and/or different hospice policies that lead to improved perceptions of the quality of care.

When interpreting these results, certain limitations of this study should be kept in mind. Data were collected from family members of deceased hospice patients using self-administered surveys. Respondents may have inaccurately perceived patients' unmet needs for emotional support and pain management. A recent review of studies on the reliability of information provided by proxies found that they were more reliable regarding observable symptoms and quality of services than subjective features of the patient experience.[11] However, it is unlikely that this discrepancy would be different among this study's comparison groups. Also, the response rate is 45%, thus adding a concern of possible selection bias.

In conclusion, the majority of respondents believed they were referred to hospice "at the right time," despite a reported short length of stay. Short hospice lengths of stay were not associated with perceptions of poor quality end-of-life care. Rather, the family members' perception that they were referred "too late" to hospice was associated with lower satisfaction, more unmet needs, and higher reported concerns. This perception of late referral varied by state and by hospice program. An important opportunity exists to educate the public about the benefits of longer hospice lengths of stay. Future research should seek to understand whether there are differences in state policies and regulations that may be contributing to late hospice referrals. Additionally, research is needed to understand whether hospices with lower rates of persons being referred "too late" are using innovative programs to better meet the needs of dying patients and their families.

Acknowledgments

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Eden Hospice at Whatcom County, LLC

Certificate of Need Application

APPENDIX 27

HOSPICE COST, QUALITY AND OUTCOME STUDIES

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THE CARE SPAN

Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number Of Different Lengths-Of-Stay

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ABSTRACT Despite its demonstrated potential to both improve quality of care and lower costs, the Medicare hospice benefit has been seen as producing savings only for patients enrolled 53–105 days before death. Using data from the Health and Retirement Study, 2002–08, and individual Medicare claims, and overcoming limitations of previous work, we found $2,561 in savings to Medicare for each patient enrolled in hospice 53–105 days before death, compared to a matched, nonhospice control. Even higher savings were seen, however, with more common, shorter enrollment periods: $2,650, $5,040, and $6,430 per patient enrolled 1–7, 8–14, and 15–30 days prior to death, respectively. Within all periods examined, hospice patients also had significantly lower rates of hospital service use and in-hospital death than matched controls. Instead of attempting to limit Medicare hospice participation, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.

As of 2012, 5 percent of the most seriously ill Americans accounted for more than 50 percent of health care spending, with most costs incurred in the last year of life as a result of hospital-based treatment.[1–3] Despite those high and escalating health care costs, numerous studies demonstrate that seriously ill patients and their families receive suboptimal care, characterized by untreated pain and physical symptoms, spiritual and emotional distress, high family caregiving burdens, and unnecessary or unwanted treatments inconsistent with their previously stated wishes and goals for care.[4–11]

Hospice has been shown to greatly improve the quality of care for patients and their families near the end of life. Under Medicare Part A, the hospice benefit covers palliative care services delivered by a team of professionals, including physicians, nurses, social workers, chaplains, home health aides, and volunteers, to dying patients—that is, patients with a life expectancy of six months or less—who are willing to forgo curative treatments.[12]

Studies have consistently demonstrated that hospice is associated with reductions in symptom distress, improved outcomes for caregivers, and high patient and family satisfaction.[8,13–15] Recent evidence also indicates that continuous hospice use reduces the use of hospital-based services—including emergency department visits and intensive care unit stays—and the likelihood of death in the hospital.[16]

The number of hospices has increased rapidly over the past twenty years, making hospice programs available to almost all eligible Americans.[17] Medicare hospice spending has risen considerably with the growth and development of new hospice programs, particularly in

the for-profit sector, and the resulting rise in the number of patients accessing the hospice benefit.[18,19]

This increase in spending has led the Centers for Medicare and Medicaid Services to explore methods of containing Medicare hospice spending, such as through payment reform or investigation of hospices with long lengths-of-stay.[20] What is not known, however, is how the length of hospice enrollment relates to overall Medicare spending at the end of life—including what periods of enrollment might decrease net Medicare costs as compared to usual care and, if they do, by how much.

The length of hospice enrollment that might achieve the greatest cost savings to Medicare is the subject of considerable debate. Some scholars have argued that beneficiaries must be enrolled in hospice longer than current practice to achieve financial savings under Medicare.[21–23] Others have found that longer hospice length-of-stay is associated with higher Medicare spending—particularly for those with noncancer diagnoses.[24]

In the largest and most rigorous study to date, Donald Taylor and colleagues observed that hospice enrollment 53–105 days before death maximized Medicare savings compared to usual nonhospice care.[23] However, this study has been criticized for its inability to control for factors not present in Medicare claims that are known to be associated with higher costs, such as patients' functional status.[25]

Another criticism cited notable differences between the hospice and control groups: Hospice users had greater costs in the period preceding hospice enrollment compared with their matched controls.[25] Such limitations cast doubt on the validity of the reported findings regarding both the timing of hospice enrollment to maximize savings and the magnitude of those savings.

Health care reform in the past decade has sharpened the focus on increasing the value of health care and on forging effective policy to guide that process. A clearer understanding of the value of existing Medicare programs thus is required. In this study we aimed to better understand the value of Medicare hospice by examining the relationship between length of hospice enrollment and overall Medicare costs.

Specifically, we compared Medicare costs for patients receiving hospice care to those of patients not receiving hospice care across four different periods of hospice enrollment: 1–7, 8–14, and 15–30 days before death, the most common enrollment periods, and 53–105 days before death. In addition, we investigated both the source of hospice-related savings, if any, such as decreased hospital admissions and fewer hospital and intensive care unit days, and the impact of hospice on selected measures of quality of care at the end of life, including thirty-day readmission rates and in-hospital death rates.

We used the rich survey data from the Health and Retirement Study, in combination with individual Medicare claims, and adjusted for previously unmeasured factors known to influence costs, such as functional status and social characteristics. These analyses revealed that net savings to Medicare are not limited to hospice enrollment 53–105 days prior to death but are also observed across the most common enrollment periods: 1–7, 8–14, and 15–30 days before death.

Study Data And Methods

We examined data from the Health and Retirement Study, a longitudinal survey administered to a nationally representative cohort of adults over age fifty. Serial interviews are conducted every two years and include information on participants' demographic, economic, social, and functional characteristics. Each interview cycle, participants who died since the last interview are identified, and dates of death are drawn from the National Death Index. More than 80 percent of participants provided authorization to merge their survey data with Medicare claims,[26,27] a necessary step in the present analysis.

SAMPLE We sampled all survey participants who died during 2002–08. We included those age sixty-five or older who had continuous Medicare Parts A and B coverage for twelve months prior to death, while excluding those enrolled with Medicare managed care (for whom claims data were therefore incomplete). This methodology yielded a final sample of 3,069 people, both enrolled and not enrolled in Medicare hospice prior to death.

For the analyses of each enrollment period, we also excluded those who enrolled in hospice prior to the study outcome period (7, 14, 30, and 105 days, respectively) and those whose final predeath interview took place within the study period.

MEASURES We categorized periods of enrollment in Medicare hospice before death based on the number of days prior to death that enrollment occurred, as follows: 53–105 days (the period expected to maximize reduction in Medicare spending),[23] 15–30 days, 8–14 days, and 1–7 days. For each period, the primary outcome was total Medicare spending measured from the beginning of the enrollment period to death.

We adjusted expenditures for inflation (2008

dollars) and for geographic differences in Medicare prices. We also examined six other measures of care utilization: hospital admissions, hospital and intensive care unit days, intensive care unit admission (any or none), thirty-day hospital readmission (any or none), and in-hospital death.

We selected independent variables based on our conceptual framework, "Determinants of Treatment Intensity for Patients with Serious Illness," which postulates that treatment intensity is influenced by both regional and patient or family determinants.[28] We selected variables that could serve as empirical measures of each construct in the conceptual model: age; sex; race or ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity.

Variables were drawn from Health and Retirement Study data, individual Medicare claims, and the *Dartmouth Atlas of Health Care*.[29] Additional details are provided in the online Appendix.[30]

STATISTICAL ANALYSES We employed doubly robust methods combining propensity score matching and regression adjustment.[31] We first determined hospice enrollment in relation to date of death from individual Medicare hospice claims. For each enrollment period, we then developed propensity scores for hospice and nonhospice patients to estimate each subject's likelihood of hospice enrollment during the specified period.

We used logistic regression to estimate the likelihood of hospice enrollment using all of the independent variables, described above, that may be associated with treatment intensity. Additionally, we included as a covariate the number of hospital days prior to the target hospice enrollment period up to six months before death, to account for prior utilization as a predictor of subsequent utilization.

We then matched hospice enrollees to one or many nonhospice controls within ± 0.02 of the standard deviation of the propensity scores. Unmatched subjects were excluded. This procedure was completed for each enrollment period, resulting in the following sample sizes: 1,801 (1–7 days), 1,506 (8–14 days), 1,749 (15–30 days), and 1,492 (53–105 days).

We examined bivariate comparisons of unadjusted measures of spending and use, as well as patient characteristics, using the matched, weighted samples. We then conducted multivariable regressions for each of the outcome measures, once again adjusting for all independent variables.

Following the estimation of each fully adjusted regression, we examined the adjusted means, including 95 percent confidence intervals, and incremental effects in outcomes between groups of hospice enrollees and matched nonhospice controls. Additional details are provided in the online Appendix.[30] Analyses were conducted using the statistical analysis software Stata, version 11.

LIMITATIONS Three study limitations are worth noting. First, the data are retrospective, following back from date of death—that is, we employed a mortality follow-back design. This retrospective approach artificially removed the prognostic uncertainty faced by patients and physicians when making treatment decisions. The mortality follow-back design and our inability to randomly assign patients to treatment groups may therefore have biased the results.

However, by using detailed survey data, propensity score matching procedures, and multivariable regression to adjust the results, we minimized the effect of this bias more than could have been achieved through the use of administrative claims data alone.

Second, we were unable to factor into the analysis direct measures of individual preferences and goals of care. We did, however, adjust for all available characteristics known to be potentially associated with treatment preferences, such as education, race, and debility.

Third, we were not able to fully assess quality of care, which, in combination with cost, determines value. We included among our secondary outcomes two markers of potentially low-quality care: thirty-day hospital readmission and in-hospital death. In addition, many prior studies have demonstrated high quality of and satisfaction with hospice and palliative care.[8,13–15,32–36]

Study Results

SUBJECT CHARACTERISTICS Among the 3,069 subjects, 1,064 (35 percent) were enrolled in hospice prior to death. The mean hospice length-of-stay was 49 days (median 16 days, range 1–362 days). Patient and regional characteristics of subjects are reported in Appendix Exhibit 1.[30] Subjects' mean age at death was eighty-three years. Subjects were predominantly non-Hispanic white (80 percent), female (56 percent), covered by supplemental private insurance (50 percent), and educated through high school or beyond (58 percent). Fifty-eight percent reported needing no assistance with basic activities of daily living leading up to the study period, while 21 percent resided in a nursing home. Twenty-three percent were eligible for both Medicare and Medicaid.

HOSPICE ENROLLMENT FOR 53–105 DAYS Eighty-eight (70 percent) subjects enrolled in hospice for 53–105 days prior to death were matched to 1,404 decedents not enrolled in hospice for 53 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 2).[30]

In fully adjusted analyses of outcomes spanning the last 105 days of life, subjects enrolled in hospice for 53–105 days prior to death had significantly lower mean total Medicare expenditures than matched controls ($22,083 versus $24,644, $p < 0.01$) (Exhibit 1). Hospice enrollees during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.01$) compared to nonhospice enrollees. Differences between the groups' total intensive care unit days were not significant in the fully adjusted model ($p = 0.11$). Additional details are provided in Appendix Exhibit 3.[30]

HOSPICE ENROLLMENT FOR 15–30 DAYS One hundred thirty-three (80 percent) subjects enrolled in hospice for 15–30 days prior to death were matched to 1,616 decedents not enrolled in hospice for 15 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 4).[30]

In fully adjusted analysis of outcomes spanning the last thirty days of life, subjects enrolled in hospice for fifteen to thirty days prior to death had significantly lower average total Medicare expenditures than matched controls ($10,383 versus $16,814, $p < 0.01$) (Exhibit 1). Those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.05$). Additional details are provided in Appendix Exhibit 5.[30]

HOSPICE ENROLLMENT FOR 8–14 DAYS Ninety (70 percent) subjects enrolled in hospice for 8–14 days prior to death were matched to 1,416 decedents not enrolled in hospice for 8 days or more days prior to death. Again, we found no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 6).[30]

In fully adjusted analysis of outcomes spanning the last fourteen days of life, subjects enrolled in hospice for eight to fourteen days prior to death had significantly lower average total Medicare expenditures than matched controls ($5,698 versus $10,738, $p < 0.01$) (Exhibit 1). Once again, we found that those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admission, hospital days, and in-hospital deaths (all $p < 0.01$).

The hospice group had fewer intensive care unit days than the nonhospice group, but this difference did not reach statistical significance ($p = 0.11$). Additional details are provided in Appendix Exhibit 7.[30]

HOSPICE ENROLLMENT FOR 1–7 DAYS Three hundred eight (80 percent) subjects enrolled in hospice for 1–7 days prior to death were matched to 1,493 decedents not enrolled in hospice for 7 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 8).[30]

In fully adjusted analysis of outcomes spanning the last seven days of life, subjects enrolled in hospice for one to seven days prior to death had significantly lower average total Medicare expenditures than matched controls ($4,806 versus $7,457, $p < 0.01$) (Exhibit 1). Consistent with those patterns observed in other enrollment periods, those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, and in-hospital deaths (all $p < 0.01$).

COMPARING OUTCOMES ACROSS HOSPICE ENROLLMENT PERIODS Exhibits 2–4 compare the incremental effects in outcomes between subjects enrolled in hospice and nonhospice matched controls across the study periods. The adjusted savings in total Medicare spending ranged from $2,561 for those enrolled 53–105 days prior to death to $6,430 for those enrolled 15–30 days (Exhibit 2).

The adjusted decrease in total hospital days ranged from 9.0 for those enrolled 53–105 days prior to death to 0.9 for those enrolled 1–7 days, and the decrease in intensive care unit days ranged from 4.9 for those enrolled 53–105 days to 0.5 days for those enrolled 1–7 days (Exhibit 3). The adjusted reduction in in-hospital deaths was similar across groups, and the adjusted reductions in intensive care unit admissions and thirty-day hospital readmissions were largest for those enrolled for 53–105 days (Exhibit 4).

Discussion

Medicare costs for patients enrolled in hospice were significantly lower than those of nonhospice enrollees across all periods studied: 1–7 days, 8–14 days, and 15–30 days, the most common enrollment periods prior to death, as well as 53–105 days, the period previously shown to maximize Medicare savings.[23]

In addition, reductions in the use of hospital

EXHIBIT 1

Health Care Use At The End Of Life For Subjects Enrolled In Hospice And Matched Nonhospice Controls

Measure of use	Hospice group, adjusted means	Propensity score matched controls, adjusted means
TOTAL MEDICARE EXPENDITURES, 2008 US DOLLARS		
Last 105 days[a]	22,083	24,644[b]
Last 30 days[c]	10,383	16,814[b]
Last 14 days[d]	5,698	10,738[b]
Last 7 days[e]	4,806	7,457[b]
TOTAL HOSPITAL DAYS		
Last 105 days[a]	3.50	12.50[b]
Last 30 days[c]	1.60	5.70[b]
Last 14 days[d]	0.19	4.36[b]
Last 7 days[e]	0.29	1.20[b]
TOTAL HOSPITAL ADMISSIONS		
Last 105 days[a]	0.58	1.22[b]
Last 30 days[c]	0.34	0.74[b]
Last 14 days[d]	0.08	0.48[b]
Last 7 days[e]	0.12	0.35[b]
TOTAL ICU DAYS		
Last 105 days[a]	0.71	5.65
Last 30 days[c]	0.31	2.91[f]
Last 14 days[d]	0.03	1.61
Last 7 days[e]	0.08	0.57[b]
PROPORTION WITH ICU ADMISSION		
Last 105 days[a]	0.15	0.37[b]
Last 30 days[c]	0.10	0.31[b]
Last 14 days[d]	0.02	0.23[b]
Last 7 days[e]	0.05	0.15[b]
PROPORTION WITH 30-DAY HOSPITAL READMISSION		
Last 105 days[a]	0.11	0.26[b]
Last 30 days[c]	0.02	0.12[b]
PROPORTION DYING IN THE HOSPITAL		
Last 105 days[a]	0.02	0.42[b]
Last 30 days[c]	0.06	0.44[b]
Last 14 days[d]	0.09	0.48[b]
Last 7 days[e]	0.15	0.53[b]

SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Sample sizes vary across periods of enrollment. For enrollment 53–105 days before death: hospice patients, $n = 88$; matched controls, $n = 1,404$. For enrollment 15–30 days before death: hospice patients, $n = 133$; matched controls, $n = 1,616$. For enrollment 8–14 days before death: hospice patients, $n = 90$, matched controls, $n = 1,416$. For enrollment 1–7 days before death: hospice patients, $n = 308$; matched controls, $n = 1,493$. Multivariable regression models adjusted for age; sex; race/ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity. 95 percent confidence intervals for all estimates are available in the online Appendix (see Note 30 in text). ICU is intensive care unit. [a]Hospice enrollment 53–105 days before death. [b]Difference between hospice and control groups statistically significant at $p < 0.01$. [c]Hospice enrollment 15–30 days before death. [d]Hospice enrollment 8–14 days before death. [e]Hospice enrollment 1–7 days before death. [f]Difference between hospice and control groups statistically significant at $p < 0.05$.

services at the end of life both contribute to these savings and potentially improve quality of care and patients' quality of life. Specifically, hospice enrollment was associated with significant reductions in hospital and intensive care unit admissions, hospital days, and rates of thirty-day hospital readmission and in-hospital death.

EVIDENCE OF MEDICARE SAVINGS Our results not only are consistent with prior studies for Medicare spending, but they also strengthen this evidence by replicating the results within a sample more thoroughly matched for individual health, functional, and social characteristics, as well as regional factors. Finding no difference between the hospice and control groups' preenrollment health care use is evidence of this improved match, as compared to prior work.[23]

Specifically, Taylor and colleagues reported a maximum reduction in Medicare spending among patients enrolled in hospice for 53–105 days prior to death.[23] We found Medicare savings among this group, too, but we also found a similar level of savings among those enrolled for 1–7 days and increased savings among those enrolled for 8–30 days prior to death. Furthermore, we demonstrated parallel reductions in hospital and intensive care unit use, hospital readmissions, and in-hospital death.

INCREASING VALUE THROUGH MEDICARE HOSPICE These findings, albeit limited to enrollment up to 105 days, are of particular importance because they suggest that investment in the Medicare hospice benefit translates into savings overall for the Medicare system. For example, if 1,000 additional beneficiaries enrolled in hospice for 15–30 days prior to death, Medicare could save more than $6.4 million, while those beneficiaries would be spared 4,100 hospital days. Alternatively, if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, the overall savings to Medicare would exceed $2.5 million.

Although our findings suggest that hospice enrollment results in savings to the Medicare program across a number of different lengths-of-stay, this work also highlights several areas for future research.

First, because of the limitations of our data set, we were unable to precisely determine the point at which hospice approaches usual care in terms of costs. Future studies will be needed to address this question.

Second, our data were also not able to identify the differential effects of hospice on specific diagnoses. This is of particular importance given the recent growth of for-profit hospices, which typically enroll more patients with noncancer diagnoses (and longer average lengths-of-stay) compared to not-for-profit programs.

We found that net Medicare savings for patients with longer lengths-of-stay are lower because of the per diem cost of hospice services. However, we note that if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, these beneficiaries could avoid 9,000

hospital days at the end of life. Indeed, our findings suggest that substantial reduction in hospital days—a primary goal of health care reform—is achieved regardless of the length of hospice enrollment.

Finally, our findings cannot be extrapolated to novel models of health care delivery or reimbursement, such as the integration of hospice programs into accountable care organizations or graded per diem payment systems, higher reimbursement for earlier and later days of enrollment, and lower reimbursement for the middle days.[20,37] The ability of these models to achieve savings while maintaining or improving quality is unclear and must be evaluated.

BARRIERS TO TIMELY HOSPICE ENROLLMENT

Our results, when taken together with those of prior studies, suggest that hospice increases value by improving quality and reducing costs for Medicare beneficiaries at the end of life. Yet aggressive efforts to curtail Medicare hospice spending, including the Office of Inspector General's investigation of hospices that enroll patients with late-stage diseases but unpredictable prognoses, are ongoing.

Our findings suggest that these efforts may be misguided. Indeed, this study reveals that savings are present for both cancer patients and noncancer patients and that reductions in the use of hospital services and numbers of hospital days, hospital admissions, and hospital deaths appear to grow as the period of hospice enrollment lengthens within the observed study period (up to 105 days). These outcomes not only are less costly but also have all been associated with higher quality of care and increased concordance with patients' preferences.

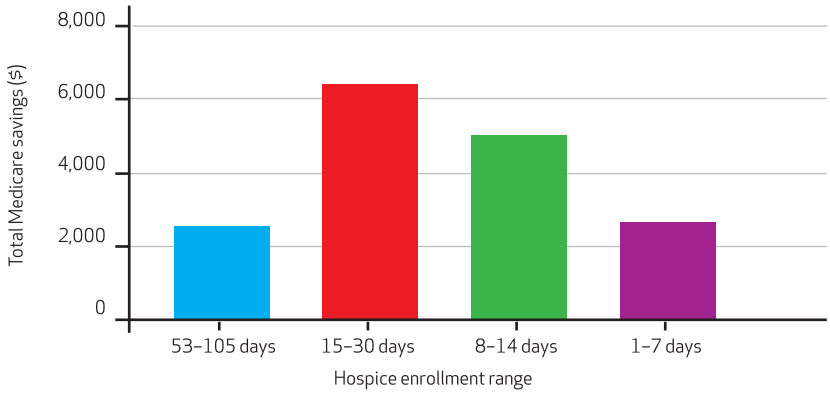
Although sample-size limitations prevented us from examining enrollment beyond 105 days, the trend in our data and the projections by Taylor and colleagues support the idea that efforts to curtail hospice enrollment may actually increase use and spending overall. Instead of working to reduce Medicare hospice spending and creating a regulatory environment that discourages continued growth in hospice enrollment, the Centers for Medicare and Medicaid Services should focus on ensuring that patients' preferences are elicited earlier in the course of their diseases and that those who want hospice care receive timely referral.

An additional barrier to timely hospice referral may be limited knowledge or misconceptions regarding hospice and palliative care.[38] In particular, the hospice requirement to forgo curative treatments—even if they might not be beneficial—may be difficult for patients and families to accept or prompt fears of health care rationing. Because some treatments may be used for both curative and palliative purposes, this regulation and the variability with which hospice providers interpret it may also cause clinicians to be uncertain about hospice eligibility.[39]

Several recent state and federal policy initiatives are designed to promote patient-centered care, specifically by increasing palliative care education among all health professionals and requiring that clinicians apprise patients of palliative treatment options early in the course of a serious illness.[40–42] Such efforts to elucidate patients' preferences and values early may increase timely referral to hospice.

EXHIBIT 2

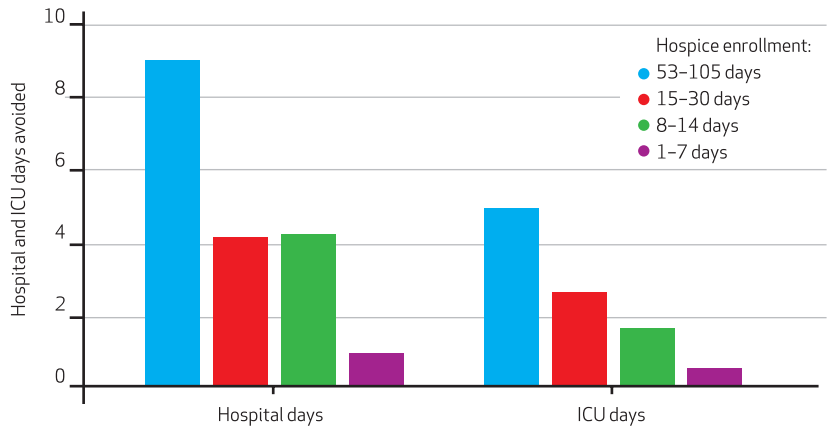
Incremental Savings In Medicare Expenditures, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Total savings to Medicare denote the incremental difference in Medicare spending between hospice and nonhospice groups.

EXHIBIT 3

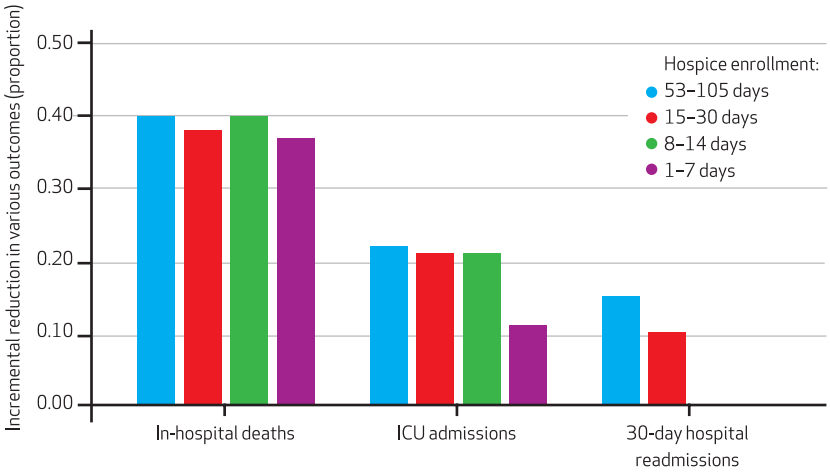
Incremental Reductions In Hospital Days And Intensive Care Unit Days, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Hospital and intensive care unit (ICU) days avoided is expressed as the incremental effect in days between hospice and nonhospice groups.

EXHIBIT 4

Incremental Reductions In Hospital Deaths, Intensive Care Unit Admissions, And Thirty-Day Readmissions, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Incremental reduction in various outcomes (in-hospital deaths, ICU admissions, and thirty-day hospital readmissions) is expressed as the incremental effect in proportion between hospice and nonhospice groups. ICU is intensive care unit.

Finally, highly specialized and fragmented care may also present a barrier to hospice access, particularly for patients with the most complex and highest-cost illnesses: those 5 percent of patients, many in their last year of life, who account for nearly half of the nation's health care spending.[1–3] Not only is care for this group characterized by costly hospital-based treatment, but it is also often highly fragmented and of poor quality, particularly among those who are dually eligible for Medicare and Medicaid.[43] Although many demonstration projects seek to address this concern,[43] few target this population's need for assistance in identifying individualized goals of care and developing comprehensive treatment plans to achieve those goals.

One such comprehensive treatment approach might be the enhancement of formal partnerships between hospital palliative care teams and hospice. Evidence from existing models that incorporate hospital palliative care services demonstrates improvement in quality indicators, heightened patient and family satisfaction, reduced hospital use, and increased rates of hospice referral.[44] These benefits may be even more substantial if formal relationships between established palliative care teams and community hospice programs were developed in order to offer a bridge to timely hospice enrollment.

Conclusion

Hospice enrollment during the longer period of 53–105 days prior to death and the most common period within 30 days prior to death lowers Medicare expenditures, rates of hospital and intensive care unit use, 30-day hospital readmissions, and in-hospital death. Building upon prior studies of hospice and palliative care that have demonstrated higher quality and improved patient and family satisfaction,[8,13–15,32–36] this finding suggests that hospice and palliative care are critical components in achieving greater value through health care reform: namely, improved quality and reduced costs.

Medicare should thus seek to expand access to hospice services so that hospice can contribute to its full potential to the overall value of care. To do so, substantial barriers to timely hospice enrollment must be overcome. The Centers for Medicare and Medicaid Services should abandon efforts to reduce Medicare hospice spending and delay hospice enrollment and should instead focus on ensuring that people who want hospice care receive timely referral.

Within the current Medicare hospice benefit, several approaches may expand access and increase appropriate and timely referral to hospice. These approaches include formalized partnerships between hospital palliative care programs and community hospice programs and the promotion of patient-centered care by educating patients, families, and physicians about the availability and benefits of hospice and palliative care services.

Finally, ongoing demonstration projects and novel models of health care delivery and reimbursement should place a high priority on the rigorous evaluation of hospice service use and its impact on the value of care. ■

Amy Kelley's work on this study is supported by the National Institute on Aging Paul B. Beeson Career Development Award (1K23AG040774-01A1). Melissa Aldridge Carlson is supported by a Career Development Award from the National Institute for Nursing Research (R00NR010495). Sean Morrison is supported by the National Institute on Aging (K24 AG022345-09) and the National Palliative Care Research Center.

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30 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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ABOUT THE AUTHORS: AMY S. KELLEY, PARTHA DEB, QINGLING DU, MELISSA D. ALDRIDGE CARLSON & R. SEAN MORRISON

Amy S. Kelley is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

In this month's *Health Affairs*, Amy Kelley and coauthors report on their study examining Medicare costs for hospice patients enrolled for different lengths-of-stay, ranging from 1 day to 105 days. Using data from the Health and Retirement Study and individual Medicare claims, they found savings for Medicare across all lengths-of-stay examined. Hospice patients also had less hospital use than matched controls, and thus a higher quality of life. The authors argue that instead of attempting to limit Medicare hospice participation for fear of not seeing savings, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.

Kelley is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and is a board-certified physician in internal medicine, geriatric medicine, and palliative medicine. Her research focuses on improving the quality of care for older adults with serious medical illness. She is particularly interested in regional practice variations and the relationship between patient characteristics and treatment intensity.

In 2012 Kelley was selected for the Paul B. Beeson Career Development Award in Aging Research from the National Institute on Aging and won the American Geriatrics Society's best paper award in geriatrics research. Kelley earned a master's degree in health services from the University of California, Los Angeles, and a medical degree from Cornell University.

Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College.

Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College and a professor at the Graduate Center, City University of New York. He is also an adjunct professor at the School of Public Health, Hunter College; a senior adviser at the Center for Medicare and Medicaid Innovation, Department of Health and Human Services; a research associate at the National Bureau of Economic Research; and a faculty fellow at the Brookdale Center for Healthy Aging and Longevity, Hunter College. Deb also serves on the editorial board of *Health Services Research*. He earned a master's degree and a doctorate in economics from Rutgers University.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai. Her work focuses on developing statistical models to study health care delivery systems. Du earned a master's degree in

statistics from the University of Chicago.

Melissa D. Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Melissa Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and the director of research methods training for the Mount Sinai Medical Student Training in Aging Research Program. She is a member of the National Palliative Care Research Center's Scientific Review Committee and serves on the editorial board of the *Journal of Palliative Medicine*. She earned an MBA from New York University, a master's degree in public health from Columbia University, and a doctorate in health policy and administration from Yale University.

R. Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai; director of the school's Hertzberg Palliative Care Institute; and the Herman Merkin Professor of Palliative Care. He is the director of the National Palliative Care Research Center and was the president of the American Academy of Hospice and Palliative Medicine. Morrison serves on the editorial board of *Palliative Medicine* and is the senior associate editor of the *Journal of Palliative Medicine*. He earned a medical degree from the University of Chicago.

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EXHIBIT 1

WHATCOM COUNTY HOSPICE ADMISSIONS PER 1,000 DEATHS: 2015-2018

Exhibit 1
Whatcom County Hospice Admissions per 1,000 Deaths: 2015-2018

Utilization has been increasing but it is still below the national average of 588.

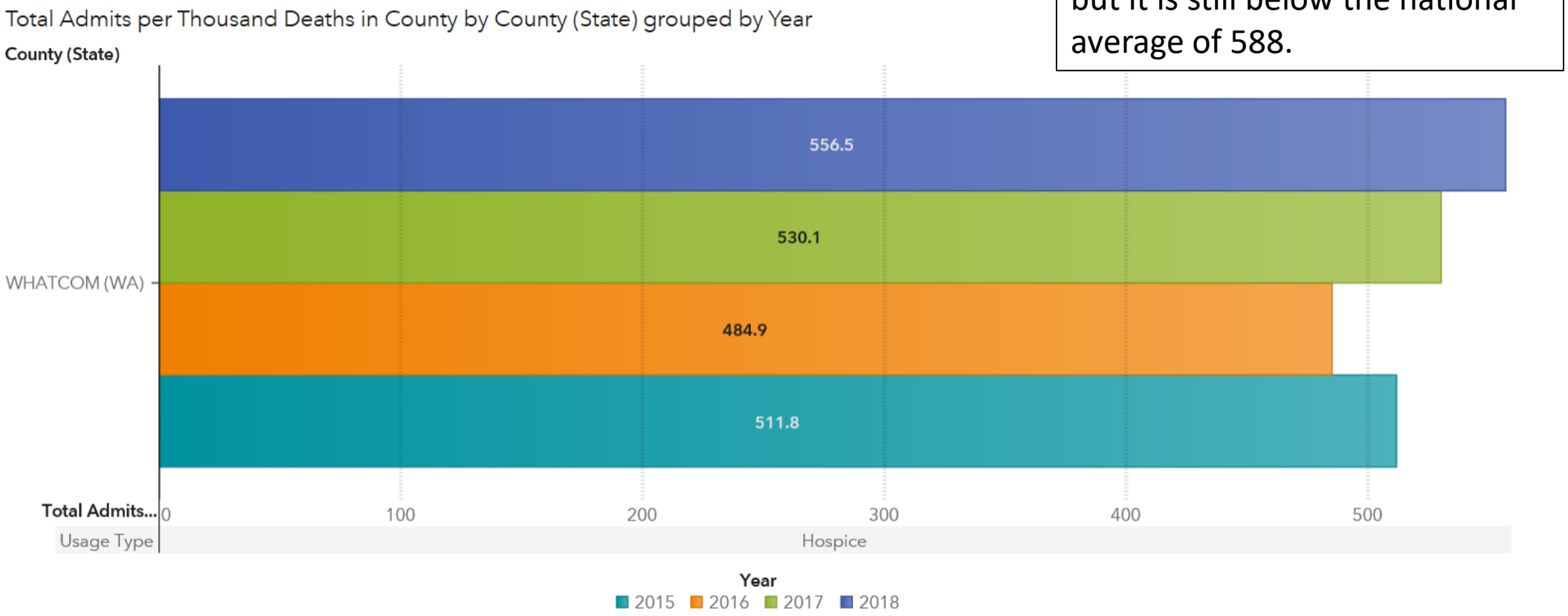

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EXHIBIT 2

AVERAGE LENGTH OF STAY

WASHINGTON HOSPICE PROGRAMS

Exhibit 2
Average Length of Stay
Washington Hospice Programs

Whatcom Hospice (green bar) has an ALOS of 55.7 days which is one of the lowest in Washington. This compares to a national average of 84 days. Fewer patients are finding their way to hospice in Whatcom County and spending less time on hospice when they are admitted than the national average.

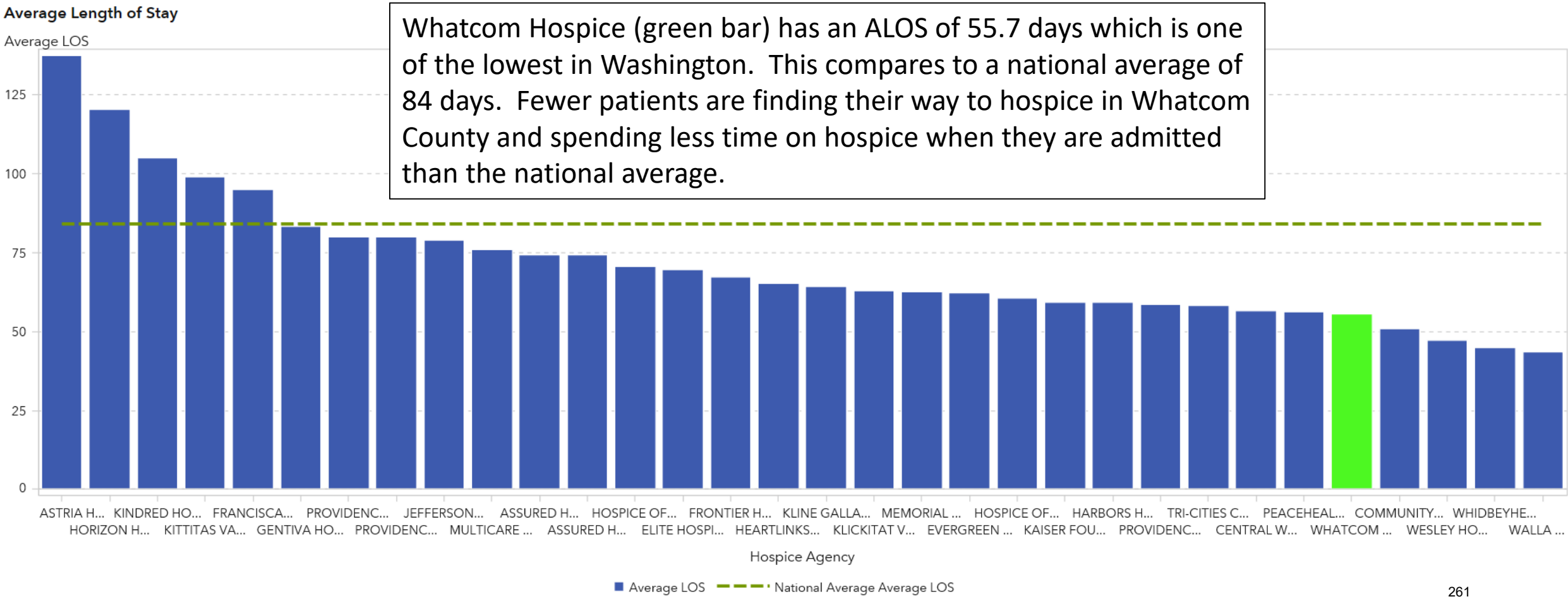

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EXHIBIT 3

SPEED OF ADMISSION

WASHINGTON HOSPICE PROGRAMS

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Speed of Admission
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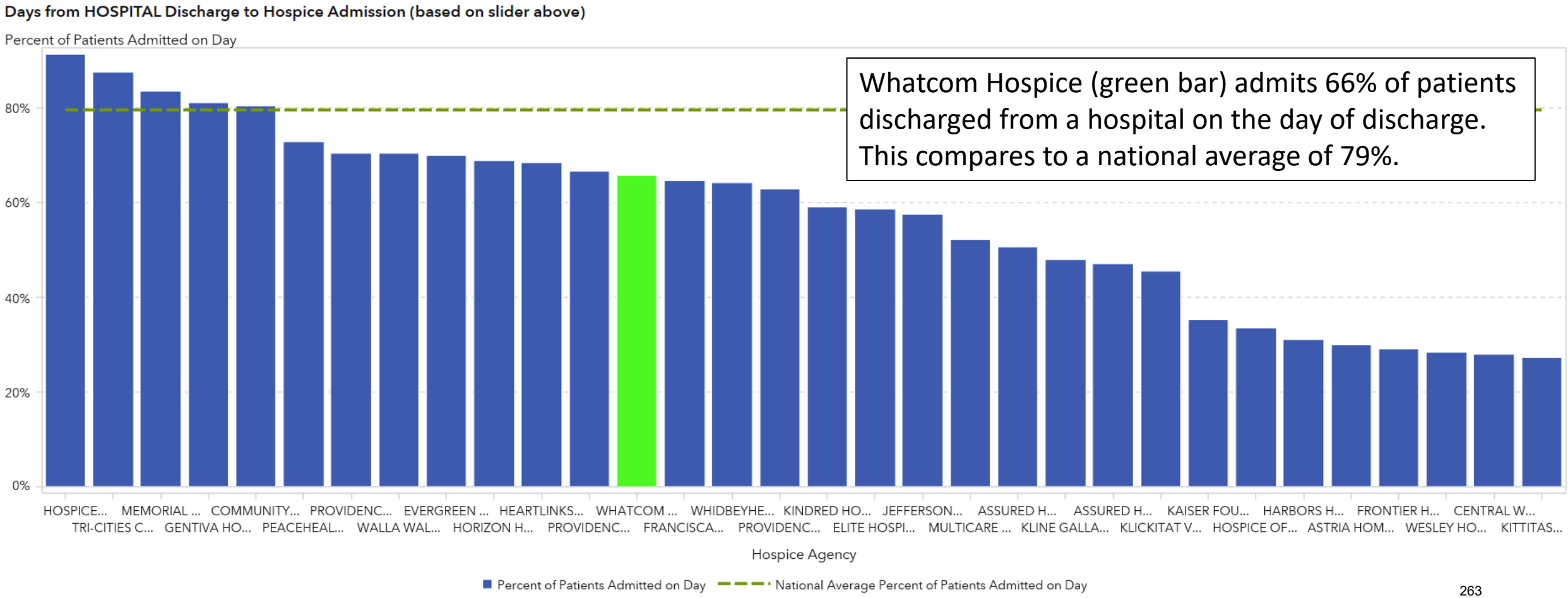

Whatcom Hospice (green bar) admits 66% of patients discharged from a hospital on the day of discharge. This compares to a national average of 79%.

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EXHIBIT 4

SPEED OF ADMISSION FOR HOSPITAL DISCHARGES

2015-2018

Exhibit 4
Whatcom Hospice Speed of Admission
For Hospital Discharges – 2015-2018

The percentage of patients admitted to hospice on the day of discharge from a hospital has declined by 14% from 2015 to 2018 at Whatcom Hospice.

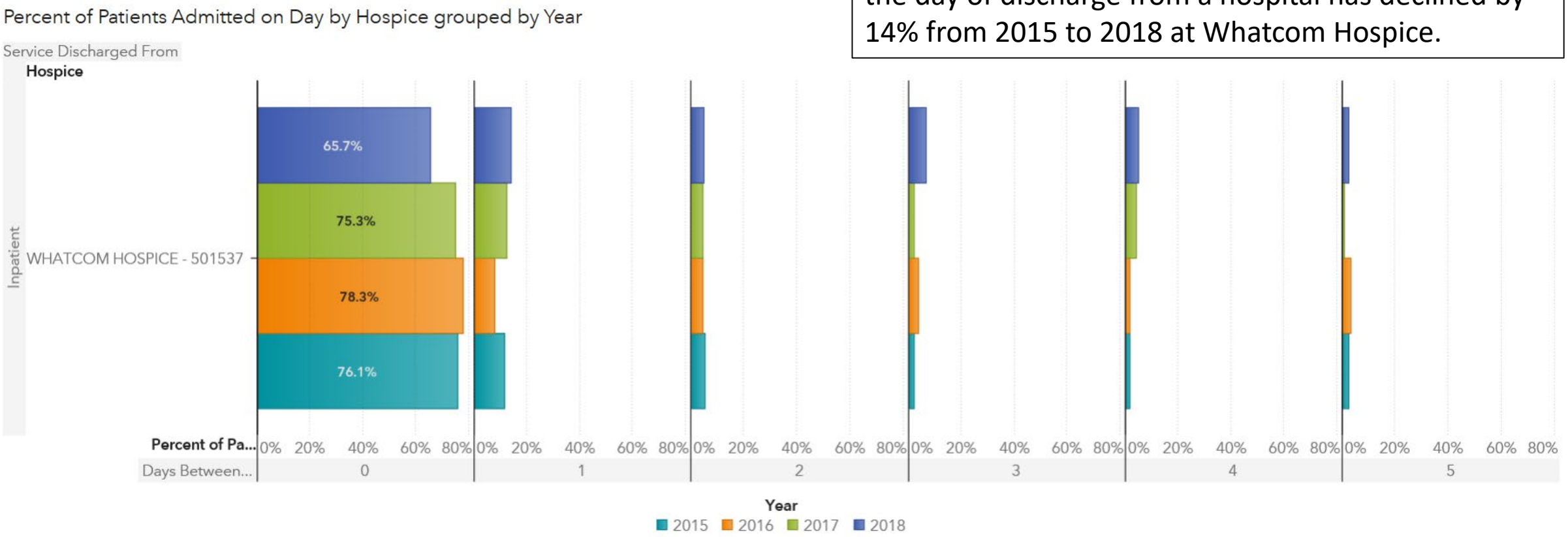

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EXHIBIT 5

WHATCOM HOSPICE SPEED OF ADMISSION FOR TRANSFER FROM HOME HEALTH 2015-2018

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Whatcom County Hospice Admissions per 1,000 Deaths: 2015-2018

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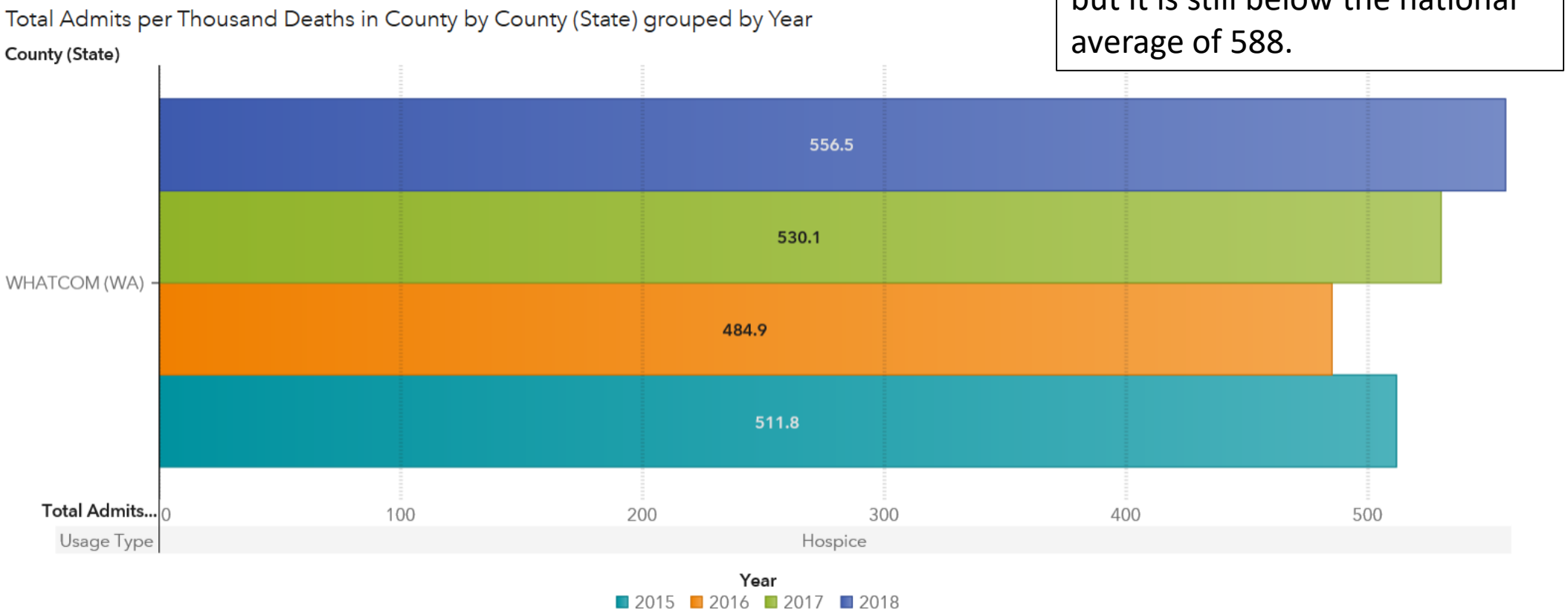

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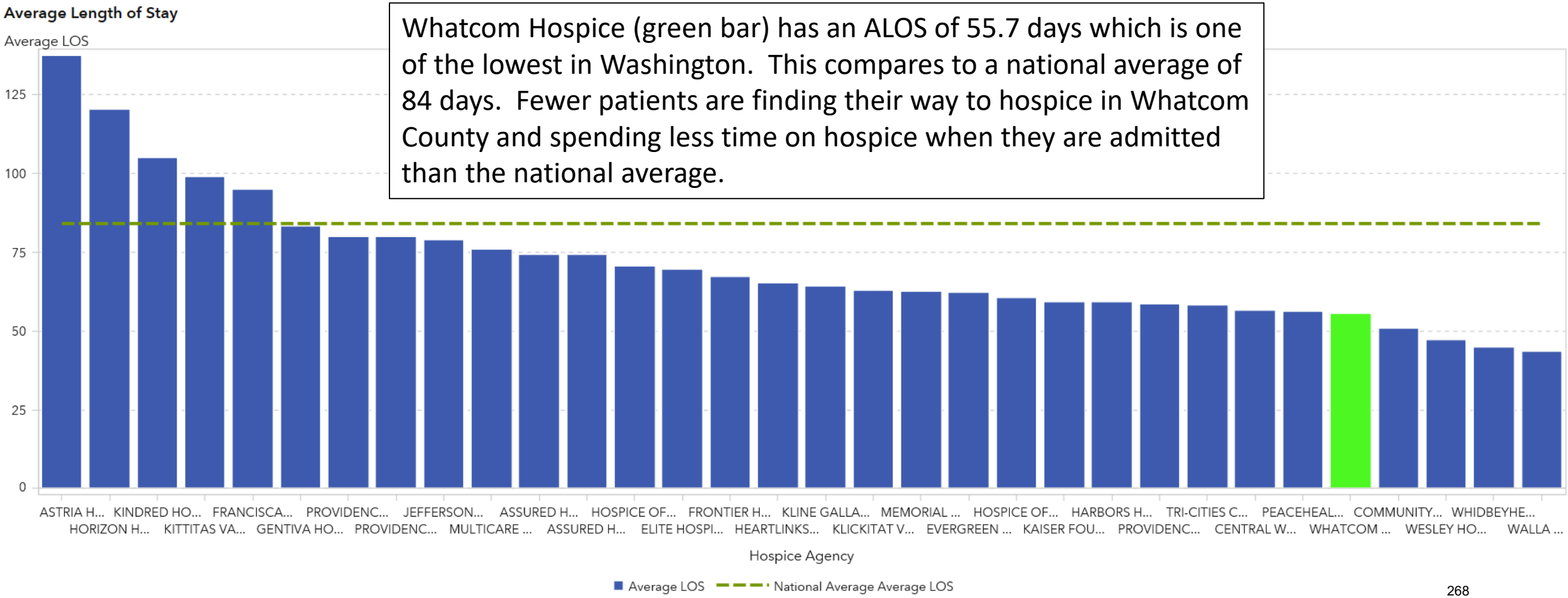

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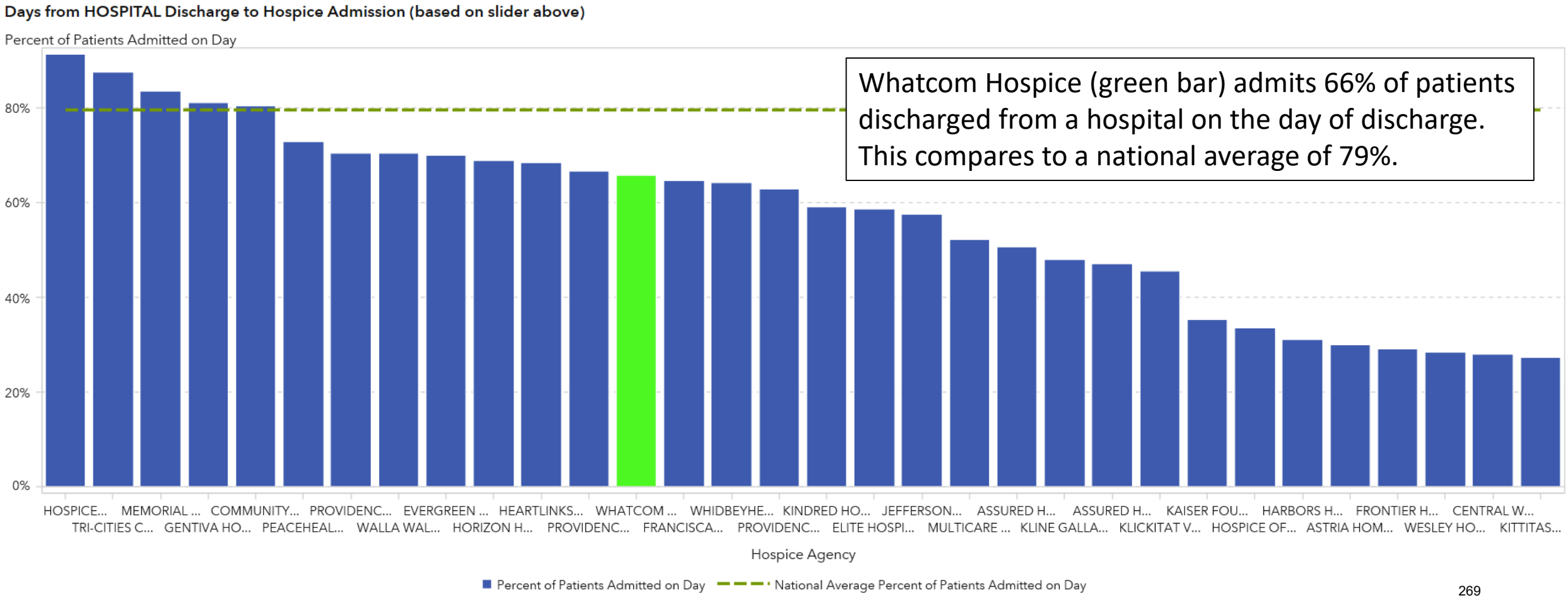

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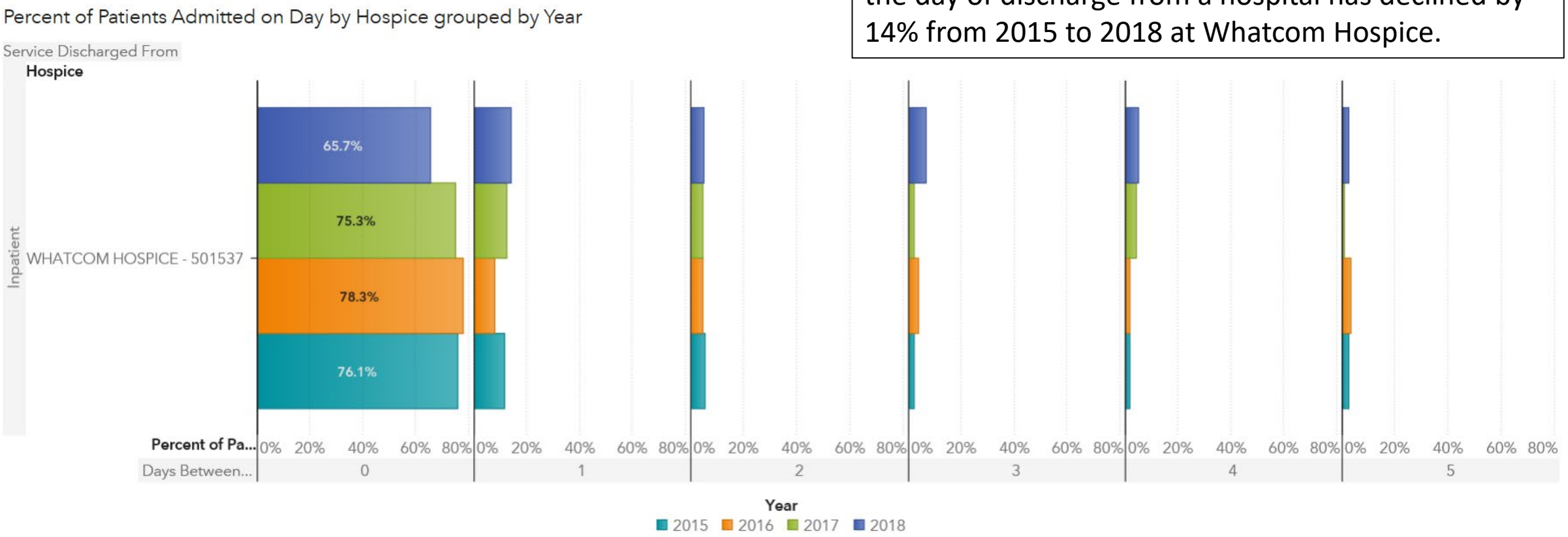


Exhibit 5
Whatcom Hospice Speed of Admission for transfers from Home Health 2015-2018

Hospice appropriate patients that are transferred from home health are admitted much slower to hospice than hospital discharges. On the 6th day after discharge 12% of the patients have not been admitted to hospice. This trend has continued for many years.

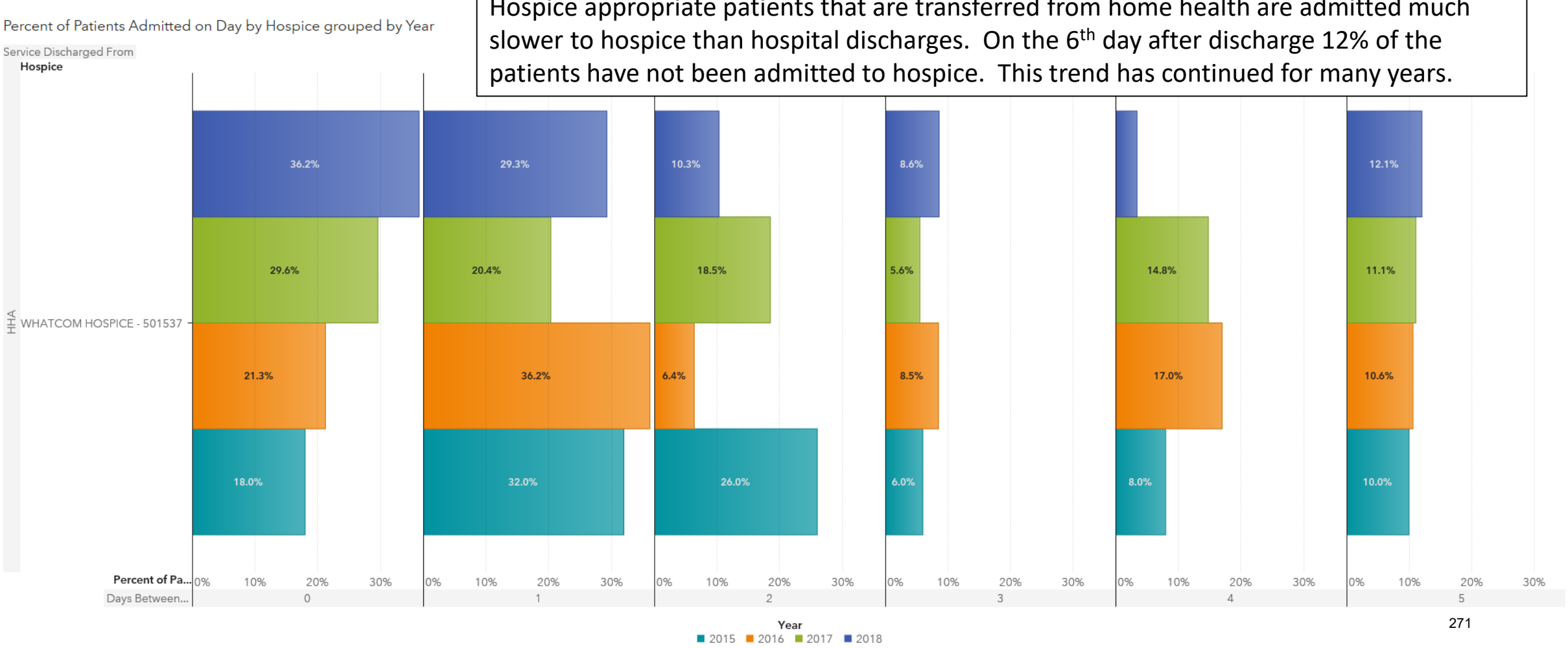
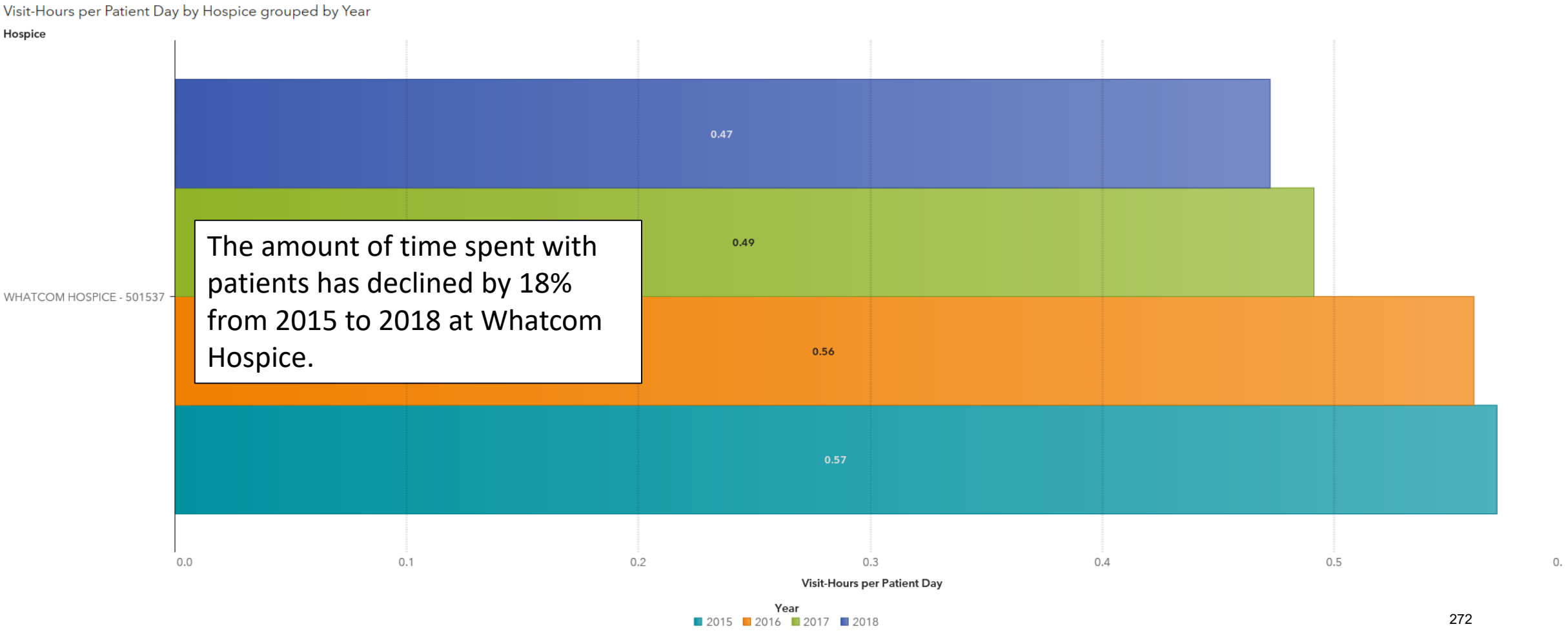


Exhibit 6
Visit Hours per Patient Day
Whatcom Hospice 2015 – 2018



The amount of time spent with patients has declined by 18% from 2015 to 2018 at Whatcom Hospice.

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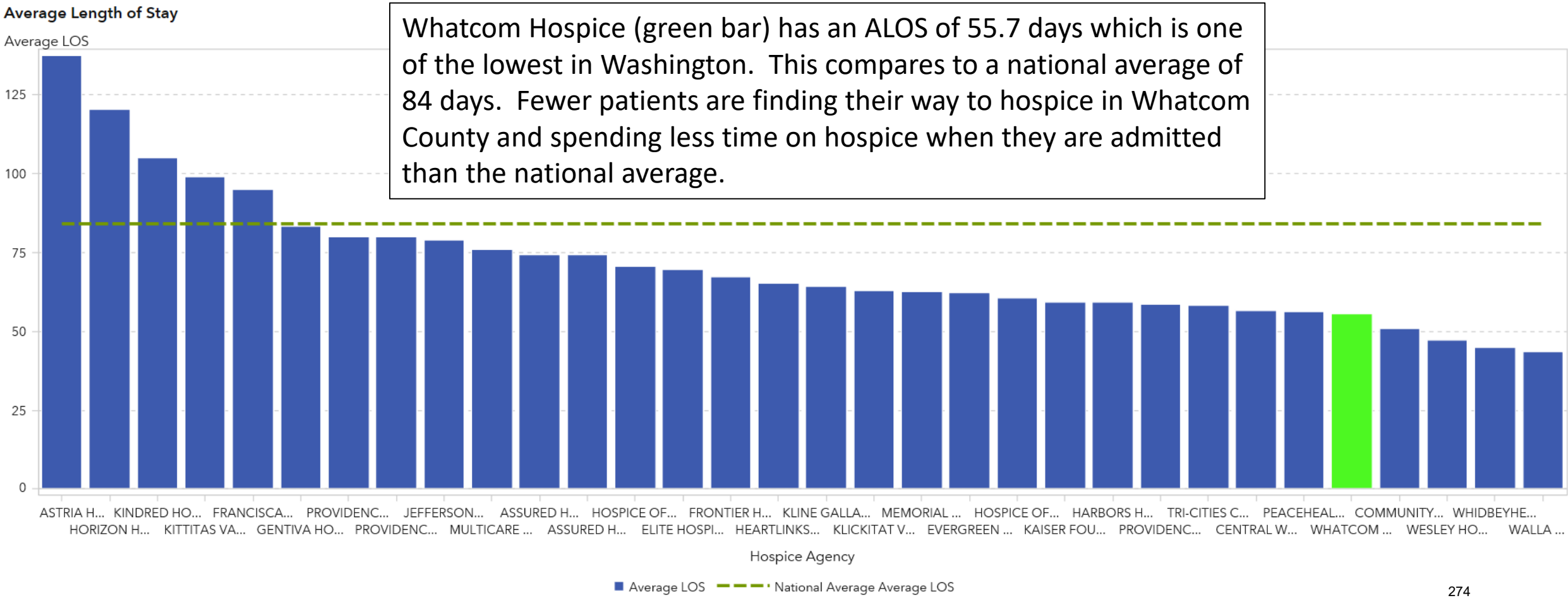

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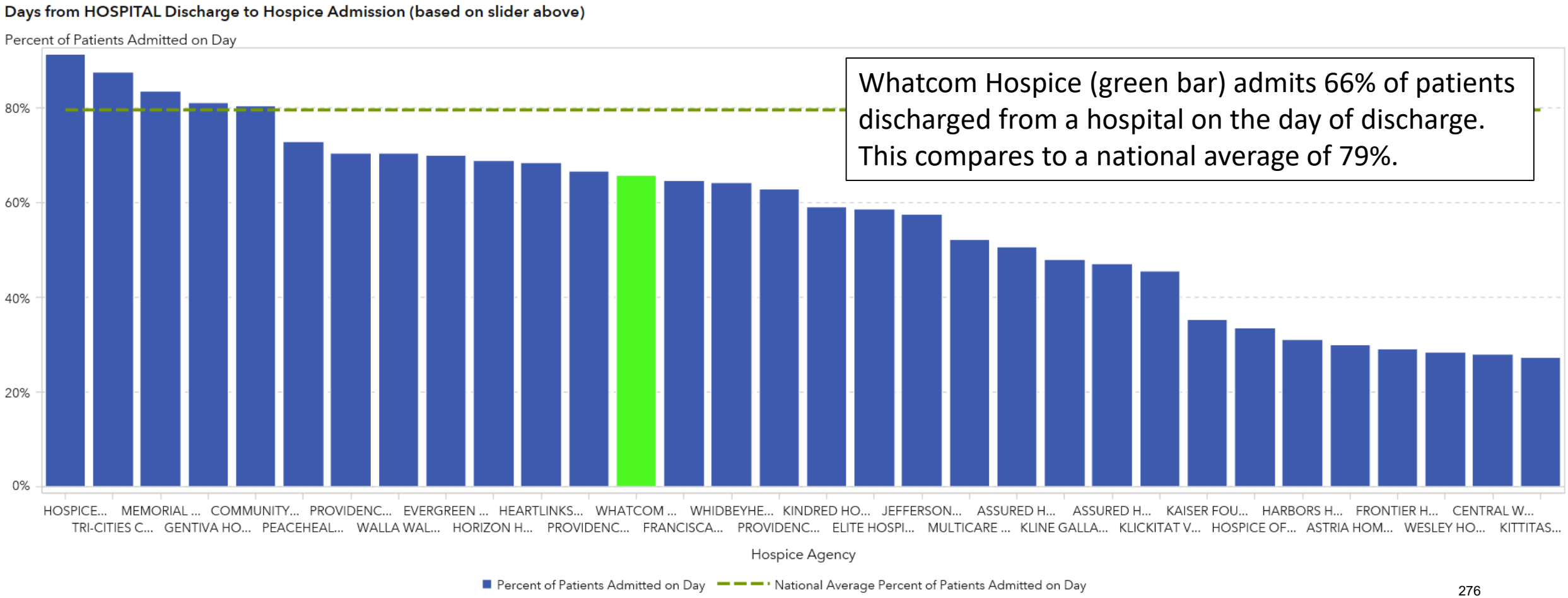

Whatcom Hospice (green bar) admits 66% of patients discharged from a hospital on the day of discharge. This compares to a national average of 79%.

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2015-2018

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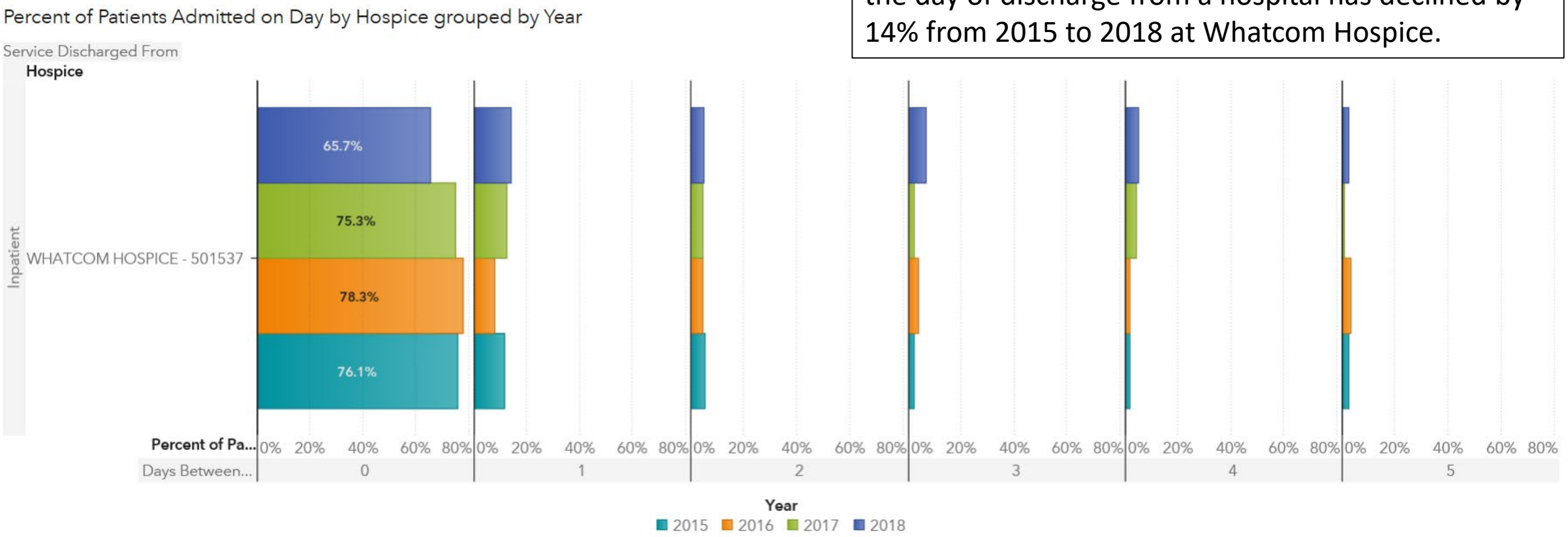

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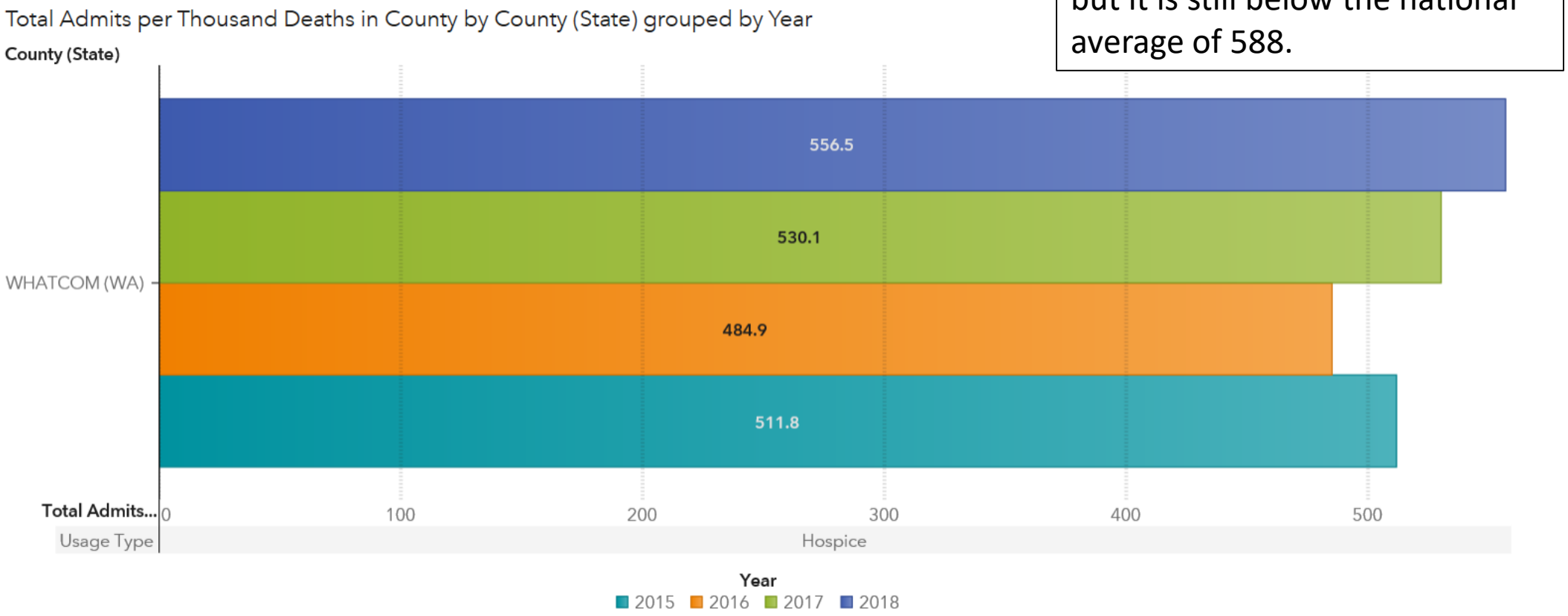

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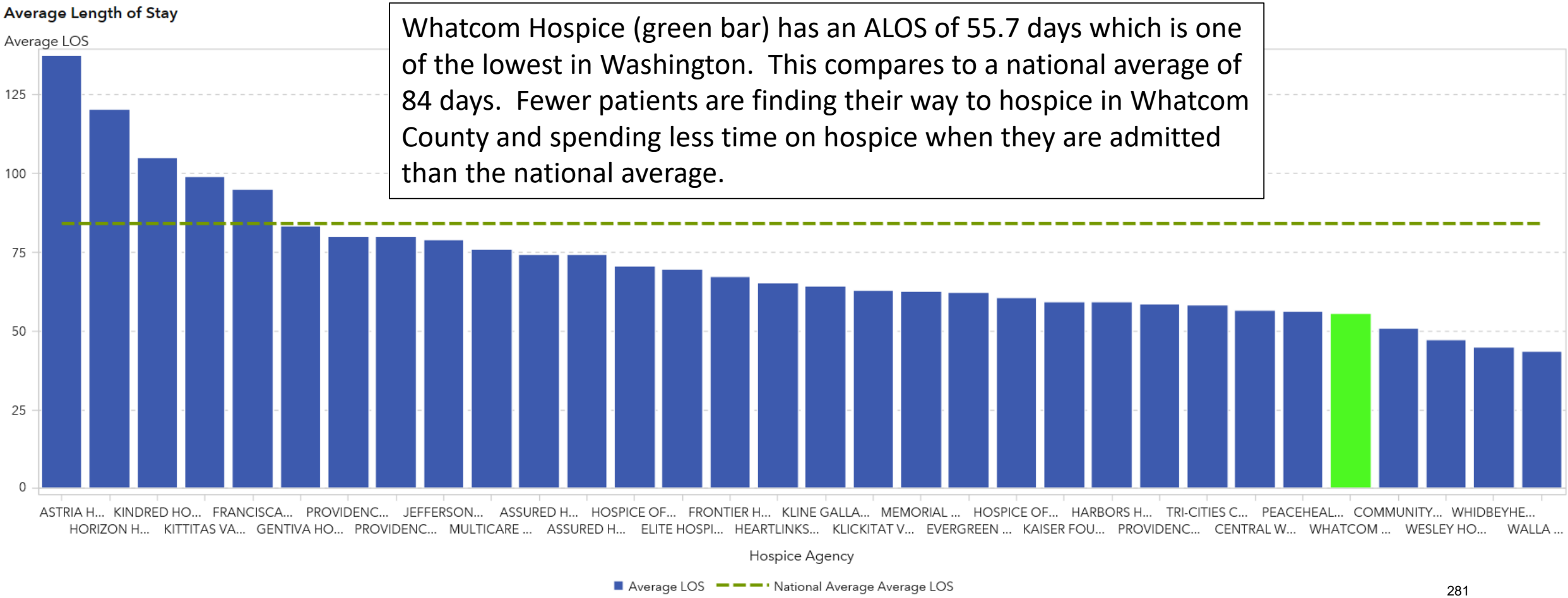

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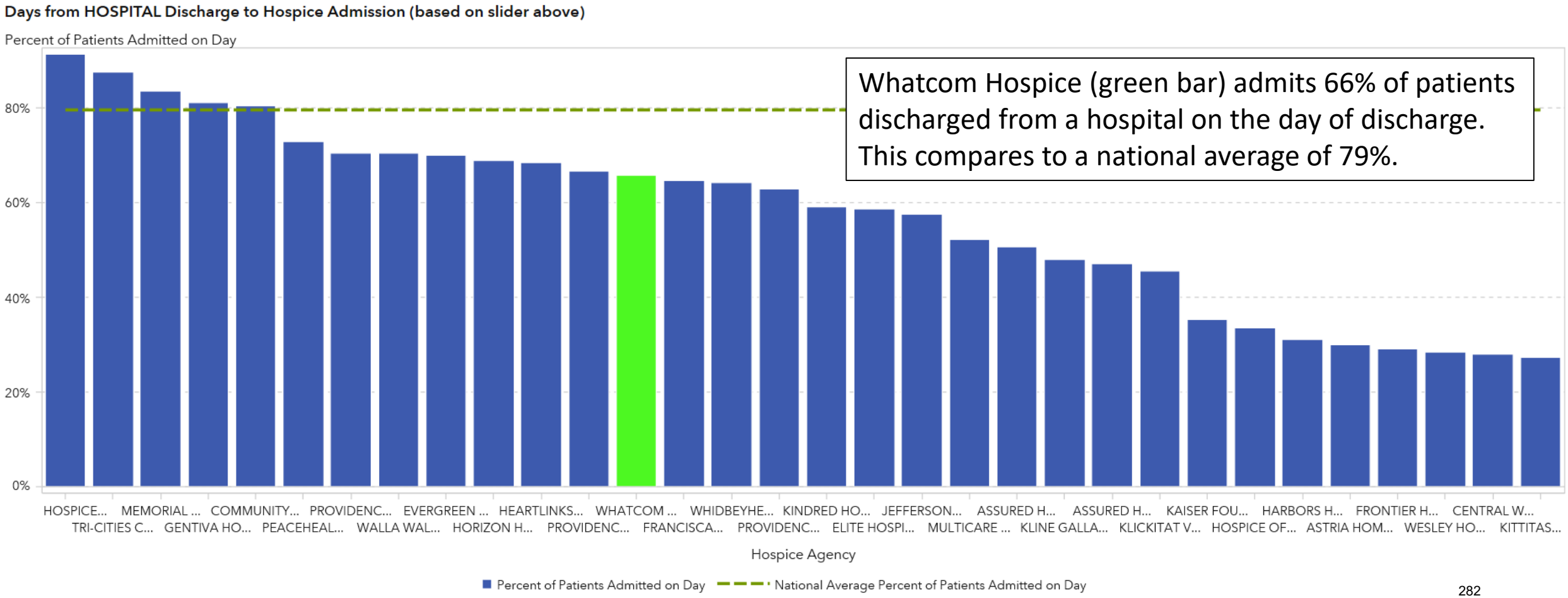

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For Hospital Discharges – 2015-2018

The percentage of patients admitted to hospice on the day of discharge from a hospital has declined by 14% from 2015 to 2018 at Whatcom Hospice.

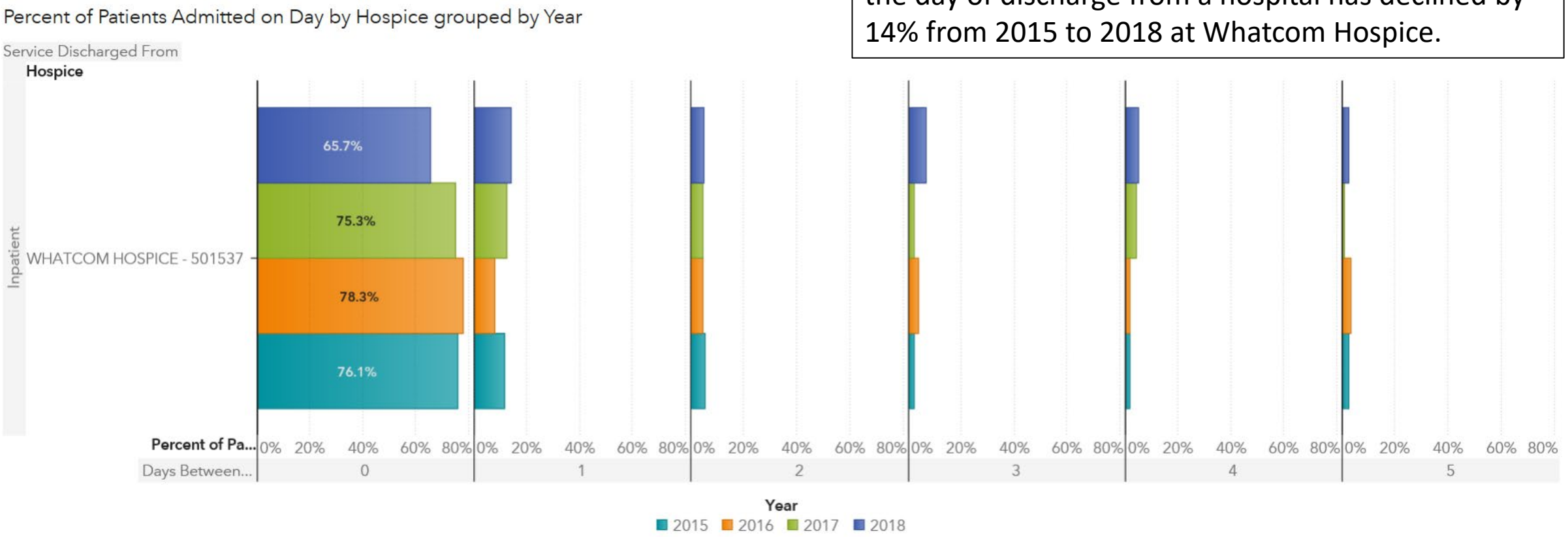


Exhibit 5
Whatcom Hospice Speed of Admission for transfers from Home Health 2015-2018

Hospice appropriate patients that are transferred from home health are admitted much slower to hospice than hospital discharges. On the 6th day after discharge 12% of the patients have not been admitted to hospice. This trend has continued for many years.

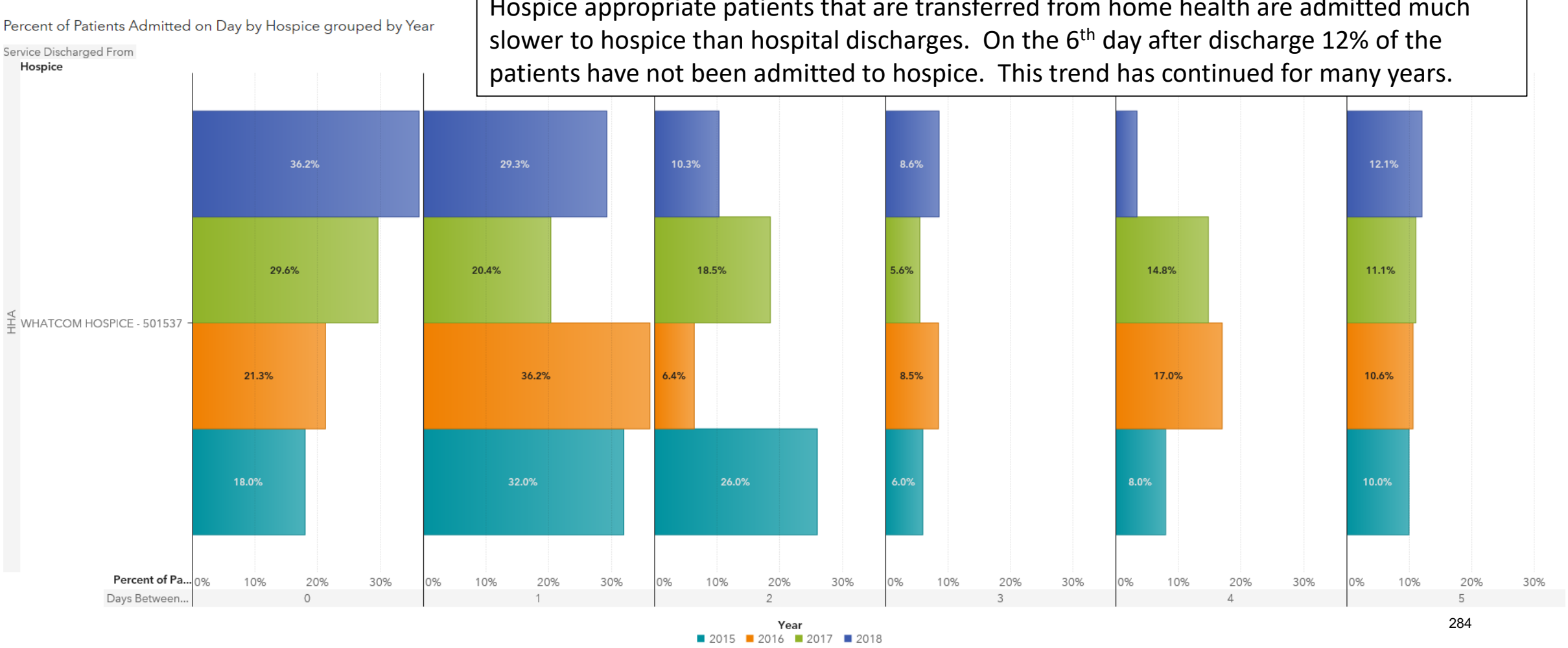
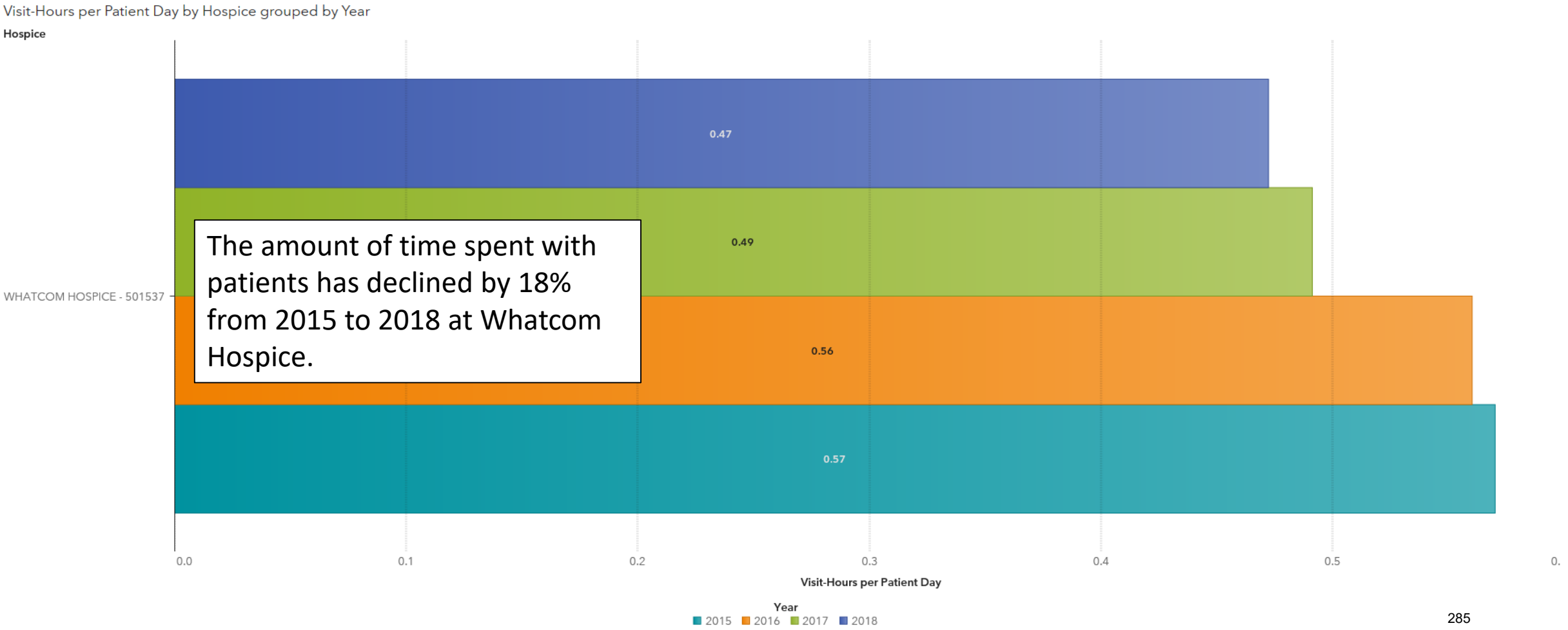


Exhibit 6
Visit Hours per Patient Day
Whatcom Hospice 2015 – 2018



The amount of time spent with patients has declined by 18% from 2015 to 2018 at Whatcom Hospice.

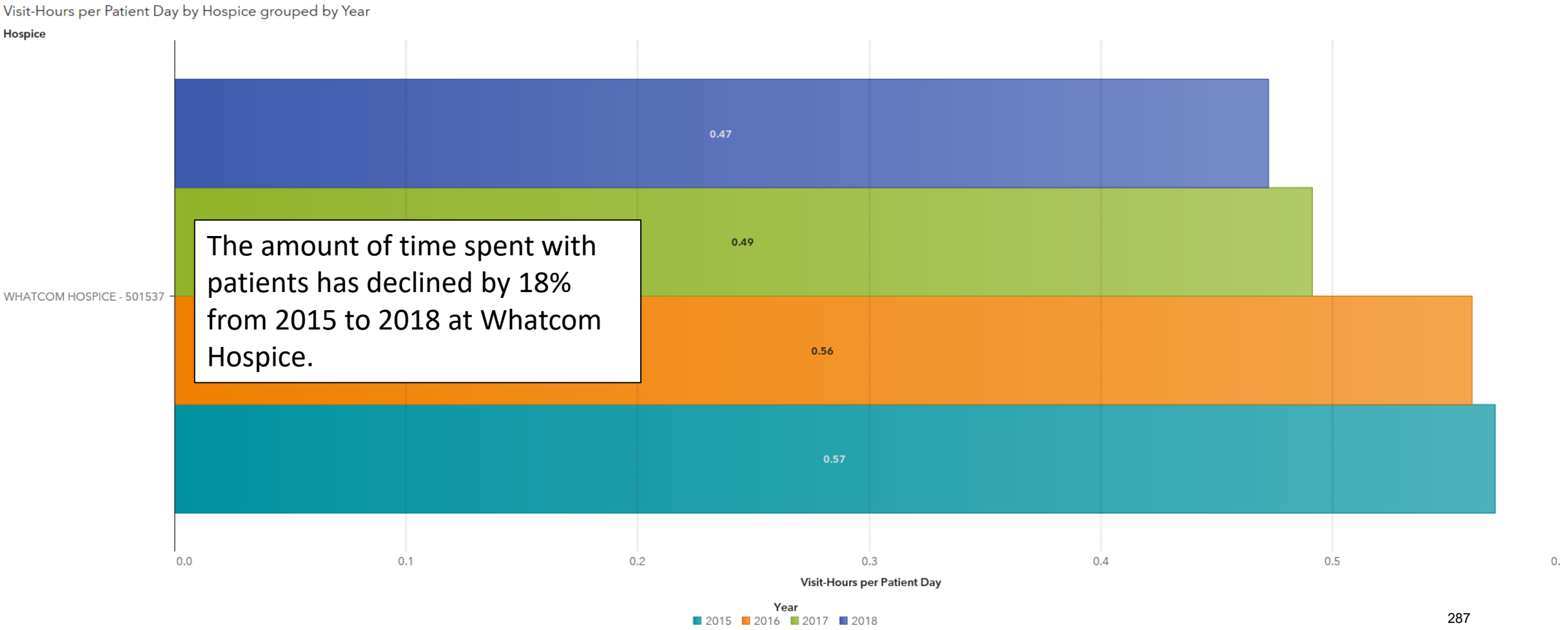
Eden Hospice at Whatcom County, LLC

Certificate of Need Application

EXHIBIT 6

VISIT HOURS PER PATIENT DAY WHATCOM HOSPICE 2015 –2018

Exhibit 6
Visit Hours per Patient Day
Whatcom Hospice 2015 – 2018



The amount of time spent with patients has declined by 18% from 2015 to 2018 at Whatcom Hospice.

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EXHIBIT 7

Providence CN 19-44 Hospice Cost Savings Analysis from CN 19-44 Table 26, 2017 WA State Hospice Analysis

Exhibit 7: Providence CN 19-44 Hospice Cost Savings Analysis[1]

From CN 19-44 Table 26. 2017 WA State Hospice Analysis

Estimated Patients without Hospice			
Resident Deaths	46,324		
Hospice Deaths	21,071		
Deaths without Hospice	25,253		
Payment Reduction Estimate			
Weeks with Hospice	**Average Payment**	**Deaths without Hospice**	**Est. Total Payments**
0	$36,944	25,253	$932,951,942
5	$32,999	25,253	$833,330,793
Reduced Payments if patients had 5 weeks of hospice			**$99,621,149**

Source: CMS Hospice State Profile -- Washington State 2017

[1] CN 19-44. Providence Health and Services Hospice Application. Page 53