APPLICATION FOR CERTIFICATE OF NEED: HOSPICE SERVICES

APPLICATION TO CONSTRUCT 12-BED GENERAL INPATIENT UNIT

Submitted To
Maryland Health Care Commission:
Centers for Health Care Facilities Planning and Development
Certificate of Need

Submitted By
Hospice of Washington County, Inc.

Hospice of Washington County, Inc.

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For internal staff use:

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

MARYLAND HEALTH CARE COMMISSION

APPLICATION FOR CERTIFICATE OF NEED: HOSPICE SERVICES

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

TABLE OF CONTENTS. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. The Table of Contents must include:

- Responses to PARTS I, II, III and IV of the following application form
- Attachments, Exhibits, or Supplements

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6.)

SUBMISSION FORMAT:
We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1]. All subsequent correspondence should also be submitted as *searchable PDFs*.

- **Microsoft Word:** The application responses and responses to completeness questions

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Hospice of Washington County, Inc. (General Inpatient Unit – Doey's House)**

Address:

Unimproved Lot 3 Parcel at intersection of Yale Drive and Medical Campus Road	**Hagerstown**	**21742**	**Washington**
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: **Hospice of Washington County, Inc.**

3. APPLICANT. *If the application has a co-applicant, provide the detail in section 3 and 4 as an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):
Hospice of Washington County, Inc.

Address:

747 Northern Avenue	**Hagerstown**	**21742**	**MD**	**Washington**
Street	City	Zip	State	County

Telephone: **301-791-6360**

Name of Owner/Chief Executive: **Eric G. Klimes, Chief Executive Officer**

4. LEGAL STRUCTURE OF LICENSEE

Check ☑ or fill in one category below.

A. Governmental ☐
B. **Corporation**
(1) Non-profit ☒
(2) For-profit ☐
C. Partnership
General ☐
Limited ☐
Other (Specify): _____
D. Limited Liability Company ☐
E. Other (Specify): _____

5. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: **Shelley Steiner, Director of Strategic Initiatives**

Mailing Address:

747 Northern Avenue	**Hagerstown**	**21742**	**MD**
Street	City	Zip	State

Telephone: **301-791-6360**

E-mail Address (required): **sjsteiner@hospiceofwc.org**

Fax: **240-420-5610**

B. Additional or alternate contact: **Eric G. Klimes, CEO**

Mailing Address:

747 Northern Avenue	**Hagerstown**	**21742**	**MD**
Street	City	Zip	State

Telephone: **301-791-6360**

E-mail Address (required): **egklimes@hospiceofwc.org**

Fax: **240-420-5610**

6. Brief Project Description (for identification only; see also item #13):

Hospice of Washington County, Inc. (HWC) proposes to build a twelve-bed inpatient unit at Unimproved Lot 3 Parcel at intersection of Yale Drive and Medical Campus Road in Hagerstown, Maryland to provide hospice care to those needing pain and symptom management that cannot be managed in a lower setting of care. HWC will also provide respite services for home care hospice patients as needed.

7. Project Services (check applicable description):

Service	**(check if description applies)**
Establish a general hospice	
Establish a General Inpatient Unit (GIP)	**X**
Add beds to a GIP	

8. Current Capacity and Proposed Changes:

A) List the jurisdictions in which the applicant is currently authorized to provide general hospice services: **Washington County, Maryland**

) Jurisdictions applicant is applying to be authorized in: **Only in the current jurisdiction of Washington County, Maryland**

9. Project Location and Site Control *(Applies only to applications proposing establishment or expansion of a GIP unit):*

A.. Site Size **4.8** acres

B. Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES_____ **NO __X___** (If NO, describe below the current status and timetable for receiving necessary approvals.)

All state and local land use approvals, including zoning, for the facility will be obtained as part of the pre-construction planning process which will begin once the Certificate of Need process has been successfully completed.

C. Site Control and utilities:

(1) Title held by: **Meritus Medical Center**

(2) Options to purchase held by: _____

(i) Expiration Date of Option _____
(ii) Is Option Renewable? _____ If yes, Please explain

_____

_____

(iii) Cost of Option _____

(3) Land Lease held by: Meritus Medical Center
(i) Expiration Date of Lease: **2064**
(ii) Is Lease Renewable **Yes**
If yes, please explain: Option to renew the Lease for up to 5 renewal terms of 10 years in duration totaling a maximum of 100 years from the beginning of the initial term.

(iii) Cost of Lease: **Annual rent of $1.00 per year**

(4) Option to lease held by: _____NA_____
(i) Expiration date of Option _____
(ii) Is Option Renewable?_____ If yes, please explain

_____

_____

(iii) Cost of Option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained. **NA**

(6) Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities:

The site chosen for the General Inpatient Unit has public water, sewer, electric and low voltage communications (telephone) adjacent to the site.

(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

10. For new construction or renovation projects.

Project Implementation Target Dates

A. Obligation of Capital Expenditure **24** months from approval date.
B. Beginning Construction **12** months from capital obligation.
C. Pre-Licensure/First Use **24** months from capital obligation.
D. Full Utilization **18** months from first use.

11. For projects not involving construction or renovations. NA

Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

12. For projects not involving capital expenditures. NA

Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from 12A above.
C. Full Utilization _____ months from first use.

13. PROJECT DESCRIPTION

Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do

Hospice of Washington County, Inc. (HWC) proposes to build a General Inpatient Unit (GIP) to support the hospice residents of Washington County, Maryland who may be at times in need of pain and symptom management unable to be controlled in a lower level care setting as well as support hospice patients and their families who may need respite care according to the CMS guidelines in order to address caregiver exhaustion for short periods of time.

Examples of symptoms that may need to be managed in the general inpatient facility are as follows:

- Uncontrolled pain requiring frequent medication adjustment, aggressive treatment, or complicated technical delivery of medication which requires an RN to do the calibration etc.
- Intractable nausea and vomiting
- Unmanageable respiratory distress
- Seizures
- Hemorrhage
- Pathological fractures
- Severe agitated delirium
- Wounds requiring complex and/or frequent (skilled) dressing changes
- Imminent death **if** skilled needs are present
- Caregiver breakdown **only** if the patient has unmet skilled needs

The proposed 12-bed General Inpatient Unit (GIP) of Hospice of Washington County, Inc. will allow HWC for the first time to provide the full continuum of hospice levels of care in a home-like setting. Currently without a GIP unit, the hospice patients in Washington County who need a higher setting of care for pain and symptom management must go to a facility that often is not philosophically committed to end-of-life care. These patients are taken to the local hospital where they run the risk of having hospitalists order tests, treatments, or explorations contrary to the patient's choice of comfort care. The sometimes hurried and chaotic atmosphere itself is often not conducive to the needs of a dying patient nor does it provide the comfort to a family experiencing anticipatory grief. The GIP unit will be a free-standing unit that continues the plan of care for the patient in a setting that will mirror the capabilities of a hospital setting but with the dedication and focus on the comfort and plan of care the patient has chosen.

Hospice of Washington County, Inc., a non-profit, free-standing hospice that operates in Washington County, Maryland, has been an incorporated hospice since June 16, 1980.

In 1989, Hospice of Washington County, Inc. was certified by the Centers for Medicare and Medicaid Services and was licensed by the state of Maryland as a General Hospice. In February 2000, HWC was accredited by the Joint Commission on Accreditation of Healthcare Organizations, now known as the Joint Commission. HWC is a member of the National Hospice and Palliative Care Organization and the Hospice and Palliative Care Network of Maryland, and the Centers for Advanced Palliative Care. In 2014, HWC was the only Maryland hospice to be granted Deyta Hospice Honors for the quality of its services based on patient satisfaction scores.

Since 1980, Hospice of Washington County, Inc. has been providing end-of-life care for terminally-ill residents. In the beginning care was given by concerned volunteers in the community. Now, not only do volunteers give care but a full professional staff is employed to provide physical, emotional, and spiritual care to the dying patient and the family and to extend services to the bereaved family members for at least 13 months following the patient's death.

The proposed GIP unit will be staffed by a highly motivated and caring team with 35 years of consistently high quality of care and layers of experience. The founder of HWC, Dr. Frederic

Kass, III, remains the Medical Director of the organization demonstrating HWC's stability and continuity.

During 2014, HWC cares for approximately 270 patients on a daily basis and participates in approximately 50% of the annual deaths that occur in Washington County. The national average for patients served by hospice is 44.6% as tracked by the National Hospice and Palliative Care Organization. HWC is on track to serve 54% of the deaths in 2014 given the projected deaths for the county.

(2) Rationale for the project – the need and/or business case for the proposed project

Reason 1 – <u>Cost savings to Maryland Healthcare System</u>

The need for a General Inpatient Unit in Washington County touches the entire community. Washington County is a rural area of approximately 147,000 residents as of the census of 2010. Its health care system involves one major hospital, Meritus Medical Center with a Total Patient Revenue model for funding. Meritus Medical Center initiated an Accountable Care Organization in January 2014 making it responsible for approximately 16,000 Medicare lives in this and the immediate bordering counties (some in West Virginia and in Pennsylvania).

During the previous year, Meritus Medical Center served 516 patients that potentially qualified as appropriate for General Inpatient Services. Only 66 of these patients actually received General Inpatient services from Hospice of Washington County. Of the 450 patients who remained as patients of Meritus Medical Center's Palliative Care unit, the average cost per admission was approximately $16,060 per stay and annual expenses exceeded $7.2 million. Conversely, of the 66 patients that received general inpatient hospice services from Hospice of Washington County, the average cost per admission was $1,921. Assuming 100% of the 450 patients were in a hospice general inpatient setting, the prospective annual estimated savings could have exceeded $6.3 million. Furthermore, if the 516 patients (assuming an average length of stay of 4.5 days) were all referred to a hospice general inpatient setting, the average daily census would have been 6.4 patients.

The building of the General Inpatient Unit is demonstrated to be a cost-savings to the health care system in Washington County. Recognizing these potential cost savings is one of the reasons Meritus Medical Center is supporting the efforts of Hospice of Washington County to build the unit.

Reason 2 – <u>Appropriate setting for hospice patients.</u>

One method to gauge market demand is to look at the ratio of general inpatient days to total days in Washington County of interest and compare it to a best-case scenario. For that scenario, we have chosen Florida, because of its predominant non-profit hospice provider base. (Some for-profit hospices have been known to abuse this aspect of the benefit).

In the 20% of counties in Florida with the highest ratio of general inpatient beds, all had at least 5.8% general inpatient days when compared to the total days for that county. This top quintile was almost 20% above the state average. Based on the aforementioned and given the average daily census for CY14 is 262.4 through 9/30/14, the following beds are needed:

Average Daily Census – 262.4 x
Average General Inpatient Utilization (%) = 5.8% x
Occupancy Rate – 85% =
12.9 beds required

(3) Cost – the total cost of implementing the proposed project

The total costs of implementation of the Hospice General Inpatient Unit are as follows:

Building - Includes Contingencies	$4,700,000
Fixed Equipment (Not included in construction)	1,000,000
Land Purchase	0
Site Preparation	1,100,000
Architect/Engineering Fees	0
Permits	51,000
TOTAL	**$6,851,000**

14. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable: (***See Appendix 2 – Printed drawings for the General Inpatient Unit, Doey's House. PDF includes these drawings as separate attachments labeled as the letters below.)***

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For projects involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

15. FEATURES OF PROJECT CONSTRUCTION

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS and COSTS"** [See Table 1 Project Budget **below** describing the applicable new construction characteristics of the project].

B. Please review **Chart 1** located in the next two pages of the document

C. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

Hospice of Washington County, Inc. has no plans for bed expansion at this time that will be incorporated into the project's construction plan. Even so, a preliminary discussion was held to plan the facility to most easily be able to add four beds in the distant future if needed. No change to the construction plans were made but the drawings reflect where the four additional beds would be located if or when an expansion was made in order to maintain the least amount of distraction and disturbance to the current patients as well as to keep the distances from the nurse's station well under the standard of an efficient healthcare facility. HWC understands that the addition of 4 beds in the distant future would require another application for approval by the Maryland Health Care Commission.

D. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

The General Inpatient Unit site has public water, sewer, electric, and low voltage communications (telephone) adjacent to the site.

PART II - PROJECT BUDGET: COMPLETE TABLE 1 - PROJECT BUDGET

TABLE 1: PROJECT BUDGET

INSTRUCTIONS: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a.	New Construction	$6,851,000
(1)	Building - Includes Contingencies	4,700,000
(2)	Fixed Equipment (not included in construction)	1,000,000
(3)	Land Purchase	0
(4)	Site Preparation	1,100,000
(5)	Architect/Engineering Fees	
(6)	Permits, (Building, Utilities, etc.)	51,000

SUBTOTAL (Additional Detail Below) **$6,851,000**

b.	Renovations	
(1)	Building	$_____
(2)	Fixed Equipment (not included in construction)	_____
(3)	Architect/Engineering Fees	_____
(4)	Permits, (Building, Utilities, Etc.)	_____

SUBTOTAL $_____

c.	Other Capital Costs	
(1)	Major Movable Equipment	_____
(2)	Minor Movable Equipment	_____
(3)	Contingencies	_____
(4)	Other (Specify)	_____

TOTAL CURRENT CAPITAL COSTS (a - c) $_____

d.	Non-Current Capital Cost	
(1)	Interest (Gross)	$_____
(2)	Inflation (state all assumptions, Including time period and rate)	_____

TOTAL PROPOSED CAPITAL COSTS (a - d) $_____

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$_____
b.	Bond Discount	_____

c.	Legal Fees (CON Related)	_____	
d.	Legal Fees (Other)	_____	
e.	Printing	_____	
f.	Consultant Fees	100,000	
	CON Application Assistance	_____	
	Other (Specify)	_____	

TABLE 1: PROJECT BUDGET (continued)

g.	Liquidation of Existing Debt	_____	
h.	Debt Service Reserve Fund	_____	
i.	Principal Amortization Reserve Fund	_____	
j.	Other (Specify)	_____	
	TOTAL (a - j)	$_____	
3.	Working Capital Startup Costs	$_____	
	TOTAL USES OF FUNDS (1 - 3)		**$6,951,000**

B. Sources of Funds for Project:

1.	Cash	$1,500,000	
2.	Pledges: Gross $2,000,000 less allowance for uncollectable 10% = $200,000 = Net	1,800,000	
3.	Gifts, bequests	800,000	
4.	Interest income (gross)		
5.	Authorized Bonds		
6.	Mortgage	2,501,000	
7.	Working capital loans		
8.	Grants or Appropriation		
	(a) Federal	0	
	(b) State (bond bill)	250,000	
	(c) Local	0	
9.	Other (Specify)	_____	
	TOTAL SOURCES OF FUNDS (1-9)		**$6,951,000**

Lease Costs:			
a. Land	$_____ x _____	= $1.00/YEAR	
b. Building	$_____ x _____	= $_____	
c. Major Movable Equipment	$_____ x _____	= $_____	
d. Minor Movable Equipment	$_____ x _____	= $_____	
e. Other (Specify)	$_____ x _____	= $_____	

Note: As of October 15, 2014, the amount raised in cash, pledges, and in-kind services totals $2.4M demonstrating the support of the community for this project that has not yet broken ground nor announced publically the site of the General Inpatient Unit.

PART III - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

10.24.01.08G(3)(a). The State Health Plan.

Applicant must address each standard from the applicable chapter of the State Health Plan (10.24.13 .05); these standards are excerpted below. Please provide a direct and concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application. Copies of the State Health Plan are available on the Commission's web site http://mhcc.dhmh.maryland.gov/shp/Pages/default.aspx

10.24.13 .05 Hospice Standards.

The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new general hospice program, expand an existing hospice program to one or more additional jurisdictions, or to change the inpatient bed capacity operated by a general hospice.

A. Service Area.
Hospice of Washington County, Inc.'s General Inpatient (GIP) Unit will provide services to the residents of Washington County, Maryland and to residents of the surrounding areas who may come into Washington County to reside in the General Inpatient Unit if they are eligible for hospice services and require a skilled GIP or respite level of care.

B. Admission Criteria.
Hospice of Washington County, Inc., (HWC) admits patients in concert with Medicare hospice benefit requirements to hospice services. HWC provides quality care to all patients regardless of race, color, creed, sex, sexual orientation, age, disability, communicable disease or places of national origin. *(See **Policy #7010** (Uniform Quality of Care/Service) located in **Referenced Exhibits**, **Appendix I** – Referenced Policies and Documents.)*

All admissions to the General Inpatient Unit will meet Medicare guidelines for hospice admission. In addition, admissions to the General Inpatient Unit will meet the following criteria to qualify for a general inpatient level of hospice care:

C. Minimum Services.

(1) Direct Services:

The services listed below will be provided **directly** by the Hospice of Washington County, Inc. (HWC) staff – hired, trained, and managed by HWC. In all cases, the hospice patient and the family in the General Inpatient Unit will receive, at a minimum, all of the care and support

provided to the home care hospice patient level of care plus any extra care needed to match the higher level of support needed for the general inpatient level of care.

a) Skilled Nursing Care.

Hospice of Washington County, Inc. will provide the needed skilled nursing for the General Inpatient Unit. A registered nurse will be on staff and present in the facility 24 hours per day, 7 days per week. The registered nurse, as the case manager, will provide the comfort care as prescribed in the patient's plan of care by administering acute symptom management as well as facilitating communication with patients, families, physicians, and staff. The RN case manager will coordinate all aspects of the care of the patient including the physical, social, emotional and spiritual aspects of care.

b) Medical Social Services.

Hospice of Washington County, Inc. will provide the services of a social worker who is medically trained to minister to the needs of an end-of-life patient and the family. From the moment of admission to the General Inpatient Unit, the social worker will begin discharge planning to a lower setting of care in anticipation of the moment when pain and symptoms are managed and a general inpatient setting is no longer needed. In addition, the medically-trained social worker will provide comfort care in the form of patient and family emotional support, help with establishing patient goals and advance directives as needed, and will help to facilitate any goals that the patient has stated as important to their well-being.

c) Physician Services and Medical Direction.

The plan of care for a patient in the General Inpatient Unit will be under the supervision of the Chief Medical Officer (CMO) of Hospice of Washington County or the physician designated by the CMO. The CMO or the designee will work with the patient's attending physician to establish the plan of care. The CMO will provide oversight to the plans of care for the GIP unit patients that will utilize all resources available for meeting needs by interacting with both medical and community resources and providing end-of-life education with those resources. The CMO or the designee will be available to the General Inpatient staff at all times for consultations and visits as needed.

d) Hospice Aide/Homemaker/Personal Care Services.

As part of the services provided to all hospice patients, a certified nursing assistant (CNA) is part of the interdisciplinary hospice team that will operate in the General Inpatient Unit. The CNA provides personal care for the patient such as bathing, personal grooming, preparing light meals according to the plan of care, and attending to needs in the patient's environment to make the patient more comfortable. A CNA will provide these services to the patients in the GIP unit.

e) Volunteer Services.

Hospice of Washington County, Inc. currently has 186 specially trained volunteers and consistently meets the Medicare requirements for volunteers within a licensed hospice. In the General Inpatient Unit, the volunteers will be trained to be available to both patients and families to provide companionship, information, communication assistance, and whatever needs arise for patients and families to be comfortable and feel "at home" in the unit. Volunteers from HWC will receive special training to volunteers within the GIP unit.

f) Spiritual Services.

Hospice of Washington County, Inc. provides spiritual care staff to each patient under their care to address spiritual care needs of the dying patient. These spiritual care staff will also provide similar care to the patients and families in the General Inpatient Unit. The needs of patients and families will likely be heightened due to the intensity of the care needed in the GIP unit. The GIP unit will provide areas for counseling and meditation to take place to address spiritual needs in a conducive setting.

g) Bereavement Counseling Services.

Hospice of Washington County, Inc. provides grief and bereavement counseling as proscribed in the Medicare regulations. Pre-bereavement counseling occurs upon admission to HWC; after the patient's death, bereavement counseling is pursued for the family for a minimum of 13 months after the death. HWC bereavement services are provided at no charge to anyone in Washington County who is in need of support services regarding the loss of a loved one. The services already provided to hospice families in Washington County will be extended to those families who have patients that make use of the General Inpatient unit. In addition, anticipatory grief counseling and support will be offered within the GIP unit itself by the HWC staff. Each counselor is a masters-prepared social worker with specialized training in grief counseling. Support services may be face-to-face, by phone call, individualized counseling, family counseling, or by support group by the patient's family choice.

h) On-Call Nursing Response.

Hospice of Washington County, Inc. has a full nursing staff who can respond to hospice patient needs on a daily basis 24 hours a day, 7 days per week. The office number is answered after hours, weekends, and holidays by a third party call center who immediately contacts the on-call nursing staff to respond within minutes to address patient needs. If a situation arose in the General Inpatient Unit that needed more support than the current nurse and staff could handle, all available on-call nursing would be able to give support to the General Inpatient Unit's needs. On-call nursing can perform every facet of care including admissions, nursing care, and attend death visits. In addition, a social worker and a chaplain are on-call for patient and family emergent needs after hours, weekends, and holidays. Physician supervision of care is also an on-call provision for emergent needs and for admitting a patient into the General Inpatient Unit.

i) Nutrition Counseling.

Hospice of Washington County, Inc. provides its patients with a per diem dietary/nutrition counselor who is available for any hospice patient when needed as a part of the plan of care. The same provision for nutritional counseling will be made available to the patients in the General Inpatient unit.

(2) Direct or Contractually Arranged Services:

a) Hospice Aide and Homemaker Services.

Hospice of Washington County, Inc. will provide aide and homemaker services directly with staff from the organization.

b) On-Call Nursing Response.

Hospice of Washington County, Inc. will provide on-call nursing response services directly with staff from the organization. A contractual agreement is used for the calls that come in from the patients and referral sources to initiate the on-call nursing response. That agreement is in place and processes for receiving those calls to initiate the nursing response are in place, in use currently, and tested regularly.

c) Pharmacy Services.

Hospice of Washington County, Inc. provides pharmacy services through its contracted relationship with Hospice Pharmacia and with Walgreen's as its local emergent need provider. These relationships will continue to support hospice patients who will be residing in the General Inpatient Unit.

d) Laboratory, Radiology, and Chemotherapy Services As Needed for Palliative Care.

Hospice of Washington County, Inc. provides laboratory, radiology, and palliative chemotherapy services through contractual agreements with area providers. These contractual agreements will be in force for services needed within the proposed general inpatient unit.

e) Medical Supplies and Equipment.

Hospice of Washington County, Inc. provides medical supplies in a contractual agreement with Medline. In addition, HWC has a contractual agreement with National Hospice Medical Equipment (HME) for durable medical equipment. Both of these contracts will be in force for the needs that arise in the General Inpatient Unit.

f) Special Therapies, Such as Physical Therapy, Occupational Therapy, Speech Therapy, and Dietary Services.

Hospice of Washington County, Inc. will supply dietary services directly through the per diem staff for dietary and nutritional counseling and support. Other special therapies (i.e., physical, occupational, and speech) are contractual agreements with various providers; these contracted services will remain in force to provide needed therapies for patients in the General Inpatient Unit.

(3) Setting.

Hospice of Washington County, Inc. currently provides care in private homes, residential units such as nursing homes and assisted living facilities as well as in group homes. The proposed General Inpatient Unit will be another setting of care to provide a home-like setting to accommodate both the patient and family in an environment where pain and symptoms can be controlled with expertise of the hospice professionals in conjunction with the patient's plan of care while providing the counseling and emotional support of the family. The General Inpatient Unit will be in sharp contrast to the hustle and bustle of an acute care facility in which the patient and their family are often subjected to an environment not always supportive of the dying patient's plan of care. The purpose of a General Inpatient Unit is to provide a home-like setting that can accommodate the patient and family in a stable and supportive environment.

(4) Volunteers.

Hospice of Washington County, Inc. currently has 186 volunteers and continues to recruit on a regular basis. HWC provides volunteer education to meet the needs of the hospice patients. Of the 186 volunteers, 128 are companion volunteers. Seventy-seven percent (77%) of HWC's volunteers provide patient care and 23% provide office support or board governance. The number of patient volunteers to ADC ratio is 54:1. Fifty-six percent (56%) of HWC's patients are served by volunteers.

HWC consistently performs at a higher level than the required 5% minimum volunteer hours of total patient care hours. June and July of 2014 revealed a Medicare match for volunteer services at 6.9% and 7.3% respectively. HWC volunteers also provide 11th hour vigils to our actively dying patients.

Our volunteer services include but are not limited to: companion, special services (haircut, massage, music, pets, etc.), bereavement, courier, office, special events, and Board of Directors.

Under the direction of a Director of Volunteer Services, these volunteers will also provide support services to the patients in the proposed General Inpatient Unit. Special education will be designed and prepared for the inpatient unit volunteers; some special recruitment may be needed to provide for the needs of these patients and families.

(5) Caregivers.

Hospice of Washington County, Inc. consistently provides education for every aspect of the care of the patient; education of the caregiver is a primary responsibility of each of the members of the interdisciplinary team as they interact with the family members or caregivers for each hospice patient. The education is not only provided for the physical aspects of patient care, but is also targeted to the family needs of understanding death and dying processes as well as stages of grief, anticipatory grief, and end-of-life preparations. Much of the efforts of caring for the patient is the building of the understanding of the dying process and confidence in the care they are providing for their loved one under the watchful eyes of the team.

In the proposed General Inpatient Unit, much of the care giving will be directly provided by the staff of the unit; however, family/caregivers will be encouraged to take an active role in supporting the patient throughout the stay in the unit. Education will be provided to support patient needs, and families will be offered education as needed to remain informed and involved in the care of their loved one.

(6) Impact.

An applicant shall address the impact of its proposed hospice program, or change in inpatient bed capacity, on each existing general hospice authorized to serve each jurisdiction affected by the project. This shall include projections of the project's impact on future demand for the hospice services provided by the existing general hospices authorized to serve each jurisdiction affected by the proposed project.

Overall, the building of *Doey's House*, a general inpatient and respite unit, will have a positive impact on the healthcare system in Washington County, Maryland both in patient care and in reduction of healthcare costs. The proposed General Inpatient Unit will impact no other

hospices as HWC is the sole hospice provider in this jurisdiction.

During the previous year, Meritus Medical Center served 516 patients that potentially qualified as appropriate for General Inpatient Services. Of the 516 said patients, only 66 of them actually received hospice services. Of the 450 patients that remained at Meritus Medical Center's Palliative Care unit, the average cost per admission was approximately $16,060 per stay and annual expenses exceeding $7.2 million. Conversely, of the 66 patients that received general inpatient hospice services, the average cost per admission was $1,921. Assuming 100% of the 450 patients were in a hospice general inpatient setting, the prospective annual estimated savings could have exceeded $6.3 million. Furthermore, if the 516 patients (assuming an average length of stay of 4.5 days) were all referred to a hospice general inpatient setting, the average daily census would have been 6.4.

(7) Financial Accessibility.

Hospice of Washington County, Inc. already has a license to operate as a Medicare-certified hospice with the agreement to accept patients whose expected primary source of payment is Medicare or Medicaid. Over 90% of HWC's revenue is generated from the payments accepted from the patients having Medicare and Medicaid as their payor source. Other patients have private insurances that also provide a hospice benefit.

More importantly, from the inception of Hospice of Washington County, Inc., the policy has been established that hospice care is not for only those who have Medicare, Medicaid or private insurance. HWC maintains that all patients and families deserve to be supported at the end-of-life regardless of the ability to pay.

HWC will provide services according to the patient's ability to pay. During the admission process, financial data will be collected for those without a payor source that will be evaluated according to an established HWC policy to determine the ability to pay or to identify resources available for payment of services. In the end, if a patient is determined to have no ability to pay, the patient will receive HWC services of the same quality as those with a payor source. (*See **Policy #13014,** Charity Care and Fee Scale located in **Referenced Exhibits, Appendix I – Referenced Policies and Documents**.)*

I. Information to Providers and the General Public.

(1) General Information. An applicant shall document its process for informing the following entities about the program's services, service area, reimbursement policy, office location, and telephone number.

Hospice of Washington County, Inc. is a well-established hospice that is well known and well used in the jurisdiction where it serves as the sole provider of licensed hospice care. The relationships within the medical and non-medical are already well established. Within the medical community, hospice has contracts with the all of local nursing home facilities, over twenty (20) of the assisted livings/group homes located in the county as well as the local acute care hospital. In addition, HWC enjoys the support of a loyal residential following as it has served thousands of the residents in this community over the last 34 years. It is supported by the community at large both by usage as well as financially though generous donations each year.

The opening of the General Inpatient Unit will only solidify this long-term relationship within the medical and the non-medical communities as it will provide for even more services without a

burden being placed upon the health care system in the county. The information to be provided to the community to promote the inpatient unit will naturally become part of the robust communication Hospice of Washington County currently delivers on a daily basis in the community. However, specific messaging and marketing efforts will be directed toward educating each entity and the public; an understanding of the role of the General Inpatient Unit in the county will be fully taught throughout the community as well as the manner of accessing the care and the method of paying for the care in the new unit.

Process for informing local healthcare and general population of inpatient facility.

(a) Each hospital, nursing home, home health agency, local health department, and assisted living provider within its proposed service area;

HOSPITALS

Hospice of Washington County, Inc. has been relying solely on Meritus Medical Center to provide the needed acute care setting for HWC's patients to receive general inpatient hospice care over the last 30 years. Meritus Medical Center is the only acute care facility in the HWC's licensed area of Washington County. As a total patient revenue facility, Meritus fully supports the conception and planning for the inpatient facility; they see the addition of this facility as an option to give more specialized care to patients and families while at the same time saving their facility both monies and utilization for other acute care patients. The surrounding hospitals may also take advantage of moving a hospice-eligible patient from acute care into the hospice inpatient facility for the same reasoning.

The process for informing the local hospitals of the proposed Doey's House, a general inpatient facility for hospice patients who need pain and symptom management related to their terminal illness will be as follows:

1) A hospital-specific brochure will be created that specifically shows the following:
    a. services offered at the inpatient facility
    b. the location and contact information for the facility
    c. the process for out-of-state patients to use the inpatient facility
    d. the fee for service if patient is not Medicare or Medicaid eligible for hospice services and the associated sliding scale calculations

2) Schedule meeting at each hospital with administrator and hospitalist manager to inform of the presence of the new inpatient facility

3) Presentation prepared for how the inpatient facility will meet the needs and add value to both the hospital as well as patients/families

4) Schedule presentations with emergency room, palliative care, critical care, nursing management, and transitions care

5) Maintain regular and frequent visits by hospice staff to keep hospital informed as to the ease of contacting, the efficiency of moving a patient to the general inpatient facility, and to supply answers to any and all questions

The following acute care facilities will most use the inpatient unit in the licensed area of

Washington County and will be the primary educational outreach targets:

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742
Phone: (301) 790-8000

Frederick Memorial Hospital
400 W 7th Street
Frederick, MD 21701
Phone: (240) 566-3300

Veterans Administration Medical Center
510 Butler Avenue
Martinsburg, WV 25401
Phone: (304) 263-0811

Berkeley Medical Center
2500 Hospital Drive
Martinsburg, WV 25401
Phone: (304) 264-1000

Waynesboro Hospital
501 East Main Street
Waynesboro, PA 17268
(717) 765-4000

Chambersburg Hospital
112 North Seventh Street
Chambersburg, PA 17201
(717) 267-3000

NURSING HOMES

Hospice of Washington County, Inc. has a contractual relationship with 9 out of the 10 skilled nursing facilities in the hospice's licensed service area. About 34% of HWC's hospice patients reside in one of the following skilled nursing facilities. HWC has a growing and stable relationship with each of these facilities making the discussion about the role of the inpatient unit very natural. HWC's primary concern is the message that HWC is not competing for the same patients they would normally be serving; the General Inpatient Unit will be present for the hospice eligible patient who is having pain and symptom management issues. HWC presents an alternative for those terminally-ill patients/families that until now would have to move to a hospital setting. The process for informing this group of skilled nursing facilities would be as follows:

1) Schedule direct meetings with each facility's Executive Director, Director of Nursing, and Medical Director to explain the facility and the role of the inpatient unit in the community;

2) Provide each facility with educational materials about the General Inpatient Unit's

role in providing a higher level of care short-term to manage pain and symptoms that in the past would push the patient to the local hospital;

3) Explain to each skilled nursing facility that this patient's option to go to the General Inpatient Unit will help the nursing home to manage its readmission rates for hospice patients that may have had a recent hospital stay. This inpatient unit could help the skilled nursing facility to increase its quality scores within the local Accountable Care Organization.

Golden Living Center
750 Dual Highway
Hagerstown, MD 21740
Phone: 301-797-4020

Coffman Nursing Home
1304 Pennsylvania Avenue
Hagerstown, MD 21742
Phone: 301-733-2914

Fahrney-Keedy Home & Village
8507 Mapleville Road
Boonsboro, MD 21713
Phone: 301-733-6284

Homewood at Williamsport
16505 Virginia Avenue
Williamsport, MD 21795
Phone: 301-582-1628

Julia Manor Health Care Center
333 Mill Street
Hagerstown, MD 21740
Phone: 301-665-8700

NMS Healthcare of Hagerstown
14014 Marsh Pike
Hagerstown, MD 21742
Phone: 301-733-8700

Ravenwood Nursing Care Center
1183 Luther Drive
Hagerstown, MD 21740
Phone: 301-790-3001

Reeders
141 S. Main Street
Boonsboro, MD 21713
Phone: 301-432-5457

Williamsport Nursing Home
154 North Artizan Street
Williamsport, MD 21795
Phone: 301-223-7971

Western Maryland Skilled Nursing and Long Term Care (Contract in progress)
1500 Pennsylvania Avenue
Hagerstown, MD 21742
Phone: 301-745-4200

HOME HEALTH AGENCIES

HomeCall
130 King Street
Hagerstown, MD 21740
Phone: 240-329-9033

Lutheran Home Health
222 E Oak Ridge Drive
Hagerstown, MD
Phone: (240) 231-0311

Meritus Home Health
1799 Howell Road
Hagerstown, MD 21740
Phone: 301-766-7800

LOCAL HEALTH DEPARTMENT

Washington County Health Department
1302 Pennsylvania Avenue
Hagerstown, MD 21742

ASSISTED LIVING PROVIDERS

Autumn Assisted Living
310 Cameo Drive
Hagerstown, MD 21740
Phone: 301-766-9190

Broadmore Senior Living
1175 Professional Court
Hagerstown, MD 21740
301-766-0066

Charlotte's Home I
212 Maple Avenue
Boonsboro, MD 21713
Phone: 301-432-2415

Charlotte's Home II
13715 Village Mill Drive
Maugansville, MD 21767
Phone: 301-791-2831

CJ's Senior Care
145 King Street
Hagerstown, MD 21740
Phone: 301-791-6186

Fahrney-Keedy Assisted Living and Bowman Center
8507 Mapleville Road
Boonsboro, MD 21713
Phone: 301-733-6284

Filcare Home
13016 Spickler Road
Clear Spring, MD 21722
Phone: 301-857-8200

Homewood Assisted Living
16505 Virginia Avenue
Williamsport, MD 21795
Phone: 301-582-1805

Holly Place
268 South Potomac Street
Hagerstown, MD 21740
Phone: 301-733-3008

Emeritus at Hagerstown
20009 Rosebank Way
Hagerstown, MD 21742
Phone: 301-733-3353

Mennonite Fellowship Home
12349 Huyett Lane
Hagerstown, MD 21740
Phone: 301-766-0707

Mennonite Home
13436 Maugansville Road
Hagerstown, MD 21740
Phone: 301-733-5899

Potomac Center
1388 Marshall Street
Hagerstown, MD 21740
Phone: 240-313-3530

Ravenwood Assisted Living
1158 Luther Drive
Hagerstown, MD 21740
Phone: 301-790-3001

Somerford Place
10114 Sharpsburg Pike
Hagerstown, MD 21740
Phone: 301-791-4829

Somerford House
10116 Sharpsburg Pike
Hagerstown, MD 21740
Phone: 301-791-7943

The ARC of Washington County
820 Florida Avenue
Hagerstown, MD 21740
Phone: 301-797-3380

The Village at Robinwood
19800 Tranquility Circle
Hagerstown, MD 21742
Phone: 240-420-4100

Star Community, Inc.
13757 Broadfording Church Road
Hagerstown, MD 21740
Phone: 301-791-0011

Twin Oaks Assisted Living
40 East Village Lane
Williamsport, MD 21795
Phone: 301-223-7971

Washington County Human Development Council
433 Brewer Avenue
Hagerstown, MD 21740
Phone: 301-791-5421

(b) At least five physicians who practice in its proposed service area

Drs. Jeffrey Hurwitz and Caroline Gessert
Internal Medicine
265 Mill Street
Hagerstown MD 21740
Phone: (240) 347-4885

Drs. Zafar Malik and Ghazala Qadir
Internal Medicine/Family Practice
1190 Mount Aetna Road
Hagerstown**,** MD 21740
Phone: (301) 790-0666

Drs. Michael McCormack and Frederic Kass, III
Hematology/Oncology
Meritus Cancer Specialists
11110 Medical Campus Rd
Hagerstown, MD 21740
Phone: 301-733-8600

Drs. Hind Hamdan, Yong Tang, and Mouhamad Bazzi
Antietam Oncology and Hematology
1130 Opal Ct
Hagerstown, MD 21740
Phone: 301-797-8279

Drs. Jonny Alencherry, Shaheen Iqbal, and Muhammad Waheed
Pulmonary Consultants
12821 Oak Hill Avenue
Hagerstown, MD 21742
Phone: 301-733-0300

Dr. Manzar Shafi
Antietam Geriatric and Internal Medicine
368 Mill Street
Hagerstown, MD 21740
Phone: 301-739-4510

(c) The Senior Information and Assistance Offices located in its proposed service area

WASHINGTON COUNTY SENIOR INFORMATION & ASSISTANCE OFFICE
Commission on Aging (manages Washington County's "Meals on Wheels")
140 West Franklin St., 4th Floor
Hagerstown, MD 21740
Phone: (301) 790-0275

Department of Social Services
122 N Potomac Street
Hagerstown, MD 21740
Phone: (240) 420-2100

(**d) The general public in its proposed service area. The following are the proposed strategies for the general public to be made aware of the inpatient unit and its policies, procedures, beneficial uses, and contact information.**

- Press Releases in local newspapers
- Feature article about the inpatient unit in local newspaper
- Presentations at local civic groups – Rotary, Lions, Kiwanis
- Educational presentations for medical education classes at Hagerstown Community College, Kaplan University, and Maryland
- Educational presentations at 747 Northern Avenue site
- Presentation at local senior center
- Local health related radio show presentation with Meritus Medical Center
- Local informational radio show presentation
- Insert in local newspaper
- Printed Brochures in local physician offices

(3) Fees. An applicant shall make its fees known to prospective patients and their families before services are begun.

Hospice of Washington County informs all patients and their families of the fees for service and their financial obligations at the time of admission. Arrangements are made at that time to utilize Medicare, Medicaid, private insurance, or self-pay. Under no circumstances is a patient turned away due to inability to pay.

The discussion regarding Financial Obligations is part of the discussion for admission to hospice. A Financial Obligation detailing what will be provided by Hospice of Washington County, Inc. under the specific payor source available for the patient is carefully explained and a copy is left with the patient/family at the time consents for hospice care is signed. Subsequent conversations are had at any time within a patient's stay in hospice if the financial circumstances change due to a payor source being removed or added. **(***See* ***Policy #1005****, Financial Responsibility,* ***Appendix I*** *– Referenced Policies and Documents.***)**

J. **Charity Care and Sliding Fee Scale**. **Each applicant shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to hospice services regardless of an individual's ability to pay and shall provide hospice services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:**

(1) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospice shall make a determination of probable eligibility.

Hospice of Washington County, Inc. (HWC) determines the eligibility for Charity Care either upon the day of request for hospice services or upon the day of the request for a current patient whose initial financial situation has changed. HWC may at times be delayed due to a holiday or weekend, a delay in the patient or family gathering proper financial information, or due to a weekend; the request for charity care is a priority and most days it is determined the same day as the request is made. HWC always operates within the two business day window.

(2) Notice of Charity Care Policy. Public notice and information regarding the hospice's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the population in the hospice's service area, and in a format understandable by the service area population. Notices regarding the hospice's charity care policy shall be posted in the business office of the hospice and on the hospice's website, if such a site is maintained. Prior to the provision of hospice services, a hospice shall address any financial concerns of patients and patient families, and provide individual notice regarding the hospice's charity care policy to the patient and family.

During the initial conversation about hospice care services, the discussion of financial responsibility is a key component for the discussion. Hospice of Washington County, Inc. (HWC) has the financial discussion using a form entitled Statement of Financial Responsibility which delineates the services offered as well as other common services and depending on their payor source the payor for each service. A copy of this financial responsibility statement is left with the patient or family.

(4) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each hospice's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income patients who do not qualify for full charity care, but are unable to bear the full cost of services.

If during the discussion, HWC learns that the patient has no payor source who offers hospice care services, a discussion ensues about financial costs. If a patient has no payor and limited funds, the patient's income is evaluated on a sliding scale based on the poverty scale of the current year as published by the HHS poverty guidelines. *(See **Policy #13014**, Charity Care and Sliding Scale Policy, **Appendix I** – Referenced Policies and Documents.)*

(4) Policy Provisions. An applicant proposing to establish a general hospice, expand hospice services to a previously unauthorized jurisdiction, or change or establish inpatient bed capacity in a previously authorized jurisdiction shall make a commitment to provide charity care in its hospice to indigent patients. The applicant shall demonstrate that:

The policy includes a provision whereby HWC will determine eligibility for charity services within two days of the patient's request for charity care services. If it is determined that the patient qualifies, the Sliding Fee Scale that is in effect at the time of admission is used to determine the fees that the patient is responsible for. The Sliding Fee Scale is based upon the household income and the household size; the resultant percentage is applied to the fees to determine the patient's obligation. In the event that the patient is unable to pay the percentage that they are responsible for at one time without undue hardship, a payment plan is negotiated.

a. Its track record in the provision of charity care services, if any, supports the credibility of its commitment.

Hospice of Washington County, Inc. is fully committed to serving the indigent and uninsured in our community. A benevolence fund is maintained to assist with such things. As of September

30, 2014, HWC has incurred more than $60,000 in charitable write-offs resulting from services provided to patients who were unable to pay.

b. It has a specific plan for achieving the level of charity care to which it is committed.

Hospice of Washington County, Inc. maintains a written policy which provides for the charity care of indigent or uninsured patients in order to ensure that they have access to hospice services regardless of the patient's ability to pay. Under no circumstances will a patient be turned away due to the inability to pay. All patients, regardless of financial means, will be given the same high quality of care. It is the desired goal of Hospice of Washington County that a minimum 1% of revenue be given in charitable care for those seeking hospice services, grief and bereavement care in the community, or any other needs in which HWC seeks to give back to patients and families in need.

HWC's policy further provides that the policy is posted in our business office and on our website in order to be available to the general public. Each request for charitable service is immediately vetted and services are not delayed due to the inability to pay or the request to be considered for charitable services.

K. Quality.

Hospice of Washington County, Inc. participates in an organizational Quality Assessment Performance Improvement (QAPI) program designated to monitor, evaluate, and improve hospice quality and standards. HWC's QAPI program is patient-centered, outcome-oriented and data-driven, consistent with the Center for Medicare and Medicaid Service (CMS) regulatory requirement. HWC chooses its quality assessment data based on the National Quality Forum (NQF) report.

Hospice of Washington County has an internal QAPI committee that meets quarterly to review statistics on performance and quality measures and will adapt any performance improvement plan to improve low scores. Hospice of Washington County, Inc. also has a Board of Director's Quality Oversight Committee that meets quarterly to review quality data.

The QAPI plan for HWC monitors those important aspects of care which are felt to be high risk, high volume or have demonstrated a trend toward potential negative patient outcome (problem prone). In addition, those aspects of care, which have been identified through the QAPI process as an area where a system or process of patient care may be improved, will be monitored. Aspects of care will be identified and chosen for monitoring through a collaborative effort utilizing information obtained from nursing, social services, spiritual support, bereavement support and pharmacologic services, regulatory body reports, medical staff evaluation, Human Resources and Finance, and other clinical services and support services, as appropriate.

i. Aspects of care for assessment include, but are not limited to:
    1. Timeliness of hospice assessment and evaluation services
    2. Timeliness of hospice interventional services, as requested by patient or family and/or determined from any member of the hospice care team
    3. Appropriateness of treatment
    4. Patient treatment plan toward end of life quality goal setting
    5. Documentation of patient progress
    6. Assessment of the efficacy of treatment administered

7. Patient/Family education
8. Effectiveness of pain management and control
9. Medication management
10. Infection control practices
11. Personnel in-service education and training
12. Patient/Family/Physician and other personnel complaints

ii. Aspects of care are subject to change due to the collaborative processes outlined above.

Performance measures and outcomes will be established as a means to systematically monitor the identified aspects of care in an ongoing manner and to provide operational linkages between the risk management functions related to the clinical aspects of patient care and safety and the QAPI functions. Performance measures will relate to the identified aspects of care and will be specific and will be structured to relate to both the processes and outcomes of patient care. Performance measures will pertain directly to all components of HWC practices and will use objective criteria that reflect current knowledge and clinical experience. Current quality measures are in line with the newly required *Hospice Item Set* implemented July 1, 2014. These item set data are made up from various National Quality Forum measurements:

iii. **Treatment Preferences** (NQF #1641) – the percentage of hospice patients with chart documentation of preferences for life sustaining treatments:
    1. Numerator: patient asked about CPR preferences, other life sustaining preferences, and hospitalization preferences
    2. Denominator: patients 18 years or older and enrolled in hospice for 7 or more days

iv. **Beliefs/Values addressed** (modified NQF #1647) – the percentage of hospice patients with documentation of a discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss:
    1. Numerator: Patient and/or caregiver was asked about spiritual/existential concerns
    2. Denominator: Patients 18 years of age or older and enrolled in hospice for 7 or more days

v. **Pain** (NQF #1634) – The percentage of hospice patients who were screened for pain during the initial assessment:
    1. Numerator: Patient screened for pain and either reported no pain or had pain (and if had pain, issued a severity measurement with standardized pain tool)
    2. Denominator: Patients 18 years of age or older and enrolled in hospice for 7 or more days

vi. **Quality Measures** – Percentage of patients who complained of pain at time of assessment had their pain relieved within 48 hours:
    1. Numerator: Number of patients who answered YES to the f/u evaluation to assess if their pain was brought to a comfortable level w/in 48 hours
    2. Denominator: Number of patients who answered YES to the question indicating their pain was at an uncomfortable level.

vii. **Dyspnea Screening** (NQF #1638) – the percentage of patients who screened positive for dyspnea who received treatment within one day of the screening:
    1. Numerator: Treatment for SOB was initiated or the patient declined treatment
    2. Denominator: Patients 18 years of age or older and enrolled in hospice for 7 or more days and screened positive for SOB during the initial nursing assessment

viii. **Bowel Regimen** (NQF #1617) – percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed:
    1. Numerator: A bowel regimen was initiated or continued or there is documentation of why a bowel regimen was not initiated or continued.
    2. Denominator: Patients 18 years of age or older and who are given a prescription for a scheduled opioid.

Quality measurement and data analysis are crucial for strategic planning, quality improvement and the ability to demonstrate the effectiveness of the program. Data from four different areas is collected in order to fully demonstrate a program's success. Hospice of Washington County, Inc. currently tracks the operational data, pain, dyspnea, patient/family satisfaction and financial data.

As previously stated, HWC participates in an organizational Quality Assessment Performance Improvement (QAPI) program designated to monitor, evaluate, and improve hospice quality and standards. HWC's QAPI program is patient-centered, outcome-oriented and data-driven, consistent with CMS's regulatory requirement.

Statistical evaluation of performance measures is structured to focus on an improvement in patient care. Thresholds will represent either pre-established levels that, when reached, trigger an intensive evaluation of the indicator under review; or benchmarks that have been identified by organization experience, which require an in-depth evaluation of the proposed aspect of care and relating performance measures. Monitoring and collection of data will be performed with a frequency sufficient to identify departures from the criteria, problems in patient care and areas for improvement. An outline of actual aspects of care under review will include description of the frequency of monitoring for each activity, how and from where the data will be obtained.

HWC will maintain a QAPI log for the routine collection of data on selected key aspects of care. The Quality, Education & Compliance Director, with approval from the Quality and Compliance Committee shall establish standards of compliance with each criterion for all performance measures under review. HWC will monitor the selected aspects of care at a predetermined frequency and enter the results of compliance on the respective data collection record. The Quality, Education & Compliance Director or designee will aggregate the data collected for reporting purposes. Data shall be collected from a variety of sources to analyze patterns or trends in care, including but not limited to: daily logs, computer reports, unusual event reports, Family/Physician/Bereavement Satisfaction Surveys, and the patient's medical record.

Performance Improvement Projects (PIP) – Hospice of Washington County, Inc. selects problems for performance improvement activities by evaluating their impact on patient care, services offered, clinical practice, fiscal accountability and cost effectiveness.

Problems are identified for possible selection as a performance improvement activity after they have been assessed. Implemented measurable healthcare standards are compared with implemented process, structure and outcome criteria to identify deviations of control limits set. An appropriate representative sample of data is obtained to evaluate any deviations. Problem identification information is communicated to individuals and the interdisciplinary team as appropriate.

Current performance improvement projects Hospice of Washington County, Inc. has undertaken are: Bereavement PIP, Community Life Center PIP, Interdisciplinary Team PIP, and a Volunteer Program PIP.

The **Bereavement PIP** was implemented to improve Family Evaluation of Bereavement Services (FEBS) scores by improving the support to the bereaved, improve time frames in which the bereaved are contacted and improve the tracking system in the Bereavement Department.

The **Community Life Center PIP** was implemented to open community life centers throughout the county in order to be able to serve our county in a more holistic fashion. These life centers are to be educational centers for those who have lost loved ones as well as to be a reflection of the needs and solutions in each community. HWC has opened two of these centers in underserved population areas and will be opening a third by the end of 2014.

The **Interdisciplinary Team (IDT) PIP** was implemented after receiving a number of Additional Development Requests (ADR) from the Centers for Medicare and Medicaid Services based on incomplete or weak IDT documentation. A focus on education and accuracy of documentation is the emphasis of this process improvement; it is ongoing education for the members of the patient care clinical team. The objective is to improve documentation and to ultimately reduce payment denials from ADRs related to IDT documentation.

Finally, the **Volunteer PIP** was implemented to help improve patient visit documentation by our volunteers and to be able to strengthen the documentation that supports the patient's terminal prognosis and day-to-day patient's condition.

Attached to this application in ***Appendix I*** are the Quality Assessment Data from 2013 and Quarters 1 & 2 of 2014. Also included are the Family Evaluation of Hospice (FEHC) survey results for 2013 and Quarters 1 and 2 of 2014. These results are compiled and issued by the National Hospice and Palliative Care Organization (NHPCO). The FEHC survey measures a hospice's performance based on 27 Quality Indicator Questions as well as provides an "Overall Rating" and Composite Score.

Hospice of Washington County's Policies and Procedures related to the Quality and Compliance Program will also be included as part of this application package as well as notification of the Joint Commission Certification.

A. Linkages to other services:
    a. HWC contracts with Meritus hospital, long-term care facilities, assisted living facilities and group homes in Washington County.

    b. HWC has established relationships with each home health organization in Washington County.

    c. HWC works closely with the Department of Social Services (DSS) to provide extra resources for the needs of hospice patients and to support DSS with needs for residents facing a terminal illness.

    d. HWC works closely with the Commission on Aging which is designated as the senior information and resource center in Washington County. The Commission on Aging is also the resource that manages "Meals on Wheels" in Washington County.

B. Respite care:
    HWC currently has contracts with NMS, Golden Living Center, Reeders, Fahrney-Keedy, Julia Manor and MMC for respite care. Upon establishment of the hospice house, HWC will provide direct respite level of care for hospice patients.

C. Public Education Programs:
    a. HWC has provided and will continue to provide symposiums in the community to reach and educate diverse racial, religious, and ethnic groups that are still in a fledgling state of hospice use.

    b. HWC provides education for the community on a regular basis by hosting topical discussions on end-of-life issues, the Maryland Order for Life Sustaining Treatment (MOLST) and advance directive planning, chronic disease management classes, dispelling the myths of hospice care, Hospice 101 and other topics for the public. HWC regularly offers grief and bereavement education in our life centers, our main office, and in the public schools for students who have suffered a loss. HWC also educates the medical community that is not well-versed on hospice care in this rural community. This medical education is offered at times to physicians in the community individually and also has been presented to large forums such as Grand Rounds in the local hospital.

    c. HWC also offers the End-of-Life Nursing Education Consortium (ELNEC) training series for any local nursing staff that wants formal end of life training. Members of HWC staff are certified ELNEC trainers.

D. Patient's rights:

a. Policy #1001, Hospice Patient Rights and Responsibilities, identifies the rights that a hospice patient has as well as identifies the expected responsibilities of the patient. In summary, this policy states a patient has the right to receive care from a team of professionals to provide quality and appropriate care based on the plan of care. A Hospice of Washington County patient receives appropriate and compassionate care regardless of age, gender, nationality, race, creed, sexual orientation, disability, availability of a primary caregiver, or ability to pay. Patients of Hospice of Washington County have the right to receive informed consent, be treated with respect, and receive training for the family so that they may assist with care. Patients of Hospice of Washington County can expect confidentiality of medical records, financial and social circumstances. Patients have the right to voice complaints without being subject to discrimination or reprisal, be informed about payment and treatments, and any changes in charges of fees. Patients will also have their pain believed and treated appropriately. Patients have the responsibility to participate in the plan of care, provide Hospice of Washington County with accurate and complete health information, remain under a physician's care while receiving services and assist with development and maintenance of a safe environment. *(See **Policy #1001** located in **Appendix I,** Referenced Policies and Document)*

b. HWC adapts the policy on patients' rights from the Medicare Regulations for Hospice Care, including the Conditions of Participation for Hospice Care 42 CFR 418.52 – Patient's Rights.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient hospice care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

Hospice of Washington County, Inc. currently provides general inpatient level of hospice care in the local hospital, Meritus Medical Center via a contractual agreement. Patients who are receiving hospice home care and become symptomatic to a level that cannot be managed in the patient's current location are taken to Meritus where the general inpatient level of care is administered until pain or symptoms are again controlled. Discharge planning takes place as a coordinated effort between the hospice social worker and the discharge planner from the hospital from the day of admission. Daily visits are made to the patient during their hospital stay as a general inpatient.

All current hospice patients in need of a higher level of care will be taken to the General Inpatient Unit for pain and symptom management under the direct care and the expertise of the interdisciplinary team of HWC. The patient's stay in the unit will be in accordance with the patient's plan of care under the watchful eyes of the hospice medical team. Discharge planning to a lower level of care will be started on the day of admission; once a patient's symptoms and pain are under control, the patient will be moved back to the hospice home care level and discharged back to the lower care setting.

If at any time, the HWC General Inpatient Unit is full and unable to take a patient under care, the

current process can be utilized to have the patient sent to Meritus Medical Center or any other contracted facility for general inpatient care.

(4) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance Programs, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

Hospice of Washington County, Inc. has been licensed to provide hospice care since 1980. HWC maintains contractual agreements with 9 (soon to be 10) skilled nursing facilities, over 27 assisted living/group home facilities, as well as Meritus Medical Center. HWC has strong relationships with the Commission on Aging who is the local provider of senior information and assistance program as well as the local "meals on wheels" programs in Washington County. In addition, the Department of Social Services and HWC have a close relationship. HWC social workers have access to the services that can be provided to patients in need.

M. Respite Care. An applicant shall document its system for providing respite care for the family and other caregivers of patients.

Currently, Hospice of Washington County, Inc.) has contracts for respite care with five skilled nursing facilities (NMS Healthcare of Hagerstown, Golden Living Center, Reeders, Fahrney-Keedy, and Julia Manor) as well as Meritus Medical Center. The respite level of care in the Medicare region in which HWC falls pays out at a lower rate than the rates of a skilled nursing home bed. Due to the lower paid bed rate, often it has been difficult to locate an available bed for respite care.

Upon establishment of the General Inpatient Unit, those patients needing a respite level of care will receive it directly from HWC. HWC will continue to maintain all contractual relationships for respite care in order to have a backup plan for those times in which the General Inpatient Unit is full.

N. Public Education Programs. An applicant shall document its plan to provide public education programs designed to increase awareness and consciousness of the needs of dying individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce the disparities in hospice utilization. Such a plan shall detail the appropriate methods it will use to reach and educate diverse racial, religious, and ethnic groups that have used hospice services at a lower rate than the overall population in the proposed hospice's service area.

Hospice of Washington County, Inc. has been an educator of the public regarding hospice care over the past 34 years. Each year, educational plans are made in which segments of the both the medical and general communities are targeted for education. In addition to that planned education, HWC is often contacted by groups asking for our speakers' bureau to deliver informative talks about various aspects of the services provided by HWC. All of these educational efforts are necessary due to HWC's holding the sole license in the county to provide hospice care; HWC takes the responsibility of this educational mission very seriously as the sole voice in the community advocating for the use of hospice care.

In recent years, HWC has been specifically designing educational programs to address the

disparity of hospice use among the various ethnic groups in Washington County. Educational seminars have been held in both the African-American and the Hispanic communities. These seminars were done within the communities and were endorsed by leaders in these communities as well as by pastors in the area. HWC has developed a relationship with the imam at the local Islamic congregation. In 2015, HWC has plans to provide education to the local Korean churches that are new to the area while continuing the ethnic educational programs initiated over the past two years.

HWC is located in the rural area of Western Maryland; Washington County demographic data shows that the population disbursement for 2013 as approximately 81.6% Caucasian, 10.7% African-American, 4% Hispanic and Latino with other ethnic groups making up the remainder of the population. In the year of 2013, HWC served 46% of all the deaths in Washington County; HWC served 46.7% of the Caucasian deaths; 28.8% of the African-American deaths; and 54.5% of the Hispanic/Latino deaths.

Other initiatives begun in 2014 are to establish life centers (centers that concentrate on providing grief counseling and education as well as providing for other community needs) in the communities that are underserved. A life center has been opened in the Hancock community to provide grief services in a community that is underserved by other resources, is challenged economically, and is somewhat cut off from the rest of the county. A new life center is now located in the downtown area of Hagerstown that allows the underserved population of the city center to reach grief counseling without having to pay for transportation to our main facility. A third life center is planned and will open in Boonsboro before the end of 2014.

Hospice of Washington County, Inc. has been striving to reach out to populations who generally do not choose hospice care by integrating education and our presence into these communities. HWC plans to continue the outreach by increasing the contacts within these groups each year.

O. Patients' Rights. An applicant shall document its ability to comply with the patients' rights requirements as defined in COMAR 10.07.21.21.

.21 Patient's Rights.

A. The hospice care program shall provide the patient or representative with a written notice of the patient's rights in advance of furnishing care. Documentation verifying receipt of and understanding of this information shall be included as part of the patient's record.

Hospice of Washington County, Inc. provides each patient/patient representative with a written document detailing the patient's rights. [See **Policy #1001 Patients' Rights and Responsibilities, Appendix I** – Referenced Policies and Documents.]

HWC presents these rights to the patient and/or the patient's representative prior to the signing of the consents for hospice care. In addition, the HWC instructs all new employees and volunteers regarding these patient rights in their orientation to hospice.

HWC adapts the policy on patients' rights from the Medicare Regulations for Hospice Care, including the Conditions of Participation for Hospice Care 42 CFR 418.52 – Patient's Rights.

In addition to education for the employees, the individuals who come into contact with patients and families reinforce these rights in practice on a daily basis. Supervisors of team members

perform supervisory visits to reinforce these rights. All staff are limited in contact with confidential information regarding patients in order to guard against privacy violations and to maintain confidentiality.

The health care status of every patient is reviewed by the interdisciplinary team every 14 days in order to assure the plan of care is the desired plan of care of the patient and the patient's designee. The social worker and the RN case manager work together with the patient/patient representative to formulate the patient's advance directives and with the patient's physician to complete the Maryland Orders for Life Sustaining Treatment (MOLST).

All patient admission packets contain the proper complaint telephone numbers for the patient/patient representative to use in the event they want to report any complaints or grievance regarding the hospice care they are receiving. These telephone numbers are left with the patient/patient representative.

During the admission process, all patients/patient representatives are informed of the levels of hospice care, the right to refuse hospice care, the details of the discharge policy, and the readmission option.

HWC addresses payment for hospice care prior to the signing of the consents for hospice by the patient/patient representative. Each service is listed and discussed as well as those items that will not be covered under hospice care. A copy of the financial responsibility form is left with the patient/patient representative. (*See **Policy #1005**, Financial Responsibility, **Appendix I** - Referenced Policies and Documents.)*

P. Inpatient Unit: In addition to the applicable standards in .05A through O above, the Commission will use the following standards to review an application by a licensed general hospice to establish inpatient hospice capacity or to increase the applicant's inpatient bed capacity.

(1) Need. An applicant shall quantitatively demonstrate the specific unmet need for inpatient hospice care that it proposes to meet in its service area, including but not limited to:

(a) The number of patients to be served and where they currently reside.

The patients served by the proposed General Inpatient Unit will be primarily the residents of Washington County, Maryland. They will be current patients of Hospice of Washington County, Inc. whose pain or symptoms need management at a higher level of care. The majority will be patients who reside in a residential setting without the availability of a skilled level of care. The General Inpatient Unit will work to get the pain or symptoms under control with the objective to move the patient back to a home level of care as soon as possible.

Patients who are already in the local hospital are expected to be moved to the General Inpatient Unit to receive hospice care for the first time; these patients also will exhibit pain and symptoms that could not be managed at a lower level of care. The inpatient team will begin discharge planning from the day of admission to move these patients safely to a lower care setting once they no longer qualify for a general inpatient level of care.

Based on projections for CY15, Hospice of Washington County projects a budgeted average daily census of 255.5. Assuming 5.8% of the patients at any given time, the prospective average daily census in the General Inpatient Unit could exceed 14.8.

The sources of the referral to the hospice General Inpatient Unit are community physicians, Meritus Medical Center and hospitals in surrounding counties, surrounding hospices in Maryland that do not have a freestanding hospice General Inpatient Unit, Hospice of Washington County staff and long term care providers in Washington county and surrounding counties.

(b) The source of inpatient hospice care currently used by the patients identified in subsection (1) (a); and

Patients currently being served in Washington County by Meritus Medical Center's (MMC) Inpatient Palliative Care Unit are the patients whose condition most closely reflects the patients who may utilize the proposed General Inpatient Unit. During CY2012, the Palliative Care Unit at Meritus Medical Center was the site where most of the hospice patients were referred when they had pain or symptoms that could not be managed in their current setting.

MMC was also a place where some of the palliative care patients who were not HWC patients were first referred to hospice care. HWC carefully evaluated MMC patients for pain and symptom management needs and enrolled the patients if they met the qualifications for a general inpatient level of care. Of 516 patients in the MMC Palliative Care unit, only 66 patients were referred and met the criteria for enrollment in hospice. HWC worked to manage the pain and symptoms, began discharge planning the first day of hospice enrollment to move the patient to a lower level of care. Average length of stay for Meritus patients who were not referred to Hospice of Washington County was 8 days; patients referred and admitted to HWC had a length of stay of 2 days.

(c) The projected average length of stay for the hospice inpatients identified in subsection (1) (a).

Currently the average length of stay in Meritus' Inpatient Palliative Care Unit is eight (8) days. When Hospice of Washington County, Inc. is brought into the Meritus unit to enroll a patient into the hospice at the General Inpatient level of care, the average length of stay under HWC's care is 2 days.

(2) Impact. An applicant shall quantitatively demonstrate the impact of the establishment or expansion of the inpatient hospice capacity on existing general hospices in each jurisdiction affected by the project, that provide either home-based or inpatient hospice care, and, in doing so, shall project the impact of its inpatient unit on future demand for hospice services provided by these existing general hospices.

Hospice of Washington County is the sole hospice provider in Washington County, Maryland. To that end, there will be no impact on other hospices in Washington County. However, there is the opportunity for patients that live in surrounding counties to receive general inpatient hospice services at a freestanding hospice inpatient unit because other hospices in surrounding Maryland counties do not provide such services except in a hospital setting. A residential unit exists in neighboring Frederick County operated by Hospice of Frederick County, but it is not equipped to take a patient needing a general inpatient level of care. It is

conceivable that the Frederick County hospice may at times want to utilize the services of HWC' s General Inpatient Unit.

(3) Cost Effectiveness. **An applicant shall demonstrate that:**

(a) It has evaluated other options for the provision of inpatient hospice care, including home-based hospice care, as well as contracts with existing hospices that operate inpatient facilities and other licensed facilities, including hospitals and comprehensive care facilities; and

(b) Based on the costs or the effectiveness of the available options, the applicant's proposal to establish or increase inpatient bed capacity is the most cost-effective alternative for providing care to hospice patients.

Overall, the building of Doey's House, a general inpatient and respite unit, will have a positive impact on the healthcare system in Washington County, Maryland both in patient care and reduction of healthcare costs. As the sole provider of hospice care in this jurisdiction, the proposed General Inpatient Unit will have no impact in this county.

During the previous year, Meritus Medical Center served 516 patients that potentially qualified as appropriate for General Inpatient Services. Of the 516 said patients, only 66 of them actually received services. Of the 450 patients that remained at Meritus Medical Center's Palliative Care wing, the average cost per admission was approximately $16,060 per stay and annual expenses exceeding $7.2 million. Conversely, of the 66 patients that received general inpatient hospice services, the average cost per admission was $1,921. Assuming 100% of the 450 patients were in a hospice general inpatient setting, the prospective annual estimated savings could have exceeded $6.3 million.

10.24.01.08G(3)(b). <u>Need</u>.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

The General Inpatient Unit will primarily serve the residents of Washington County, Maryland, a western Maryland county of 458 square miles bordering southern Pennsylvania and northern West Virginia. The 2010 Census reports the county has 147,430 residents who mostly live in a rural setting. The General Inpatient Unit could also serve the local hospitals to the north of Washington County; these patients reside in Fulton and Franklin counties in Pennsylvania where many hospices exist, but none have a General Inpatient Unit. Bordering Frederick County's hospice has a residential hospice unit, but it is not equipped to handle patients needing the general inpatient level of care.

The population of Washington County as of 2013 is estimated to be comprised of 84.8% Caucasian, 10.7% African-American, and 4.0% Hispanic or Latino descent. The remainder of the population is made up of American Indian/Alaska Native (0.3%), Asian (1.6%), and those of two or more races (2.6%). Washington County residents 65 years of age and over exceed that of the state of Maryland at 15.4% in 2013 estimates.

The number of Veterans in Washington County is over 12,478. The median income since 2008 is at $54,561 with 11.9% of the population living below poverty level.

It has been projected that the census of Washington County has grown significantly since the census of 2010. Between 2010 and 2015, the census is projected to grow by 2.5% and between 2015 and 2020; the growth is projected to be another 6% moving the census from 147,430 in 2010 to 160,300 by 2020.

Not only is the census to grow by 2020, the population will shift dramatically for those 60 years of age and over. This census of 60 and over will move from 28,590 in 2010 to 38,275 by 2020, an increase of over 25%.

As the sole provider of hospice services in Washington County, Maryland, Hospice of Washington County, Inc. is confident in its ability to grow its services with expected increase of the population of Washington County as it has for the past 34 years.

The need for the General Inpatient Unit becomes even more critical need for the county residents in light of the expected population growth. The strain upon the health care system of the single acute hospital and the Accountable Care Organization that will inherit many more Medicare lives will only find itself dependent more and more on community resources and a "stay in place" residential home care. Hospice of Washington Count, Inc. will be a powerful partner to these entities in keeping the hospice eligible patients out of the hospital and being able to provide general inpatient level of care independently.

10.24.01.08G(3)(c). <u>Availability of More Cost-Effective Alternatives</u>.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing

facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

There were other alternatives that could have been considered. Specifically, the building of a general inpatient wing in an acute care hospital could be an option. However, the expenses would be prohibitive specifically the creation of a separate

hospice General Inpatient Unit that would provide a home-like setting. There were major concerns that a hospice General Inpatient Unit in a hospital would appear too institutional. The acute care hospital in our area did have a wing. However, that wing was converted to an observation unit. At this time, no space is available in the hospital nor has any been offered as an alternative.

Operationally, the estimated variable expenses per patient day if services were provided at Meritus Medical Center would be estimated at $960 per day for FY17. Based on an estimated 2,378 days with a weighted revenue per day average of $538 the estimated annualized operational loss for FY17 is as follows:

Total Projected Days – 2,378
Projected Revenue, Per Day - $538
Projected Revenue - $1,279,364
Projected Expenses, Per Day - $960
Projected Expenses - $2,282,880
Projected Net Income – ($1,003,516)

Conversely, based on the abovementioned, the operational losses for FY17 would be substantially less for FY17. Specifically, the estimated variable expenses per patient day if services were provided at Hospice of Washington County's freestanding inpatient unit would be estimated at $674 per day for FY17. Based on an estimated 2,378 days with a weighted revenue per day average of $538 the estimated annualized operational loss for FY17 is as follows:

Total Projected Days – 2,378
Projected Revenue, Per Day - $538
Projected Revenue - $1,279,364
Projected Expenses, Per Day - $674
Projected Expenses - $1,602,772
Projected Net Income – ($323,408)

Based on the above mentioned analysis, providing general inpatient and respite care services in a freestanding unit would result in a $677K savings compared to such services being rendered at Meritus Medical Center.

For the sake of the patients and their families, the setting of the acute care hospital is counter to the mission of HWC in providing a setting that supports the plan of care of a hospice patient. The acute care setting is fraught with philosophies that run counter to the hospice care a patient has chosen.

The personnel of Hospice of Washington County, Inc. (HWC) is superior to any other personnel in the county in the area of palliative and hospice care. As the only licensed provider of hospice care in the jurisdiction, Hospice of Washington County, Inc. has taken its responsibility to provide excellent end-of-life care for the residents. HWC has invested heavily in the training of our clinical team to provide superior care. HWC as an organization is an active member in the National Hospice and Palliative Care

Organization (NHPCO) and has fully taken part in all aspects of the educational arm of that organization. Our staff is regularly trained to keep abreast of all changes and improvements in the management of pain and symptoms for the dying patient. Each of the Registered Nurses at HWC are encouraged to become a Certified Nurse in Hospice and Palliative care; over 50% of our registered nurses have achieved this special certification.

Hospice of Washington County, Inc. (HWC) is also continuously seeking to achieve a higher level of quality in the provision of care for the residents of Washington County. HWC is an active member in the Maryland Network of Hospice and Palliative Care as well as Centers for Advanced Palliative Care (CAPC). The education provided by all of these groups is regularly accessed to provide high quality end-of-life care. HWC subscribes to a third-party survey group who independently surveys the families and caregivers of our deceased patients to determine the satisfaction of the care HWC provided. This quality survey is the impetus for improving areas of care on a regular basis. In 2014, HWC received Hospice Honors from this survey group for the satisfaction of our services, the only Maryland hospice to receive this honor.

10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

Please see Audited Financial Statement for 2012 and 2013 attached to this document under **Appendix III.**

Please see **Part II B. Sources of Funds for Project** in the last pages of this document prior to the Appendices.

C. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1995, and their status.

Hospice of Washington County, Inc. has not been issued any Certificates of Need except the one for providing hospice care in Washington County, Maryland. This organization has not applied for nor been granted any Certificates of Need since 1995.

10.24.01.08G(3)(f). <u>Impact on Existing Providers</u>.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

As part of this criterion, complete Table 5, and provide:

1. **An assessment of the sources available for recruiting additional personne**l.

Per policy for Human Resources, Hospice of Washington County, Inc. (HWC) would post all open positions for Doey's House internally to see if any current employees would be interested. If there is no internal interest, HWC would then advertise in the various local papers and internet sites to recruit for the needed positions. (See **Policy #9022**, Recruiting and Hiring Process located in **Appendix I,** Referenced Policies and Documents.)

2. **Recruitment and retention plans for those personnel believed to be in short supply.**

Currently the Washington County, Maryland area does not have a shortage of certified nursing assistants and LPN's. HWC would recruit for RN's, part-time Social Workers and Chaplains. HWC may contract for Physician or Nurse Practitioner services as needed. Historically, recruitment practices would be to place ads in local newspapers and national Internet sites to recruit for any positions needed to staff the facility. In all cases, HWC is confident that the staffing for the General Inpatient Unit would be attainable in a short period of time and needed personnel would be available as the unit grows from the opening of the unit until fully staffed.

Retention plans for current Hospice of Washington County, Inc. employees are always being updated. The strongest retention is the steady leadership of an organization that compensates at a 75th percentile or higher compensation level compared to other hospices, works to maintain a complete and attractive benefits package, and runs an organization that is compliant conscious as well as financially stable. In addition, Human Resources conducts employee surveys, initiates communication-building activities, and emphasizes employee recognition.

3. A report on average vacancy rate and turnover rates for affected positions.

For the last twelve months, Hospice of Washington County, Inc. averaged approximately one Registered Nurse opening per month, and only one Chaplain and Social Worker for the period. Three Certified Nursing Assistants and three Licensed Practical Nurse positions were filled during this period.

During this same twelve month time period, HWC had no turnover for Certified Nursing Assistants or Social Workers. One per diem Chaplain resigned with a chaplain turnover rate of 20%; three LPN's resigned with a turnover rate of 60% and we have hired only five LPN's. Seven Registered Nurses resigned, two of whom were per diem, for a turnover rate of 22.6%.

In each of these cases, the organization was able to recruit and fill the needed positions without any undue delay to availability of qualified candidates.

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

3. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identity and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

Cynthia Perini
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19610 Cresap Drive
Hagerstown, Maryland 21742

Max Burnham
Board Vice-Chair, Hospice of Washington County
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Cheryl Brown, B.S.
Director of Development
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Greencastle, Pennsylvania 17225

Shelley Steiner, M.B.A.
Director of Strategic Initiatives
255 Brynwood Street
Hagerstown, Maryland 21740

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

None of the persons listed above has been involved or is involved now in the ownership,

development, or management of another health care facility.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

Hospice of Washington County, Inc. has never had its Maryland license or certification suspended nor revoked; HWC has never been subject to any disciplinary action at any time including in the last five years.

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

Neither Hospice of Washington County, Inc. nor any of the persons listed in the questions above have ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services which have led to an action to suspend, revoke, or limit the licensure or certification at any facility.

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

Neither Hospice of Washington County, Inc. nor any of the persons listed above have ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

_____

Signature of Owner or Authorized Agent of the Applicant

Eric G. Klimes
Chief Executive Officer
Hospice of Washington County, Inc.

Date: **October 28, 2014**

Charts and Tables Supplement

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE FACILITY

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

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TABLE 2A – STATISTICAL PROJECTIONS – ENTIRE FACILITY

Instructions: Complete Table 2A for the Entire Facility, including the proposed project, and **Table 2B** for the proposed project only using the space provided on the following pages. **Only existing facility applicants should complete Table 2A. All Applicants should complete Table 2B. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).**

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE FACILITY

	Two Most Current Actual Years		**Projected years – ending with first year at full utilization**			
CY or FY (circle)	**2012**	**2013**	**2014**	2015	2016	2017
Admissions	690	926	990	1,008	1,110	1,577
Deaths	599	724	799	840	918	1.270
Non-death discharges	118	123	191	181	205	320
Patients served	909	1,118	1,261	1,392	1,501	1,985
Patient days	73,723	89,086	95,460	93,440	95,675	99,593
Average length of stay	117.27	91.3	103.2	80.1	75.2	75.2
Average daily hospice census	201.4	243.9	262.1	255.5	262.1	272.9
Visits by discipline						
Skilled nursing	19,448	28,260	31,902	31,264	32,990	39,661
Social work	6,470	7,032	7,531	7,380	7,895	10,056
Hospice aides	21,860	26,876	28,065	27,504	28,788	33,371
Physicians - paid	392	630	933	914	1,299	3,329
Physicians - volunteer	0	0	0	0	0	0
Chaplain	4,813	6,332	6,485	6,355	6,849	8,990
Other clinical	0	384	558	547	741	1,758
Licensed beds						
Number of licensed beds	NA	NA	NA	NA	12	12
Occupancy % (if inpatient unit) or hospice house	NA	NA	NA	NA	17%	54%

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2016	2017	20__	20__
Admissions	81.5	528.4		
Deaths	61	396		
Non-death discharges	20.5	132		
Patients served	81.5	537		
Patient days	367	2,378		
Average length of stay	4.5	4.5		
Average daily hospice census	1.99	6.51		
Visits by discipline				
Skilled nursing	1,101	7,134		
Social work	366	2,378		
Hospice aides	732	4,756		
Physicians - paid	366	2,378		
Physicians - volunteer	0	0		
Chaplain	366	2,378		
Other clinical	184	1,189		
Licensed beds				
Number of licensed beds	12	12		
Occupancy % (if inpatient unit) or hospice house	17%	54%		

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2012	2013	2014	2015	2016	2017	20-NA
1. Revenue							
a. Inpatient services	0	0	0	0	196,862	1,279,606	
b. Home care services	13,426,754	16,359,139	17,186,876	17,702,482	18,233,557	18,780,563	
c. Gross Patient Service Revenue	13,426,754	16,359,139	17,186,876	17,702,482	18,430,419	20,060,169	
d. Allowance for Bad Debt	-285,740	-22,435	-101,553	-104,600	-107,738	-110,970	
e. Contractual Allowance	-2,835,238	-3,556,321	-3,667,455	-3,777,479	-3,890,803	-4,007,527	
f. Charity Care	-59,531	-38,249	-75,411	-77,672	-81,971	-95,200	
g. Net Patient Services Revenue	10,246,245	12,742,134	13,342,457	13,742,731	14,349,907	15,846,472	
h. Other Operating Revenues (Specify)	0	0	0	0	0	0	
i. Net Operating Revenue	10,246,245	12,742,134	13,342,457	13,742,731	14,439,907	15,846,472	
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	7,692,141	7,995,420	8,257,280	8,504,998	9,148,982	10,201,363	

	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2012	2013	2014	2015	2016	2017	20__
b. Contractual Services	1,476,768	1,684,408	1,766,784	1,819,788	1,874,381	1,930,613	
c. Interest on Current Debt	30,811	21,734	20,641	21,260	21,898	22,555	
d. Interest on Project Debt	0	0	0	0	57,576	112,433	
e. Current Depreciation	151,197	133,093	132,091	136,054	140,135	144,339	
f. Project Depreciation	0	0	0	0	86,888	173,775	
g. Current Amortization	0	0	0	0	0	0	
h. Project Amortization	0	0	0	0	0	0	
i. Supplies	12,031	17,616	19,556	20,143	31,788	90,429	
j. Other Expenses (Specify)	957,780	1,223,502	1,399,540	1,441,526	1,502,790	1,598,291	
k. Total Operating Expenses	10,320,728	11,075,773	11,595,892	11,943,769	12,864,438	14,273,798	
3. Income							
a. Income from Operation	-74,483	1,666,361	1,746,565	1,798,962	1,485,469	1,572,674	
b. Non-Operating Income	423,198	859,849	1,230,690	1,267,611	1,305,639	1,344,808	
c. Subtotal	348,715	2,526,210	2,977,255	3,066,573	2,791,108	2,917,482	
d. Income Taxes	0	0	0	0	0	0	
e. Net Income (Loss)	348,715	2,526,210	2,977,255	3,066,573	2,791,108	2,917,482	

Table 3 (CONTINUED)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2012	2013	2014	2015	2016	2017	20___
4. Patient Mix							
A. As Percent of Total Revenue							
1. Medicare	88.95	88.72	89.40	89	89	89	
2. Medicaid	2.71	2.11	1.94	2	2	2	
3. Blue Cross	3.27	2.75	2.45	2	2	2	
4. Commercial Insurance	4.06	5.14	4.68	5	5	5	
5. Self-Pay	1.01	1.28	1.53	2	2	2	
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare	91.93	91.67	93.33	92	92	92	
2. Medicaid	2.27	2.83	1.72	3	3	3	
3. Blue Cross	2.11	1.56	1.67	2	2	2	
4. Commercial Insurance	2.33	3.06	2.27	2	2	2	
5. Self-Pay	1.36	.88	1.01	1	1	1	
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2016	2017	20___	20___
1. Revenue				
a. Inpatient services	196,862	1,279,606		
b. Home care services				
c. Gross Patient Service Revenue	196,862	1,279,606		
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care	-1,968	-12,796		
g. Net Patient Services Revenue				
h. Other Operating Revenues (Specify)				
i. Net Operating Revenue	194,894	1,266,810		
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	388,834	1,178,410		
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt	57,576	112,433		
e. Current Depreciation				
f. Project Depreciation	86,888	173,775		
g. Current Amortization				
h. Project Amortization				
i. Supplies	11,040	69,060		
j. Other Expenses (Specify)	18,018	68,976		
k. Total Operating Expenses	562,356	1,602,654		
3. Income				
a. Income from Operation	-367,462	-335,844		
b. Non-Operating Income				
c. Subtotal	-367,462	-335,844		
d. Income Taxes				
e. Net Income (Loss)	-367,462	-335,844		

TABLE 4 (CONTINUED)	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2016	2017	20___	20___
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare	89	89		
2. Medicaid	2	2		
3. Blue Cross	2	2		
4. Commercial Insurance	5	5		
5. Self-Pay	2	2		
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)				
1. Medicare	92	92		
2. Medicaid	3	3		
3. Blue Cross	2	2		
4. Commercial Insurance	2	2		
5. Self-Pay	1	1		
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%

TABLE 5. MANPOWER INFORMATION

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration	31.2	+1	79,368	Employee	79,368
Direct Care					
Nursing	35.9	+16	56,750	Employee	908,000
Social work/services	7.2	+.3	54,572	Employee	16,372
Hospice aides	18.5	+10	30,954	Employee	309,540
Physicians-paid	1	+.3	196,535	Employee	58,960
Physicians-volunteer	0	0	0	N/A	0
Chaplains	4	+.3	49,609	Employee	14,883
Other clinical	1	+1.0	89,932	Employee	89,832
Support					
Other support	10.5	+1.0	34,721	Employee	34,721
				Benefits*	408,153
				TOTAL	1,919,829

Notes:
Hospice of Washington County's benefit cost is based upon the total cost of the employee 403b Plan, health insurance, long-term disability, and short-term disability. These total costs as a percentage of payroll is **27%**.

The **TOTAL COST** (above) represents only the increase in costs due to the in-patient facility and does not include the salary cost of the current facility.

These costs represent the total staffing that will be in place **at the end of the first full year of operations**. Staff will gradually increase from inception until the end of the first full year as census dictates. Therefore, the cost of salaries as indicated on Table 4 is lower than the cost figures above to reflect the gradual increase in staffing during the periods indicated.

REFERENCED EXHIBITS

APPENDIX I

REFERENCED POLICIES AND DOCUMENTS

Policies

Quality Assessment Documents

2.0 EMPLOYMENT PRACTICES

2.1 Equal Opportunity Employer

In conformity with applicable laws, Hospice of Washington County, Inc. is an Equal Opportunity Employer. It is HWC's policy to recruit, hire, train, and promote individuals, as well as administer any and all personnel actions, without regard to race, color, creed, religion, sex, sexual orientation, age, marital status, national origin, or disability. HWC will not tolerate any unlawful discrimination and any such conduct is prohibited.

HWC will make reasonable accommodations for qualified individuals with known disabilities unless doing so would result in an undue hardship. This governs all aspects of employment, including selection, job assignment, compensation, corrective counseling, termination, and access to benefits and training.

Any employee with questions or concerns about any type of discrimination in the workplace is encouraged to bring these issues to the attention of their immediate supervisor or designee. Employees can raise concerns and make reports without fear of reprisal. Anyone found to be engaging in any type of unlawful discrimination would be subject to corrective counseling, up to and including termination of employment.

[HWC Handbook Revised September, 2012, Page 5]

SUBJECT: HOSPICE PATIENT RIGHTS AND RESPONSIBILITIES	REFERENCE #1001
DEPARTMENT: HWC CLINICAL SERVICES	PAGE 1 of 2
REVIEWED: Jeffrey G. Crosby, RN, CHPN	EFFECTIVE: DATE: 9/16/2014
APPROVED BY: P & P Committee	REVISED:

As a patient, you have the right to:

- Receive care from a team of professionals who will provide high quality comprehensive health care services as needed and appropriate based on your Plan of Care.
- Know the availability of services and how to access these services 24 hours a day, 7 days a week.
- Receive appropriate and compassionate care, regardless of age, gender, nationality, race, creed, sexual orientation, disability, availability of a primary caregiver, or ability to pay.
- Be fully informed of your health status in order to participate in the planning of your care.
- Be fully informed of the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments or services. You will receive information about "Advance Directives" which will allow you to make your wishes known to those caring for you.
- Be treated with respect and dignity for your person, family, caregivers, and property.
- Receive training for your family and caregivers so that they may assist with your care.
- Expect confidentiality of medical records, financial and social circumstances. Patient information and records will be released only with written consent from yourself, your agent, or as required by law.
- Voice complaints without being subject to discrimination or reprisal and have those complaints addressed by this agency.
- Be informed, in writing, of how payment will be made for treatment received in advance of services provided.

- Be informed, in writing, of any changes in the amount of charges as soon as possible but no later than 30 days from the date this agency is aware of the change.

- Have your reports of pain believed, your pain treated and symptoms managed.

- You have a right to access any insurance or entitlement program for which you may be eligible.

As a patient, you have the responsibility to:

- Participate in developing your plan of care and updating it as your condition or needs change.
- Provide this agency with accurate and complete health information.
- Remain under a physician's care while receiving services.
- Assist with development and maintenance of a safe environment in which your care can be provided.

SUBJECT: FINANCIAL RESPONSIBILITY	REFERENCE #1005 PAGE:
DEPARTMENT: HWC CLINICAL SERVICES	EFFECTIVE: 1/6/2003
REVIEWED BY:	DATE: 10/17/2014
APPROVED BY: P & P COMMITTEE	REVISED:

PURPOSE:

To assure that the patient, family or caregiver understands the financial responsibility for hospice services.

POLICY:

HWC staff members inform the patient of financial responsibility for hospice services. HWC informs the patient of any subsequent changes in financial responsibility. In no case shall a patient be turned away due to their inability to pay because they are indigent or lack insurance coverage.

PROCEDURE:

- At the admission visit HWC staff members explain insurance coverage and the patient's responsibility for payment. A written copy of this information is provided.
- The Billing Specialist is contacted if staff members need more information to verify coverage. The Billing Specialist may help the patient in developing a tailored payment plan.
- HWC notifies the patient who may incur financial liability in writing within thirty calendar days from the date HWC became aware of a financial change.
- HWC will document all written or verbal notifications of the patient's financial responsibility in the billing record.
- If a patient does not have insurance, HWC's services costs will be billed based upon the sliding scale currently in effect.
- A patient can request charitable care status. Refer to Policy #10314 for details.

SUBJECT: QUALITY ASSURANCE PLAN	REFERENCE #6001 PAGE:
DEPARTMENT: QUALITY IMPROVEMENT	EFFECTIVE: 1/5/2004
REVIEWD BY: Kim Green RN CHPN	DATE: 9/24/2014
APPROVED BY: P & P COMMITTEE	REVISED: 10/15/10

POLICY:

HWC participates in an organizational Quality Assessment Performance Improvement (QAPI) program designated to monitor, evaluate and improve hospice quality and services.

PURPOSE/OBJECTIVES:

- To identify opportunities through continuous assessment of systems and processes of care;
- To implement solutions and actions which will bring about the desired change;
- To facilitate a positive patient outcome;
- To maintain a safe environment for personnel, patients and their families.
- To adhere to the Joint Commission's published guidelines for describing information in its Quality Report.

- Responsibility:
  - The Board of Director's (BOD) through its Quality Oversight Committee (QOC) is responsible for establishing and implementing a QAPI program. The program shall integrate HWC services quality assessment/improvement and quality control activities into a system that will foster improvements in patient care. The BOD's QOC and HWC's Chief Executive Officer (CEO) also shall delegate responsibilities for monitoring, action, evaluation, and reporting.

- Scope of Care:
    - Patient services are provided to those patients and their family/support structure requesting hospice care. Services include, but are not limited to:
        - Initial evaluation and assessment of patient needs
        - Establishment of treatment plans and goals
        - Application of appropriate modalities of pain control and end of life palliative measures
        - Patient and family education
        - Recommendations for the continuity of care, through the end of life process
        - Monitoring the extent to which services have met the therapeutic goals relative to the initial and subsequent examinations, as well as the degree to which the patient's pain is controlled and/or eliminated, and the extent to which quality of life has been optimized
- Aspects of Care:
    - The QAPI plan for HWC shall monitor those important aspects of care which are felt to be high risk, high volume or have demonstrated a trend toward potential negative patient outcome (problem prone). In addition, those aspects of care, which have been identified through the QAPI process as an area where a system or process of patient care may be improved, will be monitored. Aspects of care will be identified and chosen for monitoring through a collaborative effort utilizing information obtained from nursing, social services, spiritual support, bereavement support and pharmacologic services, regulatory body reports, medical staff evaluation, Human Resources and Finance, and other clinical services and support services, as appropriate.
    - Proposed aspects of care for assessment include, but are not limited to:

- Timeliness of hospice assessment and evaluation services
- Timeliness of hospice interventional services, as requested by patient or family and/or determined from any member of the hospice care team
- Appropriateness of treatment
- Patient treatment plan toward end of life quality goal setting
- Documentation of patient progress
- Assessment of the efficacy of treatment administered
- Patient/Family education
- Effectiveness of pain management and control
- Medication management
- Infection control practices
- Personnel in-service education and training
- Patient/Family/Physician and other personnel complaints

- Aspects of care are subject to change due to the collaborative processes outlined above.

- Performance Measures and Outcomes:

  - Performance measures and outcomes will be established as a means to systematically monitor the identified aspects of care in an ongoing manner and to provide operational linkages between the risk management functions related to the clinical aspects of patient care and safety and the QAPI functions. Performance measures will relate to the identified aspects of care and will be specific. Performance measures will be structured to relate to both the processes and outcomes of patient care. Performance measures will pertain directly to all components of HWC practices and will use objective criteria that reflect current knowledge and clinical experience.

- Thresholds:
    - Statistical evaluation of performance measures will be structured to focus on an improvement in patient care. Thresholds will represent either pre-established levels that, when reached, trigger an intensive evaluation of the indicator under review; or benchmarks that have been identified by organization experience, which require an in-depth evaluation of the proposed aspect of care and relating performance measures.

- Data Collection and Monitoring Methodology:
    - HWC will routinely and systematically monitor and evaluate the major patient care related activities in a continuous and ongoing manner. Existing information from other healthcare providers providing care to the hospice patient (such as PT/OT service) that may be useful in identifying clinical problems and/or opportunities to improve the quality of patient care will be accessible and included in the monitoring and evaluation of QAPI functions.
    - Monitoring and collection of data will be performed with a frequency sufficient to identify departures from the criteria, problems in patient care and areas for improvement. An outline of actual aspects of care under review will include description of the frequency of monitoring for each activity, how and from where the data will be obtained.
    - HWC will maintain a QAPI log for the routine collection of data on selected key aspects of care. The Quality, Education & Compliance Director, with approval from the Quality and Compliance Committee shall establish standards of compliance with each criterion for all performance measures under review. HWC will monitor the selected aspects of care at a predetermined frequency and enter the results of compliance on the respective data collection record. The Quality, Education & Compliance Director or designee will aggregate the data collected for reporting purposes.
    - Data shall be collected from a variety of sources to analyze patterns or trends in care, including but not

limited to: daily logs, computer reports, unusual event reports, Family/Physician/Bereavement Satisfaction Surveys, the patient's medical record, and staff suggestions.

- Evaluation:
    - The CEO and the Quality and Compliance Committee shall review and evaluate the data presented for analysis of outcome. Evaluation shall focus on identifying opportunities to improve both the processes of patient care and actual identified problem areas that effectuate a negative outcome. Conclusions will be drawn regarding the evaluation of data presented with recommendations considered.

- Action:
    - Upon review of the data presentation, conclusions and recommendations, HWC will take actions to resolve identified problems and will direct efforts to those areas which have the greatest potential for improving patient care. HWC shall utilize existing facility resources, committees and problem-solving techniques to resolve identified problems and to improve patient care.
    - HWC will analyze and use information about system or process failures and, when conducted, the results of proactive risk assessments (FMEA). The information learned from the analysis will be conveyed to all staff that provide services for the specific situation.

- Assessment for Effectiveness:
    - HWC will perform follow-up monitoring to assure that actions taken are effective and that any progress achieved is sustained. The criteria used for follow-up monitoring should be the same or similar to those used in the initial identification of the problem/opportunity for improvement; however, the sample size may vary or focused monitoring may be utilized for effectiveness.

- Communication and Integration of Information:
    - The Quality, Education & Compliance Director shall ensure that documentation is maintained and that reports are forwarded as prescribed by the QAPI plan. The Quality and Compliance Committee will review the outcome of HWC's ongoing QAPI activities not less than quarterly. HWC staff members may also receive performance/quality related information as appropriate. Documentation and reports shall include:
        - Findings from monitoring activities
        - Conclusions regarding identified opportunities for improvement
        - Recommendations concerning potential actions
        - Actions taken to effectuate change
        - Outcome of action effectiveness (results of follow-up monitoring performed to determine extent of effectiveness)
- Annual Evaluation of Performance Improvement Program:
    - The BODs QOC shall evaluate the effectiveness of the QAPI Plan on at least an annual basis. The evaluation shall be documented and forwarded to the Board of Directors.

SUBJECT: UNIFORM QUALITY OF CARE/SERVICE	REFERENCE #7010
	PAGE:
DEPARTMENT: HWC LEADERSHIP	EFFECTIVE: 4/1/2010
REVIEWED BY: Susan Taylor, MS, RN	DATE: 9/24/2014
APPROVED BY: P & P COMMITTEE	REVISED:

PURPOSE:

To ensure uniform quality of patient care and service for all patients.

POLICY:

All HWC patients regardless of race, color, creed, sex, sexual orientation, age, disability (mental or physical), communicable disease or places of national origin, have the right to receive the same quality of care.

PROCEDURE:

- The care the patient receives, and the skill level and training of HWC personnel, is based on the standards of care and practices outlined within this manual and by the patient's needs.

- HWC maintains a medical record review process to assure that HWC policy is followed by all personnel, including direct or contract personnel.

- HWC does not discriminate against an individual based on whether the individual has executed an advance directive.

SUBJECT: COMPLIANCE OFFICER AND COMMITTEE	REFERENCE #7021
	PAGE:
DEPARTMENT: HWC LEADERSHIP	EFFECTIVE: 6/15/2012
REVIEWED BY: Kim Green RN CHPN	DATE: 9/24/2014
APPROVED BY: P & P COMMITTEE	REVISED:

POLICY:

A compliance officer is designated to implement, maintain, and evaluate the compliance program for HWC. A compliance committee is established to advise the compliance officer and assist with compliance activities and training.

The Quality & Compliance Director (QCD) is the designated Compliance Officer for HWC.

The Quality & Compliance Committee serves as the Compliance Committee and is an extension of the compliance officer and provides HWC with increased oversight.

PROCEDURE:

- Compliance Officer:

  The Compliance Officer has the responsibility to:

  - Oversee and monitor the implementation and maintenance of the compliance program plan;
  - Report, at a minimum quarterly, to the CEO, Quality & Compliance Committee, and the BOD QOC;
  - Periodically revise the program in light of changes in the organization's needs, and in the law and policies and procedures of Government and private payor health plans;
  - Review personnel's certifications that they have received, read and understood the Standards of Conduct;
  - Provide oversight for the training and education program that focuses on the elements of the compliance program, and seeks to ensure that all relevant personnel are knowledgeable of, and comply with, pertinent Federal and State standards;

- Provide oversight for, and evaluate all monitoring and auditing procedures related to compliance standards.

- Implement and maintain reports reporting noncompliance issues.

- Establish and maintain open lines of communication with facility departments and services, including the Billing Department and organizational personnel and contracted providers to ensure effective and efficient compliance policies and procedures.

- Investigate misconduct, both intentional and accidental.

- Coordinate existing compliance policies and procedures, develop new compliance policies and procedures and assure all revisions and new policies and procedures are properly standardized whenever possible and practicable.

- Work closely with all regulatory body auditors and annual organizational auditors.

- Forward recommendations to the Quality & Compliance Committee regarding standards and criteria relevant to compliance issues.

- Prepare and forward compliance reports as required by the Quality & Compliance Committee, but no less than on a quarterly basis.

- Review the compliance program plan on an annual basis and make any update, modifications or revisions in the plan.

- All questions and concerns regarding compliance with any of the directives set forth within this plan are to be directed to the Compliance Officer. All personnel are required to fully cooperate and assist the Compliance Officer as outlined in the performance of his or her duties. Any uncertainty regarding compliance issues on behalf of personnel should be brought to the attention of the Compliance Officer for assistance and direction.

- Compliance Committee:

- The compliance program plan shall be implemented under the guidance and supervision of the Quality & Compliance Committee, who will advise and assist the Compliance Officer as needed. Their functions may include:

    - Analyzing the legal requirements with which it must comply, and specific risk areas;

    - Assess existing policies and procedures that address these risk areas for possible incorporation in the compliance program;

    - Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out HWC's standards, policies, and procedures as part of its daily operations;

    - Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential or actual violations;

    - Developing a system to solicit, evaluate, and respond to complaints and problems;

    - Monitoring audits and investigations for the purpose of identifying troublesome issues and deficient areas experienced by HWC and implementing corrective and preventive action.

- Meetings shall be held on a quarterly basis.

The BOD QOC shall be updated on a quarterly basis.

SUBJECT: COMPLIANCE EDUCATION & TRAINING	REFERENCE # 7023
	PAGE:
DEPARTMENT: HWC LEADERSHIP	EFFECTIVE: 6/15/2012
REVIEWED BY: Kim Green RN CHPN	DATE: 9/24/2014
APPROVED BY: P & P COMMITTEE	REVISED:

POLICY:

HWC provides an ongoing program for the training on matters related to the compliance program, fraud and abuse, ethical practices, and compliance with federal and state hospice regulations.

HWC effectively communicates its standards and policies and procedures.

PROCEDURE:

- Education may be provided through in-services and by disseminating publications/other printed materials or on-line information that explain in a practical manner, the requirements of corporate compliance. The education to be provided may include, but is not limited to:
  - Fraud and abuse laws
  - Ethical marketing techniques
  - Noncompliance reporting
  - Disciplinary actions
  - Medicare reimbursement principles
  - Billing Medicare and Medicaid for services not rendered
  - Misrepresenting the nature of the services rendered
  - Alterations of medical records
  - Patient confidentiality/release of information
  - Marketing and development
  - Admission and discharge policies
  - Medical necessity of services provided
  - Contracts/conflict of interest
  - Patient's freedom of choice
- Compliance training is included in the orientation of all new employees and volunteers.

- The Clinical Education Coordinator maintains a record of dates, attendance, topics, and distributed materials.
- Attendance and participation in compliance education is a condition of employment.
- Adherence to the compliance program and attendance of compliance education will be a component of the individual's annual performance evaluation.

SUBJECT: COMPLIANCE RESPONSE AND CORRECTIVE ACTION	REFERENCE #7024
	PAGE:
DEPARTMENT: HWC LEADERSHIP	EFFECTIVE: 6/15/2012
REVIEWED BY: Kim Green RN CHPN	DATE: 9/24/2014
APPROVED BY: P & P COMMITTEE	REVISED:

POLICY:

Reports of potential wrongdoing or suspected fraud and abuse are thoroughly investigated, documented, and, if appropriate reported to federal or state authorities. If warranted, immediate corrective action is applied to prevent further occurrences.

PROCEDURE:

- Immediate response to reports of potential wrongdoing or suspected fraud and abuse will be investigated by the Quality & Compliance Director (QCD).
- Under direction of legal counsel, when appropriate, prompt reporting to federal or state authorities when wrongdoing is substantiated will be completed by the QCD, or designee.
- Corrective action protocols are implemented to prevent future occurrences.
- If overpayments are identified, prompt repayment to the payer source will occur.
- Through its systematic reporting, monitoring and auditing systems, HWC will investigate and remediate identified systematic and personnel concerns.
- Discipline of individuals responsible for the failure to detect a violation and/or individuals who commit a violation will be conducted.
- Detection of Misconduct Procedures:
    - Upon determination by the QCD and Human Resource Director (HRD) that a personnel member or contracted provider has

violated the conduct requirements as set forth in this plan, the individual case will be forwarded to the Quality & Compliance Committee for their review and determination.

- The responsible personnel member or agent will temporarily be suspended from their position without pay until the determination from the Quality & Compliance Committee has been rendered.

- Should the determination find the personnel member or agent did not violate any of the directives in the corporate compliance program plan, and did not act in a willingly unethical manner, the individual(s) will be reinstated immediately and receive compensation for time lost. All Committee deliberations and determinations will be confidential to the committee members and the organizational administrative team only.

- Should the determination find the individual guilty in violation, the disciplinary process as defined in this plan will be conducted.

- Penalty Guidelines:

  - Management personnel are made aware of their responsibility for compliance training and for the misconduct of subordinates.

  - All personnel and contracted providers are informed that adherence to the compliance program will be an element of annual evaluations and that willful violation or failure to comply with organizational policies/procedures and the compliance program plan will be grounds for immediate termination.

  - All disciplinary actions will be conducted in a fair and consistent manner that affords the personnel member confidentiality and due process.

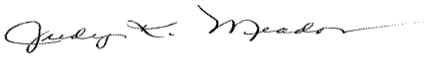
  - Self-disclosure of misconduct is encouraged and personnel/contracted providers are advised that while self-reporting will not result in immunity from discipline, it will be considered as a strong mitigating factor when corrective action is required.

- Any individual who has engaged in illegal or unethical behavior and/or who has been convicted of healthcare related crimes will be terminated.

- Any personnel member or agent in a position of discretionary authority, displaying evidence that he/she is unwilling to comply with the compliance program plan will be terminated.

- Any personnel member or agent that has been under federal or state sanctioning will be immediately terminated.

- As a condition of employment, all potential employees will have a background evaluation performed prior to hire. Upon discovery of any state or federal sanctions, the potential staff member will no longer be considered for hire.

SUBJECT: RECRUITING AND HIRING PROCESS	REFERENCE #9022 PAGE:
DEPARTMENT: HWC HUMAN RESOURCES REVIEWED BY: 	EFFECTIVE: 2003 DATE: 4/15/2011
APPROVED BY: P & P COMMITTEE	REVISED: 4/15/2011

POLICY:

HWC seeks to hire the most qualified applicant in an equitable, consistent, and organized manner.

PROCEDURE:

- When an available position exists, a Personnel Requisition Form is initiated by the requesting director.
- The job opening will be posted internally for five business days. Qualified internal and external applicants will be considered.
- The HRD will then advertise vacant positions when appropriate.
- Applicants are asked to complete the Employment Application Packet which includes:
    - Employment Application
    - Sex, Race, and Ethnic Group Identification Form
    - Background Information
- All resumes and applications that are received will be logged by HR.
- HR will review resumes and applications and conduct initial interviews with those applicants who meet the minimum qualifications of the position
- Selected applicants will be asked to return for a departmental interview.
- Interviews will be scheduled by HR after consulting with the director.
- Behavior Interviews will be conducted and interviewer will use the "S.T.A.R." technique to evaluate the applicant's responses. The applicant should describe the **Situation** they were in or the **Task** they needed to accomplish; describe the **Action** they took, and the **Results**.
- The most qualified applicant is identified and the following steps are taken:

- HWC verifies the employment history (dates of service) listed on the applicant's resume or application;
- The appropriate licensing board is contacted to verify license and status as applicable;
- A minimum of 2 work-related references are completed and documented on the Reference Check Form
- A Criminal Background Check, which includes social trace, driving history, criminal and sex offenses is completed;
- If the Criminal Background report is acceptable, a conditional offer of employment is made to the applicant, contingent upon successful completion of a drug screening test and when applicable, discipline specific body mechanics evaluation will be completed at Health@Work.

- Applicants interviewed and not selected will be notified and their employment application packet will be kept on file for a minimum of six months.

SUBJECT: CHARITY CARE AND FEE SCALE	REFERENCE #13014
	PAGE: 1 of 1
DEPARTMENT: HWC FINANCE	EFFECTIVE: 10/17/2014
REVIEWED:	DATE: 10/17/2014
APPROVED BY: P & P COMMITTEE	REVISED:

PURPOSE:

To assure that all prospective HWC patients have access to hospice services regardless of their ability to pay.

POLICY:

HWC staff members inform the patient of the charity care and sliding fee scale available to uninsured or indigent patients. In no case shall a patient be turned away due to their inability to pay because they are indigent, lack insurance coverage, or are underinsured.

PROCEDURE:

- At the admission visit, HWC staff members explain insurance coverage and the patient's responsibility for payment. Upon the patient's request for charity care services, HWC will, within two business days, make a determination of probable eligibility.

- The Billing Specialist is contacted if staff members need more information regarding insurance coverage.

- The Sliding Fee Scale that is in effect at the time of admission is used to determine the fees that the patient is responsible for. [See Sliding Scale for 2014 following]

- If a patient does not qualify for full charity care and is unable to bear the full cost of services, a time payment plan will be negotiated.

Note: This policy will be renewed annually and will be posted in the Business Office as well as on the Hospice of Washington County, Inc. website at www.hospiceofwc.org

HOSPICE OF WASHINGTON COUNTY, INC.

SLIDING FEE SCALE FOR UNINSURED/UNDER-INSURED PATIENTS **Print Date 10/17/14**

ATTACHMENT A to HWC Finance Policy 13014 - Charity Care and Fee Scale

HOUSEHOLD SIZE	1	2	3	4	5	6	7	8
% OF CHARGES								
0%	$ 23,340	31,460	39,580	47,700	55,820	63,940	72,060	80,180
10%	$ 25,674	34,606	43,538	52,470	61,402	70,334	79,266	88,198
20%	$ 28,241	38,067	47,892	57,717	67,542	77,367	87,193	97,018
30%	$ 31,065	41,874	52,681	63,489	74,296	85,104	95,912	106,720
40%	$ 34,172	46,061	57,949	69,838	81,726	93,614	105,503	117,392
50%	$ 37,589	50,667	63,744	76,822	89,899	102,975	116,053	129,131
60%	$ 41,348	55,734	70,118	84,504	98,889	113,273	127,658	142,044
70%	$ 45,483	61,307	77,130	92,954	108,778	124,600	140,424	156,248
80%	$ 50,031	67,438	84,843	102,249	119,656	137,060	154,466	171,873
90%	$ 55,034	74,182	93,327	112,474	131,622	150,766	169,913	189,060
100%	$ 60,537	81,600	102,660	123,721	144,784	165,843	186,904	207,966

Patients without insurance are billed on a per-visit, per-item basis, and sliding fee discounts are applied to those charges. Patients whose insurance requires co-payments are also eligible for consideration.

Effective date: **1/22/2014**

HHS POVERTY GUIDELINES

2014

1	2	3	4	5	6	7	8
$ 11,670	15,730	19,790	23,850	27,910	31,970	36,030	40,090

http://aspe.hhs.gov/poverty/14poverty.cfm

Quality Assessment Documents

2013 Quality Assessment Data
2014 Quarters 1 and 2

[as of 1/5/14]

Quality Assessment Performance Improvement Plan
2013 – 4th Quarter

Area	Quality Indicators	Benchmark (I) Internal (E) External	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Yearly Average
I. Patient/Family Outcomes	1. % of pts who report their pain at an unacceptable level will have pain relief within 48 hrs: a. New Admissions b. Established Patients	a. 90% *(I)* b. 90% *(I)*	a. 100% b. 91%	a. 100% b. 89%	a. 83% b. 87%	a. 90% b. 85%	a. 93% b. 88%
	2. % of pts who report their dyspnea at an unacceptable level will have dyspnea relief w/in 48 hrs	90% *(I)*	98%	94%	79%	91%	91%
	3. Bowel regimen in place within 24 hours of opioid initiation a. New Admissions b. Established patients	a. 90% *(I)* b. 90% *(I)*	a. 97% b. 96%	a. 82% b. 92%	a. 77% b. 79%	a. 92% b. 88%	a. 87% b. 89%
	4. Pt falls (home patient)/1000 pt days	8.7 *(I)*	7.6	11.9	9.2	10.6	9.8
	5. Falls w/ injury resulting in ER visit (home patient)	5% *(I)*	1.6%	1.4%	2%	2%	1.8%
	6. Oxygen safety will be assessed with all newly admitted pt	100% *(I)*	97%	100%	100%	100%	99.25%
	7. Patient infections/1000 pt days	6 *(I)*	4.6	3.4	5.4	4.6	4.5
	9. Compliance with CDC hand hygiene guidelines a. RN b. CNA c. SW d. Chaplain e. Volunteer	90% *(I)*	Not Reportable	a. 100% b. 100% c. 100% d. 100% e. 100%	Not Reportable		

Area	Quality Indicators	Benchmark (I) Internal (E) External	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Yearly Average
Patient/Family Outcomes [cont'd]	10. Staff who receive influenza vaccination *(Annual Reporting)*	65% ***(I)***	No Report	No Report	No Report	79%	79%
	12. Total # of hospice family members served per death. *(Annual Reporting)*	1.3***(E)***	1.3	No Report	No Report	No Report	1.3%
	13. Contacts per Family Member: *(Annual Reporting)* a. Phone calls/visits b. Mailings	a. 2.0 ***(E)*** b. 4.4 ***(E)***	a. 1.4 b. 4.9	No Report	No Report	No Report	a. 1.4% b. 4.9%
	14. Contacts per Community Member*(Annual Reporting)* a. Phone calls/visits b. Mailings	a. 1.0 ***(E)*** b. 0.4 ***(E)***	a. 2.6 b. 0	No Report	No Report	No Report	a. 2.6% b. 0
II. Processes of Care	1. Increase the average # of monthly referrals	110 ***(I)***	117.6	120	128	105	117.7
	2. Increase average # of admissions	80 ***(I)***	70.6	81	82	71	76
	3. The first call generates a visit	90% ***(I)***	94.8%	96.4%	No Data	93.7	95
	4. # of days from referral to admission	a. Median 2 ***(I)*** b. Mean 4 ***(I)***	a. 1.0 b. 1.9	a. 1.0 b. 1.6	a. 1.0 b. 1.7	a. 1.0 b. 1.6	a. 1.0 b. 1.7
III. Operations	1. Days cash on hand	150 days (I)	165	175	189	186	179
	2. a. Direct Labor b. Patient-Related Expenses c. Indirect Expenses	a. 41% ***(I)*** b. 18% ***(I)*** c. 32% ***(I)***	a. 43.4% b. 14.1% c. 33.9%	a. 41.7% b. 14.4% c. 32.0%	a. 38.8% b. 14.9% c. 31.2%	a. 40.1 b. 14.7 c. 33.1	a. 41 b. 14.5 c. 32.6

Area	Quality Indicators	Benchmark (I) Internal (E) External	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Yearly Average
IV. Hospice Services	1. Volunteer hours/total patient care hours (%)	5% ***(E)***	7.6%	7.9%	7.3%	6.4	7.3
	2. Volunteer hours/# of volunteers (*Annual Reporting*)	38.3 ***(E)***	31.4	No Report	No Report	No Report	31.4
	3. Male companion volunteers/companion volunteers	15% ***(I)***	17.7%	17.5%	15.5%	15.8	16.6
	4. Retention rate for active companion volunteers	80% ***(I)***	95%	96.4%	87.5%	89.1	92
	5. Meet or exceed the standard of excellence as indicated by the overall rating on the FEHC survey (G1)	75% ***(E)*** *Maryland* 73.5% ***(E)*** *National*	78.2%	81.8%	72.3%	82.0	79
	6. Evening/weekend response to needs was excellent (G2)	68.8% ***(E)*** *Maryland* 66.7% ***(E)*** *National*	74.5%	76.7%	64.3%	77.2	73
	7. Family was always kept informed of patient's condition (D5)	81.2% ***(E)*** *Maryland* 81.1% ***(E)*** *National*	84.6%	88.9%	79.4%	86.9	85
	8. % that would recommend HWC to others (G3)	87.9% ***(E)*** *National* 85.4% ***(E)*** *Maryland*	98.2%	92.4%	88.2%	91.9	93
	9. Patient's personal care needs were always taken care of (C1)	78.3% ***(E)*** *Maryland* 78.7% ***(E)*** *National*	81%	86.3%	75%	84.1	82
	10. Quality of care improved after hospice was involved (G5a= NH)	62.9% ***(E)*** Maryland 64.2% ***(E)*** National	73.3%	56.5%	66%	57.1	63

[as of 1/5/14]

Quality Assessment Performance Improvement Plan
2014 –2nd Quarter

Area	Quality Indicators	Benchmark (I) Internal (E) External	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Yearly Average
I. Patient/Family Outcomes	1. % of pts who report their pain at an unacceptable level will have pain relief within 48 hrs:	90% *(I)*	88	91			
	3. % of pts who report their dyspnea at an unacceptable level will have dyspnea relief w/in 48 hrs	90% *(I)*	88	90			
	4. Bowel regimen in place within 24 hours of opioid initiation	90% *(I)*	93	97			
	5. Pt falls (home patient)/1000 pt days	8.7 *(I)*	7.4	12.3			
	6. Falls w/ injury resulting in ER visit (home patient)	5% *(I)*	0.3	1.4			
	7. Oxygen safety will be assessed with all newly admitted pt	100% *(I)*	100	100			
	8. Patient infections/1000 pt days	5 *(I)*	4.7	3.9			
	9. Compliance with CDC hand hygiene guidelines a. RN b. CNA c. SW d. Chaplain e. Volunteer	90% *(I)*	Not Reportable	a. 100 b. 100 c. 100 d. 100 e. 96.7	Not Reportable		

Area	Quality Indicators	Benchmark (I) Internal (E) External	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Yearly Average
Patient/Family Outcomes [cont'd]	10. Staff who receive influenza vaccination *(Annual Reporting)*	70% ***(I)***	No Report	No Report	No Report		
	11. Bereavement Department will increase the overall number of clients served	10% ***(I)***	No Report	No Report	No Report		
	12. Total # of hospice family members served per death. *(Annual Reporting)*	1.3***(E)***	1.2	No Report	No Report	No Report	
	13. Contacts per Family Member: *(Annual Reporting)* a. Phone calls/visits b. Mailings	a. 2.1 ***(E)*** b. 4.4 ***(E)***	4,311	No Report	No Report	No Report	
	14. Contacts per Community Member*(Annual Reporting)* a. Phone calls/visits b. Mailings	a. 1.2 ***(E)*** b. 0.4 ***(E)***	793	No Report	No Report	No Report	
II. Processes of Care	1. Increase the average # of monthly referrals	Q1-110, Q2-112, Q3-114, Q5-115 **(I)**	117	124.3			
	2. Increase average # of admissions	Q1-80, Q2-82, Q3-83, Q4-84 ***(I)***	81.3	82.3			
	3. The first call generates a visit	90% ***(I)***	95.2	94.1			
	4. # of days from referral to admission	a. Median 2 ***(I)*** b. Mean 4 ***(I)***	1 1	1.82 1			
III. Operations	1. Days cash on hand	150 days (I)???	244	240			
	2. a. Direct Labor b. Patient-Related Expenses c. Indirect Expenses	a. 42.6% ***(I)*** b. 16% ***(I)*** c. 32.4% ***(I)***	37.4 14.3 28.2	36.8 11.9 34.3			

Area	Quality Indicators	Benchmark (I) Internal (E) External	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Yearly Average
IV. Hospice Services	1. Volunteer hours/total patient care hours (%)	5% ***(E)***	6.3	7.0			
	2. Volunteer hours/# of volunteers (*Annual Reporting*)	42.2 ***(E)***	32.83	No Report	No Report	No Report	
	3. Male companion volunteers/companion volunteers	15% ***(I)***	14.29	17.09			
	4. Retention rate for active companion volunteers	80% ***(I)***	100	94.7			
	5. Meet or exceed the standard of excellence as indicated by the overall rating on the FEHC survey (G1)	72.8% ***(E)*** *Maryland* 73.5% ***(E)*** *National*	85.5	80.8			
	6. Evening/weekend response to needs was excellent (G2)	67.2% ***(E)*** *Maryland* 66.9% ***(E)*** *National*	72.4	75.4			
	7. Team clearly explained plan of care to patient's family (G2a)	95.8% ***(E)*** *Maryland* 96.2% ***(E)*** *National*	98.4	98.6			
	8. % that would recommend HWC to others (G3)	92.7 ***(I)***	95.2	95.9			
	9. Confidence in doing what was needed to care for patient (D3)	71.8% ***(E)*** *Maryland* 72.0% ***(E)*** *National*	70.4	78			
	10. Quality of care improved after hospice was involved (G5a= NH)	62.3% ***(E)*** Maryland 63.4% ***(E)*** National	80	84.2			
	11. Composite Score (overall measure of a hospice's performance)	85.1% **(E)** Maryland 85.9% **(E)** National	83.3	89			

APPENDIX II

PROJECT DRAWINGS

Part A. **Floor Plan**

Part B. **Aerial View of Site**

Part C. **Concept Plan**

Part D. **Architectural Rendering**

APPENDIX III

2012 and 2013 Audited Financial Statements

FINANCIAL STATEMENTS
YEARS ENDED DECEMBER 31, 2013 AND 2012

Hospice of Washington County, Inc.

Contents

ALBRIGHT CRUMBACKER MOUL & ITELL | Certified Public Accountants & Business Consultants

Independent Auditors' Report

Board of Directors
Hospice of Washington County, Inc.
Hagerstown, Maryland

We have audited the accompanying financial statements of **Hospice of Washington County, Inc.** (a Not-for-Profit Organization), which comprise the statements of financial position as of December 31, 2013 and 2012, and the related statements of activities, functional expenses and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of **Hospice of Washington County, Inc.** as of December 31, 2013 and 2012, and the changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Albright Crumbacker Moul & Itell, LLC

Hagerstown, Maryland
May 13, 2014

December 31,	**2013**	2012
Assets		
Current assets		
Cash and cash equivalents	**$ 1,889,905**	$ 1,879,944
Investments	**4,606,511**	2,399,607
Patient accounts receivable, less allowance for doubtful accounts of $117,921 and $243,817, respectively	**1,729,511**	1,625,431
Pledges receivable	**278,680**	16,835
Prepaid expenses	**91,064**	170,353
Other assets	**22,000**	-
Total current assets	**8,617,671**	6,092,170
Property and equipment		
Land	**424,984**	424,984
Building improvements	**748,079**	626,192
Buildings	**1,375,794**	1,375,794
Furniture, fixtures and equipment	**581,810**	909,284
	3,130,667	3,336,254
Less accumulated depreciation	**(1,010,268)**	(1,225,810)
	2,120,399	2,110,444
	$ 10,738,070	$ 8,202,614

Hospice of Washington County, Inc.

Statements of Financial Position

December 31,	**2013**	2012
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt	**$ 21,515**	$ 20,672
Accounts payable	**230,973**	214,063
Accrued expenses	**23,402**	25,000
Accrued payroll expense	**287,006**	294,702
Total current liabilities	**562,896**	554,437
Long-term debt, less current portion	**502,190**	523,403
	1,065,086	1,077,840
Net assets		
Unrestricted		
Undesignated	**4,622,506**	5,656,880
Board designated	**4,606,511**	1,364,247
Temporarily restricted	**443,967**	103,647
	9,672,984	7,124,774
	$ 10,738,070	$ 8,202,614

The accompanying notes are an integral part of the financial statements.

Hospice of Washington County, Inc.

Statements of Activities

Years ended December 31,	2013	2012
Changes in unrestricted net assets:		
Revenues and support:		
Patient care	$ 12,765,779	$ 10,531,985
Contributions	189,033	152,291
Bequests	14,617	13,930
Net investment return	294,860	176,376
Other	31,011	5,302
Total revenues and support	13,295,300	10,879,884
Net assets released from restrictions:		
Satisfaction of donor restrictions	32,744	89,580
Total unrestricted revenues and support	13,328,044	10,969,464
Expenses:		
Program	9,127,429	9,025,083
Management and general	1,761,871	1,454,874
Development	230,854	196,905
Total expenses	11,120,154	10,676,862
Change in unrestricted net assets	2,207,890	292,602
Changes in temporarily restricted net assets:		
Contributions	373,064	145,692
Net assets released from restrictions	(32,744)	(89,580)
Change in temporarily restricted net assets	340,320	56,112
Change in net assets	2,548,210	348,714
Net assets - beginning	7,124,774	6,776,060
Net assets - ending	$ 9,672,984	$ 7,124,774

The accompanying notes are an integral part of the financial statements.

Hospice of Washington County, Inc.

Statements of Functional Expenses

Year ended December 31, **2013**

	Program Services	Management and General	Development	Total
Advertising	$ 112,754	$ -	$ 1,931	$ 114,685
Bad debt, net of recoveries	22,685	-	-	22,685
Building expense	21,651	4,907	457	27,015
Communications	57,877	32,328	344	90,549
Computers	218,463	49,517	325	268,305
Continuing education	35,992	27,715	70	63,777
Contracted physician services	127,797	-	-	127,797
Contributions and support	-	-	20,165	20,165
Depreciation expense	106,665	24,177	2,251	133,093
Development expense	-	-	100	100
Dues and subscriptions	9,482	18,544	1,461	29,487
Employee benefits	940,741	213,231	19,858	1,173,830
Insurance	27,953	6,336	590	34,879
Interest expense	17,418	3,948	368	21,734
Maintenance	58,325	13,220	1,231	72,776
Medical expenses	1,685,619	-	-	1,685,619
Miscellaneous	40,647	24,832	1,493	66,972
Office	16,352	12,996	8,207	37,555
Payroll taxes	367,401	83,276	7,756	458,433
Printing	28,280	6,410	597	35,287
Professional fees	5,183	111,968	58,944	176,095
Salaries and wages	4,909,518	1,112,804	103,636	6,125,958
Special events	-	-	321	321
Transportation/mileage	283,715	8,202	54	291,971
Utilities	32,911	7,460	695	41,066
	$ 9,127,429	$ 1,761,871	$ 230,854	$ 11,120,154

The accompanying notes are an integral part of the financial statements.

Hospice of Washington County, Inc.

Statements of Functional Expenses

Year ended December 31, 2012

	Program Services	Management and General	Development	Total
Advertising	$ 65,745	$ -	$ 1,736	$ 67,481
Bad debt	285,740	-	-	285,740
Building expense	20,425	3,934	364	24,723
Communications	54,683	28,496	100	83,279
Computers	145,807	29,865	325	175,997
Continuing education	35,592	8,665	3,420	47,677
Contracted physician services	98,500	-	-	98,500
Contributions and support	-	-	15,413	15,413
Depreciation expense	124,910	24,060	2,227	151,197
Development expense	-	-	248	248
Dues and subscriptions	3,289	23,300	1,060	27,649
Employee benefits	1,055,697	203,347	18,821	1,277,865
Insurance	18,954	3,651	338	22,943
Interest expense	25,455	4,903	455	30,813
Maintenance	59,789	11,517	1,066	72,372
Medical expenses	1,476,768	-	-	1,476,768
Miscellaneous	31,997	8,820	5,228	46,045
Office	11,446	8,059	4,181	23,686
Payroll taxes	373,877	72,016	6,665	452,558
Printing	15,679	3,211	6,097	24,987
Professional fees	36,782	84,845	-	121,627
Salaries and wages	4,819,737	928,370	85,927	5,834,034
Special events	-	-	42,622	42,622
Transportation/mileage	229,865	1,199	-	231,064
Utilities	34,346	6,616	612	41,574
	$ 9,025,083	$ 1,454,874	$ 196,905	$ 10,676,862

Hospice of Washington County, Inc.

Statements of Cash Flows

Years ended December 31,	2013	2012
Cash flows from operating activities		
Change in net assets	$ 2,548,210	$ 348,714
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities		
Depreciation	133,093	151,197
Bad debt, net of recoveries	22,685	285,740
Donated stock	(11,021)	-
Reinvested interest and dividends	(58,849)	(47,378)
Investment expense	21,195	10,117
Realized loss (gain) on investments	(106,728)	(161,378)
Unrealized loss (gain) on investments	(150,478)	22,263
Decrease (increase) in operating assets		
Patient accounts receivable	(126,765)	(146,376)
Pledges receivable	(261,845)	(2,290)
Prepaid expenses	79,289	18,639
Other	(22,000)	-
Increase (decrease) in operating liabilities		
Accounts payable	16,910	(67,085)
Accrued expenses	(1,598)	(442,615)
Accrued payroll expense	(7,695)	13,272
Net cash (used in) provided by operating activities	2,074,403	(17,180)
Cash flows from investing activities		
Purchases of property and equipment	143,048	(130,783)
Proceeds from sale of investments	1,040,421	432,965
Purchase of investments	(3,227,541)	(432,966)
Net cash used in investing activities	$ (2,044,072)	$ (130,784)

The accompanying notes are an integral part of the financial statements.

Hospice of Washington County, Inc.

Statements of Cash Flows

Years ended December 31,	**2013**	2012
Cash flows from financing activities		
Repayment of long-term debt	**$ (20,370)**	$ (66,268)
Net cash used in financing activities	**(20,370)**	(66,268)
Net increase (decrease) in cash and cash equivalents	**9,961**	(214,232)
Cash and cash equivalents - beginning	**1,879,944**	2,094,176
Cash and cash equivalents - ending	**$ 1,889,905**	$ 1,879,944
Supplemental disclosure of cash flow information		
Cash paid during the years for interest	**$ 21,734**	$ 30,813

The accompanying notes are an integral part of the financial statements.

1. **Summary of significant accounting policies**

This summary of significant accounting policies of **Hospice of Washington County, Inc.** (the Hospice) is presented to assist in understanding the Hospice's financial statements. The financial statements and notes are representations of the Hospice's management, who is responsible for their integrity and objectivity.

Nature of activity: The Hospice provides medical, social, emotional, spiritual, and other support to ease the pain and preserve the dignity of the terminally ill, and console the bereaved. The Hospice offers its services to residents of Washington County, Maryland.

Principles of accounting: The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

Basis of presentation: The Hospice reports information regarding its financial position and operations according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. Temporarily restricted net assets are comprised of funds whose use has been limited by donors to a specific time period or purpose. If a donor- imposed restriction is met in the same reporting period as the donation, the donation is reported as unrestricted support. Permanently restricted net assets are funds in which the principal is held in perpetuity. The Hospice has no permanently restricted net assets as of December 31, 2013 and 2012. In addition to donor-restricted net assets the Hospice's Board of Directors have designated resources as a cash reserve fund. Such amounts are reported as unrestricted board designated net assets.

Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates for the Hospice include its allowance for doubtful accounts.

Cash and cash equivalents: The Hospice considers all short-term highly-liquid investments such as money market accounts and certificate of deposits, with an original maturity of three months or less to be cash equivalents.

Patient accounts receivable: Patient accounts receivable represents patient fees due from third party payers and patients, including Medicare and Medicaid. The Hospice uses the allowance method to determine net accounts receivable. The allowance is based on an analysis of patient accounts and additional documentation requests from Medicare.

Pledges receivable and contribution revenue: Unconditional promises to give are recognized as contributions in the period the promise is made. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on non-current amounts are computed using risk-free interest rates (1%) applicable to the years in which the promises are received. Amortization of the discounts is recognized as contribution revenue over the life of the pledge. Contributions that are restricted by the donor are reported as increases in unrestricted net assets if the restrictions are met in the year in which the contributions are recognized. All other donor-restricted contributions are reported as increases in temporarily or permanently restricted net assets depending on the nature of the restrictions. When a restriction expires, temporarily restricted net assets are classified to unrestricted net assets. Conditional promises to give are recognized when the conditions on which they depend are substantially met. The Hospice feels that all contributions are fully collectible; therefore no allowance has been recorded.

Investments: The Hospice's investments are stated at fair value. The fair values of marketable equity and debt securities are based on quoted prices in active markets. Shares of mutual funds are valued at the net asset value of shares held at year end. Changes in unrealized gains and losses are included in net investment return and reported on the statements of activities. Realized gains and losses on investments are reported as increases or decreases in unrestricted net assets unless their use is temporarily or permanently restricted by the donor or by law and are included in net investment return. Also included in net investment return is other investment income, such as dividend and interest, which is recognized in the period earned as increases in unrestricted net assets unless the use is limited by donor-imposed restrictions. Return on investments is shown net of related investment fees.

FASB ASC 820-10 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The Hospice uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. When available, the Hospice measures fair value using Level 1 or Level 2 inputs because they generally provide the most reliable evidence of fair value. No Level 3 inputs were utilized by the Hospice for the years ended December 31, 2013 and 2012.

Fair value measurements: The Hospice complies with the Financial Accounting Standards Board's (FASB) Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosures*, which (a) defines how fair value should be determined for the invested assets, (b) establishes a framework for measuring fair value, and (c) requires statement preparers to disclose information about their fair value determinations in their financial statements. The three levels of fair value hierarchy under ASC 820-10 are described below:

Level 1: Unadjusted quoted prices in active markets that are accessible at the measurement date for identical assets or liabilities;

Level 2: Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly;

Level 3: Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable.

Property and equipment: Property and equipment are recorded at cost, if purchased, or fair value, if donated. The Hospice capitalizes individual property and equipment over $3,000. Lesser amounts are expensed. Depreciation is computed on the straight-line method over the estimated useful lives ranging from three to forty years. Maintenance and repairs are charged to expense as incurred; major improvements that increase the useful lives of the assets are capitalized. Upon sale or retirement, the costs and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss is included in revenues and support in the period realized.

Patient care income: The majority of the Hospice's patients are beneficiaries under Medicare programs. In addition, some patients have coverage under Medicaid and/or private insurance programs. The differences between the third-party payer's rates and the Hospice's established rates are recorded as contractual allowances. Unreimbursed treatment of uninsured individuals is reported as charity care. Hospice care revenue is reported at the estimated net realizable amounts from patients and third-party payers for services rendered.

Charity care: The Hospice provides care to anyone, regardless of their ability to pay. Patients identified as private pay are billed for services performed. Patients that are unable to pay for the services performed by the Hospice are identified based on financial information obtained from the patient and subsequent analysis. Estimated charges for charity care are not included in revenue because the Hospice does not expect payment.

Advertising costs: Advertising and marketing costs are expensed as incurred, and totaled $114,685 and $67,481, respectively for the years ended December 31, 2013 and 2012.

Income tax status: The Hospice is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The Hospice qualifies for the charitable contribution deduction under Section 170(b)(1)(a) and has been classified as a public charity rather than a private foundation. The Hospice complies with ASC 740-10, which establishes a threshold for determining when an income tax benefit of a tax position can be recognized. Under ASC 740-10, a tax position includes, among other things, (a) a decision not to file a tax return (b) an allocation or a shift of income between jurisdictions (c) the characterization of income or a decision to exclude reporting taxable income in a tax return (d) a decision to classify a transaction, entity, or other position in a tax return as tax exempt and (e) an entity's status, including its status as a tax-exempt not-for-profit entity. Based on its interpretation of the requirements of ASC 740-10, management believes that the Hospice has no uncertain tax positions that qualify for either recognition or disclosure. Management believes that the Hospice is no longer subject to income tax examinations for years prior to 2010.

Volunteer contributions: The Hospice relies on the services of volunteers to accomplish their mission. Hospice volunteers contributed approximately 6,900 and 6,500 hours each during 2013 and 2012, respectively. Because such volunteer contributions do not meet the criteria for recognition under ASC 958-605-50, *Accounting for Contributions Received and Contributions Made,* no amount for volunteer in-kind contributions has been recorded in the statements of activities.

2. Risks and uncertainties

The Hospice currently maintains a significant portion of its cash balances in a cash management account ("CMA") with a local financial institution. Although not insured by FDIC insurance, these funds are collateralized, in part, by government securities under a Collateral Security Interest as required by Federal Banking Law. Any uncollateralized portion under the Collateral Security Interest will be supplemented on a pro rata basis by the aggregate value of any non-pledged portion of the government bonds reserved by the bank as collateral for its CMA accounts.

The Hospice also keeps a significant portion of its cash balances at one financial institution, which at times, may exceed federally insured limits. Management considers these circumstances to be a normal business risk.

The Hospice grants credit without collateral to its patients, who are residents of the area served by the Hospice and generally insured under third-party payer agreements. Aggregate revenue from patients under Medicare and Medicaid programs approximated 92% and 97% for 2013 and 2012, respectively. Accounts receivable from patients under the Medicare and Medicaid programs approximated 94% and 95% as of December 31, 2013 and 2012, respectively.

As a provider of services covered under the Medicare and Medicaid programs, the Hospice is subject to Additional Document Requests (ADR's) by CGS Administrative Services, which may result in the denial of claims for services performed. The Hospice believes its allowance for doubtful accounts is adequate to cover the potential disallowance of such fees.

The Hospice invests in a portfolio that contains a variety of investment types. Such investments are exposed to various risks, such as market, credit and interest rate risk. Due to the level of risk associated with such investments, it is at least reasonably possible that such risk may change in the near term and that such changes could materially affect the fair values of those investments as reported in the Hospice's financial statements. Management believes that there has been no significant decrease of fair value since December 31, 2013.

3. Investments The fair value of investments as of December 31 by major investment class consisted of the following:

	2013		2012	
Description	(Level 1)	(Level 2)	(Level 1)	(Level 2)
Money Market	$ 1,208,405	$ -	$ 167,608	$ -
Certificates of Deposit	-	720,332	-	365,879
Mutual Funds				
Equity	1,967,523	-	774,828	-
Fixed Income	710,251	-	1,091,292	-
	$ 3,886,179	$ 720,332	$ 2,033,728	$ 365,879

Net investment return (loss) for the years ended December 31 consisted of the following:

	2013	2012
Interest/dividends	$ 58,849	$ 47,378
Realized gain on sale of securities	106,728	161,378
Unrealized gain (loss) on investments	150,478	(22,263)
Investment expense	(21,195)	(10,117)
	$ 294,860	$ 176,376

4. Long-term debt Long-term debt as of December 31 consisted of the following:

	2013	2012
Mortgage payable - secured by real estate, payable in monthly installments of $3,505, including interest at 4%, matures March 2031	$ 523,705	$ 544,075
Less current portion	(21,515)	(20,672)
	$ 502,190	$ 523,403

Aggregate principal maturities of long-term debt for the years ending December 31 are as follows:

2014	$ 21,515
2015	22,391
2016	23,303
2017	24,253
2018	25,241
Thereafter	407,002
	$ 523,705

5. Line of credit

The Hospice has a $2,000,000 unsecured line of credit with a local bank. There is no expiration on the note and any draws bear interest at the 30-day LIBOR rate, plus 2.4% with a stipulated floor rate of 4%.

6. Temporarily restricted net assets

The activity in temporarily restricted net assets, which consists of cash and cash equivalents, was as follows:

	Balance at 1/1/2013	Contributions	Satisfaction of Restrictions	Balance at 12/31/2013
Kass Scholarship Fund	$ 13,523	$ 3,539	$ (3,000)	$ 14,062
Mortgage Burning Fund	17,169	14,894	-	32,063
Coast Hospice Fund	4,068	8,469	(4,888)	7,649
Jennifer Fund	32,105	9,094	-	41,199
Special Events Fund	27,481	2,100	(321)	29,260
Benevolence Fund	9,301	15,518	(12,278)	12,541
Wish Fund	-	500	(500)	-
Hospice House	-	318,950	(11,757)	307,193
	$ 103,647	$ 373,064	$ (32,744)	$ 443,967

	Balance at 1/1/2012	Contributions	Satisfaction of Restrictions	Balance at 12/31/2012
Kass Scholarship Fund	$ 14,826	$ 1,697	$ (3,000)	$ 13,523
Mortgage Burning Fund	15,577	33,137	(31,545)	17,169
Coast Hospice Fund	2,637	10,862	(9,431)	4,068
Jennifer Fund	6,481	30,583	(4,959)	32,105
Special Events Fund	243	64,901	(37,663)	27,481
Benevolence Fund	7,771	4,512	(2,982)	9,301
	$ 47,535	$ 145,692	$ (89,580)	$ 103,647

7. Pension plan The Hospice has a salary reduction plan (the Plan) under Section 403(b) of the Internal Revenue Code covering all eligible employees contributing to the Plan. After one year of service, the Hospice matches 100% of each participant's contribution to the Plan up to 3% of the individual participant's compensation. The employer's matching contribution in 2013 and 2012 approximated $111,000 and $114,000, respectively, and is included in employee benefits.

8. Functional allocation of expenses Certain costs have been allocated among the programs and supporting services. Allocations of costs by function are based principally on specific identification of costs to program, management and general or development. Non-specifically identified costs are based on management's allocation of time requirements and/or square footage for the various functions based on its analysis of historical activities.

9. Reclass-ifications Certain accounts in the prior year financial statements have been reclassified for comparative purposes to conform to the presentation in the current year financial statements.

10. Subsequent events The Hospice has evaluated events and transactions subsequent to December 31, 2013 through May 13, 2014, the date these financial statements were available to be issued. Based on the definitions and requirements of accounting principles generally accepted in the United States of America, management has not identified any events that have occurred subsequent to December 31, 2013 through May 13, 2014, that require recognition or disclosure in the financial statements.