For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED: HOSPICE SERVICES

for General Hospice Services in Prince George's County

Applicant:

Montgomery Hospice, Inc.
1355 Piccard Drive
Rockville, MD 20850
301-921-4400

October 7, 2016

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Prince George's County Government, Deputy Chief Administrative Officer for Health, Human Services and Education

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PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Hospice Provider : Montgomery Hospice, Inc.

Address:

1355 Piccard Dr, Ste. 100	Rockville	20850	Montgomery
Street	City	Zip	County

Name of Owner (if differs from applicant):
N/A

2. OWNER

Name of owner: N/A, Community non-profit organization

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):
Montgomery Hospice, Inc.

Address:

1355 Piccard Dr., Ste.100	Rockville	20850	MD	Montgomery
Street	City	Zip	State	County

Telephone: 301-921-4400

Name of Owner/Chief Executive: Ann Mitchell, MPH, President & CEO

Is this applicant one of the following? (Circle or highlight description that applies.)

Licensed and Medicare certified general hospice in Maryland **See Appendix C, Exhibit 1**
Licensed and Medicare certified hospice in another state
Licensed hospital in Maryland/ other state
Licensed nursing home in Maryland/other state
Licensed and Medicare certified home health agency in Maryland/other state
Limited license hospice in Maryland
IF NONE OF THE ABOVE, NOT ELIGIBLE TO APPLY (See COMAR 10.24.13.04A.)
DO NOT COMPLETE REMAINDER OF APPLICATION

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: Ann Mitchell, MPH, President & CEO
Mailing Address:

1355 Piccard Dr., Suite 100	Rockville	20850	MD
Street	City	Zip	State

Telephone: 301-921-4400
E-mail Address (required): amitchell@montgomeryhospice.org
Fax: 301-921-4433

B. Additional or alternate contact: Monica Escalante, CFO
Mailing Address:

1355 Piccard Dr., Suite 100	Rockville	20850	MD
Street	City	Zip	State

Telephone: 301-921-4400
E-mail Address (required): mescalante@montgomeryhospice.org
Fax: 301-921-4433

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

Montgomery Hospice, a licensed and Medicare-certified general hospice that currently holds a CON for hospice in Montgomery County, will extend its area of service into the contiguous Prince George's County.

7. Project Services (check applicable description):

Service	(check if description applies)
Establish a general hospice	X
Establish a General Inpatient Unit (GIP)	
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. (If services provided in other state(s), list them.)

- Montgomery County

B) Jurisdiction applicant is applying to be authorized in:

- Prince George's County

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

N/A. This project will provide primarily home-based hospice care. There will be no construction required.

(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 _____months from approval date.
B. Beginning Construction _____months from capital obligation.
C. Pre-Licensure/First Use _____months from capital obligation.
D. Full Utilization _____months from first use.

11. For projects not involving construction or renovations.

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.

Project Implementation Target Dates

A. Obligation ~~or expenditure~~ of 51% Project Budget __3____ months from CON approval date.
B. Pre-Licensure/First Use _____6_____ months from CON approval.
C. Full Utilization _____36_____ 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
(2) ***Rationale for the project*** *– the need and/or business case for the proposed project*
(3) ***Cost*** *– the total cost of implementing the proposed project*

Brief Description of the Project

Montgomery Hospice, a licensed and Medicare-certified general hospice that now serves Montgomery County, will extend its area of service into the contiguous Prince George's County. Montgomery Hospice served more than 2,000 hospice patient residents of Montgomery County in 2015, and anticipates serving an additional 700 to 900 patients per year residing in Prince George's County once this project is fully operational.

During its 35 years of service to Montgomery County residents, Montgomery Hospice has developed the skills and staff appropriate to serving a large population in a mixed area of urban,

suburban, and rural character. In particular, Montgomery Hospice has the special expertise needed to serve the most vulnerable families in this area, who may be members of minority populations or speakers of languages other than English.

Montgomery Hospice is financially sound and well positioned to enlarge its area of service. That said, Montgomery Hospice's financial planning assumptions depend upon the state of Maryland awarding only one CON for the jurisdiction, as its leaders anticipate that a significant investment will be required in order to ensure that the new county's hospice needs are fully met.

Montgomery Hospice will offer general hospice services, including care within the patient home, general inpatient care, inpatient respite care and continuous care for times of particular short term need. Montgomery Hospice already owns and operates Casey House, a 14-bed specialized hospice inpatient facility, located in central Montgomery County. To supplement these inpatient beds and provide locally based care for Prince George's County residents, Montgomery Hospice will contract with hospitals in that county and with another existing Medicare certified hospice for inpatient hospice beds.

By Year 4 of this project, Montgomery Hospice anticipates serving approximately 700 Prince George's County residents a year. In addition, it will provide abundant end-of-life education to thousands of residents using the capabilities of its Center for Learning, which includes online education free of charge.

Rationale for the Project

This project is designed to completely address the unmet need identified by the state of Maryland as published in the table "Maryland Hospice Need Projections for Target Year 2019," published in the Maryland Register, Friday, May 27, 2016. Projections for Prince George's County predict an unmet need of 662 patients, even if existing hospices serving that county continued to grow at historical rates. This unmet need is well over the threshold of 359 that triggers CON review. Montgomery Hospice is large enough to meet that annual need entirely, without the need for new services from any additional providers. Montgomery Hospice already operates in the county directly adjacent to Prince George's County, and has extensive relationships with local providers and referral sources that can easily cross the county borders. The hospice's employee base already crosses county lines: 11% of Montgomery Hospice's employees currently reside in Prince George's County. Service to 662 new patients would represent an increase of 35% over the number of admissions served in Montgomery County in 2015, which management considers a reasonable and manageable level of growth over the years of the plan included in this application.

Montgomery Hospice believes that with its ethnically diverse senior management team (50% minority) and overall staff (49% minority), it can improve hospice utilization in Prince George's County, bringing culturally appropriate hospice care to those who need it. If Montgomery Hospice is awarded the CON for Prince George's County, it will explore a re-branding effort to avoid confusion about its coverage area and community commitment due to the current hospice name.

Montgomery Hospice has extensive experience working with communities of color, learning from them the preferred cultural approach to end-of-life care. Senior management at Montgomery Hospice is now establishing relationships to build bridges to the faith and medical communities in Prince George's in order to provide the best hospice care possible. Montgomery Hospice is already very committed to the spiritual needs of hospice patients and families. Currently, Montgomery Hospice maintains a case load of no more than 35 patients and families per chaplain. This is a low chaplain/patient ratio. The National Hospice and Palliative Care Organization recommends a chaplain caseload of 40-60 patients.

According to the Maryland Vital Statistics Administration, 361 more people died in Prince George's County in 2015 than in 2014. Two-thirds of the deaths were black. The increase in deaths contributes to the growing unmet need in Prince George's County, already identified by

the Maryland Health Care Commission staff. In 2014, the most recent year for which statistics are available, the hospice utilization rate for Prince George's County was just 26.6%, compared with a state-wide average utilization of 40.6% for Maryland as a whole.

Cost of the Project

Montgomery Hospice estimates this project will require $2.5 million in working capital before services in Prince George's County become self-sustaining operationally.

Total revenue for this project in a four-year period is expected to be $25,238,956. The expenses for the same period are budgeted at a total of $27,146,839, giving a net loss of $1,907,883 from operations by the end of the fourth year. This project is expected to start breaking even at the end of the third year of operations, once 700 or more patients are served per year.

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.

N/A. This project will provide primarily home-based hospice care. Inpatient services will be provided in existing facility beds under contract.

15. FEATURES OF PROJECT CONSTRUCTION:

N/A. This project will provide primarily home-based hospice care. There will be no construction required.

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

A. Use of Funds

1. Capital Costs (if applicable):

a.	New Construction	$_____	
(1)	Building	_____	
(2)	Fixed Equipment (not included in construction)	_____	
(3)	Land Purchase	_____	
(4)	Site Preparation	_____	
(5)	Architect/Engineering Fees	_____	
(6)	Permits, (Building, Utilities, Etc)	_____	
SUBTOTAL			$_____
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	130,000	
(2)	Minor Movable Equipment	240,000	
(3)	Contingencies	_____	
(4)	Other (Specify)	_____	
TOTAL CURRENT CAPITAL COSTS (a - c)			$ 370,000
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)	18,000
d.	Legal Fees (Other)	_____
e.	Printing	_____
f.	Consultant Fees	
	CON Application Assistance	8,000
	Other (Specify)	_____
g.	Liquidation of Existing Debt	_____
h.	Debt Service Reserve Fund	_____
i.	Principal Amortization Reserve Fund	_____

	j. Other (Specify)	_____	
	TOTAL (a - j)	$ 26,000	
3.	Working Capital Startup Costs	$ 2,141,400	
	TOTAL USES OF FUNDS (1 - 3)		$ 2,537,400

B. Sources of Funds for Project:

1.	Cash	2,537,400	
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	_____	
3.	Gifts, bequests	_____	
4.	Interest income (gross)	_____	
5.	Authorized Bonds	_____	
6.	Mortgage	_____	
7.	Working capital loans	_____	
8.	Grants or Appropriation		
	(a) Federal	_____	
	(b) State	_____	
	(c) Local		
9.	Other (Specify)		
TOTAL SOURCES OF FUNDS (1-9)			$ 2,537,400

Lease Costs:

a. Land	$_____	x _____	= $_____
b. Building	$_100,000 ___	x ____4_____	= $_400,000 __
c. Major Movable Equipment	$_____	x _____	= $_____
d. Minor Movable Equipment	$_____	x _____	= $_____
e. Other (Specify)	$_____	x _____	= $_____

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. (All applicants must address standards A. through O. Applicants proposing a General Inpatient facility must also address P.)

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**. An applicant shall designate the jurisdiction in which it proposes to provide services.*

Montgomery Hospice currently serves all of Montgomery County, and proposes to expand its service to Prince George's County if awarded a CON for that jurisdiction.

B. ***Admission Criteria**. An applicant shall identify:*
(1) Its admission criteria; and
(2) Proposed limits by age, disease, or caregiver.

Montgomery Hospice requires patients to meet eligibility requirements to be admitted for Medicare/Medicaid-covered services. (See **Appendix B: Policies and Procedures** for the full text of Policy PFC.A20.) The same admission eligibility policy applies to patients covered by commercial insurance. The only difference in the admission process regards any specific insurance verification forms required by the payer. It must be noted that Montgomery Hospice would not stop or delay admission of a patient for lack of or insufficient insurance-related documentation.

Montgomery Hospice's limits to eligibility for service are outlined in MH Policy CES.D15 (See **Appendix B** for full text). It states that hospice service may be discontinued for several possible reasons:

- patient moves outside the geographic area
- patient no longer meets Medicare or insurance eligibility for hospice care
- patient desires aggressive treatment inconsistent with the philosophy of hospice or the patient's plan of care
- patient chooses to receive treatment from an inpatient facility with which Montgomery Hospice does not have a written agreement
- patient no longer desires hospice services
- for cause, if the hospice determines that the behavior of the patient (or of others

in the patient's home) is disruptive, abusive or uncooperative to the extent that the delivery of care to the patient or the ability of the hospice to operate effectively or safely is impaired.

Montgomery Hospice follows detailed and explicit procedures for all discharges to ensure that a discharge plan is made to ensure continuity of care, that the patient's attending physician is consulted, and that the patient and/or their representative understands any reasons for discharge with cause and is given an opportunity to address them.

C. Minimum Services*.*

(1) An applicant shall provide the following services directly:

(a) Skilled nursing care;
(b) Medical social services;
(c) Counseling (including bereavement and nutrition counseling);

(2) An applicant shall provide the following services, either directly or through contractual arrangements:

(a) Physician services and medical direction;
(b) Hospice aide and homemaker services;
(c) Spiritual services;
(d) On-call nursing response
(e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management);
(f) Personal care;
(g) Volunteer services;
(h) Bereavement services;
(i) Pharmacy services;
(j) Laboratory, radiology, and chemotherapy services as needed for palliative care;
(k) Medical supplies and equipment; and
(l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.

Montgomery Hospice provides comprehensive services for end-of-life care to terminally ill patients and their families within its geographical service area and in the setting defined by the patient and family as the patient's place of residence. Hospice patients and their families receive the services of the hospice's interdisciplinary groups, which include:

a. skilled nursing care;
b. medical social services;
c. counseling services, (including spiritual counseling, nutrition counseling. and bereavement services);
d. physician services and medical direction (from the hospice Medical Director and/or the patient's attending physician);
e. hospice aide and homemaker services;
f. spiritual services and on-call nursing response
g. volunteer services
h. bereavement
i. other therapies including physical therapy, occupational therapy, speech therapy and pathology, and dietary services, as identified in the patient's plan of care

In order to provide patient care, Montgomery Hospice directly employs the following people:

- 106 nurses who also provide dietary counseling
- 21 social workers
- 8 bereavement counselors
- 6 physicians who provide physician services and medical direction
- 47 hospice aides who perform personal care
- 14 chaplains who provide spiritual care
- 19 on-call nurses
- 4 paid employees who direct 300 volunteers performing volunteer and homemaker services
- 3 complementary therapists
- 3 dietary services employees

Montgomery Hospice provides physical therapy, occupational therapy and speech therapy through contractual arrangements. It also provides laboratory, radiology and chemotherapy services as needed for palliative care through contractual arrangements. Pharmacy services, medical supplies and equipment are provided under contractual arrangement, as well.

In addition to the services of the IDG, the hospice provides medical supplies and equipment and drugs that are used for the management of pain and symptom control related to the patient's terminal illness.

Nursing services, physician services, and drugs and biologicals are routinely available on a 24-hour basis 7 days a week, and other services on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.

Montgomery Hospice provides short term inpatient care and crisis care directly to all patients that need it. In 2015, the hospice provided more than 4,000 days of inpatient-level care (3,728 days of GIP or general inpatient level care, and 314 days of inpatient respite care). It also provided 16 days of continuous care, or round-the clock skilled care in the patient's home in response to a short-term crisis.

> *(3) An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient.*

The Montgomery Hospice bereavement program currently employs eight bereavement counselors, all with Masters level educations.

During 2015, the Montgomery Hospice Bereavement Department supported more than 4,000 family members of patients. Members of the Bereavement Department made approximately 15,000 phone calls and visits to hospice families. The Bereavement Team sent more than 15,000 packets via mail, and conducted 60 grief workshops and support groups.

Initially, Montgomery Hospice will hire a bereavement counselor to serve Prince George's County. As the census increases, Montgomery Hospice will expand the number of paid bereavement counselors to reflect a ratio of 250-300 bereaved family members per bereavement counselor. Bereavement services in Prince George's County will include grief workshops and support groups that will be held in the Montgomery Hospice Prince George's office, and where possible, in other venues throughout the county such as places of worship and senior centers.

> *C.* ***Setting****. An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.*

Hospice services will be delivered in the setting in which patients reside, including private homes, residential units, assisted living facilities, nursing facilities, or any combination of the

above. General inpatient services will be provided in an inpatient unit when appropriate, per regulations and Montgomery Hospice policy. Please see **Section L.(1) Linkages**, for more details about Montgomery Hospice's contacts with providers that can supply GIP-appropriate beds.

D. ***Volunteers****. An applicant shall have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program.*

Montgomery Hospice will have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program. (See **Appendix B** for Policy WE.V55 regarding volunteer services.)

Currently, Montgomery Hospice volunteers support patients and families in a wide variety of ways, including reading to patients, providing companionship for patients, respite for the caregiver, running errands, helping with writing letters and creating memory books. Montgomery Hospice volunteers, who are carefully screened, attend a three-day volunteer training prior to beginning service, and participate in educational events throughout the year. Volunteers visit in patient homes, in nursing faciliities and at Casey House.

In 2015, the 300 active Montgomery Hospice volunteers donated more than 19,000 hours, made more than 14,000 patient visits, and drove more than 110,000 miles in order to help our patients.

F. ***Caregivers****. An applicant shall provide, in a patient's residence, appropriate instruction to, and support for, persons who are primary caretakers for a hospice patient.*

It is the policy of Montgomery Hospice to provide appropriate instruction within a patient's residence to primary caretakers for a hospice patient. Please See **Appendix B** for the complete text of Policy CES.P15. As additional resources for this purpose, Montgomery Hospice has developed multiple documents that serve as an in-home guide for caregivers. Please see **Appendix C: Citations and Exhibits**, for Exhibits 4 and 5, *Montgomery Hospice Patient and Family Handbook*, and *When Death is Near: A Caregiver's Guide*.

Montgomery Hospice clinicians use the handbook to educate caregivers, using sections that include content on:

- Care of the Patient
- Home Safety and Emergencies
- Medications
- Caregiver Support
- Patients' Rights and Responsibilities

G. ***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.*

Montgomery Hospice expects the impact of its project on hospice volumes at existing providers to be minimal in the short term. Although there are currently 8 hospices authorized to serve Prince George's County, their combined admissions in 2014 were only 2,349. Although all existing

providers have been made aware that the hospice service rate in the county is well below average, the service rate has been relatively flat since 2012, at 26.6%, far below the level of the state as a whole (40.6%)

The Maryland Hospice Need projections include the assumption that existing providers will continue to grow at their past rates. Thus, the current hospice need formula is designed to minimize impact on existing providers, as CON review is only triggered once unmet need exceeds the threshold of 359, **even after assuming that current providers will continue to grow as they have in the past**.

In spite of the built-in presumption that existing providers will continue to grow according to their past trends, there is still a forecast net need of 667 hospice patients in 2019, the target year. Montgomery Hospice is projecting full utilization for its project by the end of 2019, and has developed its project budget and assumptions to meet the entire need once it achieves full utilization.

H. Financial Accessibility*. An applicant shall be or agree to become licensed and Medicare-certified, and agree to accept patients whose expected primary source of payment is Medicare or Medicaid.*

Montgomery Hospice is currently a Maryland-licensed general hospice that provides care to patients insured by Medicare and Medicaid, among other payers. In 2015, Montgomery Hospice served 23 patients insured by Medicaid. If awarded the CON, Montgomery Hospice will serve all patients without discriminating according to patient payment source, as is its policy. That policy also provides for periodic review of all admission criteria and eligibility limitations to identify potential impediments to patient access. See **Appendix B**, Policy IA.A10.

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:

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

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

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

(d) The general public in its proposed service area.

Montgomery Hospice has full-time staff members dedicated to educating both the professional community and the general public about its services. Montgomery Hospice maintains an extensive website with information about its services, how its services are paid for, how to make a referral, what the Medicare Hospice Benefit covers, its office locations, and how to reach its staff. It will update its website upon receipt of the CON to reflect the expanded geographic service area, and is considering a re-branding effort to avoid confusion about its coverage area due to the hospice name.

In addition to the website, Montgomery Hospice will conduct a broad mailing upon the start of service in Prince George's County to communicate this information to all area facilities (such as nursing home and assisted living facilities), home health agencies, and hospitals. Montgomery Hospice staff will both visit, and mail information to, Prince George's County physicians, especially those who work in oncology and geriatrics, to let them know how its staff can work with them to help their patients who are nearing end of life.

Montgomery Hospice employs full time professional liaisons who call regularly at area hospitals and physician practices to discuss patients who may be appropriate for referral to hospice care,

and who facilitate the process of transferring such patients to hospice if necessary. Montgomery Hospice anticipates adding up to 2 full time liaisons to its staff once service to Prince George's County begins.

Upon being awarded the CON for Prince George's County, Montgomery Hospice's community education staff will evaluate methods of communicating with providers and the general public, and will adapt those methods that were previously found to be successful for the specific needs of Prince George's County.

Montgomery Hospice looks forward to working with the Prince George's County Department of Family Services, Area Agency on Aging in Camp Springs, MD in order to support area seniors with hospice services, advanced care planning and bereavement services. Montgomery Hospice staff members have already initiated contact with the agency and received its support (See Appendix A: Letters of Support).

In addition to these forms of outreach to those already caring for the elderly and ill of Prince George's County, Montgomery Hospice plans to prepare a mailing, introducing itself and its services, to contacts in the Department of Parks and Recreation and Senior Services, and to County senior centers. The large cadre of volunteers attached to Montgomery Hospice will distribute flyers about its services to county libraries. The hospice will also run advertisements in local community newspapers, especially those read by seniors.

> *(2) Fees. An applicant shall make its fees known to prospective patients and their families before services are begun.*

Montgomery Hospice maintains information on paying for its services on the organization website, and also presents a written fee schedule to clients prior to admission. Please see **Appendix C, Exhibit 6**, "Montgomery Hospice 2016-2017 Fee Schedule." See also the information for patients and families available on the Montgomery Hospice website at:

http://www.montgomeryhospice.org/patients-families/how-hospice-paid

There are no co-pays for Medicare and Medicaid patients. Copays for patients under commercial insurance coverage vary depending on the policy.

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.*
>
> ***(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.*

(3) 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.*

(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:*
(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and
(b) It has a specific plan for achieving the level of charity care to which it is committed.

For Montgomery Hospice's policy on charity care, see **Appendix B: Policies and Procedures** for the full text of Policy 8-006: "Financial Assistance Policy and Procedure."

Montgomery Hospice provides care to all hospice-eligible patients regardless of ability to pay. In this effort, it has a robust Financial Assistance Policy and Procedure that includes not only the uninsured but also the underinsured. Upon admission, or when the financial need is identified, a hospice staff member will assist the patient or decision maker in completing the financial assistance application. A determination is made by the Director of Finance regarding the level of financial assistance that will be provided. If payment is needed, a sliding fee scale will be offered to the patient/decision maker with terms of payment that takes into account the patient's ability to pay. This pertains to all levels of care the patient may require during their hospice admission. The Finance Department keeps records of all charity care and financial assistance provided by Montgomery Hospice. In 2015, Montgomery Hospice provided $467,316 in charity care.

Montgomery Hospice's policy on charity care is printed on most of the hospice's patient literature and on the organization website stating that Montgomery Hospice will care for patients regardless of their ability to pay. Insurance status never delays admission or provision of care. Response time, from the moment a referral is received to the moment a patient is admitted, is tracked by management. Patients without insurance are admitted using the same high standards for service established for all patients. The average response time from first call to admission is less than three days.

Montgomery Hospice has budgeted to provide $450,000 in charity care each year within Prince George's County once service begins.

K. Quality.

(1) An applicant that is an existing Maryland licensed general hospice provider shall document compliance with all federal and State quality of care standards.

(2) An applicant that is not an existing Maryland licensed general hospice provider shall document compliance with federal and applicable state standards in all states in which it, or its subsidiaries or related entities, is licensed to provide hospice services or other applicable licensed health care services.

(3) An applicant that is not a current licensed hospice provider in any state shall demonstrate how it will comply with all federal and State quality of care standards.

(4) An applicant shall document the availability of a quality assurance and improvement program consistent with the requirements of COMAR 10.07.21.09.

(5) An applicant shall demonstrate how it will comply with federal and State hospice quality measures that have been published and adopted by the Commission.

Since 1998, Montgomery Hospice has paid to be surveyed by an external quality review agency, the Joint Commission. Montgomery Hospice has been accredited successfully by the Joint Commission six times, and it expects its seventh accreditation to occur later this fall. Please see **Appendix C: Exhibit 2** for Montgomery Hospice's most recent accreditation certificate from the Joint Commission.

As further evidence of our long standing quality and community reputation, please see **Appendix C: Exhibit 3** for the multiple citations of honor that Montgomery Hospice has received, from the following organizations:

- The County Executive of Montgomery County, Maryland, in recognition of ten years of service by Montgomery Hospice's Casey House inpatient facility, August 2009
- Senator Benjamin Cardin, of the United States Senate, in recognition of the tenth anniversary of Casey House, August 2009
- Representative Chris Van Hollen, United States Congress, in recognition of the of the tenth anniversary of Casey House, August 2009
- The Maryland General Assembly, in recognition of 30 years of extraordinary service, October 2011
- Governor's Citation from Gov. Martin O'Malley, April 2012

Montgomery Hospice develops, implements and maintains an ongoing, hospice-wide and data-driven quality assessment and performance improvement (QAPI) program that reflects the complexity of the hospice's organization and services, and that ensures compliance with all federal and State quality of care standards, as well as federal and State hospice quality measures that have been published and adopted by the Commission.

See **Appendix B**, Policy PM.Q20, which outlines Quality Assessment and Performance Improvement policy and procedures.

The QAPI program analyzes quality indicators, including adverse patient events, collects data that is used to monitor the effectiveness and safety of services and quality of care, including areas of high risk and adverse patient events, and conducts activities aimed at performance improvement.

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.

(2) 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.

Although Montgomery Hospice's goal is to care for patients in their places of residence, there will be numerous times when Prince George's County hospice patients medically require care delivered in an inpatient setting. For Prince George's County residents, Montgomery Hospice

proposes to use three inpatient locations:

1. **Montgomery Hospice Casey House**, a 14 bed inpatient hospice in Derwood MD, located with easy access from the ICC
2. **Prince George's Hospital Center**, a Dimensions Healthcare System hospital in Cheverly MD
3. **Rebecca Fortney Inpatient Care Center** in Pasadena, an inpatient hospice owned by Hospice of the Chesapeake

Inpatient hospice care will be delivered directly by Montgomery Hospice when Prince George's County residents are admitted to Casey House. Casey House is certified by Medicare and Medicaid as an inpatient hospice. It is licensed by the state of Maryland and accredited by the Joint Commission. It meets rigorous standards and has an excellent reputation among referring hospitals and community physicians.

Casey House has at least two RNs on site caring for patients at all times. During the daytime hours, four RNs work in the inpatient facility. This generous nurse staffing is made possible by an endowment from the Eugene B. Casey Foundation. Additional staffing on site at Casey House includes professional social workers who work with patients and families seven days a week, and a dedicated chaplain who is on-site Monday—Friday. A rotating staff of nursing assistants ensures that two are always on site to provide personal care to Casey House patients 24 hours a day.

Contracted services for General Inpatient (GIP) care have already been discussed with two other healthcare organizations. Over the past few months, Montgomery Hospice has met with senior executives at Prince George's Hospital Center. Both parties are receptive to signing a contract which would allow Montgomery Hospice patients to be admitted to the hospital for hospice General Inpatient (GIP) care.

Montgomery Hospice also has begun conversations with Hospice of the Chesapeake about contracting to use its 14-bed inpatient care center in Pasadena as another source of inpatient (GIP) beds for Prince George's County residents. Montgomery Hospice and Hospice of the Chesapeake look forward to working together to provide high quality inpatient hospice care.

Montgomery Hospice believes strongly in collaborating with other healthcare providers in order to provide terminally-ill patients the highest quality care. As evidenced by the Letters of Support, Montgomery Hospice already has established linkages with hospitals, nursing homes, home health agencies, AERS, Senior Information and Assistance programs, adult day care programs, the local Department of Social Services and home delivered meal programs.

In August of this year, Montgomery Hospice had a productive and positive meeting with the Prince George's County Department of Health, Family Services, Aging and Disabilities Services, Senior Provider Network and Area Agency on Aging. County officials requested that Montgomery Hospice begin sending a representative to the Senior Provider Network meetings in Prince George's County. Montgomery Hospice immediately identified a staff member who is now a member of the Network and regularly attends meetings with other members of the Prince George's County Network.

As further evidence of Montgomery Hospice's efforts to ensure linkages with other providers in Prince George's County, please see **Appendix A: Letters of Support**, for letters from the following:

- Prince George's County Government, Area Agency on Aging
- Prince George's County Government, Deputy Chief Administrative Officer for Health, Human Services and Education
- Washington Adventist Hospital
- Hospice of the Chesapeake
- Professional Healthcare Resources

- Food & Friends

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

Montgomery Hospice offers respite care to patients and their families/caregivers as required. Montgomery Hospice currently has 3 contracts with area nursing facilities, and also offers inpatient respite care at its Casey House facility. A detailed procedure is agreed upon with each contract facility to ensure that the process of providing respite care goes smoothly. See **Appendix B,** Policy PFC.L25, "Levels of Care – Respite Care". If needed, Respite Care can also be offered at our Inpatient Unit, Casey House, especially for psychosocially or medically complex patients.

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.*

For 35 years, Montgomery Hospice has been committed to providing hospice care to all who need it within its service area. The staff of Montgomery Hospice works daily to educate people about what hospice care is and how to access it. Through targeted educational programs, Montgomery Hospice staff provides specific details about how hospice care is provided, and lets people know that money is never an obstacle to service. Montgomery Hospice strives to recognize the uniqueness of each patient, and to honor and value each person's personal goals and priorities.

Knowing that people learn in a number of different ways, Montgomery Hospice uses a variety of tactics to reach out to the community. These include:

- Community Health Fairs – hospice staff and volunteers hold friendly and informative discussions with people about what is happening in their families.
- Senior Centers and other cultural centers – Montgomery Hospice representatives give talks on hospice services, grief and loss, caregiving, and also show films on topics such as Atul Gawande's *Being Mortal*.
- Information in multiple languages – Montgomery Hospice publishes information about hospice services in six different languages, and has a Spanish section on its website that includes culturally sensitive information for grieving persons and their friends, hospice care education and advanced directives forms.
- Website – the extensive information on the Montgomery Hospice website is always available, and includes videos as well as text information. Video subjects include information about the Medicare Hospice Benefit and also information for caregivers and physicians on how to have a conversation about end of life subjects. For a list of videos available on the hospice website, please see **Appendix C: Exhibit 7**: Videos on the Montgomery Hospice Website.
- Social media – we provide information on a wide variety of topics, including grief and loss, and palliative care. The hospice maintains a Facebook page with 600 followers, as well as a Twitter account with 716 followers. The hospice uses social media to reach adult children who are caring for aging parents.
- Newsletter – Montgomery Hospice regularly mails a print newsletter to 18,000 people in its community, sharing free education. Back issues may be found on the Montgomery Hospice website at:

http://www.montgomeryhospice.org/education-resources/publications.

- Faith communities – Montgomery Hospice outreach staff members work with many different faith groups, providing education about hospice services, and collaborating with them in order to support their members.
- Online and face-to-face education - community members can learn about hospice services remotely though online classes and in-person workshops sponsored by Montgomery Hospice. In 2015 the hospice offered 120 educational programs on a variety of topics, with a total of 1,290 people in attendance.

For some communities, including the African American community, there are trust issues due to past experiences. We acknowledge those feelings, and work to develop mutual respect. We have several partnerships with African American churches, working together to educate and support their members. Montgomery Hospice has on multiple occasions brought in outside experts to speak to the community on a variety of topics. The organization also listens carefully to its own staff members, as there are diverse cultures represented both among clinicians and within the senior leadership team of the hospice.

For a list of recent conferences hosted by Montgomery Hospice, please see **Appendix C: Exhibit 8**: Recent Conferences.

Montgomery Hospice looks forward to making the same commitment to providing education and developing trust, while carefully seeking to understand the specific needs of people in Prince George's County.

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

Every patient admitted to Montgomery Hospice receives a written explanation of Patient's Rights and also receives a verbal explanation to be sure that the patient and family understand their rights and responsibilities. Please see **Appendix B: Montgomery Hospice Policies and Procedures** for the text of Policy EBR.P10. Copies of the explanatory document used by staff are also available in Spanish.

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.*

N/A. This project will provide primarily home-based hospice care. Inpatient services will be provided in existing facility beds under contract.

10.24.01.08G(3)(b). Need.

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.

This project is designed to completely address the unmet need identified by the state of Maryland as published in the table "Maryland Hospice Need Projections for Target Year 2019," published in the Maryland Register, Friday, May 27, 2016. Projections for Prince George's County predict an unmet need of 662 patients, even if existing hospices serving that county continue to grow at historical rates. This unmet need is well over the threshold of 359 that triggers CON review.

Montgomery Hospice is large enough to meet that annual need entirely, without the need for new services from any additional providers, and furthermore, will be able to initiate services quickly, due to its current location in the adjacent county of Montgomery.

Although there are currently 8 hospices authorized to serve Prince George's County, their combined admissions in 2014 were only 2,349. That indicates that service in the county is fragmented, with current providers serving only small portions of the total hospice-eligible population. Although all existing providers have been made aware that the hospice service rate in the county is well below average, the hospice service rate (hospice deaths divided by total resident deaths) has been relatively flat since 2012:

Hospice Service Rate in Prince George's County

Year	Hospice Service Rate
2012	28.4%
2013	24.2%
2014	26.6%

Source: "Hospice Market Share and Service in Maryland, 2014," a report produced by NHPCO Edge, the Consulting Services division of the National Hospice and Palliative Care Organization, Alexandria, VA, November 30, 2015. Based upon data from the Maryland Health Care Commission *Annual Hospice Survey*, 2014. The hospice service rate is calculated by dividing the number of resident hospice deaths by the number of total resident deaths.

In spite of the presumption built into the Maryland Hospice Need projections, that existing providers will continue to grow according to their past rates, there is still a forecast net need of 667 hospice patients in 2019, the target year. Montgomery Hospice is projecting full utilization for its project by the end of 2019, and has developed its project budget and assumptions to meet the entire need once it achieves full utilization.

In Montgomery Hospice's application, it has made special emphasis on its plans to serve the African American and Hispanic populations of Prince George's County. The reason for this is that there is indication that those portions of the county are underserved, even after accounting for the low hospice service rate within the jurisdiction.

According to the Maryland Department of Vital Statistics, 67% of all deaths in Prince George's County are black, and 4% are Hispanic residents of any race.

Deaths by Race, Prince George's County 2014

Deaths for All County Residents	White	Black	Asian	All Other
5,369	1,594	3,617	125	33
100%	30%	67%	2%	0.6%

Source: "Table 39: Number of Deaths by Race, Hispanic Origin, Region and Political Subdivision, Maryland 2014," Maryland Vital Statistics Annual Report 2014, Vital Statistics Administration, DHMH, Baltimore, MD.

Montgomery Hospice has purchased market data from a proprietary database, Hospice Analytics, that reports Medicare Hospice claims data from CMS, the Center for Medicare and

Medicaid Services. Those statistics show that black hospice patients were only 59% of the total hospice deaths for county residents that year. Thus, not only are all residents of the county under-served by hospice, but black residents are disproportionately under-served at present.

Medicare Beneficiaries Residing in Prince George's County Who Died in Hospice, 2014

Medicare Hospice Deaths for all County Residents	Hospice Deaths, White	Hospice Deaths, Black	Hospice Deaths, Asian	Hospice Deaths, All Other
1,765	645	1,037	25	58
100%	37%	59%	1%	3%

Source: "Report 11: Hospice Race by Beneficiary County, Prince Georges County, Maryland," reported by Hospice Analytics, Fort Collins, Colorado, based upon data from the Center for Medicare and Medicaid Statistics, 2014 hospice claims data. Data are for residents of Prince Georges County served by any hospice, including hospices outside of Maryland.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

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.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

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.

Montgomery Hospice offers a highly effective vehicle to meet the current unmet need for hospice services in Prince George's County and improve the hospice service rate for the jurisdiction. It also offers the most cost effective alternative.

Hospice care in general has been demonstrated to offer cost savings over the alternative of treating poor prognosis patients without hospice care. ("Use of Hospice Care by Medicare Patients Associated with Lower Rate of Hospitalization, ICU Admission, Invasive Procedures and Costs," Obermeyer et al., JAMA, November 12, 2014.)

Montgomery Hospice anticipates a rapid and cost-effective start to providing service in the county, because it already operates in the county directly adjacent, and has extensive relationships with local providers and referral sources that can easily cross the county's borders. As an established and well-regarded, high-quality provider, Montgomery Hospice can begin services sooner than other alternatives and has already demonstrated its skill in working successfully with minority and non-English speaking populations in urban portions of Montgomery County. The hospice currently has an average of 184 encounters a month that require translation to the following languages: Spanish, Haitian Creole, Vietnamese, Mandarin, French, Korean, Farsi, Greek and Cantonese. That number does not include the encounters that bilingual staff have with patients that do not require translation services. In addition, the hospice's current employee base already crosses county lines: 11% of Montgomery Hospice's

employees currently reside in Prince George's County.

When combined with Montgomery Hospice's pre-existing relationships within the county, and the anticipated rapid start to hiring and staffing, Montgomery Hospice expects to be able to begin serving at least some portions of Prince George's County within six months of the award of a CON for the jurisdiction.

In addition to being an efficient and cost-effective alternative, Montgomery Hospice has demonstrated a high commitment to quality as demonstrated by external assessments. The hospice has been certified for hospice care by the Joint Commission since 1998, and intends to maintain this high level of clinical and operational achievement throughout its expansion into Prince George's County.

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.

Please include in your response:

a. 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.

b. 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.

Montgomery Hospice has a history as a well-managed and financially secure organization, as demonstrated in the audited financial statements included in **Appendix C, Exhibit 9**. It will rely upon existing capital reserves for the project, as listed in Part II.

Montgomery Hospice does not anticipate that costs for the proposed project will affect its current cost structure or pricing in any way, as financial analysis performed by Management indicates that the project will achieve break-even status at an annual volume of between 750 and 850 patients.

Montgomery Hospice does not expect that its entry into the Prince George's County market for hospice services will negatively affect costs or charges for other providers in that county. The great majority of hospice patients are covered by Medicare, which sets prices for all hospice providers on a county level that varies subject to CMS' wage index calculations, and does not vary according to other market conditions.

For uninsured patients, Montgomery Hospice anticipates using the same fee schedule as that used in Montgomery County.

Service to 662 new patients would represent an increase of 35% over the number of admissions served in Montgomery County in 2015. While this growth is significant, management at

Montgomery Hospice is confident that it can be administrated effectively due to the already-large size of Montgomery Hospice.

Montgomery hospice will use its reserves as working capital to fund the project, and estimates it will need approximately $2.5 million to fund the operations for the first two years. The new operation is projected to start to break even towards the end of the third year and hospice management has budgeted to have a modest operating surplus for Year 4. Montgomery Hospice operations in Montgomery County are not expected to be affected by this investment.

That said, management's analysis makes clear that it is essential that the Maryland Health Care Commission should grant only one new CON during this round of review. The financial projections built into Montgomery Hospice's plans for the project assume that all existing hospice providers will continue to grow at their historic rates, and that all unmet need will therefore be available as potential hospice patients for the expansion of Montgomery Hospice into the new jurisdiction. Montgomery Hospice will be using reserves built through years of generous community contributions and efficient management, and believes that if it would be required to compete with one or more new hospice providers in addition to the existing eight approved providers, it would negatively affect the viability of the proposal.

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.

Montgomery Hospice was licensed to serve Montgomery County in 1983, prior to the existence of a CON process for hospice care, and has successfully served that jurisdiction ever since. Its inpatient facility, Casey House, was licensed and opened in 1999, and was not subject to CON review at that time.

10.24.01.08G(3)(f). Impact on Existing Providers.

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 personnel;*
2. *recruitment and retention plans for those personnel believed to be in short supply;*
3. *(for existing facilities) a report on average vacancy rate and turnover rates for affected positions.*

Montgomery Hospice expects the impact of its project on hospice volumes at existing hospice providers to be minimal in the short term, and perhaps even positive, in the long term. Although

there are currently 8 hospices authorized to serve Prince George's County, their combined admissions in 2014 were only 2,349. That indicates that service in the county is fragmented, and as a result, current providers may lack the expertise and resources to provide the deep and broad community outreach that Montgomery Hospice plans as a part of this project.

In considering the potential impact on non-hospice providers, Montgomery Hospice believes that the effects will be uniformly positive. Hospice care has been demonstrated to improve outcomes for patients discharged from acute care to hospice (see citation under "Availability of More Cost-Effective Alternatives," p. 23.) Hospice care can be an essential part of cost management within the health care system as a whole, therefore it is to the benefit of the state health system in general to encourage and enhance hospice utilization on a broad basis.

Montgomery Hospice also is working with Washington Adventist Hospital and MedStar Heart and Vascular Institute to build a community of care for advanced heart failure patients.[1] According to management's discussions with MedStar's physicians, many of the Washington Hospital Center patients with advanced heart failure live in Prince George's County. In 2014, 1,300 residents of Prince George's County died from diseases of the heart.

Montgomery Hospice has a seasoned recruitment team in Montgomery County that recently demonstrated a successful recruitment strategy to add additional staff necessitated by a rapid census increase in Montgomery County. Since April 2016 Montgomery Hospice has recruited and hired 43 new employees, including 20 nurses, 13 other clinical staff, and 10 non-clinical employees. The hospice's effective recruitment strategy will be applied to the search for staff for the Prince Georges program. Montgomery Hospice utilizes multiple sources for recruitment including online, print and frequent employee referrals. The organization anticipates a communication effort to faith communities and healthcare providers announcing its new presence in Prince Georges County. When appropriate, that effort will also include employment opportunities. The hospice will also mobilize its current staff who reside in Prince Georges to identify and refer potential staff from their connections in the community. The organization does not anticipate difficulties recruiting new staff nor are is it seeing shortages in any position or discipline that would be needed in the new program.

[1] "Advanced heart failure is a common clinical condition of significant morbidity and mortality, requiring multidisciplinary long-term support to manage symptom burden and functional decline." (Panke, Ruiz, et al; *Journal of Pain and Symptom Management*; Vol 52 No. 2; 2 August 2016; pp313-317.)

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

1. *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.*

The applicant is Montgomery Hospice, Inc., a 501c3, which was formed and incorporated in the state of Maryland in 1979. The President and CEO, Ann Mitchell, has been assigned the responsibility for the proposed project and its implementation.

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.*

No.

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.*

No.

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.*

No.

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).*

No.

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 Authorized Agent of the Applicant

Ann Mitchell, MPH
CEO

Date:_____

Hospice Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE FACILITY

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: MANPOWER INFORMATION

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 (if applicable):

a.	New Construction	$_____	
(1)	Building	_____	
(2)	Fixed Equipment (not included in construction)	_____	
(3)	Land Purchase	_____	
(4)	Site Preparation	_____	
(5)	Architect/Engineering Fees	_____	
(6)	Permits, (Building, Utilities, Etc)	_____	
SUBTOTAL			$_____
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	130,000	
(2)	Minor Movable Equipment	240,000	
(3)	Contingencies	_____	
(4)	Other (Specify)	_____	
TOTAL CURRENT CAPITAL COSTS (a - c)			$ 370,000
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)	18,000
d.	Legal Fees (Other)	_____
e.	Printing	_____
f.	Consultant Fees	
	CON Application Assistance	8,000
	Other (Specify)	_____
g.	Liquidation of Existing Debt	_____

h.	Debt Service Reserve Fund	_____	
i.	Principal Amortization Reserve Fund	_____	
j.	Other (Specify)	_____	
	TOTAL (a - j)	$ 26,000	
3.	Working Capital Startup Costs	$ 2,141,400	
	TOTAL USES OF FUNDS (1 - 3)		$ 2,537,400

B. Sources of Funds for Project:

1.	Cash	2,537,400	
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	_____	
3.	Gifts, bequests	_____	
4.	Interest income (gross)	_____	
5.	Authorized Bonds	_____	
6.	Mortgage	_____	
7.	Working capital loans	_____	
8.	Grants or Appropriation		
	(a) Federal	_____	
	(b) State	_____	
	(c) Local		
9.	Other (Specify)		
	TOTAL SOURCES OF FUNDS (1-9)		$ 2,537,400

Lease Costs:			
a. Land	$_____	x _____	= $_____
b. Building	$_100,000 ___	x ____4_____	= $_400,000 __
c. Major Movable Equipment	$_____	x _____	= $_____
d. Minor Movable Equipment	$_____	x _____	= $_____
e. Other (Specify)	$_____	x _____	= $_____

Instructions: Complete Table 2A for the Entire General Hospice Program, 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 Hospice Program

	Two Most Current Actual Years		Projected years - ending with first year at full utilization			
CY or FY (circle)	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Admissions	1,729	1,920	2,148	2,492	2,766	3,125
Deaths	1,484	1,647	1,826	2,118	2,351	2,657
Non-death discharges	243	245	301	349	387	438
Patients served	2,064	2,257	2,470	2,865	3,181	3,594
Patient days	124,668	130,494	146,000	168,904	186,384	207,320
Average length of stay	71.8	66.4	72	65	63	64
Average daily hospice census	341.6	357.5	400.0	462.8	510.6	568.0
Visits by discipline						
Skilled nursing	28,323	30,398	32,526	35,470	39,141	43,537
Social work	6,984	7,179	7,394	8,445	9,319	10,366
Hospice aides	24,870	25,257	26,267	30,403	33,549	37,318
Physicians - paid	4,573	4,200	4,410	5,067	5,592	6,220
Physicians - volunteer	0	0	0	-	-	-
Chaplain	5,968	6,064	6,307	6,756	7,455	8,293
Other clinical	973	1,128	1,354	1,689	1,864	2,073
Licensed beds						
Number of licensed GIP beds	14	14	14	14	14	14
Number of licensed Hospice House beds						
Occupancy %						
GIP (inpatient unit)	93%	93%	93%	93%	93%	93%
Hospice House						

TABLE 2B: STATISTICAL PROJECTIONS - PROPOSED PROJECT

CY or FY (circle)	2017	2018	2019	2020
Admissions	213	450	722	802
Deaths	181	383	614	682
Non-death discharges	28	59	94	104
Patients served	230	497	773	866
Patient days	14,509	30,164	49,275	54,750
Average length of stay	50	53	56	60
Average daily hospice census	40	83	135	150
Visits by discipline				
Skilled nursing	3,047	6,334	10,348	11,498
Social work	725	1,508	2,464	2,738
Hospice aides	2,612	5,429	8,870	9,855
Physicians - Paid	435	905	1,478	1,643
Physicians - Volunteer	-	-	-	-
Chaplain	580	1,207	1,971	2,190
Other clinical	145	302	493	548

TABLE 3: REVENUES AND EXPENSES - ENTIRE Hospice Program (incl. proposed project)

(See Appendix for Audited Financial Statements)

	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CALENDAR YEAR	2014	2015	2016	2017	2018	2019	2020
1. Revenue							
a. A. Inpatient services	2,904,957	2,947,459	3,159,784	3,622,095	4,056,033	4,546,687	4,751,969
b. Hospice at home services	19,116,426	20,654,590	22,830,425	25,898,001	29,581,764	33,509,885	35,484,647
c. Home care services							
d. Gross Patient Service Revenue	22,021,382	23,602,050	25,990,208	29,520,096	33,637,797	38,056,572	40,236,616
e. Allowance for Bad Debt	-306,853	-452,465	-320,354	-429,779	-504,567	-570,849	-603,549
f. contractual Allowance	-421,717	-447,377	-534,888	-643,656	-727,966	-818,160	-863,746
g. Charity Care	-407,481	-467,316	-711,133	-1,019,794	-1,220,295	-1,492,255	-1,604,065
h. Net Patient Services Revenue	20,885,331	22,234,892	24,423,833	27,426,867	31,184,969	35,175,308	37,165,256
i. Other Operating Revenues (Specify)	2,678,709	2,547,890	1,616,405	2,187,376	2,478,471	2,791,725	2,936,877
j. Net Operating Revenue	23,564,040	24,782,782	26,040,238	29,614,243	33,663,440	37,967,033	40,102,133
2. Expenses							
a. Salaried, Wages, and Professional Fees, (including fringe benefits)	16,951,065	17,434,086	19,437,009	23,380,771	25,380,157	27,599,866	28,940,589
b. Contractual Services	2,116,675	2,188,018	2,340,168	3,029,781	3,808,172	4,671,835	5,045,161
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation	344,425	298,115	229,124	227,256	228,392	229,534	230,682
f. Project Depreciation				25,000	25,000	35,000	40,000
g. Current Amortization							
h. Project Amortization							
i. Supplies	563,611	481,403	554,444	646,728	731,225	819,273	868,881
j. Other Expenses (Specify)	2,698,109	2,486,868	2,544,278	3,286,932	3,637,213	4,083,746	4,354,828
k. Total Operating Expenses	22,673,886	22,888,490	25,105,022	30,596,468	33,810,159	37,439,254	39,480,142
3. Income							
a. Income from Operation	890,154	1,894,292	935,217	-982,226	-146,720	527,779	621,991
b. Non-Operating Income	-6,510	-493,963	365,883	0	0	0	0
c. Subtotal	883,644	1,400,329	1,301,099	-982,226	-146,720	527,779	621,991
d. Income Taxes	0	0	0	0	0	0	0
e. Net Income (Loss)	883,644	1,400,329	1,301,099	-982,226	-146,720	527,779	621,991

Table 3 Cont.	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CALENDAR YEAR	2014	2015	2016	2017	2018	2019	2020
4. Patient Mix							
A. As Percent of Total Revenue							
1. Medicare	84.3%	86.3%	84.4%	85.0%	84.1%	83.3%	83.1%
2. Medicaid	1.0%	1.3%	1.4%	1.8%	2.0%	2.3%	2.4%
3. Blue Cross	4.5%	5.0%	6.1%	5.1%	5.0%	4.9%	4.9%
4. Other Commercial Insurance	8.0%	5.4%	5.5%	4.6%	4.9%	5.2%	5.2%
5. Self-Pay	0.2%	0.1%	0.2%	0.3%	0.3%	0.4%	0.4%
6. Other (Specify)	1.9%	2.0%	2.4%	3.3%	3.6%	3.9%	4.0%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. As Percent of Patient Days/Visits/Procedures(as applicable)							
1. Medicare	85.3%	87.5%	86.0%	84.9%	84.1%	83.3%	83.1%
2. Medicaid	1.2%	1.2%	1.5%	1.8%	2.1%	2.3%	2.4%
3. Blue Cross	7.5%	4.8%	5.3%	5.2%	5.1%	5.0%	5.0%
4. Other Commercial Insurance	4.0%	4.8%	4.2%	4.8%	5.1%	5.5%	5.6%
5. Self-Pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6. Other (Specify)	2.0%	1.8%	3.0%	3.3%	3.6%	3.9%	4.0%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTIONS: Each applicant should complete this table for the proposed project only)

	Projected Years (ending with first full year at full utilization)			
CY or FY (circle)	2017	2018	2019	2020
1. Revenue				
a. A. Inpatient services	266,883	650,493	1,079,847	1,222,726
b. Hospice at home services	1,898,875	4,628,526	7,684,115	8,701,449
c. Home care services				
d. Gross Patient Service Revenue	2,165,758	5,279,019	8,763,962	9,924,175
e. Allowance for Bad Debt	-32,486	-79,185	-131,460	-148,862
f. contractual Allowance	-43,315	-105,581	-175,280	-198,484
g. Charity Care	-151,603	-369,532	-613,477	-694,692
h. Net Patient Services Revenue	1,938,354	4,724,721	7,843,745	8,882,137
i. Other Operating Revenues (Specify)	160,000	370,000	620,000	700,000
j. Net Operating Revenue	2,098,354	5,094,721	8,463,745	9,582,137
2. Expenses				
a. Salaried, Wages, and Professional Fees, (including fringe benefits)	1,934,244	3,192,890	4,649,637	5,204,509
b. Contractual Services	494,070	1,134,645	1,873,585	2,110,560
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation	25,000	25,000	35,000	40,000
g. Current Amortization				
h. Project Amortization				
i. Supplies	40,585	92,138	150,372	167,386
j. Other Expenses (Specify)	960,770	1,297,620	1,730,655	1,988,172
k. Total Operating Expenses	3,454,669	5,742,293	8,439,249	9,510,628
3. Income				
a. Income from Operation	-1,356,315	-647,573	24,496	71,509
b. Non-Operating Income				
c. Subtotal	-1,356,315	-647,573	24,496	71,509
d. Income Taxes				
e. Net Income (Loss)	-1,356,315	-647,573	24,496	71,509

Table 4 Cont.	**Projected Years** (ending with first full year at full utilization)			
CALENDAR YEAR	2017	2018	2019	2020
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare	75%	75%	75%	75%
2. Medicaid	5%	5%	5%	5%
3. Blue Cross	4%	4%	4%	4%
4. Other Commercial Insurance	8%	8%	8%	8%
5. Self-Pay	1%	1%	1%	1%
6. Other (Specify)	7%	7%	7%	7%
7. Total	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures(as applicable)				
1. Medicare	75%	75%	75%	75%
2. Medicaid	5%	5%	5%	5%
3. Blue Cross	4%	4%	4%	4%
4. Other Commercial Insurance	9%	9%	9%	9%
5. Self-Pay		0%	0%	0%
6. Other (Specify)	7%	7%	7%	7%
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 (rate/ hour)	Employee/ Contractual	Total Cost
Administration					
Administration	20.85	5.25	31		1,689,661
Direct Care					
Nursing	82.7	24.5	44	3.4	10,076,483
Social work. services	17.1	7.8	36	0.3	1,868,428
Hospice aides	45.4	17.5	20		2,564,952
Physicians-paid	2.0	1.5	90	7.5	2,055,832
Physicians-volunteer					
Chaplains	11.0	4.5	31	0.1	1,024,317
Bereavement Staff	7.6	2.3	32		657,135
Other clinical	28.5	16.0	36	1.2	3,432,685
Support					
Other support	10.5	2.0	30	0.5	802,772
				Benefits	4,768,324
				Total	28,940,589

Note: The number of contractual employees is converted at 2,080 working hours without paid holiday or leave.

Updated June 2016.

APPENDIX A: LETTERS OF SUPPORT

for Montgomery Hospice in Prince George's County

APPENDIX B: MONTGOMERY HOSPICE POLICIES AND PROCEDURES

APPENDIX C: CITATIONS AND EXHIBITS

JOSELINE A. PEÑA-MELNYK
21st Legislative District
Prince George's and
Anne Arundel Counties

Health and Government
Operations Committee

Subcommittees
Government Operations
Public Health and Long Term Care

The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 157
Annapolis, Maryland 21401
410-841-3502 · 301-858-3502
800-492-7122 *Ext.* 3502
Fax 410-841-3342 · 301-858-3342
Joseline.Pena.Melnyk@house.state.md.us

District Office
P. O. Box 1251
College Park, Maryland 20741-1251

September 2, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. McDonald:

I write to express my strong support for the Certificate of Need application filed by Montgomery Hospice. Approving this application will establish a licensed general hospice care program in Prince George's County. Demand for hospice care is growing. It is our duty as public servants to ensure our county residents have adequate access to hospice services. I believe that Montgomery Hospice will provide an important addition to the hospice options available in our county.

Montgomery Hospice is already established and well-respected by colleagues in neighboring Montgomery County. Their experience in delivering comprehensive, culturally sensitive care to their patients is vital in addressing the increasingly diverse needs of Prince George's County families. Hospice care is special in that services are as necessary to grieving family members as to the patients enrolled in the program. I am aware that Montgomery Hospice provides family services for 13 months.

I urge you to give favorable consideration to Montgomery Hospice

Sincerely,

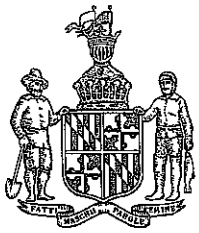
Joseline A. Peña-Melnyk

Joseline A. Peña-Melnyk

JOANNE C. BENSON
Legislative District 24
Prince George's County

Finance Committee

Joint Committees
Children, Youth, and Families
Ending Homelessness
Fair Practices and State Personnel Oversight
Management of Public Funds
Protocol



THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 214
Annapolis, Maryland 21401
301-858-3148 · 410-841-3148
800-492-7122 *Ext.* 3148
Fax 301-858-3149 · 410-841-3149
Joanne.Benson@senate.state.md.us

September 1, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. McDonald:

I am writing to express my support for the CON application filed by Montgomery Hospice to establish a licensed general hospice care program in Prince George's County. As a State Senator representing Prince George's County, I believe that Montgomery Hospice will provide an important addition to the hospice options available to our residents.

Montgomery Hospice is known and respected by colleagues in Montgomery County. Montgomery Hospice is a mission driven hospice which cares for terminally ill residents with a comprehensive, culturally sensitive, and innovative array of services. It also has a robust bereavement counseling center that works for at least 13 months with grieving family members.

I urge you to give favorable consideration to Montgomery Hospice. I believe that Montgomery Hospice will bring additional resources to its citizens, and that it will contribute positively to the attainment of Population Health priorities.

Sincerely,

Joanne C. Benson

Joanne C. Benson

cc: Ann Mitchell, Montgomery Hospice

Rushern L. Baker, III
County Executive

THE PRINCE GEORGE'S COUNTY GOVERNMENT

Department of Family Services
Area Agency on Aging

August 16, 2016

Monica Escalante
CFO/COO
Montgomery Hospice
1355 Piccard Drive, Suite 100
Rockville, MD 20850

Dear Ms. Escalante:

It was indeed a pleasure meeting with you and the Montgomery Hospice leadership team yesterday. I applaud Montgomery Hospice's great work to support families in Montgomery County and its efforts to expand services to Prince George's County residents. I look forward to the opportunity to work with Montgomery Hospice to increase public education on this vital resource.

I encourage you to reach out to the Prince George's Senior Provider Network (PGSPN). PGSPN is a group of organizations who collaborate to help seniors get the education, support and assistance they need. If you need any information about the Prince George's County Area Agency on Aging, please feel free to contact me at 301-265-8466 or via email at tmgrant@co.pg.md.us.

Sincerely,

Theresa M. Grant
Director, Area Agency on Aging

Rushern L. Baker, III
County Executive

PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

August 18, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. McDonald:

I am writing to express my support for the application for a Certificate of Need which was filed by Montgomery Hospice to establish a licensed general hospice care program in Prince George's County. Prince George's County government, in particular its Health Department, Department of Social Services and Department of Family Services, including the Area Agency on Aging, recognizes the importance of adequate access to hospice services. We believe that Montgomery Hospice will provide an important addition to the hospice options available in Prince George's County.

Montgomery Hospice is well known and respected by colleagues in Montgomery County's Office of the County Executive, as well as by other not-for-profit hospice providers located in Prince George's County. Montgomery Hospice is a mission driven hospice which cares for terminally ill residents with a comprehensive, culturally sensitive, and innovative array of services. It also has a robust bereavement counseling center that works for at least 13 months with grieving family members.

I urge you to give favorable consideration to the application of Montgomery Hospice. We believe that Montgomery Hospice will bring additional resources and compassionate care to terminally ill residents of Prince George's County, and that it will contribute positively to the attainment of population health priorities.

Sincerely,

Betty Hager Francis

Betty Hager Francis
Deputy Chief Administrative Officer
for Health, Human Services and Education

Adventist HealthCare
Washington Adventist Hospital

September 29, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. McDonald:

I am writing to express my support for the CON application filed by Montgomery Hospice to establish a licensed general hospice care program in Prince George's County. Washington Adventist Hospital has collaborated with Montgomery Hospice for over 20 years. Our close working relationship has been positive, and we have seen first-hand how committed Montgomery Hospice is providing excellent hospice service. We believe that Montgomery Hospice will provide an important addition to the hospice options available in Prince George's.

Montgomery Hospice is known and respected by our colleagues in Montgomery County as an invaluable community partner that helps with the goals of Population Health. Montgomery Hospice is a mission driven hospice which cares for terminally ill residents with a comprehensive, culturally sensitive, and innovative array of services. Our patients have been very well served by its skillful interdisciplinary hospice teams.

I urge you to give favorable consideration to Montgomery Hospice. Washington Adventist Hospital believes that Montgomery Hospice will bring medically helpful and important resources to the citizens of Prince George's.

Sincerely,

Erik Wangsness
President

xc: Ann Mitchell, Montgomery Hospice

hospice of the chesapeake
JOHN & CATHY BELCHER CAMPUS

90 Ritchie Highway • Pasadena, MD 21122
phone: 410.987.2003 • fax: 443.837.1558
hospicechesapeake.org

October 4, 2016

Kevin R. McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. McDonald:

I would like to convey my support for the Montgomery Hospice's application for the general hospice Certificate of Need that is open in Prince George's County. Montgomery Hospice has been a long-standing hospice provider in Maryland with whom Hospice of the Chesapeake has collaborated on many end of life care initiatives through the Hospice and Palliative Care Network of Maryland and, most notably, through our mutual membership in Alliance Kids. Our shared goals for serving pediatric patients and their families who need hospice care has helped us, and other Alliance Kids member organizations, unite our efforts to provide the highest quality of care to families who are coping with their child's advanced complex illness and end of life needs.

I see this same united effort carrying over to our goal of providing greater access to quality hospice and palliative care for residents of all ages in Prince George's County. As hospice organizations that understand the expectations of making hospice care more readily accessible in Prince George's county, we would work together, along with the other current providers of hospice care in the County, to achieve that goal.

Please do not hesitate to contact me if you have any questions, or if I can be of any assistance in the application and decision-making process.

Sincerely,

Ben Marcantonio
President and CEO, Hospice of the Chesapeake

Professional Healthcare
RESOURCES
Home Healthcare You Can Count On

October 3, 2016

Montgomery Hospice
Attn: Ann Mitchell
President and CEO
1355 Piccard Drive, Suite 100
Rockville, MD 20850
Amitchell@montgomeryhospice.org

Dear Ms. Mitchell,

This letter is to support the application of Montgomery Hospice as a provider of choice for Hospice services in Prince George County, Maryland. Professional Healthcare Resources (PHR) Home Health, Hospice, and Private Duty divisions -advocate Montgomery Hospice as a hospice provider to deliver this specialized care to the underserved and highly in – need population of patients in Prince George County.

With the percentage of residents over sixty five years of age growing to 11.7% in 2015 in Prince George's county, the elderly population is growing; and so is the need for healthcare providers that specialize in end of life care. Montgomery Hospice has expanded its services to meet the need in Prince George's county - by providing hospice services for the highly acute patient population, providing inpatient hospice services at the Casey House; all in the while of maintaining the quality of care that is so deserved by the community of the terminally ill.

PHR is promoting Montgomery Hospice as the Hospice of choice in Prince George County because of their diversity of services and a positive reputation in the delivery of quality of Hospice Care. Montgomery Hospice has proven to maintain quality of care and high level of services to a high volume of patients (and caregivers) with its inpatient hospice facility (Casey House), and robust programs and staff of hospice professionals.

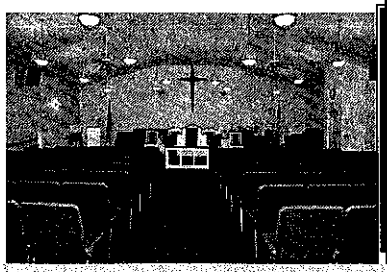
It is an honor to promote Montgomery Hospice to expand its territory; and be a Hospice provider for the Prince George Communities. Please feel free to contact Leigh Layne, PHR Director of Hospice or myself with questions or comments.

Best Regards,

Eileen DeCesare
President & CEO Emeritus

Cc: File

HomeCare Elite 2007 TOP AGENCY



New Horizon Gospel Ministries

8324 Woodyard Road
Clinton, MD 20735
301-599-8351 Fax: 301-599-8352
Email: nhgm@verizon.net

"We've Come This Far By Faith."

August 31, 2016

Maryland Healthcare Commission
4160 Patterson Ave
Baltimore, MD 21215

To Whom It May Concern:

The New Horizon Gospel Ministries is in full support of Montgomery Hospice providing services to Prince George's county residence.

Montgomery Hospice has been serving Montgomery County, Maryland for 35 years. Every year Montgomery Hospice staff members provide compassionate, professional care to more than 2,000 patients who are living with a terminal illness. (2,257 patients in 2015) Most patients remain in their own homes (including nursing homes and assisted living facilities); they are cared for by a team of experts, including physicians, nurses, certified nursing assistants, social workers, chaplains, and volunteers. This team also helps patients' families. Montgomery Hospice has an extensive Complementary Therapies program, including music, massage and aromatherapy (among other services). More than 300 Montgomery Hospice volunteers support patients and families.

Montgomery Hospice's grief and loss program has professional counselors providing free grief support and education to families of patients, as well as the entire community. Montgomery Hospice has an active charity care program; no hospice patients are turned away, even those who have no health insurance. Montgomery Hospice also cares for dying children, with its specialized pediatric hospice program.

New Horizon Gospel Ministries strongly feel that if Montgomery Hospice is afforded the opportunity to serve the residence of Prince Georges County, everyone in the county will have the wonderful experience that one of my members shared at Casey House. My member didn't live in Montgomery County but he was hospitalized at Walter Reed in Bethesda and was admitted into the hospice program not to long after being admitted into the hospital. The experience

that my member's wife had with the staff at Montgomery Hospice was phenomenal. I'm sure the service they give at home is just as phenomenal as their in-patient facility.

We at New Horizon Gospel Ministries completely support, and are looking forward to such an organization as this to care for the many underserved residence in the county who may be in need of hospice care.

Again, it is our pleasure as a church family and ministry to God's people to recommend Montgomery Hospice as a provider of loving, caring and compassionate hospice care throughout Prince George's County.

Blessing,

Willie L. Reaves.

Pastor

MT. JEZREEL BAPTIST CHURCH
420 UNIVERSITY BOULEVARD EAST
SILVER SPRING, MARYLAND 20901

OFFICE TELEPHONE
301.431.2800

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GREGORY BROWN
LAY PASTOR, TRUSTEES

CAROLYN L. ALSTON
LAY PASTOR, CHURCH ADMINISTRATION

GLORIA D. GARDNER
CHURCH CLERK

July 26, 2016

Maryland Healthcare Commission
4160 Patterson Avenue
Baltimore, MD 21215

To Whom It May Concern:

I and the Mount Jezreel Baptist Church Fmily lend our full support to our friends and colleagues, Montgomery Hospice, as they endeavor to provide hospice care for the residents of Prince George's County.

Montgomery Hospice has been serving Montgomery County, Maryland for 35 years. It grew from a small volunteer-run operation based in a church basement to an organization of 250 employees.

Every year Montgomery Hospice staff members provide compassionate, professional care to more than 2,000 patients who are living with a terminal illness (2,257 patients in 2015). Most patients remain in their own homes (including nursing homes and assisted living facilities); they are cared for by a team of experts, including physicians, nurses, certified nursing assistants, social workers, chaplains, and volunteers.

Montgomery Hospice's vision statement includes a commitment to the "community's multicultural residents." The organization is committed to meeting the diverse needs of people in our community, including the African American community. And they have lived up to this vision by hosting several workshops and conferences focused on educating the African American community on hospice care.

The aforementioned accolades speak volumes about the service that Montgomery Hospice provides. However, the Mount Jezreel Baptist Church, especially our Pastoral Care Ministry, has come to know them as co-laborers who live out our church motto of "Loving, Caring, and Sharing" with utmost integrity and selflessness!

Over the last six years Montgomery Hospice has made themselves available to participate in our annual Pastoral Care conferences as well as partnering with us to educate our members about hospice services, and about "caring for the caregiver." In addition, we remain grateful for the care Montgomery Hospice has provided to several of our members as they transitioned.

Again, it is our pleasure as a church family and ministry to God's people to recommend Montgomery Hospice as a provider of loving, caring and compassionate hospice care throughout Prince George's County.

Yours in Christ,

E. L. Spearman

The Rev. Eldridge Spearman
Senior Pastor

Mount Calvary Baptist Church

Leon Grant
Pastor

Lora F. Hargrove
Assistant Pastor

608 North Homers Lane
Rockville, Maryland 20850
Phone: 301/424-8717

Terrie James - Taylor
Facility Manager/Community Outreach Manager
Montgomery Hospice
1355 Piccard Drive, Suite 100
Rockville, MD 20850

July 20, 2016

Dear Terrie,

On behalf of the Health & Wellness Ministry of Mount Calvary Baptist Church of Rockville, I would like to thank Montgomery Hospice for the partnership that we have developed over the years. As we reflect today, Montgomery Hospice has provided outstanding education and awareness opportunities in enhancing our knowledge about 'hospice support and services'.

An excellent example of your commitment to Mt. Calvary and the community was the development of the first 'all church' conference, "The Need for Hospice Care in the African American Community". This was a much needed conference and was highly regarded by those in attendance.

Some of the other great opportunities that were provided to Mt. Calvary by your organization were the delivery of the following workshops:

- Dementia and Dementia updates
- Hospice 101 Seminar
- Coping During Difficult Times
- Care for the Caregiver
- Bereavement Classes

Not only has Montgomery Hospice supported the Health & Wellness Ministry efforts, but also has provided support to the Counseling, the Women and the Seniors Ministries. We are very pleased that you now will be working with the Veterans Ministry.

Again we want to thank you for your outstanding support and look forward to a continued partnership in planning and delivering futures programs; and in the use of your services for our Church and Community.

Sincerely,

Hettie T. Fleming
Co-Chairperson
Health & Wellness Ministry
Tel: 301.869.9134

cc: Adranna A. Grant
Co-Chairperson
Health & Wellness Ministry

FOOD & FRIENDS®
Delivering hope, one meal at a time®
219 RIGGS ROAD NE
WASHINGTON, DC 20011
PHONE (202) 269-2277
WWW.FOODANDFRIENDS.ORG

September 29, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. McDonald:

I am writing to express my support for the CON application filed by Montgomery Hospice to establish a licensed general hospice care program in Prince George's County. Food & Friends recognizes the importance of adequate access to hospice services. We believe that Montgomery Hospice will provide an important addition to the hospice options available in Prince George's.

Montgomery Hospice is known and respected by colleagues in Montgomery County. Montgomery Hospice is a mission-driven hospice which cares for terminally ill residents with a comprehensive, culturally sensitive, and innovative array of services. It also has a robust bereavement counseling center that works for at least 13 months with grieving family members.

I urge you to give favorable consideration to Montgomery Hospice. Food & Friends believes that Montgomery Hospice will contribute positively to the accessibility of hospice care for all residents.

Sincerely,

Carrie Stoltzfus
Director of Program Services
Food & Friends

Cc: Ann Mitchell, Montgomery Hospice

October 2nd 2016

From:
Parthasarthy Pillai, PhD
9000 Acredale Court
College Park, MD 20740
Home: 301-935-5321 Cell: 240-461-9429
<ParthaPillai2@gmail.com>

To
Kevin R. McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

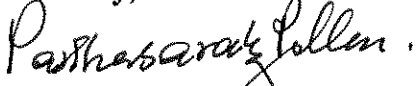
Dear Mr. McDonald:

I am pleased to write a letter in support of Montgomery Hospice's application to provide hospice service in Prince George's County. Montgomery Hospice is highly regarded for its quality hospice care, which is provided to all terminally ill residents, regardless of their insurance status or ability to pay. The hospice is accredited by the Joint Commission and certified by Medicare and Medicaid.

Montgomery Hospice feels strongly that the family of a terminally ill patient needs support, along with the patient. This hospice model, which is promoted by the federal hospice requirements, is central to the success of Montgomery Hospice. Montgomery Hospice employs interdisciplinary care teams that collaborate carefully to provide excellent hospice services to the patient and his or her family.

I appreciate your careful consideration of Montgomery Hospice as a potential hospice provider in Prince George's County. I believe my county would be extremely well-served by this acclaimed hospice. I recommend that Montgomery Hospice be awarded the Certificate of Need for Prince George's County.

Sincerely,



Parthasarthy Pillai

ADMISSION TO HOSPICE - ELIGIBILITY	Policy Number: PFC.A20 Page 1 of 2
NHPCO Standard(s): PFC 2.1; IA 1.2; IA 1.3; CLR 2.2	
Regulatory Citation / Other: 42 CFR 418.20	

POLICY STATEMENT: Patients must meet eligibility requirements to be admitted to Montgomery Hospice for Medicare/Medicaid-covered services.

PROCEDURES:

1. To be eligible to elect the hospice benefit, the patient must:
    a. be entitled to the benefit; and
    b. be certified by the hospice Medical Director or designee and attending physician as being terminally ill (having a prognosis of six months or less if the illness follows its normal course).

2. The hospice admits a patient only on the recommendation of the hospice Medical Director or designee in consultation with, or with input from, the patient's attending physician (if there is one).

3. Montgomery Hospice adopts and implements Local Coverage Determinations (LCD's), formerly Local Medical Review Policies (LMRP's), provided by its fiscal intermediary.

4. Prior to admission, all patients are assessed for hospice appropriateness and eligibility using the LCD guidelines. Patients who meet the LCD guidelines are eligible for admission.

5. Failure to meet the LCD guidelines does not disqualify a patient for admission to Montgomery Hospice. Patients who do not fully meet the LCD guidelines are discussed with the hospice Medical Director or designee in order to determine hospice appropriateness and eligibility. Additional documentation is needed to support hospice eligibility.

6. Hospice staff may use the following assessment tools to measure and document functional status:
    a. Palliative Performance Scale (PPS);
    b. Reisberg Functional Assessment Staging (FAST); and/or
    c. Karnofsky Performance Scale (KPS).

7. Complete and timely documentation of the specific clinical factors that qualify a patient for the Medicare hospice benefit is provided in the patient's clinical record.

DISCHARGE FROM HOSPICE CARE	Policy Number: CES.D15 Page 1 of 3 Revised: 2/13/2013 Revised: 6/4/2013
NHPCO Standard(s): CES 9; CES 9.1; CES 9.4; CES 21.7; IA 1.2	
Regulatory Citation / Other: 42 CFR 418.26; 418.104(e)	

POLICY STATEMENT: Montgomery Hospice follows a consistent plan for discontinuance of services and supports the patient/caregiver with referrals and planning for continued care as appropriate.

PROCEDURES:

1. Hospice services may be discontinued:
    a. if the patient moves outside the geographical area serviced by the hospice or transfers to another hospice;
    b. if the patient no longer meets the eligibility requirements for hospice care;
    c. if the patient desires curative care or aggressive treatment that is inconsistent with the hospice philosophy and/or the patient's plan of care;
    d. if the patient chooses to receive treatment from an inpatient facility with which Montgomery Hospice does not have and/or can not obtain a written agreement;
    e. if the patient no longer desires hospice services; and/or
    f. for cause, if the hospice determines that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that the delivery of care to the patient or the ability of the hospice to operate effectively or safely is impaired.

2. Before the patient can be discharged for cause, the hospice:
    a. advises the patient that a discharge for cause is being considered;
    b. makes a serious effort to resolve the problem(s) caused by the patient's behavior or the situation;
    c. ensures that the decision to discharge the patient is not related to the patient's use of necessary hospice services; and
    d. documents in the patient's clinical record the problem(s) and the efforts made to resolve the situation.

3. When a patient is discharged from hospice (and is not transferring to another hospice), he or she is no longer covered under the Medicare hospice benefit, resumes Medicare coverage of the benefits waived by the election of hospice care and may, at any time, elect to receive hospice care again in the future if he or she meets the eligibility requirements

4. Prior to discharge:
    a) The Clinical Manager discusses recommended discharges with a clinical VP when discharge discussion is initiated by either the PCT or IDG. Documentation of the collaboration and the rationale for the discharge (if this is decided) is to be documented in Suncoast under "Disch/Rev Consult Comment" in the Comments area of the chart by the Clinical Manager.

    b) If the recommendation is for discharge, the Primary Nurse discusses the findings of the consultation with the Medical Director. If the Medical Director is in agreement, a discharge order is received. When a patient is in a facility, there is also to be a discharge order in the NH record from the NH physician.

    c) Throughout this process, the Primary Nurse and/or the Team Physician is in contact with the attending physician to obtain further information for consideration, as well as to initiate discharge plans if the decision is made to discharge a patient.

    d) The Primary Nurse or Team Physician discusses plan with attending physician. For Medicare patients, the CMS mandated discharge notice form is given to the patient 5 days prior to discharge in a face to face meeting between the patient and staff member.

5. Discharge Plan:
   If the decision is made that the patient is to be discharge, discharge planning occurs as follows:
    a. the Primary Nurse consults with the patient's attending physician regarding the pending discharge and needs for other health care services and obtains appropriate referral orders;
    b. the Primary Nurse or Social Worker arranges for these services at the request of the patient/caregiver after acquiring physician approval;
    c. the patient and his or her caregivers are included in the discharge planning process and members of the IDG provide appropriate education and support as needed; and
    d. notification of the discharge date is provided to the patient and to the patient's attending physician as soon as it is determined. For Medicare patients who are discharged for eligibility reasons, the CMS mandated Discharge Notices are to be provided.
    e. One business day before the discharge date, the Medical Director will talk with the attending physician to discuss whether any recent evidence has surfaced that would reverse the discharge decision.

6. The patient or their representative is provided a copy of the Discharge Summary at the time of discharge.

7. When the patient is discharged from hospice, the hospice provides a copy of the clinical record (if requested) and the hospice discharge summary to the patient's attending physician. This discharge summary includes at least:
    a. the reason for the discharge;
    b. a summary of the patient's stay including treatments, symptoms and pain management;
    c. any other documentation that will assist in post-discharge continuity of care.

8. Appealing the decision to discharge for other than cause:

Medicare Patient - If a Medicare patient disagrees with the plan to discharge due to eligibility, they can appeal through KePRO.

Non-Medicare Patient - If a non-Medicare patient disagrees with a planned discharge for other than cause, Montgomery Hospice will convene the Discharge Review Group. The name and phone of the Director of QAPI will be provided to the patient or their representative if they request to appeal the discharge decision. The Discharge Review Group meeting will be held within 3 business days of the appeal request received by the Director of QAPI. The Discharge Review Group is comprised of the following: Clinical Manager for the patient's Team, Primary Nurse, President/CEO, Medical Director, Senior VP of Nursing Services, VP of Social Work, VP of Spiritual Care, VP of Casey House (when appropriate) and Director of QAPI. . The Director of QAPI will present the patient's reasons for appealing the discharge decision. If the patient or their representative wishes to attend the meeting they are welcome to attend. Attendance by phone is permitted.

VOLUNTEERS – SERVICES	Policy Number: WE.V55 Page 1 of 2
NHPCO Standard(s): WE 9; WE 9.1; WE 18; WE 18.1; WE 18.2	
Regulatory Citation / Other: 42 CFR 418.78	

POLICY STATEMENT: The Volunteer Program is designed to meet Federal regulations for the provision of volunteer services to hospice patients and their caregivers. The Volunteer Program is monitored on a continuous basis to ensure it is functioning as intended and meeting the needs of the hospice program and its patients.

PROCEDURES:

1. Volunteers are supervised by the Volunteer Services Manager and are used in prescribed roles including, but not limited to:
    a. providing emotional and practical support to patients and families;
    b. providing respite for the patient's caregiver;
    c. assisting in bereavement education and support services;
    d. assisting with program administration and development; and
    e. assisting with office duties

2. Recruitment efforts are sufficient to ensure that the hospice has enough volunteers to meet the needs of patients and families and the requirements of Federal regulations.

3. Volunteers are selected regardless of race, color, national origin, ancestry, age, sex, religious creed, sexual orientation, or disability.

4. Applicants for volunteer positions are carefully screened and are required to complete an application form and interview process.

5. Volunteers are required to complete an orientation and training program prior to assignment to patients and caregivers.

6. A personnel file is maintained for each volunteer that contains prescribed contents.

7. Volunteers are assigned to patients and their caregivers based on assessed needs and appropriateness.

8. Volunteers report to and are supervised by the Volunteer Services Manager and are provided with ongoing support and continuing education.

9. Volunteers are required to document all contact with patients and their caregivers and meet the documentation requirements of Montgomery Hospice.

PATIENT / CAREGIVER EDUCATION	Policy Number: CES.P15
NHPCO Standard(s): PFC 13.3; CES 2.3; CES 3.3; CES 4.10; CES 13.1; CES 17.2; CES 18.2	
Regulatory Citation / Other:	

POLICY STATEMENT: Patients/caregivers are provided with written and verbal education and information as appropriate and needed.

PROCEDURES:

1. Members of the interdisciplinary team assess the patient's/caregiver's education and training needs based on the care being provided to the patient.

2. As appropriate to each patient/caregiver, verbal or written information may be provided related to, but not limited to the following:
    a. effective pain management;
    b. the disease process and the palliation of symptoms;
    c. signs and symptoms of approaching death;
    d. safe and effective use of medications, including side effects, preparation and storage;
    e. prevention and control of infection;
    f. safe use of medical equipment;
    g. nutritional needs of the hospice patient;
    h. community resources;
    i. emergency preparedness;
    j. appropriate and safe use of restraints; and
    k. basic home safety

3. All teaching provided to patients/caregivers, whether verbal or in the form of written materials, is documented in the patient's clinical record and includes the information provided and the patient/caregiver's understanding and response.

ACCESS TO HOSPICE CARE	Policy Number: IA.A10
NHPCO Standard(s): IA 1; IA 1.3; IA 1.4	
Regulatory Citation(s):	

POLICY STATEMENT: Montgomery Hospice is committed to increasing access to hospice care to eligible patients and their caregivers.

PROCEDURES:

1. Montgomery Hospice provides care and services to patients and families who meet hospice admission criteria regardless of race, color, national origin, ancestry, age, sexual orientation, religious creed, disability, diagnosis, or ability to pay.

2. The hospice provides information to the community and to referral resources regarding hospice services, eligibility for hospice care and how services may be obtained.

3. When appropriate, community outreach efforts and education regarding hospice are provided, including periodic community needs assessments, with the goal of increasing access to hospice care to underserved populations.

4. Admission criteria and eligibility limitations are periodically evaluated to identify potential impediments to access.

FINANCIAL AID	Policy Number: 8-006
NHPCO Standard(s):	
Regulatory Citation(s):	

PURPOSE

To identify the criteria to be applied when enrolling patients for charity care or fee for service.

POLICY

Patients without third-party payer coverage and who are unable to pay out of pocket for hospice care will be accepted for financial assistance after completing a Financial Assistance Application.

Patients who reach the private insurance cap with third-party payer coverage will be accepted for financial aid.

PROCEDURE

1. When it is identified that the patient has no source for payment of services or has reached the limit of benefits with a private insurance and requires hospice care, the determination for the provision of a fee-for-service or charity care will be made. The Director of Finance and Chief Financial Officer will review all applicable patient information and discuss determination with social worker.

2. Financial Assistance would include staff visits, 24 hour availability of On Call support and basic medical supplies; it does not include contracted services such as durable medical equipment or medication. Montgomery Hospice will use every resource available to ensure patients in need of financial aid will have the same care other patients receive. A social worker will meet with the patient to determine potential eligibility for financial assistance from other community resources and to explore other avenues of support.
   In the case of patients with private insurance, the Supervisor of Billing and Reimbursement will arrange for direct payment of contracted services like medications and durable medical equipment if such benefit is available.

   The Montgomery Hospice Contracted Services Fund will also be used if in need of additional financial aid.

3. The final determination for Financial Assistance should be documented in the Medical Record. The Financial Assistance Application and accompanying documentation shall be kept with the patient's financial record.

4. If the patient becomes no longer medically eligible for hospice care and needs to be discharged, the social worker will include appropriate referrals to possible community resources as part of the discharge plan.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPI)	Policy Number: PM.Q20 Page 1 of 2
NHPCO Standard(s): PM 1; PM 1.1; PM 1.2; PM 1.3; PM 1.4; PM 1.5; PM 1.6; PM 2; PM 2,1; PM 4; PM 4.1; PM 4.2; PM 7; CES 15.1; OE 2.1	
Regulatory Citation(s): 42 CFR 418.58	

POLICY STATEMENT: Montgomery Hospice develops, implements and maintains an effective, ongoing, hospice-wide and data-driven quality assessment and performance improvement (QAPI) program that reflects the complexity of the hospice's organization and services.

PROCEDURES:

1. The QAPI program includes processes for measuring, analyzing, and tracking quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, services and operations.

2. The hospice collects data that is used to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement.

3. Performance improvement activities focus on high risk, high volume or problem-prone areas that affect palliative care outcomes, patient safety and quality of care with a consideration of incidence, prevalence and severity of problems in those areas.

4. Performance improvement activities track adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

5. As a result of its performance improvement activities, the hospice takes actions aimed at performance improvement and measures and monitors improved performance to ensure that improvements are sustained.

6. The number and scope of performance improvement projects conducted annually reflects the scope, complexity and past performance of the hospice program.

7. Documentation of the QAPI program includes:
    a. all performance improvement projects being conducted;
    b. the reasons for conducting these projects;
    c. measurable progress achieved during performance improvement projects; and
    d. evidence that demonstrates the operation of the hospice's QAPI program.

LEVELS OF CARE – INPATIENT RESPITE CARE	Policy Number: PFC.L25
NHPCO Standard(s): PFC 2.3	
Regulatory Citation / Other: 42 CFR 418.204(b); 418.302(b)(3); 418.108(b)	

POLICY STATEMENT: The inpatient respite level of care is available to patients **at Casey House or in** a contracted facility on an as needed basis.

PROCEDURES:

1. The IDG identifies the patient's need for respite care. Situations indicating a need for respite care may include, but are not limited to:
    a. injury or impairment of the caregiver; and/or
    b. the caregiver requires or requests an interval (5 days or less) of rest or relief from providing continual care to the patient.

2. The Social Worker or Case Manager assesses the need for respite care and arranges inpatient respite care.

3. The RN Case Manager obtains orders for inpatient respite care from the patient's attending physician.

4. The Social Worker or Case Manager in conjunction with the Team Manager makes arrangements with the facility for the patient's transfer and for transportation, if needed.

5. The Team Assistant completes a *Level of Care Change* form and forwards it to the hospice billing department.

6. The Social Worker or the RN Case Manager provide report and documentation of the patient's condition to Casey House or the facility staff, including but not limited to:
    a. hospice diagnosis, current medications, and treatment orders;
    b. DNR status and advance directives if available; and
    c. current plan of care.

7. The IDG continues to provide services to the patient/caregiver during the period of respite and re-evaluates and updates the comprehensive assessment and the plan of care at the time of discharge from inpatient respite care.

8. Casey House staff document in the patient's clinical record. If the patient goes to a contracted facility, the Case Manager will enter a summary note in the clinical record.

10. The Volunteer Services Manager maintains records of volunteer activity and records levels of volunteer participation and cost savings on a monthly and annual basis.

11. Ongoing efforts to retain volunteers include, but are not limited to:
    a. regular and consistent contact with the Volunteer Services Manager and other members of hospice's Interdisciplinary Team;
    b. attendance at Interdisciplinary Team meetings, when possible;
    c. notification of and invitation to in-services provided to hospice staff; and
    d. monthly support meeting, phone coaching and mentoring.

12. An annual performance evaluation is completed by the Volunteer Services Manager for each "active" volunteer.

8. The hospice's Board of Directors ensures that the QAPI program is developed implemented and maintained and delegates coordination and management of the program to the hospice Administrator.

9. The President/CEO assures the overall implementation of the program and regularly reports activities and findings to the Board of Directors that are documented in Board meeting minutes.

10. All hospice employees and contracted staff are responsible for the quality of care and services within their respective departments and are expected to participate in the hospice's QAPI program.

11. The QAPI Committee, which includes representatives from all disciplines, assists in the management of the on-going performance improvement process through regularly scheduled meetings.

12. Improvements in processes or outcomes as a result of the QAPI program are communicated throughout the hospice.

PATIENT'S RIGHTS AND RESPONSIBILITIES	**Policy Number: EBR.P10** **Page 1 of 2**
NHPCO Standard(s): EBR 1; EBR 1.7; EBR 4; EBR 4.1; EBR 4.2; EBR 4.3	
Regulatory Citation(s): 42 CFR 418.52	

POLICY STATEMENT: Montgomery Hospice informs patients of their rights, and protects and promotes the exercise of these rights.

PROCEDURES:

1. If the patient is incapacitated, the patient's representative may exercise the patient's rights in accordance with and to the extent allowed by State laws.

2. Patients and/or their representatives are provided with verbal and written notice of the patient's rights and responsibilities.

3. The notice of patient's rights and responsibilities is provided in a language and a manner that the patient understands prior to furnishing care.

4. The notice of the patient's rights and responsibilities includes, but is not limited to, the patient's right:
    a. to be informed verbally and in writing of his or her rights prior to the start of care in a language and manner that is understandable to him or her;
    b. to be informed of and receive information about the hospice's policies on advance directives in accordance with State law;
    c. to exercise his or her rights as a patient of the hospice without being subjected to discrimination or reprisal for exercising these rights;
    d. to be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of an unknown source, and misappropriation of his or her property;
    e. to voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of Montgomery Hospice)Montgomery Hospice's complaint procedure will be followed);
    f. to receive effective pain management and symptom control;
    g. to be involved in developing his or her plan of care;
    h. to refuse care or treatment;
    i. to confidentiality of protected health information and the related privacy and security protections mandated by federal law and outlined in the hospice's Notice of Privacy Practices; and
    j. to receive information about the services covered under the Medicare hospice benefit or by other payor sources, the services the hospice will provide and any specific limitation(s) on those services, and to be informed of any charges/ services not covered by insurance.

5. Education regarding patient rights and responsibilities is provided during the orientation to hospice for new employees and volunteers to ensure that all personnel protect and promote the patient's exercise of his or her rights.

6. Documentation in the patient's clinical record confirms that patients and / or their representatives received a copy of the written notice of rights and responsibilities.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. H1503

Issued to: MONTGOMERY HOSPICE, INC.
1355 PICCARD DRIVE, STE 100
ROCKVILLE, MD 20850

Type of Facility or Community Program: HOSPICE- GENERAL

Date Issued: FEBRUARY 1, 2014

AREAS SERVED: MONTGOMERY COUNTY

TYPE OF HOSPICE: INPATIENT HOSPICE

NUMBER OF BEDS: 14 BEDS

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Annotated Code of Maryland, including all applicable rules and regulations promulgated there under. This document is not transferable.

Expiration Date: FEBRUARY 1, 2017

Patricia Tomaskin May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

Montgomery Hospice, Inc.

Rockville, MD

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

October 18, 2013

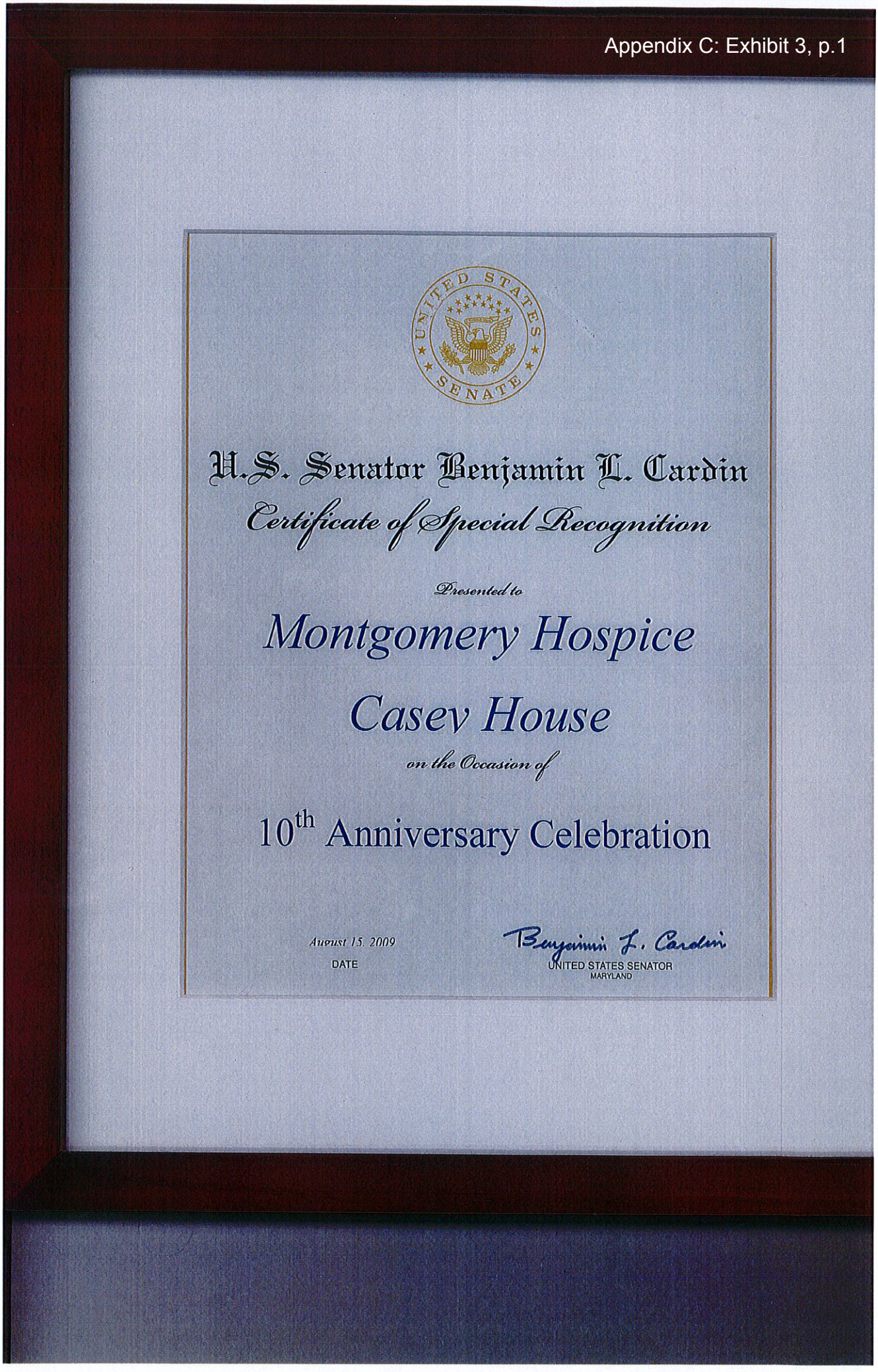
Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #5353
Print/Reprint Date: 02/03/2014

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



U.S. Senator Benjamin L. Cardin

Certificate of Special Recognition

Presented to

Montgomery Hospice

Casey House

on the Occasion of

10th Anniversary Celebration

August 15, 2009

DATE

Benjamin L. Cardin

UNITED STATES SENATOR

MARYLAND

This Citation Is Presented To

Montgomery Hospice
Casey House

***

IN CELEBRATION OF
ITS TENTH ANNIVERSARY

With gratitude for your dedicated and compassionate caring for your patients and their families and for all that you do to offer comfort and dignity to so many.

Chris Van Hollen
Member of Congress

On This Day,
The Fifteenth of August,
Two Thousand and Nine

The State of Maryland

Governor of the State of Maryland, to

MONTGOMERY HOSPICE , Greetings:

Be it Known: That on behalf of the citizens of this State,

in recognition of ***the more than 30 years of dedicated service to the residents of Montgomery County, Maryland providing the highest quality end-of-life care in homes, extended care facilities and at Casey House… in appreciation of the dedication and commitment of the staff and volunteers who play an integral role and the philanthropic support of the community; and as our citizens join together in expressing our highest regard and sincere best wishes for the future,***

we are pleased to confer upon you this

Governor's Citation

Given Under My Hand and the Great Seal of the State of Maryland,
this **21st** day of **April**
Two Thousand
and twelve

Governor

The County Executive of Montgomery County, Maryland

Awards this Certificate to

Montgomery Hospice Casey House

in Recognition and Appreciation

of your ten years of dedicated service and commitment
to creating a loving and nurturing atmosphere
for your residents and their families.
I want to express my sincere congratulations
on your tenth anniversary and
wish you continued and ongoing success in the future.

Isiah Leggett

ISIAH LEGGETT
COUNTY EXECUTIVE

August 15, 2009
DATE

The Maryland General Assembly

Official Citation

Be it hereby known to all that
sincerest congratulations
are offered to

Montgomery Hospice

in recognition of

Thirty years of extraordinary commitment
to the Montgomery County community.

Presented on this 21st day of October 2011

by

Senator Roger Manno

Delegate Sam Arora

Delegate Bonnie Cullison

Delegate Benjamin F. Kramer

of Montgomery County – Legislative District 19

Patient and Family Handbook

301-921-4400

Call any time, any day.

Montgomery HOSPICE

Montgomery Hospice

301-921-4400

Call any time, any day.

If no answer on main number, call the answering service at **240-638-9740**.

In the unlikely situation that you cannot reach us using one of the two numbers above, call Casey House (Montgomery Hospice's inpatient facility) at 240-631-6800.

Montgomery Hospice team:

Nurse _____

Social Worker_____

Chaplain_____

Hospice Aide (CNA)_____

Volunteer _____

Our Mission:

To gentle the journey through serious illness and loss with skill and compassion.

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Handbook revised January 2015

General Information

This section contains information about who to call, about the Montgomery Hospice team and about this handbook.

We thank you for inviting Montgomery Hospice into your home for this part of your life's journey. We deeply appreciate the opportunity "to gentle your journey" during this difficult time. We hope you will find this handbook helpful. Our staff is also available to answer questions and address concerns 24 hours a day, 7 days a week.

We are a private nonprofit agency with a single mission: to gentle the journey through serious illness and loss with skill and compassion. Our goal is to work with you, your doctor and your family, to listen carefully to your wishes and hopes, and to ease the burdens of your illness.

24 hours a day, 7 days a week please call 301-921-4400

If you cannot reach us at this number, call our answering service at 240-638-9740. In the unlikely situation that you cannot reach us on the main number or through the answering service, call Casey House at 240-631-6800.

Our staff is available to assist you 24 hours a day, 7 days a week. During office hours, your calls are answered by our receptionist. Tell the receptionist what you need or with whom you need to speak. If that person is not in the office, the receptionist may page him or her. In an emergency, ask to talk to a nurse in the office.

When the office is closed, your call will be answered by our answering service. Give your name and phone number, and a nurse will call you back soon. If you do not receive a call back within 15 minutes, please call again.

Please call if:

- you feel anxious or unsure
- you have questions about medications, especially if there have been recent changes
- your pain medicine is not working well
- you have questions about symptoms, or if new symptoms develop
- your condition seems to have changed
- you have a fall

Often the nurse can help you over the phone. If necessary, the nurse can visit you to address your concerns. When a nurse visits you at night, turn on the outside house lights, watch for the nurse's arrival and answer the door as quickly as possible.

Please call Montgomery Hospice (301-921-4400) before calling 911.

The Montgomery Hospice Team

At Montgomery Hospice we hope to provide you and your loved ones with a safety net of comprehensive care. Our team of hospice staff members will work with your own doctor to care for you. Our team includes doctors, nurses, chaplains, social workers, hospice aides and volunteers. The most important members of the team are you, your family and your caregivers. We are counting on you to tell us how we can best help you. We will communicate with you, your doctor and with each other to provide you the best possible care.

Montgomery HOSPICE

Providing a safety net of comprehensive care for patients and their families.

DOCTORS: Our doctors collaborate with patients' physicians. Medical Director takes a holistic approach to patient's care, including pain management and medication review.

NURSES: Available 24/7 for support by visits and phone calls. Nurses visit regularly, coach and teach caregivers, coordinate care and monitor symptoms.

SOCIAL WORKERS: Facilitate family communication, counsel patients and family members on Advanced Directives, insurance issues, anticipatory grief and other end-of-life concerns.

SPIRITUAL COUNSELING: Chaplains are available to assist with life review and spiritual needs of patients and their families.

CERTIFIED NURSING ASSISTANTS: Assist with bathing, skin care, feeding and making occupied beds; provide care tips to family members.

VOLUNTEERS: Provide respite and friendly visits and other practical assistance to patients and family members.

COMPLEMENTARY THERAPIES: are techniques such as massage and music, that can be used to help ease pain and anxiety, and assist with relaxation.

CASEY HOUSE: Hospice patients stay at Casey House for short periods when they have symptoms that require intensive medical care.

BEREAVEMENT: Montgomery Hospice support continues for families. Our counselors provide grief support to families for 13 months after patient's death.

Doctors

We have specialized doctors on our staff who will communicate with your own doctor as needed.

Nurses

Your nurse will work with you, your family and your doctor to assess your condition, manage any bothersome symptoms and help you plan for your changing needs. You will have a nurse who is assigned to you and who will visit you regularly. Because we work as a team, other nurses from Montgomery Hospice may also visit as the need arises.

Social Worker

Your social worker is an experienced counselor who can help you talk about the changes that are happening, open up family communication and work with you to find the services you need. Your social worker can also help you work on your advance directives and any other decisions you may need to make.

Chaplain

Your chaplain can help you explore spiritual concerns and questions of meaning. The chaplain can help you find a member of the clergy of your faith tradition or work with your own clergy if desired.

Hospice Aides – Certified Nursing Assistants

Your nurse may recommend help from one of our hospice aides. Our hospice aides help people with their personal care needs, such as bathing, shaving, feeding, hair care, mouth care and bed changes. Periodically, the aide may visit you, staying for about an hour. All of our aides are Certified Nursing Assistants (CNAs) and have experience in caring for patients who are seriously ill.

Volunteers

Volunteers support you and your caregivers, offering practical help and support. They may do lavender oil hand massages, play the Reverie Harp, run errands, do occasional light housework, read aloud, write letters, help in recording memories, or perform other tasks that you might find helpful. Our volunteers are carefully screened and are required to complete a comprehensive volunteer training.

Complementary Therapies

"Complementary Therapies" are techniques that can be used along with conventional medical care to provide comfort. These techniques help ease pain and anxiety, and aid relaxation. Examples include massage, music and aromatherapy. Montgomery Hospice uses lavender oil hand massage, Comfort Touch® massage, Reiki and "Music by the Bedside" (including Reverie Harps, instruments that make peaceful, calming music, and customized selections from an extensive music library).

Bereavement

Our hospice bereavement counselors provide support to patients' families and friends after their loss, helping them deal with feelings of grief and sadness. The hospice team considers each family's unique needs as they plan bereavement support.

Casey House

Most patients are able to stay in their homes. Occasionally the hospice team may recommend admission to Casey House for care. We use Casey House when symptoms cannot be effectively managed at home. Many times the crisis is resolved by the medical staff at Casey House and you will be able to return home. Casey House has a warm, homelike atmosphere with private patient rooms.

Using This Handbook

The Montgomery Hospice team is able to offer a variety of resources for you and for your family. At different times in your journey you will have different needs. As your needs change, please stay in communication with any team member so that we can be the most helpful to you. This book is a tool to help you and your caregivers have information easily at hand. More in-depth information and resources are available from members of your team.

We have tried to make this information book simple yet thorough. You will notice that the book is divided into sections to make it easier to find various kinds of information. Some of the contents of this book will apply immediately to you and will be helpful to your caregivers. You may never need other sections. Please glance through the entire book and read more thoroughly the sections that more directly apply to your care. If you have questions or concerns, please remember to speak to any of us. We thank you for your trust and confidence as we journey together.

Care of the Patient

This section contains information about common symptoms: what to expect and ways to help with these symptoms.

Common Symptom Chart

Possible causes to consider and some things to try while calling the nurse:

Symptoms	Behaviors	What to Do Before Calling the Nurse
Pain (see pages 15 & 20)	Grimacing, yelling Grabbing body part that hurts Crying	Give prescribed medications Distraction techniques Relaxation techniques Gentle massage of hands or feet
Shortness of breath (see page 12)	Pulling off clothes Trying to get out of bed Moving head back and forth Breathing hard	Sit patient upright Stay with patient Open window Place oxygen if ordered Fan patient's face (cheek) Give medications as instructed
Nausea and vomiting (see page 9)	Sensitivity to odors Disinterest in food Abdominal bloating Vomiting before or after a meal Belching	Avoid strong smells Avoid spicy foods and dairy products Sit patient upright Do not force patient to eat Give medications as instructed
Full Bladder (see page 11)	Multiple trips to bathroom but no urination or only small amount	Run water in bathroom Have patient gently press on lower abdomen Place hand in warm water
Constipation (see page 11)	Straining on toilet Complaint of rectal pain Complaint of stomach pain Complaint of nausea	Give prescribed laxatives Increase fluid intake Have patient walk or do abdominal exercises (tighten & release muscles)

Common Symptom Chart *(continued)*

Symptoms	Behaviors	What to Do Before Calling the Nurse
Restlessness, confusion, and agitation (see page 21)	Pulling at clothes or oxygen Trying to get out of bed/ wandering Moving arms or legs without purpose Unable to sleep or concentrate	Protect the patient from falls Stay with the patient Decrease noise and other stimulation in the room Give medications as instructed
Emotional or spiritual distress	Crying Withdrawing from others Unable to focus on conversation Angry outbursts Wandering, trying to leave Restlessness	Hold patient's hand Sit quietly together Soft soothing music Try to make eye contact Give medications if prescribed Provide gentle reassurance Pray with patient Try to talk with patient, ask questions

Additional information about common symptoms and methods for dealing with them are found in the next section.

Eating and Drinking

Nutrition

Most of us eat for social as well as nutritional reasons. Preparing and eating meals with family can be an important social time. At times people may want to express their care and concern for you by encouraging you to eat. You may experience a loss of appetite with your illness. This is normal but can be distressing to your loved ones. Forcing yourself to eat to please others may cause nausea or discomfort.

If you have a loss of appetite, consider:

- Eat smaller meals or snacks throughout the day.
- Food is often better tolerated in the morning and mid-afternoon.
- Food supplements such as instant breakfast mixes or protein supplements can provide extra nutrition.

- Low-fat foods at room temperature are usually better tolerated when you feel nauseated.
- Eating fruits and vegetables can help avoid constipation.
- Flavored ices, popsicles and frozen juices may be helpful when your mouth feels dry.

Swallowing Difficulty

Some patients have trouble swallowing. If you have people feeding you, it is important that they do not feed you if you can't swallow.

Caregivers should stop feeding a patient and report this to the hospice nurse if there are any of these warning signs:

- coughing, sneezing, or runny nose during or after eating
- gagging or choking
- holding food in the mouth

Things that help you if you have trouble swallowing:

- Sit as upright as possible.
- Be fully awake and alert.
- Start with a sip of water.
- Tilt your head forward and put your chin to the chest when swallowing.
- Add thickener to liquids if ordered by the physician.

Nausea and Vomiting

Nausea and vomiting may be caused by constipation, medications, pain, acid reflux, physical changes or infection. Comfort measures include:

- using prescribed medications
- avoiding strong smelling foods and other odors that may trigger nausea
- drinking clear liquids or eating bland, non-spicy foods
- avoiding dairy products
- using relaxation techniques
- sitting up for 30 minutes after eating

Let your nurse know if you are having nausea or vomiting.

Mouth Care

Many people have **dryness of the mouth**. This is more common if you are eating and drinking less than usual, using oxygen or taking certain medications. To soothe dry mouth, try some of the suggestions below and be sure to do mouth care several times per day. Your caregiver can help you with mouth care if you are unable to do it yourself.

Remedies for dry mouth:

- sucking on ice chips or hard candy
- frequent sips of water or other beverage
- popsicles or Italian ice
- humidification in the room
- frequent mouth care
- special swabs will be provided for you if needed

Mouth Care Procedure

Make sure you are sitting upright or have the head of the bed elevated. Never leave gauze or cloth inside your mouth.

1. Gently swab your teeth, gums and tongue using any of the following:
    - a soft bristle toothbrush
    - a piece of gauze moistened with water
    - a soft wash cloth moistened with water
    - specialized swabs provided for you
2. Rinse your mouth with plain water if able.
3. Apply lip balm or chapstick to moisten your lips.

Excess Saliva

Some people have trouble with a large amount of saliva in their mouth.

Try these things:

- Put a washcloth or disposable pad under the chin to soak up extra saliva.
- Apply skin cream to protect your skin from irritation.
- If you can no longer swallow, you should be positioned as upright as possible, on your side with your head turned to the side also.
- Discuss the use of medications with your nurse.

Bladder and Bowel Issues

Bladder Management

You may notice a change in the frequency of urination. If you are eating or drinking less then you will likely urinate less frequently. You may notice the color of your urine is darker. This is normal. If you notice an unusual or strong odor to the urine, you should notify your nurse.

You may experience loss of control of your bladder. This is called **incontinence**. If this occurs, notify your nurse. Sometimes there is a reason that can have a simple solution. Other times this may be due to increasing weakness and may continue. If you are incontinent, good skin care is important to avoid skin breakdown.

If you are incontinent, consider these simple solutions for keeping your skin dry:

- Use adult diapers which absorb liquid and help keep your skin and bedding dry. These can be provided to you by your nurse.
- Cloth pads for the bed can be purchased at a medical supply store.
- Washing your skin and using lotion or other skin barrier creams after each episode of incontinence can help protect your skin.

You may experience a time when you are unable to urinate. This is called **urinary retention**. This can cause discomfort, and your caregivers may notice that you are more restless or agitated. If you have been unable to urinate for more than 8 hours, notify your nurse.

Bowel Management

Bowel habits often change when someone is ill. You may experience constipation or diarrhea. Treatments and medications can have an effect on your bowels. You should have a bowel movement every 2 to 3 days (even if you are eating very little). If you notice a change in the color or consistency of your stool, or if you see blood in your stool, you should notify your nurse.

Constipation is the inability to move your bowels or having hard, dry stools. Constipation can occur with certain medications or when you have a decrease in your food or fluid intake. It can also be caused by inactivity or physical changes. Pain medicines are one of the most frequent causes of constipation. Eating high fiber foods, drinking water and high fiber juices and increasing your activity will help with constipation. A daily laxative is usually needed if you are taking daily pain medicines.

Diarrhea is loose or watery stools that occur frequently. Often times stomach cramping and nausea will occur with diarrhea. Diarrhea can be caused by certain medications, medical treatments, emotional upset or certain illnesses. Limiting your diet to clear liquids and some starches such as rice, toast, bananas and applesauce can help. Notify your nurse if you are experiencing diarrhea.

Breathing Topics

Breathing Problems

Shortness of breath is a sensation of difficulty breathing. People describe this in many ways, but often people say they are “not getting enough air” or describe breathing as “labored, uncomfortable, or distressing.” You may breathe faster than normal, look as if you are breathing too hard, or breathe through pursed lips. Another sign of difficulty breathing is agitation, especially pulling clothes off or trying to get out of bed.

If you are feeling short of breath, here are some simple, non-medication tips you can try:

- Sit as upright as possible or raise the head of the bed.
- Raise your arms up on pillows or place the over-bed table in front of you and lean forward on it (called the “tripod” position).
- Point a fan towards your face.
- Open a window.
- Keep the room cool.
- Alternate periods of activity with rest periods.
- Use relaxation techniques.
- Play relaxing music, watch TV or use another way to distract yourself.
- Practice pursed-lip breathing (see technique below).

Pursed lip breathing technique

- Breathe in through your nose.
- Breathe out through your mouth as if you are blowing out a match.

Medications

There are many medications that help with breathing. Your nurse will teach you how to take medications that will be the most helpful to you.

Oxygen

Some people find oxygen helpful with breathing difficulties. Below are some safety precautions and tips for oxygen use. Your nurse will teach you how to use oxygen.

Most people use an oxygen concentrator at home and oxygen tanks if they leave the home. Most people also have a large oxygen tank at home for use if the power goes out, as oxygen concentrators have to be plugged in. Oxygen concentrators “concentrate” oxygen from the air around us. This does not affect the amount of oxygen in the room.

Both the concentrator and the tanks have a gauge to adjust how much oxygen flows. Your nurse will show you how to use these. Most people find tubing with nasal prongs to be much more comfortable than an oxygen mask. Oxygen masks are not appropriate for most people. Oxygen causes dryness. Your nurse will show you how to use the humidification bottle to add moisture to the oxygen.

If you feel as if you are not getting enough oxygen, make sure the tubing isn’t kinked or caught underneath something. Your nurse will show you how to adjust the amount of oxygen you are getting, within the limits prescribed by your doctor. If the oxygen tubing makes the tops of your ears sore, wrap a piece of gauze around the tubing or pad it with cotton pads.

Safe use of oxygen

- Do not smoke near oxygen.
- Do not use oxygen within 10 feet of open flames, such as candles, fireplaces, wood burning stoves, gas stoves and other heat sources.
- Make sure portable oxygen tanks are stored securely. Do not store them in a place where they might easily get knocked over.
- If using an oxygen concentrator, make sure there is space for air flow behind and around the machine.
- Do not use any flammable products (like cleaning fluids, paint thinner, aerosol sprays) while using oxygen.
- Avoid use of petroleum-based products, including Vaseline, Blistex and Chapstick.
- Do not change the flow of oxygen unless directed by your nurse.
- Use a properly grounded wall outlet for an oxygen concentrator.
- Do not use extension cords with an oxygen concentrator.
- Turn the cylinder valve off when not using oxygen.
- Avoid using electric razors and hair dryers while using oxygen. Battery operated razors and hair dryers that are less than 10 volts can be used.

- Do not use an appliance with a control box, such as a heating pad. Control boxes may throw sparks.
- Avoid static electricity. It is a good idea to avoid nylon or woolen clothing and bedding, as these items are more likely to cause static electricity.
- Use a humidifier in the winter to add moisture to dry air in the house.
- Notify the fire department to inform them that oxygen therapy is being administered in the home. Hang a sign on the door of your residence to let the fire department know that oxygen is being used.
- Install smoke alarms on every floor of your home, including the basement. Place smoke alarms near rooms where people sleep. Test smoke alarms every month to make sure they are working.

Cough

Different causes of a cough will require different treatments. You can help your nurse by discussing what seems to trigger your cough and what has helped in the past.

Some things that can contribute to a cough:

- smoking
- reflux
- lung disease
- tumors in the throat or lungs
- infections, thick secretions
- fluid retention
- certain medications

Some things that can help a cough:

- sitting as upright as possible
- frequent sips of water or tea with honey or lemon
- throat lozenges or hard candy, when you are awake and aware of your surroundings
- using a room humidifier
- removing allergens from the room
- using medications as prescribed to calm cough
- nebulized (inhaled mist) medications

Hiccoughs

Hiccoughs can be caused by medications, chemical imbalances in the body, tumors, inflammation or infection of the chest or abdominal region. They can also occur after some surgeries. Notify your nurse if hiccoughs are causing you discomfort.

Some things that can help with hiccoughs:

- breathing in a paper bag
- drinking a glass of water slowly
- acupuncture
- relaxation techniques
- medications can also be helpful

Whole Body Concerns

Techniques to Help with Pain or Discomfort

This section contains some things that might help you relieve uncomfortable symptoms.

Heat Applications

Heat may relieve the following:

- muscle aches or spasms, such as neck or low back pain
- joint pain
- rectal pain

Precautions

- Do not lie on top of heating pad.
- Do not use heat over skin where menthol ointment or an oily substance has been applied.
- Do not use heat if pain increases.
- Think warm, not hot. Keep the sensation at a warm, comfortable level.
- Cover the heat source with a towel.
- Moisture increases the intensity of heat.
- Do not use over an area that is bleeding or recently injured.

Equipment for heat application

- hot water bottle
- electric heating pad
- hot moist compresses (towels)
- immersion in water (tub, basin, whirlpool)

Application of heat

- Cover heat source with a pillowcase or one or more towels.
- Keep it at a comfortably warm intensity.
- Do not fall asleep when using a heating pad.

- Apply to painful area for 10-20 minutes. You may use warmth for any length of time if it remains at a comfortable level that does not irritate your skin.
- If you cannot get to the area that hurts, apply the heat pack to any or all of the following sites:
  — opposite side of body corresponding to the pain (left leg if right leg hurts)
  — above the pain
  — below the pain

Cold Applications

Cold often works better than heat, and may relieve the following:

- muscle aches or spasms, such as neck or low back pain
- joint pain
- headache
- itching

Precautions

- Do not use cold over areas of poor circulation or skin being treated with radiation.
- Do not use cold if it increases pain.
- Think cool, not cold. Keep the sensation of cold at a cool, comfortable level.
- Cover the ice pack with a towel.
- Moisture increases the intensity of cold.
- Remove cold pack if your skin becomes numb.
- Do not freeze your skin.

Equipment for cold can be any of the following:

- ice bag
- gel pack
- ice and water in plastic bag
- a bag of frozen peas or corn
- slush pack made by freezing in a sealed plastic bag: 1/3 alcohol and 2/3 water
- towel soaked in water and ice chips and wrung out
- flexible cold pack made with damp cloth or towel, folded in desired shape, sealed in plastic bag then placed in freezer

Application of cold

- Cover ice pack with a pillowcase or one or more towels.
- Keep it at a comfortably cool intensity.
- Apply to the painful area for 10-20 minutes. You may use cold for any length of time if it remains at a comfortable level of coolness and does not irritate your skin.
- If you cannot get to the area that hurts, apply the cold pack to any or all of the following sites:
  — opposite side of body where it hurts (left leg if right leg hurts)
  — above the pain
  — below the pain

Massage

Massage is an age-old method of helping someone relax. The forms of massage listed below can be done easily and do not take a lot of time.

Brief touch or massage (handholding or briefly touching or rubbing a person's shoulder).

Warm foot soak
Soak feet in a warm basin of water, or wrap the feet in a warm wet towel. Be sure the water or towel is not too hot.

Massage (3-10 minutes)
May consist of whole body or be restricted to back, feet, or hands. If the patient is modest or does not move or turn easily in bed, consider massage of the hands or feet.

Use a warm lubricant (e.g. a small bowl of hand lotion warmed in the microwave or by placing the bottle of lotion in a sink of hot water for 10 minutes).

Massage for relaxation is usually done with smooth, slow strokes. Try varying pressure and different types of massage (kneading, stroking, circling) to determine which the patient prefers.

Especially for the elderly person, a back rub that effectively produces relaxation may consist of no more than 3 minutes of slow, rhythmic stroking (about 60 strokes/minute) on both sides of the spine from the crown of the head to the lower back. Keep one hand on the patient's back at all times. Each time one hand will be lifted, place the other hand on the patient's body first.

Set aside a regular time for the massage. This gives the patient something to look forward to and depend on.

Meditation

Meditation can help you relax, focus and think more clearly. If you need help learning the following technique, ask your hospice team:

1. Find a quiet and comfortable place. Sit in a chair, on the floor or your bed with your head, neck and back straight but not stiff. Try to put aside all thoughts of the past and the future and stay in the present.
2. Become aware of your breathing, focusing on the sensation of air moving in and out of your body as you breathe. Feel your belly rise and fall, the air enter your nostrils and leave your mouth. Pay attention to the way each breath changes and is different.
3. Watch every thought come and go, whether it is a worry, fear, anxiety, or hope. When thoughts come up in your mind, do not ignore or suppress them, but simply note them, remain calm and use your breathing as an anchor.
4. If you find yourself getting carried away in your thoughts, observe where your mind went off to, without judging, and simply return to your breathing. Remember not to be hard on yourself if this happens.
5. As the time comes to a close, sit for a minute or two, becoming aware of where you are. Get up gradually.

Muscle relaxation

Progressive muscle relaxation is a technique that can be effective for both pain and stress. Begin by lying or sitting comfortably in a quiet place.

- Close your eyes and pay attention to your breathing.
- Take slow deep breaths and allow your belly to rise with each breath and lower when you breathe out.
- Start at the top of your head and tense the muscles of your scalp, then release and relax the same muscles.
- Next do the same with the muscles of your face
- neck muscles
- shoulder muscles
- arm muscles
- hands
- chest
- belly and spine
- thighs
- calves
- feet and toes

If you are still feeling tense, repeat the entire process. Relax in this way for as long as you want.

Guided Imagery

Imagery can be used with other non-medicinal techniques to improve comfort. Start by lying or sitting in a comfortable position in a quiet room. If possible, first go through the muscle relaxation exercise.

Using Imagery

- Close your eyes.
- While breathing deeply and regularly, try to clear your mind of all thoughts.
- Imagine yourself in a favorite place, like the beach, or the mountains.
- Imagine what the sun feels like on your skin, what the air smells like, what sounds you can hear.
- Then begin noticing how your body feels.
- Just listen to what it is telling you and affirm that you have heard. (“My spine is tight”)
- Imagine that there is relief for whatever discomfort you may have (“opening of my spine”). Imagine the discomfort floating up and away from you.
- Continue breathing regularly, check in on your surroundings in your favorite place.
- After a few minutes say goodbye to this place and gradually bring your awareness back to the room.

Distraction

Distraction is a technique that involves redirecting one’s attention from the pain or discomfort to something else, as a means to reduce that pain or anxiety. It can be used alone or with any other therapy. You may already be using this without realizing it. Although the following list may seem like simple things to do, they can be very effective when needed.

- playing with a pet
- listening to favorite music
- playing a game
- watching a movie
- working on a puzzle
- talking with friends and/or family
- doing a craft or hobby
- looking at family photos
- other forms of reminiscing – telling favorite stories

Let the hospice team know if you need help with any of these techniques; they will be glad to help you.

Pain

Managing your pain is a priority of your entire hospice team. Our staff is specially trained in pain management techniques; we also have pain physicians and a pharmacist available for consultation.

There are many types of pain that people experience: physical, emotional, social and spiritual.

It is not unusual to have more than one type of pain at a time and to have several areas of physical pain that feel different from each other. Each of these different types of pain requires a different treatment, medication or approach.

You can expect your nurse and other members of the hospice team to ask you if you have pain. Describe what you are feeling in order to get the most effective medication or treatment to relieve your pain. Ways to relieve pain include taking your prescribed medications, and the techniques described in this handbook such as heat applications, cold applications, massage, meditation, relaxation, guided imagery and distraction.

Skin Problems

A person who sits or lies down for long periods of time must pay attention to the health of his or her skin. Two common skin problems patients develop are pressure sores and chafed skin, which can be prevented or made less severe by proper skin care.

Pressure sores

Pressure sores are caused when an area of skin loses its blood supply for an extended period of time. The area begins to break down, and the skin cells may eventually die as a result.

Parts of the body where this often happens are the tailbone, back of the head, ears, hips, spine, elbows, heels, ankles and shoulder blades. If redness appears and does not go away from these areas a short time after pressure is removed, the skin may not be receiving enough blood flow. Please report this to your nurse.

The following may help caregivers prevent pressure sores:

- Change the patient's position frequently (at least every 2 to 4 hours) while awake unless directed differently by your nurse.
- Use a lift sheet whenever repositioning the patient.
- Special equipment such as an egg crate mattress, an alternating air pressure mattress or a sheepskin pad may be helpful by reducing pressure on the bony prominences.
- Keep skin clean, warm and dry by using incontinence pads and cleaning the patient whenever soiled. Barrier creams may also be helpful by keeping irritating urine and stool off the skin.
- Gowns or pajamas that are open in the back help keep clothing from bunching up under the patient and are easier to change.

When positioning the patient, make sure to support all parts of the body using pillows or blankets and make sure there is at least a slight bend in any joint (knees, elbows, wrists, fingers). Think about how your joints work and how they would feel most comfortable.

Even with the most attentive care, a patient may develop pressure sores because of his/her declining condition. Special dressings can be placed over sores to help prevent further breakdown and make the area more comfortable.

Chafed Skin

Chafed or irritated skin is caused by a combination of heat, moisture and friction. This occurs most often in areas of the body where skin folds are prevalent. Common areas include the groin, under the breasts, or in the abdominal area. For chafed skin problems, it is especially important to keep the area clean and dry.

Your nurse will provide individualized instructions about how to provide proper skin care.

Confusion, Restlessness and Agitation

Confusion, restlessness and agitation are very common in seriously ill patients. Many different factors can cause these symptoms. Management and treatment will depend on the specific cause. Whatever the cause, it is a very distressing and challenging situation for even an experienced caregiver. What makes it more difficult is that the patient usually cannot accurately express what is causing the distress. Your hospice nurse will ask you questions about the patient's behavior to help determine the underlying problem. Patient safety is the first priority. Protect the patient from any falls or injuries. Watch them closely (even if they do not want you to do so).

Depression

Having your depression treated can greatly improve the quality of your life and of the lives of those you love.

Signs of depression:

- insomnia
- lack of energy
- weight loss
- change in appetite
- inability to concentrate
- crying spells
- suicidal thoughts

Treatments may include:

- medications
- supportive counseling
- pet therapy
- relaxation techniques

Let anyone from your hospice team know if you have any of these symptoms and are concerned that you might be depressed.

Fatigue

Fatigue is very common in an advanced illness. It may be severe enough to restrict you from doing things you enjoy or from doing your own activities of daily living such as dressing or bathing.

Possible causes of fatigue:

- inability to sleep well because of pain
- shortness of breath or anxiety
- low blood counts
- dehydration
- abnormal medication levels
- infections and other disease processes

Tips that may help:

- Engage in gentle exercise when possible.
- Take only short naps when needed to avoid being wakeful at night.
- Schedule important activities during the time of day that you have the most energy.
- Avoid very hot showers and baths.
- Use equipment to help conserve energy (such as a wheelchair or a walker).

Let your nurse know if you are feeling very fatigued. The nurse will discuss this with your doctor and explore actions that may help.

Insomnia

Insomnia is not being able to sleep well. Relaxation techniques may be helpful when this occurs. Your nurse and other members of your hospice team can teach you relaxation techniques. Massage or healing touch therapies may be helpful. Your nurse will want to address any physical symptoms that are causing you discomfort and may be preventing you from sleeping well.

Fever

Having a fever may make you feel tired and achy. A fever is a body temperature over 99.5. Fevers can be caused by infections, dehydration, certain tumors or by progression of your illness. A very high fever can cause chills and infrequently may cause seizures.

You should check your temperature if you think you have a fever. This can be done by using an oral thermometer, an ear thermometer, or by placing the thermometer under your arm in the area of your arm pit.

Report a fever to your nurse and let the nurse know how you took your temperature.

Tips for dealing with a fever:

- You may be instructed to take a medication that will lower your body temperature, such as Tylenol.
- Increase your fluid intake if you are able.
- A cool sponge bath may be recommended if your fever is very high.
- You should avoid becoming overly chilled. Chills may cause shivering which can increase your body temperature more.

Your nurse will instruct you on the best way to treat your fever.

Getting Around

Many people have trouble with weakness and become unsteady on their feet as illness advances. You can use walkers, canes and/or wheelchairs to help you stay as independent as possible and to help prevent falls.

Using a Walker

- Make sure the walker is adjusted to the proper height for you.
- Place the walker a short distance in front of you and walk up to it. Lift it or roll it again and walk up to it.
- When sitting down or standing up from a chair, hold onto the arms of the chair, not the walker.

Using a Cane

- Your nurse or a physical therapist will help decide which type of cane is best for you.
- Make sure your cane is adjusted to the proper height for you.
- Use your cane on your weaker side.

Using a Wheelchair

- Remember to lock the wheels when getting in and out of the wheelchair.
- Remove foot rests before getting in or out of the wheelchair.
- Do not use wheelchairs on escalators.
- Your nurse can provide a wheelchair cushion to make the seat more comfortable and protect your skin.

Moving from Bed to Chair

1. Place the chair as close to the bed as possible.
2. Roll over onto one side and bring your legs over the side of the bed.
3. Come to a sitting position. If using a hospital bed, use the control to raise the head of the bed to help with this. Ask your caregiver to support your shoulders if you need help getting to a sitting position.
4. Sit on the edge of the bed for a few minutes to avoid dizziness when standing up.
5. If you need help standing, have your caregiver support you under your arms and lift as you push up with your feet.
6. Stabilize the chair and swing your hips around to sit in the chair.

Positioning in Bed

If you are too weak to pull yourself up in bed, your caregiver can assist you. Your caregiver will use a “draw” or “lifting” sheet to help pull you up in bed if you slide down. Using a draw sheet helps avoid skin irritation and pulling directly on your arms and legs. Your caregiver can make a draw sheet by folding a flat sheet in half or quarters and placing it under you so it extends from your shoulders to your thighs.

Follow these steps:

1. If using a hospital bed, raise or lower the bed so it is at your hip or waist level. This helps to protect your lower back.
2. Lower the head of the bed as low as tolerated by your family member.
3. Raise the foot of the bed if tolerated.
4. Stand at the head of the bed, grasp the draw sheet near the shoulders and pull your family member up. Try to use your legs, not your back.

Note for more than one caregiver:

- Stand on either side of the bed. Grasp the draw sheet near the shoulders and close to the thighs to lift and slide your family member up in bed. Try to use your legs, not your back.

Reposition pillows and smooth out wrinkles in bed sheets for comfort.

Using a Patient Lift (Hoyer Lift)

A Hoyer lift is a mechanical, hydraulic lift that allows caregivers to lift you if you cannot move on your own. It uses a canvas sling that goes underneath you. The sling attaches to metal bars on the lift. A handle is used to lower and raise the sling, lifting you in the air. The entire mechanism is on wheels, allowing caregivers to move you from one place to another. Your nurse will help you to decide if a Hoyer lift might be helpful you.

Important safety tips for your caregiver:

- Do not use a Hoyer lift without instruction from the equipment company or from hospice staff.
- Keep the legs of the base open wide to stabilize the lift.
- Stabilize the canvas sling to make your loved one feel secure. Reassure if the patient feels frightened.
- Make sure arms and legs are carefully tucked within the seat to keep from pinching.
- Never leave someone unattended in the lift.

Safety

This section contains general safety tips and guidelines.

Basic Home Safety

Preventing Falls

Falls are often due to hazards that are overlooked but easy to fix. You and your caregiver can use the following Self Assessment to think about things that would indicate that you are at a high risk for falling.

- history of falling – 2 or more falls in last 6 months
- vision loss – changes in ability to detect and discriminate objects
- hearing loss – may not be as quickly aware of a potentially hazardous situation
- medications – taking four or more medications
- balance and walking problems – decline in balance; decline in speed
- high or low blood pressure – that causes unsteadiness
- hazards inside – tripping and slipping hazards, poor lighting, bathroom safety, spills, stairs, reaching, pets that get under foot, scatter rugs
- hazards outside your home – uneven walkways, gravel or debris on sidewalks, no handrails, hazardous materials (snow, ice, water, oil)

Safety tips for preventing falls:

- Keep the Montgomery Hospice phone number in large print near each phone.
- Keep other emergency numbers in large print near each phone.
- Wear shoes that give good support and have thin non-slip soles.
- Remove things you can trip over (such as papers, books, clothes, and shoes) from stairs and places where you walk.
- Remove small throw rugs or use double-sided tape to keep the rugs from slipping.
- Keep outside walks and steps clear of snow and ice in the winter.
- Clean up spills immediately.
- Keep items used often within easy reach (about waist high) in cabinets.
- Place night-lights in bathrooms, halls, and passageways so you can see where you are walking at night.
- Get up slowly after you sit or lie down.

- Be careful not to trip over oxygen tubing.
- Caregivers: stay with patients who are confused or restless.
- Caregivers: consider putting the patient's mattress on the floor if he or she is trying to climb out of bed.

Contact Montgomery Hospice if you fall so that we can check to see if you need help.

Note that if you need help getting up, you can call 911. Tell them it is not an emergency, but that you fell and need help getting up.

Preventing Infection

Caregivers should use the following guidelines to prevent infections, or to prevent infections from spreading if they do occur.

Basically, caregivers should limit their exposure to the patient's blood or body fluids. Avoid coming into contact with any body waste or other body fluids (such as blood, urine, stool). **Good hand washing before and after caring for the patient is the most important thing that you can do to stop the spread of infection.** Waterless alcohol based hand sanitizers can be used when hands are not visibly soiled with any body waste or fluid.

Placing a barrier between you and body fluids also helps prevent infection. Types of barriers include gloves, gowns, masks and eye goggles. You will probably be using gloves the most. Your nurse will instruct you in specific measures you need to use.

Hand Washing Techniques:

- Turn warm water on and wet your hands thoroughly.
- Apply soap and rub vigorously for 15 to 20 seconds. Sing "Happy Birthday" or the "ABC" song very slowly – that should be around 15 to 20 seconds.
- Rinse thoroughly.
- Dry hands with a paper towel and use the paper towel to turn off the water. This towel can also be used to open the bathroom door & then be discarded in the waste container.

Note: Montgomery Hospice staff and volunteers who visit your home will wash their hands or use the liquid hand sanitizer – both before and after providing care. All of you in the family and in the home should do the same. This helps protect the patient from infections, as well as protecting you. Please have liquid hand soap and paper towels available for your hospice team near your sink.

Disposal of Waste:
Biomedical waste means items that have been soiled with body wastes. Examples are: used gauze dressings, used wound dressings, disposable gloves, disposable diapers, and tubing from IV's (intravenous infusions). Biomedical waste also refers to "sharps" or needles or other sharp objects used for treating patients or preparing medications.

Soiled Dressings and Adult Diapers (Pull-up or Regular Style Diapers):

Whenever you are changing dressings or diapers, please follow these steps:

- Wear disposable gloves.
- Put the dirty items in a plastic bag, tie or seal, and place in the regular home trash.
- Take care when removing and handling wet/soiled dressings to not splash or spill.
- Always wash your hands with soap and water after removing your gloves.

Soiled Linens:

- Before changing the patient's bed or clothes, have a plastic bag or laundry basket nearby to put the soiled linens in. Use gloves if your hands may have a likelihood of touching the soiled areas.
- Place linens into the washing machine and wash with detergent and hot water. You may need to pre-soak stains with detergent.
- Wash your hands after handling soiled linens, or after you remove your gloves.

Sharps (Needles):

- Hospice will provide a needle box for needle disposal if necessary.
- Follow your nurse's instructions.
- Always be careful when disposing of needles.
- Do not place the needle protector cap back onto the needle after use.
- Never let the needle box fill up past three-quarters full. The nurse can replace this for you when it is full.
- Keep box in a location that is out of reach of children.

Cleaning Equipment:
You might need to clean equipment in the house such as a bedside commode. You can make a solution of 1 cup of bleach and 10 cups of water (or one-half cup of bleach to 5 cups of water). This solution will be good for 24 hours. After 24 hours, throw this solution out and make a new one.

Do not mix undiluted bleach with urine (which has ammonia in it) – dangerous gases could be produced!

Many household bathroom/kitchen cleaners and wipes kill up to 99 percent of household germs, also. If the patient has no known infections – these household cleaners can be used. You can talk to your hospice nurse about this.

Emergency Safety

Discuss with your nurse where you would go if you had to leave your home in an emergency. If you do leave your home, call Montgomery Hospice so that we can continue to provide care for you.

Fire Safety

In case of fire:

- Get everyone out of the house and make sure they stay out.
- Have a meeting place for your family that you all know about.
- If your clothes are on fire – stop, drop and roll.
- A bedbound patient can be evacuated to a safe area by placing him/her on a sturdy blanket and pulling/dragging them out of the home.
- Crawl on the floor through smoke.

Power Outage

Notify Montgomery Hospice if you do not have power.

If you do not have power and need help, and Montgomery Hospice phone lines are down:

- If you are in crisis or have an emergency situation, call 911 or go to the nearest hospital emergency room.
- If it is not an emergency, call your closest relative or neighbor.

Winter Storms

Heavy snow and extreme cold can immobilize an entire region. Even areas which normally experience mild winters can be hit with a major snow storm or extreme cold. The results can range from isolation due to blocked roads and downed power lines to the havoc of cars and trucks sliding on icy highways.

Gather emergency supplies:

- battery powered radio, flashlights, battery-powered lamps, extra batteries.
- food that doesn't require cooking and a manual can opener.
- your medications.
- extra blankets.
- extra water in clean soda bottles or milk containers.

Preparing for a Hurricane or Tornado

If you are under a hurricane watch or warning, here are some basic steps to take to prepare for the storm:

- Learn about your community's emergency plans, warning signals, evacuation routes and locations of emergency shelters.
- Identify potential home hazards and know how to secure or protect them before the hurricane strikes. Be prepared to turn off electrical power when there is standing water, fallen power lines, or before you evacuate. Turn off gas and water supplies before you evacuate. Secure structurally unstable building materials.
- Locate and secure your important papers, such as insurance policies, wills, licenses, stocks, etc.
- Post emergency phone numbers at every phone.
- In a house or small building: Go to the basement or interior room on the lowest level if not basement. Get under a sturdy table, hold on and protect your head.
- Move away from windows. Use heavy blankets or pillows to protect head and face.
- In high-rise buildings: Go to a small interior room or hallway on the lowest floor possible.
- In a vehicle, trailer or mobile home: Get out immediately and go to a more substantial structure.

If you are ordered to evacuate to a shelter bring:

- a two-week supply of medications/supplies
- non-perishable special dietary foods and a manual can opener
- air mattress, lightweight folding chair, sleeping bag, blankets, pillow
- extra clothing, personal hygiene items, glasses
- assistive devices such as wheelchair, walker, cane and portable oxygen
- If you are electrically dependent and have been assigned to a Special Needs Shelter, you must bring your electrical device (such as oxygen concentrator) with you. Special Needs Shelters have electrical power from a generator.

Medications

This section contains information about various hospice medications that may be part of your care.

Medication Information

Medications related to your hospice diagnosis will be paid for and provided to you through Montgomery Hospice. The Montgomery Hospice Admission nurse will discuss your medications with you when you first start as a Montgomery Hospice patient. **Please tell the nurse about any prescription and over the counter medications (including herbal and other supplemental remedies) that you are taking.**

Narcotics (Morphine) Myths and Facts

Many people have concerns or are afraid of taking medications. They may be especially fearful of narcotic medications (like morphine) that are used to control pain.

Myths

- Morphine is given only when death is imminent.
- People who take morphine will get addicted.
- People who take morphine will become so sedated that they can't function.
- People who take morphine die sooner because morphine causes them to stop breathing.

Facts

- Patients in hospice have their symptoms treated using the least powerful medication in the lowest dose that is effective.
- If a patient needs narcotic pain medications, the lowest effective dose will be used.
- Narcotic medications are safe when used as instructed.
- Hospice patients do not get addicted to pain medications because they are being used appropriately.
- The slight sedation that can occur with narcotics usually diminishes after a couple of days as the body adjusts to the new medication or the new dose.

Talk with your nurse if you have any concerns about taking medications.

How to Take Medications

Some medicines, especially those used to relieve pain, need to be taken on a regular schedule in order to be effective. It can be difficult to manage medications. Your nurse can help you organize a schedule to make this easier and safer.

Oral Medications (by mouth)

Plenty of Fluids

Taking a sip of fluid before taking the pill will help prevent "sticking." Any fluid is okay, except it is best to avoid grapefruit juice since some medications interact with this juice. Also be sure to drink enough to swallow the pills completely. If a pill does get stuck, sometimes eating a piece of bread will help dislodge it.

Crushing Tablets

Check with your nurse before crushing any medications. In some cases, your nurse may recommend crushing tablets that are too large to swallow easily. In these cases, the tablets may be crushed and mixed with a little juice, yogurt, ice cream, applesauce, sherbet, or pudding, which will help disguise the taste of the medicine. DO NOT CRUSH MS CONTIN OR OXYCONTIN. If you are not sure if a certain medication may be crushed, call your nurse.

Capsules

Sometimes people have difficulty swallowing capsules. Tilting your head forward helps the capsule float to the back of the mouth making it easier to swallow. Or with some medicines, the capsule can be opened and the powder inside mixed with a little ice cream or juice. Ask your nurse for help **before** doing this. Some capsules are time-released and should not be opened.

Difficulty Taking Pills

If you have difficulty because of the number of pills needing to be taken at once, these pills may sometimes be put into one gelatin capsule and swallowed. Or a different form of the medication may be available. Let your nurse know if you are having difficulty.

Other Ways to Give Medicines

Gastrostomy Tube

- Giving medications through a feeding tube is similar to giving food and water through the tube.
- Be sure to dilute the medication appropriately and to flush the tube with water before and after giving medicines to help prevent a blockage in the tube.
- Check with your nurse about which medications can be given by tube and if there are any other precautions.

Sublingual (Under the Tongue) Medications

Some medications are available either in concentrated liquid form or quick-dissolve tablets that can be used under the tongue.

- Carefully measure and place the liquid medicine or quick-dissolve tablet under your tongue or between your cheek and gums at the side of your mouth.
- The medication is absorbed through the blood vessels in the mouth and immediately enters the bloodstream.
- Relief from distressing symptoms can occur as fast as 5 to 15 minutes.
- Follow the nurse's instructions carefully when administering sublingual medications.
- It may be helpful to clean your mouth before taking sublingual medications or to moisten your mouth if it is dry.

Subcutaneous (Under the Skin) Medications

Some medications are only effective when given by injection or are most effective when given this way. Many injections may be comfortably given subcutaneously – that means right under the skin. There are very small plastic catheters that can be left in place under the skin for several days. This is a painless method of ensuring that there is a constant flow of medicine when it is needed the most.

- Your nurse will monitor and care for this site, and also teach you how to care for this site.
- Always notify the nurse if you see redness, leakage, or experience any discomfort at the site.

Nebulized or Inhaled Medications

Some medications are given by inhaling them through the mouth and into the lungs. A Nebulizer machine is a compressor that creates a mist of medication that can be inhaled. Your nurse and the equipment supply company will instruct you in the proper use of this equipment and the medication.

Rectal Suppositories

Sometimes it may be necessary to give medicines by the rectum. Respect is given to your wishes, as well as to your caregiver's comfort level.

Caregivers: to give a suppository, you will need:

- gloves
- suppository
- lubricating jelly
- wash clothes or wipes

Then, follow these steps:

- Wash your hands.
- Put on disposable gloves.
- Explain what you are going to do (even if the patient is unconscious).
- Position patient on his/her side, bending the knees up toward the chest.
- Lift the buttock as necessary to visualize the rectal area.
- Clean area if necessary.
- Place lubricant on suppository.
- If the patient has hemorrhoids, gently move them to the side or ask the nurse for help.
- Gently insert suppository no more than one inch.

Topical medications

Topical medications treat a condition on the skin. It is common for hospice patients to have skin irritations or infections.

- Follow the specific instructions given for each medication.
- Use only a small amount of ointment.
- Apply to clean, dry skin.

Transdermal medications

Transdermal medications may be in a patch or in a cream form that is applied to the skin. The medication is absorbed through the skin and eventually enters the bloodstream.

- Transdermal medications need to be placed on a fleshy body part to allow proper absorption.
- Avoid placing on bony prominences.
- Follow the instructions carefully.
- If at any time, there is a change that you are concerned about, let the nurse know right away.

Montgomery Hospice Emergency Medication Kit

Some Montgomery Hospice patients may receive an Emergency Medication Kit. This kit has been discussed with your physician. This kit contains starter doses of some of the most frequently used medications needed by hospice patients in an emergency. When you receive this kit, you are asked to keep it unopened in your refrigerator. A hospice nurse will instruct you on the use of these medications when the time comes that they are needed. As with all medications, this kit should be kept away from children.

Please call Montgomery Hospice prior to starting ANY medication in the Emergency Medication Kit.

Working with a Montgomery Hospice Contracted Pharmacy

Montgomery Hospice works with local pharmacies to provide hospice medications to you. The pharmacists are familiar with our patients and their needs for specific, often difficult-to-find medications. You and your family will be given the name, location and phone number of the contracted pharmacy that will be providing your hospice medications. Keep this information in your Montgomery Hospice Handbook for quick reference. Your nurse will order (or reorder) your hospice medications through this pharmacy. You and your family can either pick up the medications from the pharmacy, or, in some cases, the pharmacy may deliver medications (for a fee).

Medication Disposal in the Home

Medications play an important role in treating certain symptoms and diseases, but they must be taken with care. Unused portions of medications must be thrown out properly to avoid harm. Almost all medications can be thrown away in the household trash after mixing them with some bad tasting things (such as kitty litter or coffee grounds) and sealing them in a container.

However, certain medications may be especially harmful and, in some cases, deadly in a single dose if they are used by someone other than the person the medication was prescribed for. For this reason, these medications have special directions and should be flushed down the sink or toilet after the medication is no longer needed. If you throw these medications down the sink or toilet, they cannot be accidently swallowed by children, pets or anybody else.

To dispose of non-narcotic medications:

- Scratch or mark out the patient information on the label.
- Place pills/powder with some water into a plastic bag, along with some kitty litter or coffee grounds.
- Seal the bag and throw it into the household trash.

To dispose of narcotic medications:

- All narcotic medications should be flushed down the sink or toilet.

Medicines Recommended for Disposal by Flushing

Source: FDA – Food and Drug Administration website

The list on the following page from the FDA tells you what unused or expired medicines you should flush down the sink or toilet to help prevent danger to people and pets in the home. Flushing these medicines will get rid of them right away and help keep your family and pets safe.

FDA continually evaluates medicines for safety risks and will update the list as needed.

Medicine	Active Ingredient
Actiq, oral transmucosal lozenge *	Fentanyl Citrate
Avinza, capsules (extended release)	Morphine Sulfate
Daytrana, transdermal patch system	Methylphenidate
Demerol, tablets *	Meperidine Hydrochloride
Demerol, oral solution *	Meperidine Hydrochloride
Diastat/Diastat AcuDial, rectal gel	Diazepam
Dilaudid, tablets *	Hydromorphone Hydrochloride
Dilaudid, oral liquid *	Hydromorphone Hydrochloride
Dolophine Hydrochloride, tablets *	Methadone Hydrochloride
Duragesic, patch (extended release) *	Fentanyl
Embeda, capsules (extended release)	Morphine Sulfate; Naltrexone Hydrochloride
Exalgo, tablets (extended release)	Hydromorphone Hydrochloride
Fentora, tablets (buccal)	Fentanyl Citrate
Kadian, capsules (extended release)	Morphine Sulfate
Methadone Hydrochloride, oral solution *	Methadone Hydrochloride
Methadose, tablets *	Methadone Hydrochloride
Morphine Sulfate, tablets (immediate release) *	Morphine Sulfate
Morphine Sulfate, oral solution *	Morphine Sulfate
MS Contin, tablets (extended release) *	Morphine Sulfate
Onsolis, soluble film (buccal)	Fentanyl Citrate
Opana, tablets (immediate release)	Oxymorphone Hydrochloride
Opana ER, tablets (extended release)	Oxymorphone Hydrochloride
Oramorph SR, tablets (sustained release)	Morphine Sulfate
Oxycontin, tablets (extended release) *	Oxycodone Hydrochloride
Percocet, tablets *	Acetaminophen; Oxycodone Hydrochloride
Percodan, tablets *	Aspirin; Oxycodone Hydrochloride
Xyrem, oral solution	Sodium Oxybate

*These medicines have generic versions available or are only available in generic formulations. List revised: March 2010

For specific drug product labeling information, go to DailyMed (in the NIH website) or Drugs@FDA (in the FDA website).

Medication – Labeling, Disposing and Storing of Drugs and Biologicals

MEDICATION – LABELING, DISPOSING AND STORING OF DRUGS AND BIOLOGICALS	Policy Number: CES.M33
NHPCO Standard(s): CES 4.4	
Regulatory Citation / Other: 42 CFR 418.106(e)	

POLICY STATEMENT: The hospice labels, disposes and stores drugs and biologicals in accordance with accepted standards of practices and State and Federal laws and regulations.

PROCEDURES:

1. Drugs and biologicals are labeled in accordance with currently accepted professional practice that includes appropriate usage and cautionary instructions as well as an expiration date (if applicable).
2. At the time when controlled substances are first ordered, the Interdisciplinary Group (IDG):
   a. provides a copy of the hospice's written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;
   b. discusses the hospice's policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and
   c. documents in the patient's clinical record that the written policies and procedures for managing controlled drugs were provided and discussed.
3. Patient/caregiver education regarding the hospice's policies and procedures on controlled substances may be in the form of written educational information on the safe use and disposal of controlled substances.
4. All education/information provided to the patient/caregiver related to controlled substances is documented in the patient's clinical record.

5. The RN Case Manager or designee identifies and documents any misuse of controlled substances and notifies the patient's attending physician, the pharmacist and the VP of Casey House or the VP of Nursing for Hospice at Home for further intervention.

6. An Occurrence Report is completed for suspected or actual diversion of controlled substances and the IDG, in consultation with the hospice Medical Director, the patient's attending physician and the pharmacist determine the appropriate course of action, including reporting the diversion to appropriate authorities.

Disposal

1. Controlled drugs no longer needed by the patient are disposed of in compliance with State and Federal regulations and disposal instructions and activities are documented.

2. A hospice nurse, accompanied by a witness, is responsible for disposing of the patient's drugs in a manner consistent with State and Federal regulations.

3. At the time of destruction, the following information is documented in the patient's clinical record:

   a) name and dose of the medication;
   b) amount or quantity of the medication remaining and destroyed;
   c) date of disposal and name of witness;
   d) method of destruction/disposal used.

4. In the event the patient/caregiver refuses to allow medication to be destroyed, the refusal is documented in the patient's clinical record with the name and strength of the medication and the amount remaining. Included with the documentation is the patient/caregiver's signature attesting to the refusal, and the date the patient's attending physician was notified of the refusal.

Commonly Prescribed Medications

There is information in this handbook about some of the medications that are frequently used to help hospice patients be more comfortable. These teaching sheets are a reference for you in addition to instructions from your nurse, physician or pharmacist.

PLEASE CALL Montgomery Hospice prior to starting ANY medication or supplement.

Ativan (brand name)
Lorazepam (generic name)

NON-NARCOTIC

TYPE OF MEDICINE: Anti-anxiety, sedative

DESCRIPTION: Comes in quick dissolve tablets that may be cut in half and in a concentrated liquid form

USES:

- Relieves anxiety
- Relieves insomnia caused by anxiety
- Relieves shortness of breath caused by anxiety
- Used for certain types of seizures

DOSAGE AND ADMINISTRATION:

- Take only as directed; start with the lowest dose prescribed (tablets are scored)
- May be increased if needed per doctor's order only
- May be placed under the tongue for rapid absorption into the bloodstream

POSSIBLE SIDE EFFECTS: If one or more of these occur, call your nurse:

- Dizziness
- Weakness
- Unsteady walking
- Vision changes
- Disorientation
- Nausea
- Headache
- Low blood pressure

PRECAUTIONS:

- Avoid activities that require alertness (driving, operating machinery)
- Avoid alcohol
- Smoking may decrease medication effectiveness
- Store liquid form in the refrigerator
- **Stopping medications: Do not suddenly stop taking your medication**; the dose should be lowered gradually. Call your nurse for directions.

REMEMBER!

- Don't run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Atropine

NON-NARCOTIC

TYPE OF MEDICINE: Anti-cholinergic

DESCRIPTION:
Atropine tablets and liquid
Prescription Strength: 0.4 mg

USES: Decreases excessive secretions at the end of life

DOSAGE AND ADMINISTRATION:

Take as directed under the tongue for excessive secretions.

POSSIBLE SIDE EFFECTS: If these occur call your nurse.

- Headache, blurred vision, sensitivity to light, delirium in geriatric patients
- Dry mouth, nausea, vomiting, abdominal pain, constipation, urinary retention
- Rash, dry skin, flushing

PRECAUTIONS:
Review the risks and benefits for patients who have COPD, Renal Disease, Hypertension, Paralysis, have Gastric Ulcers, and for older patients

REMEMBER!

- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Dilaudid (brand name)

Hydromorphone (generic name)

NARCOTIC

TYPE OF MEDICINE: Narcotic pain medication

DESCRIPTION: Comes in tablet form: 1 mg, 2 mg, 3 mg, 4 mg
Also comes in liquid, injectable, and suppository forms

USES:

- Relieves moderate to severe pain
- Relieves cough

DOSAGE AND ADMINISTRATION:

- Take only as directed
- The dose may change, follow your physician's instructions

POSSIBLE SIDE EFFECTS: If these occur call your nurse.

- Sleepiness
- Blurred vision
- Shallow breathing
- Cough
- Constipation

PRECAUTIONS:

- Take before pain is intense
- Take with food if upset stomach occurs
- Be careful getting out of bed
- Avoid activities requiring alertness (driving, operating machinery)
- Avoid alcohol
- Stopping Medications: Do not suddenly stop taking your medicine. Follow your physician's directions to gradually lower your dose.

REMEMBER!

- Don't run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Dulcolax Suppository (brand name)

Biscodyl (generic name)

NON-NARCOTIC

TYPE OF MEDICINE: Laxative with bowel stimulant

DESCRIPTION: Suppository

USES: Relief of constipation

DOSAGE AND ADMINISTRATION:

- Take only as directed
- These directions may change

POSSIBLE SIDE EFFECTS: If these occur call your nurse.

- Muscle cramps
- Pain
- Weakness
- Dizziness

PRECAUTIONS:

- Do not use dulcolax suppository if you have or suspect you have a bowel obstruction.

REMEMBER!

- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Haldol (brand name)
Haloperidol (generic name)

NON-NARCOTIC

TYPE OF MEDICINE: Neuroleptic

DESCRIPTION: Can be provided in pills or liquid form

USES: Nausea
Agitation, delirium, paranoia

DOSAGE AND ADMINISTRATION:

- Take only as directed
- Dose may be adjusted as symptoms change
- May be taken with or without food
- Lower doses may be necessary for elderly patients
- Use liquid form if having trouble swallowing

POSSIBLE SIDE EFFECTS: If these occur call your nurse.

- Difficulty walking, shaking, confusions or tremors
- Unable to urinate
- Any increase in agitation or paranoia after taking the medication

PRECAUTIONS:

- Do not stop medication suddenly; may be slowly reduced over several days as delirium resolves
- Do not double your dose if you have missed a dose
- Speak to your nurse if you have a history of Parkinson's disease
- DO NOT EXCEED 20mg/24hrs

REMEMBER!

- Don't run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Methadone

NARCOTIC

TYPE OF MEDICINE: Opioid narcotic

DESCRIPTION: Tablets: 5mg, 10mg, 40mg dispersable (dissolvable) tablets
Oral liquid 10mg/ml, 5mg/5ml

USES: Narcotic pain reliever

DOSAGE AND ADMINISTRATION:

Take only as directed. This drug takes about 5 days to reach the maximum effectiveness.

POSSIBLE SIDE EFFECTS:

- Expect the nurse to visit or call every day when beginning this medicine or when adjusting the dose.
- Call your nurse if you (or the patient) seems too sleepy
- Since this is a long-acting medicine, you will be prescribed a short-acting medicine to take for breakthrough pain
- Nausea, vomiting, dizziness, sleepiness
- Respiratory depression
- Itching
- Constipation
- Change in heart rhythm – let your nurse know if you have any heart problems
- Tell your nurse about all medicines you take. This drug has interactions with many other drugs that may make them either more potent or less effective.
- Do not take this medicine if you are taking MAO (monoamine oxidase inhibitors)

PRECAUTIONS:

- Stopping Medications: Do not suddenly stop taking your medicine.
- Check with your nurse before taking any other medicines
- Avoid alcohol when taking this medication
- Avoid activities requiring alertness (driving) until you have adjusted to this medicine
- Avoid prolonged exposure to the sun

REMEMBER!

- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Morphine Sulfate Immediate Release

BRAND NAMES:

Morphine Sulfate Tablets
MSIR (Morphine Sulfate Immediate-Release)

NARCOTIC

TYPE OF MEDICINE: Opioid (narcotic)

DESCRIPTION: (Generics may look different)
MSIR comes in two strengths

15 mg tablet: white round
30 mg tablet: white oblong
15 mg capsule: white and blue
30 mg capsule: gray and purple

USES: Relieves moderate to severe pain
Sometimes used to control cough and/or shortness of breath

DOSAGE AND ADMINISTRATION:

- Take only as directed. You should feel pain relief in 30 to 60 minutes
- You may need to adjust your dose or schedule with instructions from your nurse
- There is no maximum dose or number of tablets your doctor can prescribe for you
- Usually taken every 3-4 hours
- May be taken alone or in addition to your other pain medications
- May be taken with other medications
- May be taken with or without food
- If you miss a dose of your medicine, take it as soon as possible. If it is almost time for the next dose, skip the missed dose. Do not take two doses at one time to make up for your missed dose.
- Inform your nurse before you begin taking any new medicine, either prescribed or over-the-counter.
- Capsule contents can be sprinkled over soft food, added to liquids, or given in gastric or NG tubes.

POSSIBLE SIDE EFFECTS:

- Constipation: this can be controlled with daily laxatives
- Nausea and vomiting: less common than constipation. Can be controlled with other medicines. If this occurs, call your nurse.
- Drowsiness: May occur when starting morphine or increasing dose. This usually goes away in 48 to 72 hours. Rest as needed.

- Confusion: This is less common than drowsiness. If this happens, call your nurse.
- Itching

PRECAUTIONS:

- Be careful driving or using machinery such as lawn mowers, power tools, or saws
- Be careful when drinking alcohol. Alcohol will increase drowsiness
- Call your nurse if pain increases or if you do not get pain relief
- Stopping Medications: **Do not suddenly stop taking this medicine.** Morphine and other opioids must be stopped gradually. Call your nurse for directions.

REMEMBER!

- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Morphine Liquid Concentrate

BRAND NAMES:

Ethex
MSIR Oral Solution Concentrate
Roxanol (Morphine Sulfate Immediate-Release, Concentrated Oral Solution)

NARCOTIC

TYPE OF MEDICINE: Opioid (narcotic) short acting

DESCRIPTION: A colorless liquid (20mg/ml)
IMPORTANT: CHECK CONCENTRATION

USES: Relieves moderate to severe pain
Controls shortness of breath

DOSAGE AND ADMINISTRATION:

- Take as directed; you should feel pain relief in 30 to 60 minutes.
- Doses are prescribed in ml (milliliters), cc (cubic centimeters), or mg (milligrams)
- May be mixed with juice or water
- One drop of blue food coloring may be added to the bottle if you have trouble seeing how to measure the liquid
- **Usually taken every 2-4 hours**
- You may need to adjust your dose or schedule with instructions from your nurse
- May be taken alone or in addition to your other pain medications
- May be taken with other medications
- May be taken with or without food
- If you miss a dose of your medicine, take it as soon as possible. If it is almost time for the next dose, skip the missed dose. Do not take two doses at one time to make up for your missed dose.
- Inform your nurse before you begin taking any new medicine, either prescribed or over-the-counter.

POSSIBLE SIDE EFFECTS:

- **Constipation:** this can be controlled with daily laxatives
- Nausea and vomiting: less common than constipation. Can be controlled with other medicines. If this occurs, call your nurse. Usually decreases after the first 48 to 72 hours.
- Drowsiness: may occur when starting morphine or increasing dose. This usually goes away in 48 to 72 hours. Rest as needed.
- Confusion: this is less common than drowsiness. If this happens, call your nurse.

- Itching: if this happens call your nurse. If this persists, changing the medication may be necessary.

PRECAUTIONS:

- Measure your dose with a dropper, medicine cup, or syringe. Do not use a teaspoon or tablespoon. Remember mg(milligrams) do not equal ml (milliliters)
- **(1cc = 1 ml) Check concentration on your label!!**
- Be careful when drinking alcohol. Alcohol will increase drowsiness
- Call your nurse if you do not get pain relief
- **Stopping medications: do not suddenly stop taking this medicine.** Morphine and other opioids must be stopped gradually. Call your nurse for directions.

REMEMBER!

- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Controlled-Release Morphine

BRAND NAMES: MS Contin

NARCOTIC

TYPE OF MEDICINE: Opioid (narcotic)

DESCRIPTION: MS Contin tablets come in five strengths:

15mg: blue
30mg: purple
60mg: orange
100mg: gray
200mg: green

USES: Relieves moderate to severe pain.

DOSAGE AND ADMINISTRATION:

- Take only as directed. It will take 2 hours to feel pain relief.
- You may need to adjust your dose or schedule with instructions from your nurse
- There is no maximum dose or number of tablets your doctor can prescribe for you
- The morphine in MS Contin is **slowly released**. Pain relief should last 12 hours.
- Usually taken every 12 hours
- Take at same time every day
- Short-acting pain medicines will be ordered to use in between doses if needed to control pain.
- May be taken alone or in addition to your other pain medications
- May be taken with other medications
- May be taken with or without food
- If you miss a dose of your medicine, take it as soon as possible. If it is almost time for the next dose, skip the missed dose. Do not take two doses at one time to make up for your missed dose. If you miss your dose by 4 or more hours, take your short-acting pain medicine for pain relief until the next dose of MS Contin is due.
- Inform your nurse before you begin taking any new medicine, either prescribed or over-the-counter.

POSSIBLE SIDE EFFECTS:

- Constipation: this can be controlled with daily laxatives.
- Nausea and vomiting: less common than constipation. Can be controlled with other medicines. If this occurs, call your nurse.

- Drowsiness: May occur when starting morphine or increasing dose. This usually goes away in 48 to 72 hours. Rest as needed.
- Confusion: This is less common than drowsiness. If this happens, call your nurse.

PRECAUTIONS:

- **Do not break, crush, or chew tablets**
- Be careful driving or using machinery such as lawn mowers, power tools, or saws
- Be careful when drinking alcohol. Alcohol will increase drowsiness
- Call your nurse if pain increases or if you do not get pain relief
- Stopping Medications: **Do not suddenly stop taking this medicine.** Morphine and other opioids must be stopped gradually. Call your nurse for directions.
- Itching

REMEMBER!

- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Senokot-S, Senna S (brand names)

Docusate and senna (generic names)

NON-NARCOTIC

TYPE OF MEDICINE: Laxative/stool softener with bowel stimulant

DESCRIPTION: Comes in tablets, suppositories and syrup

USES: Prevention and relief of constipation

DOSAGE AND ADMINISTRATION:

- Take as directed
- As narcotic dose changes, senna dose will usually also change
- May be taken with or without food.

POSSIBLE SIDE EFFECTS: If these occur call your nurse.

- Nausea and vomiting
- Diarrhea
- Abdominal cramping
- Discoloration of stool

PRECAUTIONS:

Do not use senna-s if you have or if you suspect you have a bowel obstruction

REMEMBER!

- **ALL NARCOTICS CAUSE CONSTIPATION!!! DO NOT SKIP YOUR BOWEL MEDICATION.**
- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Tylenol (brand name)
Acetaminophen (generic name)

BRAND NAME: Tylenol, Panadol

NON-NARCOTIC

TYPE OF MEDICINE: Pain reliever, fever reducer

DESCRIPTION: Comes in tablets, caplets, liquid, and suppository:
Caplets: 160 mg or 500 mg
Tablets: 160 mg, 325 mg, 500 mg, 650 mg
Liquid: 160mg/5 ml or 500mg/15ml
Suppositories: 80 mg, 120 mg, 300 mg, 325 mg, 650 mg

USES: Relieve mild pain and reduce fever

DOSAGE AND ADMINISTRATION:

- Take only as directed
- These directions may change
- May be taken with or without food
- Lower doses may be necessary for patients with liver disease or liver dysfunction
- Use liquid form if having trouble swallowing

POSSIBLE SIDE EFFECTS: If these occur call your nurse.

- Rash
- Itching

PRECAUTIONS:

- **Maximum daily adult dose is 4000 mg= 4 Grams**
- Many over the counter medications contain acetaminophen. Ask your nurse before taking any other medicines.

REMEMBER!

- Don’t run out of medicine – remember to talk with your nurse about refilling your prescription a few days before you run out.

WARNING: Keep this and all medications out of the reach of children.

Caregiver Support

This section is for family members and friends who are supporting the patient.

Volunteer Support

Montgomery Hospice volunteers support patients and their families. Montgomery Hospice volunteers are carefully screened and attend a three-day volunteer training.

Volunteers visit patients in their homes. Volunteers may sit quietly with a patient, read aloud, provide lavender oil hand massages, play the Reverie Harp or have a conversation. Some work with patients on genealogy research, crafts, letter writing or memory books. Volunteers also help families. Their visits allow caregivers to take a break or run necessary errands.

Volunteers are not allowed to do any personal care for patients. They cannot help with bathroom needs or prescription medications.

About a week after a patient enters hospice, a volunteer coordinator will call to discuss whether having a volunteer might be helpful. The coordinator will then make arrangements for a volunteer to visit. This process usually takes several days.

Volunteers typically visit once a week, for around 2 hours.

Care for the Caregiver

It can be very difficult to focus on one's own needs when faced with caring for a loved one who is very ill. Routines and schedules are different or non-existent. You can expect to get little sleep, have no sense of regularity, and experience uncertainty about what might happen next and how to handle it. The feeling has often been described as being on a roller coaster.

Taking care of yourself may feel selfish but it is essential to being a good caregiver. You need to replenish your internal resources to be able to give what your loved one needs.

Some caregivers are reluctant to accept help from anyone else, even family members. It can be difficult to even think of what someone else could do. You may be uncomfortable asking for help. But there may be many people

who really want to help, and giving them tasks to do can help you and help them at the same time.

The Montgomery Hospice team is available to assist you in figuring out how to handle all of these difficulties. They can provide their expertise to help you identify what help would be needed and where you can locate it.

Here are some other ideas:

Physical

- Get sleep when you can. Have someone sit with your loved one if you need to – or request a volunteer.
- Eat regular, balanced meals. If you need help with getting out to the grocery store, let Montgomery Hospice know. Our volunteers can assist with this or your social worker can identify resources to help with meal delivery.
- A bath or shower can feel very therapeutic and comforting and may help you feel more normal.
- Keep your regular medical/dental appointments if at all possible.
- Continue taking your prescribed medications. Be careful not to run out of medications.
- Do some physical activity. You may feel exhausted from the physical toll of being a caregiver but it is a different kind of effort. Just going for a short walk outside can give you more energy and also help you sleep better.
- Accept help from others so you can get some relief and have time for yourself.

Emotional

Caregivers may have intense feelings during this time. Sadness, panic, anger about what is happening and a sense of helplessness are not unusual. As caregiving responsibilities increase, family members and friends may feel resentful or guilty that there is little time for other activities or for rest.

It can help to share these feelings. Your hospice team can help you sort through these feelings. Family members can encourage each other to talk together, to remember and review the good times and the difficult times that made up life together. Acknowledging and expressing feelings of sadness are steps in the grief process and may make you feel less lonely. It may not always be possible for the one who is ill to share in these talks, but try to include them as much as possible. If you have questions, or need help with these talks, please ask your social worker or chaplain.

Social

Caregiving can be very isolating and stressful. It is very important to keep in touch with others who are supportive of you. Make it a goal to call some friends each week. Talk to your hospice team or with someone who can help you feel normal, supported and connected to the world.

Spiritual

There are many ways in which people deal with serious illness. You may find that your spiritual beliefs and practices are of immense support right now. Taking time to honor these practices and inviting others to be with you can help you find meaning and peace in your present situation. Your chaplain can offer support through visits and phone calls and can contact other clergy in the community to make visits.

For some people, serious illness can make them question their lifelong beliefs. This can be very distressing and make caregiving even more difficult. If you are finding yourself with questions and are struggling to find comfort and peace, please talk to your chaplain or social worker.

Managing Visitors

Many of your friends, neighbors, and relatives will be concerned about you and your family. Their well-meaning attention may be difficult to handle. It is okay to limit visitors and phone calls. In fact, at times it is essential.

Home

It may at times be helpful to place a sign on your door that says “No visitors today, please.” Leave it there every day if necessary.

Phone calls and email

Many people put a message on the answering machine saying, “We may not be able to speak with you right now but we do appreciate your messages. When and if we are able, we will call you back.” You may want to ask your friends to email instead of calling. You can send a group response as you are able.

Have a spokesperson

Have a close friend or relative be the spokesperson from your family, especially if you are part of a large social group. This person could also help coordinate receiving meals that others will want to make for you. Be honest about your needs and let them be known. If you don’t need meals, but really need help with errands, let people know.

How to Know When Death is Near

Is Death Near?

Please discuss this with your hospice team.

Many families have questions and concerns about what the patient's death will be like. Hospice staff members know that many people fear the unknown and often find it helpful to have some information about what to expect.

The expected way of death for any individual depends upon many things, including the specific diagnosis, the way a disease progresses, and which body systems seem to be failing most quickly. Members of your hospice team will tell you as much as possible about what the death will be like, but sometimes they do not know until fairly close to the end. If any difficult symptoms do occur, your hospice team will work with you to relieve them.

Here is some general information about what changes you might see and, if necessary, what you can do to help:

Appetite

The appetite will decrease (if it has not already). A lack of interest in food and fluids will progress to an inability to swallow. This is a normal part of the body's "slowing down" process, and the resulting dehydration will cause sleepiness. Most patients appear comfortable. Your nurse can teach you ways of giving critical medicines when the patient cannot swallow.

Decreased Urine Output

There will be a decrease in the amount of urine and it may become darker in color. Because of increased weakness there may be some incontinence of urine and stool. Your nurse will show you how to manage and how to provide skin care.

Increase in Body Temperature

There may be an increase in body temperature, while at the same time the hands and feet become cooler, maybe even "blue" or mottled. Generally neither the raised temperature nor the coolness and mottling are distressing to the patient.

Congestion/Noisy Respiration

Mucus may collect in the mouth, throat or lungs causing a gurgling sound. This is usually not distressing to the patient but is difficult for caregivers to hear. Turning the patient to lie on his/her side usually relieves this. Sometimes using a humidifier helps. Your nurse may recommend a medication to help dry the secretions.

Communication

Communication with others usually decreases, as the patient becomes weaker and sleepier. However, even when the patient becomes too weak to speak, or becomes unconscious, she or he will still be able to hear. Hearing is the last sense to be lost.

Confusion

Many patients say things which do not immediately seem to make sense. However this “confusion” often has meaning and may contain significant messages and/or requests. Please discuss this with your hospice team.

Caregiver: What You Can Do

- Stay with the patient as much as possible. Just sitting quietly may not seem to be much, but it is often very comforting to the patient.
- Offer ice chips or sips of water if the patient is alert. Do not attempt to give fluids to an unconscious person, but keep the mouth moist and comfortable with frequent mouth care.
- If the patient is alert, keep his or her head and shoulders elevated. If the patient is unconscious, position him/her turned on one side with his/her knees bent. Your nurse will show you how to use pillows for support.
- Place incontinence pads under the patient’s buttocks in case of “accidents.” Cleanse the skin thoroughly after the passage of urine or stool, and, if the skin is dry, massage gently with lotion.
- Depending upon the patient’s wishes you may want to call other members of the family or a member of the clergy.
- Call Montgomery Hospice when you see any of the signs of approaching death mentioned above, including a change in breathing pattern, difficulty swallowing, or unconsciousness, and especially if you see any signs of distress.

This information is very general. Questions about how the person will die should be addressed to your nurse. Please discuss any concerns you have with members of your hospice team.

AT TIME OF DEATH AT HOME—DO NOT CALL 911

CALL MONTGOMERY HOSPICE: 301-921-4400

Call Montgomery Hospice at 301-921-4400 – 24 hours a day.

A nurse will come to your home to confirm that the patient has died, and will then notify the physician and assist you with contacting the funeral home. The nurse will also destroy all of the patient’s narcotic medicines. Please tell the nurse about any specific questions, concerns, or any special considerations that you may have or need.

Coping with Grief

For most hospice families, grief begins as soon as the doctor says the patient has a limited time to live. A terminally ill person and members of the family begin to experience grief before death actually occurs.

The patient and family may grieve past, present and future losses. There may be regret about past events that can no longer be changed. There may be fear of losing control as the person faces physical changes, less energy and a reduced ability to do things. At times, these changes can seem overwhelming.

Family members and close friends also grieve, but each person grieves in their own way. This can cause misunderstandings and conflicts in the closest of families. Your social worker and chaplain can help you work through these situations.

After the death, grieving begins in a new way. When the funeral and memorial services are over and friends have returned to their routines, the permanency of loss becomes more real. The pain and sadness of grief intensifies even more for some family members. For other family members who have worked on their grieving during the illness and long-term caregiving, their grief may not intensify. Often these persons need to begin building a new life for themselves that includes lots of self-care which has been neglected. Focusing on self-care is very important as you learn to live with your loss.

Each important loss in our lives brings major changes and upheavals. The goal of grief is to use this change, as painful as it may be, to learn, grow, develop, and to emerge with a new sense of self and perhaps a deeper respect for how temporary and important relationships are. When we do the work of grieving, we find healing and growth through the pain.

The grief process may take a long time and will have ups and downs along the way. Montgomery Hospice offers Bereavement Care to help you with these feelings.

Grief and Bereavement Counseling

Although we all know that grief is the natural response to loss, sometimes our personal grief can be overwhelming. Adjusting to life after a death can be made easier with support. Montgomery Hospice provides professional support to family members who live in our local area for 13 months after the death. Our bereavement counselors and volunteers have special education and expertise in working with issues of loss and grief, and in supporting people who have experienced the death of someone they love.

Family members will be invited to take part in individual grief support as well as grief workshops and support groups. If you feel the need for individual grief therapy on a weekly basis, our bereavement counselors will offer referrals to therapists in the community. Our workshops and grief support groups are also open to anyone who lives or works in Montgomery County.

Family members who live out-of-town may receive our mailings and a list of bereavement resources in their community.

Please ask a member of your Montgomery Hospice team if you have any questions about the Bereavement Program.

Funeral Planning

Hospice encourages families to talk over funeral arrangements with each other and with the patient ahead of time. Some patients want to be involved in this planning and take comfort in doing so; they may have a special way they want to be remembered. Others would prefer the family make the decisions. Although it may seem difficult to do now, it is usually better to plan before the death because your emotions at the time of death may interfere with your ability to think clearly. Many families express a sense of relief at having such arrangements settled. Your social worker and chaplain would be very happy to help you think through these arrangements. Here are a few basic ideas that may help you:

- Choosing a funeral home: Your social worker can provide you with a list of funeral homes and cremation services. Some people choose a funeral home based on proximity to their homes, on past experience, or on the basis of religious preferences. Type of arrangements and cost are also important considerations. The funeral home or cremation service can provide you with prices for their services. Cremation is generally less costly.
- Planning the funeral or memorial service: Think of songs, poems, readings, or hymns that will celebrate the life of the person you love.

- Financial Assistance: For patients who meet the income criteria for Medicaid, the Montgomery County Department of Health and Human Services will assist in payment for funeral costs. After the person dies, application must be made in person at the County office. For information, please talk to your social worker.
- Body Donation: There are several medical schools and other organizations in our area that accept these donations. One can also donate their corneas to the Eye Bank. These arrangements must be made in advance of the person's death.
- Out of state burials or funerals: These arrangements are usually made by contacting the out of state funeral home which will, in turn, direct you to the local funeral home that will be used at the time of death.

What to do the First Few Months After the Funeral

You may be emotionally and physically exhausted after the funeral. Even during this period of grief, though, important financial and legal arrangements must be made. Use the following list to assist with organizing practical considerations that you will need to attend to. The collecting of papers can be done in advance as well to save you some stress at this difficult time. You may also want to get the professional assistance of a lawyer or financial advisor. Your social worker can also provide you with more detailed information.

Collecting Papers: The first step is to collect necessary papers you will need to file for various benefits and finalize the estate.

- Obtain a copy of the deceased's will or trust. Select a lawyer if legal advice is needed. You may need to notify the executor of the will or administrator of the trust. If you have questions, the Register of Wills office can be very helpful.
- Death Certificates: Be sure to get enough copies of the death certificate. They are supplied by the funeral home for a fee per copy. Depending on the complexity of the deceased's estate, you may need at least a dozen copies. Many companies require a certified copy.
- Locate important papers: deeds, bankbooks or account statements, stock certificates or investment account statements, and insurance policies. You may need to find out passwords to various accounts as well.

- Locate important certificates: Marriage certificates, birth certificates, military discharge papers, Social Security cards, tax forms, and birth certificates for any minor children should be found. These records are needed to establish claims for Social Security, life insurance, or veteran's benefits.

Notifications:

- Social Security: The funeral director will prepare Social Security Form SSA 721. Call Social Security at 800-772-1213 to find out about benefits and to stop monthly checks. Any checks or deposits received after the death must be returned to Social Security.
- Advise all creditors in writing, including issuers of credit cards, that the person has died. If there are any loans, find out if they are insured. The estate should pay any payments due on credit cards.
- Life Insurance: Each company will need a statement of claim and a death certificate before the beneficiary can receive benefits. Keep copies of all correspondence.
- Check with the deceased's present and past employers for possible benefits that have been overlooked. This would include contacting the Civil Service Commission if the deceased was employed by the Civil Service for more that 18 months.
- Contact the regional Veteran's Administration office if the deceased was a veteran. They will require the full name of the deceased, branch of service and service serial number to search for benefits. If you are unable to find the veteran's discharge certificate, you can contact the National Personnel Records Center, 9700 Page Ave., St. Louis, MO 63132-5100 or if you are the next of kin, go to vetresc.archives.gov.
- Contact the Internal Revenue Service office to determine tax filing requirements. You will need to file both federal and state taxes on the deceased's income during the year of death. These taxes are due on the normal filing date of the next year, unless you file for an extension.

Books about Grief

General Reading on Loss/Grief

- Byock, Ira. Dying Well: The Prospect for Growth at the End of Life. NY: Riverhead Books, 1997.
- Kushner, Harold. When Bad Things Happen to Good People. NY: Avon Books, 1983.
- Nuland, Sherwin. How We Die. NY: Knopf, 1994.
- Rando, Therese. How to Go on Living When Someone You Love Dies. NY: Bantam Books, 1991.
- Rosof, Barbara. The Worst Loss: How Families Heal from the Death of a Child.

Books For Parents

- Fitzgerald, Helen. The Grieving Child: A Parent's Guide. NY: Simon & Schuster, 1992
- Goldman, Linda. Great Answers to Difficult Questions about Death: What Children Need to Know. Philadelphia: Jessica Kingsley Publishers, 2009.
- Grollman, Earl. Talking About Death: A Dialogue between Parent and Child. Boston: Beacon Press, 1990.

Books for Young Children

- Aliki. The Two of Them. NY: Mulberry Books, 1979.
- Brown, Laurene Krasny, and Marc Brown. When Dinosaurs Die. New York: Little Brown & Company, 1995.
- Buscaglia, Leo. The Fall of Freddie the Leaf. NJ: Slack, 1982.
- Greenlee, Sharon. When Someone Dies. Atlanta: Peachtree Publishers, 1992.
- Holmes, Margaret M. A Terrible Thing Happened. Washington, DC: Magination, 2000.
- Mellonie, Bryan & Robert Ingpen. Lifetimes. NY: Bantam, 1983.
- Miles, Miska. Annie and the Old One. Boston: Little, 1972.
- Varley, Sunsa. Badger's Parting Gifts. New York: Mulberry Books, 1984.
- Viorst, Judith. The Tenth Good Thing about Barney. New York: Aladdin, 1971.

For School Age Children and Older

- Krementz, Jill. How It Feels When a Parent Dies. NY: Knopf, 1988.
- Schwiebert, Pat and DeKlyen, Chuck. Tear Soup. Portland: Millcross Litho, 2001.
- Grollman, Earl A. Straight Talk about Death for Teenagers. Boston: Beacon Press, 1993.

Reference

Patient Rights and Responsibilities

As a patient of Montgomery Hospice you have the right to:

- be cared for by a team of professionals who will provide high quality, comprehensive hospice services as needed and appropriate for you and your family (including extended and alternative family);
- appropriate and compassionate care, regardless of diagnosis, race, color, religion, gender, sexual orientation, national origin, handicapping condition, marital status, type of residence, or the ability to pay for services rendered;
- exercise your rights as a patient of Montgomery Hospice and be free from discrimination or reprisal for exercising your rights;
- receive information about the scope of services that Montgomery Hospice will provide and specific limitations on those services;
- privacy;
- receive effective pain management and symptom control;
- be involved in developing your plan of care by being fully informed regarding your health status. (The hospice team will assist you and your family identifying which services and treatment will help you reach your goals.)
- be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as you wish. (The hospice team will provide you with information and work with you on ways to make your wishes known to those caring for you.)
- be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, and misappropriation of patient property;
- choose your attending physician;
- have your cultural and personal values, beliefs and preferences respected;
- have your property and person treated with respect;
- be informed of short-term inpatient care options available for pain control, management and respite;
- confidentiality with regard to information concerning your health status as well as social and/or financial circumstances, and confidentiality in all aspects of service or treatment. (Patient information and/or records will be confidential and released only on your, or your agent's written consent, or as permitted or required by law.)

- formulate advance directives as provided under state law;
- be informed of our discharge policy;
- receive information about the services covered under the hospice benefit;
- be informed orally and in writing, before care is initiated, of any fees or charges for which you may be responsible. (You have the right to access any insurance or entitlement program for which you may be eligible.)
- have unlimited access to visitors and others you choose, and to keep and use personal clothing and possessions if you are at Casey House;
- voice complaints or grievances regarding treatment or care and/or the lack of respect for property by Montgomery Hospice staff without threat or fear of retaliation.

Patient and Family Complaint Procedure

If at any time you have a concern or problem regarding your care, hospice staff members or safety, please call us at 301-921-4400. Please ask to speak with someone from the Senior Leadership. Or you may write to us at:

Montgomery Hospice
1355 Piccard Drive, Suite 100
Rockville, MD 20850

All complaints received by Montgomery Hospice are recorded and investigated. If we receive a complaint, you will be notified about the outcome within 10 days. We will work with you to answer your concerns.

If you prefer not to report a problem to us, you may call the Maryland State Toll Free Hotline at 1-800-492-6005, or write them at:

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center - Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228-4663

Or you may also contact the Joint Commission (an independent non-profit organization that accredits and certifies health care organizations). Montgomery Hospice is proud to be accredited by The Joint Commission. The Joint Commission can be reached by calling 800-994-6610 if Senior Leadership of Montgomery Hospice cannot resolve your concern. More information can be found at www.jointcommission.org.

You may receive a telephone call from one of our volunteers asking you to participate in a short satisfaction questionnaire. Please take the time to respond to it. We plan our services to meet the needs of patients and families like you, and we want your opinion.

Resolution of Ethical Concerns

- Occasionally decisions surrounding end of life care for patients can lead to ethical concerns. These concerns can create conflicts. Sometimes the conflict is between family members. Sometimes there is disagreement among hospice staff. And sometimes there are conflicts or disagreements between the hospice staff and the patient or patient's caregivers.
- But regardless of the specifics of the conflict, each party wants what is best for the patient. The disagreement on what course of action should be taken comes from these good intentions. These kinds of conflicts are often the result of differing values and perceptions of what is "in the best interest of the patient".
- Montgomery Hospice has an Ethics Committee comprised of experienced hospice staff, board members and community representatives with varying backgrounds. Each member is a specialist in their field, including law, psychiatry, religious studies, sociology, nursing and palliative medicine. In this committee, ethical conflicts are discussed with the hope of coming to decisions that all parties can agree upon. Specific concerns are addressed in the context of generally accepted principles of ethics. Families, patients and/or staff members may request an ethics consult whenever the need arises.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication

- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you, including contacting community resources
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Director of QAPI at 301-921-4400 or by sending a letter to 1355 Piccard Dr, Suite 100, Rockville, MD 20850.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospice directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again. If you do not wish to be contacted again for fundraising, call the Philanthropy Department at 301-921-4400.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: The hospice may disclose your health information to a physician involved in your care who needs information about your symptoms to prescribe appropriate medications. The hospice may also disclose health information about you to suppliers of medical equipment. Physician orders are faxed to your physician for review and signature.

Run our organization

We can use and share your health information to run our hospice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services. We also may combine your health information with other hospice patients in evaluating how to more effectively serve all patients.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services. Medicare and many health insurance plans require us to electronically submit invoices and health information.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. No identifiable information will be included without authorization.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

If You Have Questions Regarding this Notice

We have designated the Director of QAPI as the Privacy Official and is the contact person for issues regarding patient privacy and your rights under the Federal privacy standards. You may contact the Privacy Official at:

Director of QAPI
1355 Piccard Drive, Suite 100
Rockville, MD, 20874
301-921-4400

Effective Date of this Notice: February 2014

Informed Consent – Admission and Discharge

- I understand that admission to Montgomery Hospice is voluntary and that the goal of Montgomery Hospice is to improve the quality of my life, not to cure my terminal illness.
- The hospice staff and volunteers will work to reduce any symptoms such as pain or nausea. Hospice staff also will provide emotional and spiritual support to me, my family and/or primary care person.
- Montgomery Hospice will render all medically appropriate care for comfort and support. Hospice personnel usually do not use cardiopulmonary resuscitation (CPR) or advanced life-support systems. If I prefer to seek aggressive resuscitative measures, MH staff will work with me to plan how best to meet my needs.
- Montgomery Hospice professionals and volunteers will make visits to my place of residence or provide my care at Casey House.
- An interdisciplinary team of hospice caregivers will provide care to me. This team consists of nurses, social workers, home health aides, chaplains and volunteers, and may include services such as dietary, occupational, speech or physical therapy, if needed.
- For hospice patients/families at home, care will be provided on a scheduled basis, but assistance is available 24 hours a day.
- I am encouraged to have a “primary care person” who will be the one mainly responsible for looking after me in my home. We understand Montgomery Hospice staff will give training and support to us.
- When my care indicates a need for 24-hour help because of safety concerns, it is my responsibility to make the necessary arrangements (Montgomery Hospice may assist me).
- As long as I am a patient of Montgomery Hospice, the hospice team will coordinate my care whether I am being cared for at home, at Casey House, in a hospital, a nursing home or assisted living facility.
- The Montgomery Hospice medical record will contain information about me, my family, and/or primary care person. This information will be kept confidential.

- If I am to receive full benefits of hospice care, it is important that I make my needs and concerns known to the staff. I will actively participate in planning for my care. The hospice care plan is available to me.
- The Montgomery Hospice bereavement program is available for my family for a period of at least one year.
- I need to give Montgomery Hospice copies of my advance directives, if completed, so the staff may act accordingly.
- I understand that inpatient level of care is a short-term solution to a crisis.
- I understand that to qualify for acute inpatient care I must have one of the following situations:

    1. My pain and/or symptoms need to be managed in a way that cannot be accomplished at home.
    2. I require complex wound care that cannot be accomplished at home.
    3. My caregiver(s) and/or I need to learn the complex care/ medication delivery that I require.

- I understand that when the medically necessary condition(s) above have been resolved, I will return to my home. If I cannot go home, I must arrange another care giving situation. I understand that the hospice social worker can assist with that.
- I may choose at any time not to remain in Montgomery Hospice. (For example, you and your doctor may decide to pursue aggressive therapy or aggressive resuscitative efforts.)
- Patients may be discharged from Montgomery Hospice for any of the following:

    1. Non-agreement or non-adherence to the recommended care plan, making safe home care impossible or rendering Montgomery Hospice care and philosophy ineffective.
    2. Admission to a hospital without hospice's approval.
    3. Failure to provide a safe environment in which to render care. This includes physical aggression, harassment or threats directed at any Montgomery Hospice associate by any person in the home.

4. Recovery or improvement of the hospice related condition, making Montgomery Hospice care no longer appropriate. The patient's physician would determine this in collaboration with the Montgomery Hospice medical director. In any situation warranting discharge, a Medicare or Medicaid patient would lose the remaining benefit days of that benefit period. Sufficient notice and planning for discharge will be provided should this situation occur.
5. Moving out of Montgomery County, Maryland.

Re-admission to hospice can occur at any time medical necessity is present. Just call 301-921-4400 and Montgomery Hospice staff will assist you.

Levels of Care

Medicare and many private insurance companies use the term "Level of Care" to refer to the intensity or setting a patient needs at any given time. Each level of care must be justified by the hospice in order for the insurance company to authorize reimbursement for that care. Sometimes patients move from one level of care to another during their stay in hospice.

Routine Home Care

Most patients can be cared for in their own home by their own caregiver. Members of the hospice team will make regular visits and assist your family and caregivers to care for you. A nurse and a doctor are on call 24 hours per day, seven days a week.

General Inpatient (Acute)

At times care cannot be safely and therapeutically provided at home. The following are conditions for which the acute level of care may be medically necessary:

- Pain and/or other symptoms need to be managed in a way that cannot be accomplished at home.
- Complex wound care cannot be accomplished at home.
- Learning is needed on the complex care/medication delivery that the patient requires.

The Medicare Hospice Benefit and many private insurance companies pay in full for the days the patient is eligible for acute care. When acute care is no longer medically necessary the patient returns to his or her own home. If the patient cannot return home, the patient must move to another caregiving situation.

Respite

Routine home care patients who are covered by either Medicare or Medical Assistance can stay in a nursing home with which the hospice has a contract for up to five days for respite when caregivers at home need time off from care giving. The payment per day from Medicare or Medicaid goes directly to the nursing home.

Continuous Care

This level of care is provided to patients who may need care up to 24 hours a day to maintain the patient at home during a pain or symptom crisis. The care provided is predominately nursing care to manage pain or other symptoms and is for a brief period of time until the crisis is resolved. When the symptoms are managed the patient resumes the previous level of routine home care.

Cost, Benefits Coverage and Pre-authorization

As a licensed and certified provider of hospice care, Montgomery Hospice is able to bill Medicare, Medicaid and insurance carriers such as Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs) and traditional fee-for-service companies.

If there is no coverage for hospice services, the patient will be billed on a fee-for-service basis, which means there is a charge for each visit and for supplies and medications.

Before any care is provided, a Montgomery Hospice representative will review charges for services and payment arrangements. You will be asked to sign the admission checklist and consent form stating that you have received this explanation. Signing this form also allows Montgomery Hospice to bill the insurance company and obtain medical and billing records concerning your condition.

If you have problems paying our charges, please ask your hospice social worker to evaluate the situation. No person will be denied essential service because of inability to pay.

Medicare Hospice Benefit

The Medicare Hospice Benefit is a government program that covers hospice care out of Medicare part A. All services, medications, supplies and

treatments provided to you must be pre-authorized through the hospice program in which you are enrolled. The hospice is required to follow the Medicare regulations regarding hospice eligibility and levels of care. Medicare pays the hospice a daily per diem rate depending on the level of care required and the documentation provided by the hospice. Medicare makes regular surveys of hospices to ensure compliance with their rules.

Go to http://www.medicare.gov/Pubs/pdf/02154.pdf for more information.

You will receive a statement from Medicare telling you what was paid to the hospice. This is not a bill.

Hospice services, treatments and supplies authorized by Montgomery Hospice will be provided to you with no out of pocket expense. Examples of supplies includes: disposable diapers, chux, disposable gloves and skin lotion.

The Medicare Hospice Benefit also has established benefit periods. There are two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods. For each benefit period the hospice organization must re-certify that the recipient (patient) is eligible for the benefit and that hospice care is appropriate at that time. If at any time, the patient is no longer eligible or no longer needs hospice care, the patient will forfeit the remainder of that benefit period and be discharged from the hospice program. If a patient wants to seek aggressive or curative treatment, then the patient must sign a form to revoke the Medicare Hospice benefit in order for those treatments to be covered under his/her regular Medicare coverage. This form is in your handbook should you need it. At any time, the patient may be re-admitted to the hospice program if there is medical necessity.

Please remember that there is a Montgomery Hospice staff person available to each patient 24 hours per day. For our patients living in a facility, we provide consultations regarding your care needs at any hour of the day or night. Most facilities look to us for expert advice, and count on us to support them as well as the patient and family.

Medicaid

Medicaid is a state program that has a hospice benefit program that works just like the Medicare program. Pre-authorization for treatments may be required and a patient must continue to be eligible and appropriate for hospice care and for the level of care being given.

Private Insurance

Most insurance companies provide coverage for all or part of hospice care at home and at Casey House. Some benefit plans have out of pocket expenses – deductibles or co-pays. Montgomery Hospice has Patient Account Representatives who will work with your insurance case manager to determine any out of pocket expenses.

Advance Directives

Making decisions about medical treatments that you would want or not want is called advance care planning. You can document your wishes using advance directives. There are different kinds of advance directives:

- Durable Power of Attorney for Health Care
- Living Will

The Durable Power of Attorney for Health Care allows you to appoint a person to speak for you if you are unable to speak for yourself, in order to make decisions about your health. This person is called your Health Care Agent. This should be someone you trust, someone who understands you, someone who will be able to make decisions when the time comes. Please discuss your choice of Health Care Agent with your hospice team.

The Living Will is a statement of instructions describing your wishes about medical treatments if there comes a time when you are unable to make these decisions yourself. Please give a copy of your Living Will to your hospice team, or work with a member of the team to complete one.

MOLST

The Maryland Medical Orders for Life-Sustaining Treatment (Maryland MOLST) form is a standardized form that is signed by a doctor and is part of your medical record. This form documents specific medical treatments you want or don't want. The form is a list of "medical orders," that is, instructions from a doctor that will be followed by other healthcare professionals.

When you are admitted to Montgomery Hospice, we will talk to you about the MOLST. If you don't have a completed MOLST form (or if you want to make changes in the one that you have), we will help you complete a Health Care Decision Making Worksheet. This worksheet will then be submitted to your doctor or to our Medical Director to create your MOLST order form.

The orders on the MOLST form will be based on several factors, including your goals and wishes, your current medical condition and prognosis, the availability of potential treatments, and doctor determinations of the effectiveness of various treatment options.

The MOLST contains orders about:

1. Cardiopulmonary resuscitation (CPR)
2. Artificial ventilation
3. Blood transfusions
4. When you would want to be sent to a hospital
5. Antibiotics
6. Artificial feeding and hydration
7. Dialysis

(Some of these may not pertain to you.)

Your completed MOLST form should be kept in a visible place or on your refrigerator so it can easily be found when needed.

Gift Giving

Montgomery Hospice employees are not allowed to accept gifts of any kind from anyone to whom care is provided.

Acknowledgements

Some of the material in this handbook was adapted from:

- McCaffery M, Pasero C: Pain: Clinical Manual, 1999, Mosby.
- McCann, J, et. al, Nursing 2003 Drug Handbook, 2003, Lippincott William & Wilkins).
- HPNA guidelines 2008.

Montgomery HOSPICE

a community supported nonprofit

Hospice at Home
1355 Piccard Drive, Suite 100
Rockville, MD 20850
Phone 301-921-4400 • Fax 301-921-4433

Casey House
6001 Muncaster Mill Road
Rockville, MD 20855
Phone 240-631-6800 • Fax 240-631-6809

When Death is Near

A CAREGIVER'S GUIDE

Montgomery HOSPICE

May the longtime sun shine upon you,
All love surround you,
And the pure light within you
Guide you on your way.

Introduction

Dying is a natural part of life, but many people do not have experience caring for someone during the dying process and find themselves navigating through new and unfamiliar territory. It is not uncommon to experience a wide range of emotions and a sense of uncertainty. At times you may feel that you are on a roller coaster, not knowing what to expect next. This booklet is designed to help you feel more confident in knowing what to expect and what you can do to care for someone in the final weeks and hours of life.

Family members, friends, and caregivers can play an important role in providing comfort and support to someone entering this final phase of life. Sometimes it is not so much what you say or do, but just being present with another, that can provide a sense of reassurance and comfort.

Each person's dying experience is unique, and no one can fully predict what it will be like or when it will occur. However, we hope the information contained in this booklet will provide some landmarks to help guide the way. Please contact hospice at any time for further information and support. It is our goal to respect the dignity of each person by providing quality comfort care.

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End-of-Life Developmental Milestones and Tasks

Source: Dr. Ira Byock

Dr. Ira Byock is a leader and educator in promoting quality care at the end of life. Below is a framework he developed that outlines some of the issues many people may be contemplating as they approach death. His findings are included here as part of a holistic understanding of the dying process. Although the journey toward death may not be easy, it can often be a time of new insights, personal growth, and inner healing.

- Sense of completion with worldly affairs
- Sense of completion in relationships with community
- Sense of meaning about one's individual life
- Experiencing love of self
- Experiencing love of others
- Sense of completion in relationships with family and friends
- Acceptance of the finality of life – of one's existence as an individual
- Sense of a new self (personhood) beyond personal loss
- Sense of meaning about life in general
- Surrendering to the transcendent, to the unknown – "letting go"

Withdrawal

It is common for people to begin to withdraw from friends, family, and the world around them as a normal part of the dying process. This process may begin as early as weeks before the death. The dying person may stay in bed all day and spend more time asleep than awake. With the withdrawal comes less of a need to communicate with others; touch and silence take on more meaning. People at this point may seem unresponsive and difficult to arouse or may appear to be in a coma-like state. This detaching from surroundings and relationships may be preparation for release and letting go.

What you can do:

- Plan activities and visits for times of day when the person seems most alert.
- Because hearing remains intact to the end, speak to the person in your normal tone of voice.
- Identify yourself by name when you speak. Tell the person what you are going to do before you do it. For example: "Bob, this is Karen. I'm going to clean your mouth now."
- Remember not to say anything in front of the person that you wouldn't say if he or she were awake.

Changes in Appetite

Near the end of life, it is natural for a person to no longer be interested in food or to be unable to eat or drink. Often nothing tastes good, and cravings come and go. This is often one of the hardest concepts for caregivers to accept because food is the way we nourish the body and share family time together.

As the body naturally begins to slow down, it is no longer able to digest and assimilate food in the same way. Weight loss is expected and does not mean that the person is hungry or being "starved" by the absence of food.

What you can do:

- Let the person be the guide; he or she will let you know if food or fluids are needed or wanted.
- Liquids are preferred to solids. Some people find thickened liquids easier to swallow. Small chips of ice or frozen juice may be refreshing in the mouth. If the person is able to swallow, fluids may be given in small amounts by syringe (without a needle) or dropper (ask the hospice nurse for guidance).
- There may be times when the taste or smell of familiar foods in small amounts is comforting.
- People who can't speak will sometimes cough, bite the spoon, clamp their teeth closed, turn their heads, or spit food out to let you know they don't want to eat.
- Respect the person's wishes by trying not to force food or drink. Often a person near death may appear thirsty but won't be able to drink water. Frequent mouth care may provide comfort; use swabs to keep the mouth and lips moist.

Changes in Elimination

Incontinence is the loss of control of the bladder and bowels that can sometimes occur as the muscles in the lower body begin to relax. As people decline, the urine output usually diminishes, and the color is usually darker than normal. It may also be cloudy or have a strong odor. This is the normal response to the decreased fluid intake as well as decreased circulation through the kidneys.

Unfortunately, incontinence can be a source of shame and embarrassment for many people. Keeping the person clean, dry, and comfortable, as well as preserving dignity, is the overall goal.

What you can do:

- Adult disposable briefs and underpads on the bed may solve the problem. The nurse or home health aide can show you how to change these for someone in bed.
- In some situations it may be appropriate for the nurse to suggest placing a catheter (a tube) into the bladder to keep the person's skin from being constantly wet. There may be a few seconds of discomfort as the catheter is inserted, but then there is generally no awareness of it at all.
- The nurse may suggest that certain lotions or creams be applied to the skin periodically.
- To help maintain dignity, provide privacy when changing pads or providing personal care. Check the person frequently to ensure that he or she is kept dry and comfortable.

Changes in Breathing

Breathing patterns often begin to change for those nearing the end of life. Breathing may slow down, or there may be rapid, shallow breaths followed by periods of no breathing. These periods can last 5 to 30 seconds, or even up to a full minute. This kind of breathing is not uncomfortable for the person but is a response to the body's weakening condition. Your hospice nurse, along with your physician, will assess and determine if oxygen would be a comfort measure at this time.

Sometimes when individuals are so weak that they can't swallow, saliva gathers in the back of the throat and makes a "rattling" sound. Suctioning usually only increases the secretions and causes discomfort. This sound may be distressing to hear, but it does not indicate that the person is suffering.

What you can do:

- Gently turning the person on his or her side may assist gravity to drain the secretions. Raising the head of the bed may also help.
- Your nurse may educate you about prescribed medications that will dry excess secretions.
- At this point the person is usually breathing with his or her mouth open. This will make the mouth very dry, so frequent mouth care is important.
- If breathing seems labored, your doctor may prescribe morphine or a similar medication to ease the breathing and provide comfort.

Changes in Body Temperature

FEVER

As the body becomes weaker, so does the temperature control mechanism in the brain. This can cause the person to have a fever or cause the body to become cool. Sometimes a person may become sweaty and clammy with or without a fever.

What you can do:

- If a fever develops, let your hospice nurse know. Often placing a cool wash cloth on the forehead and removing blankets may be all that is needed. However, your hospice nurse may suggest an over-the-counter pain reliever (such as acetaminophen) if the fever is high. As the fever lowers, the person may perspire, requiring a change of gown, pajamas, and sheets to provide more comfort.
- Consider using a fan or opening a window.
- If the person throws the covers off, it is important to remember that he or she may be warm even when you feel cool.

COOLNESS

As your loved one becomes weaker, his or her circulation decreases. You may notice that extremities feel cool to the touch and skin color may change. The hands and feet may become purplish, and the knees, ankles, and elbows may look blotchy. The person may appear pale and have a bluish cast around the lips and under the fingernails. This state doesn't cause any discomfort for the person and is a natural part of the dying process.

What you can do:

- Use a warm blanket, but not an electric blanket.
- Continue to gently reposition the person, or provide gentle massage.

Confusion and Disorientation

At times, people nearing the end of their life may have confusion about the time, their surroundings, and the identity of those around them. They may report seeing people or things that are not visible to others, and they may engage in conversation with others who are not visibly present or who have already died.

People near the end of life will sometimes talk about travel, as though they are planning a journey. They may say things such as: "I want to go home," "I want to get my keys," "I need to find my suitcase," or "Where is the train/bus?" This type of conversation is referred to as symbolic language, and may be one of the ways people let us know that they are preparing for death or are trying to tell us goodbye.

When these symptoms are present, we may wonder if the person is taking too much medicine or not enough. Most often, these symptoms are a normal part of the dying process. The hospice nurse will assess the prescribed medication at each visit and determine along with the physician if it is the correct medicine at the correct dosage.

What you can do:

- Report these symptoms to the hospice nurse or other hospice team members; they will assess and provide information on ways you can provide care and support at this time.
- If appropriate, gently try to reorient the person. Remind them of who you are and what you are going to be doing, and point out familiar landmarks in their surroundings.
- Provide reassurance by reminding them of your presence and support, and that you will take care of them and keep them safe.
- Sometimes limiting visitors can decrease the level of confusion or disorientation.

- Allow and acknowledge whatever experience the person may be having, without trying to contradict or argue it away. This experience is real to them, even though it may not seem real to you.
- Listen carefully; there may be meaningful messages being shared in symbolic language.
- You may want to keep a journal to record some of the meaningful things that are shared. This may be a source of inspiration and comfort to share with other family members.

"You don't have to do or say anything to make things better. Just be there as fully as you can."

— Sogyal Rinpoche

Restlessness and Agitation

At times, the person you are caring for may appear restless or unable to be still, and may pick at bed clothes or perform repetitive movements. This is not uncommon and may be due to a variety of physical or emotional reasons.

Restlessness may be caused in part by a slowing down of circulation, causing less oxygen to flow to the brain. Sometimes restlessness or agitation can be a symptom of physical discomfort or pain. Emotional or spiritual concerns, such as an unresolved issue or unfinished task, can be worrisome and also cause feelings of uneasiness or restlessness.

What you can do:

- Let the hospice nurse know if the person is agitated or restless. The nurse will assess for any underlying pain or discomfort.
- Continue with the medication regimen prescribed by the doctor.
- Utilize the hospice social worker and/or chaplain to address underlying concerns and provide emotional or spiritual support.
- Provide a reassuring presence by speaking slowly, calmly, and in a soothing way.
- If appropriate, help the person resolve issues and complete tasks. Sometimes offering to take over a task or suggesting it be delegated to another trusted person can provide relief.
- Try reading something inspirational or playing soft music.
- Holding hands or a light touch may be reassuring.

- Use bed rails or have someone sit with the person to keep him or her safe.
- Consider use of a baby monitor while out of the room.
- Restraints may cause further agitation and are not encouraged.
- It may be useful to limit visitors at this time and to minimize outside distractions (loud noises, radio or TV, ringing phones).
- Some people find comfort in sharing memories about special occasions or holidays, family experiences, or the memory of a favorite place.

"Among the best things we can give each other are good memories."

— Henry Nouwen

Surge of Energy

Dying loved ones may exhibit sudden unexplained surges of energy, which are usually short-lived. They may become unexpectedly alert and clear, ask to eat when they haven't had food for days, or they may want to get up to visit when they haven't been out of bed for weeks. This doesn't always happen in such dramatic ways but can be more subtle, such as being awake more when they have been sleeping most of the time. It is easy to see how this could be misunderstood and can give false hope that the individuals are getting better. It may be that they are marshalling all their physical strength for their last full-body experience in this life.

What you can do:

- Enjoy this time for what it is.
- Use the time to reminisce and say goodbye.
- Be together holding hands.

"The things that matter most in our lives are not fantastic or grand. They are the moments when we touch one another, when we are there in the most attentive or caring way."

— Jack Kornfield

Saying Goodbye

Many people have questions about saying goodbye and wonder whether it is appropriate to do so. Some are concerned that it will hasten death or communicate something unintended. Others may want to say goodbye but may not know what to say. In addition, some families have questions about whether they should give permission to let go.

When and how to say goodbye is a personal decision, and there is no right or wrong way to do it. Some families have difficulty starting the conversation but find that once begun, it can be a gift. This time with your loved one is precious.

What you can do:

- Take this opportunity while the person is alert to say or do what you need to.
- Listen to the wisdom of your heart, and follow its guidance.
- Some families begin these conversations with:
  - *"What I love most about you..."*
  - *"What I will always remember..."*
  - *"What I will miss most about you..."*
  - *"What I learned from you..."*
  - *"What I will cherish..."*
- Some people may choose this time to say, "I am sorry," share forgiveness, or let go of past conflicts.
- Some people may choose this time to share expressions of gratitude.
- It may be helpful to lie in bed with your loved one and hold them, or take their hand and say everything you need to say.
- Tears are a normal and natural part of saying goodbye, and could be a healthy expression of your love.

Review of Possible Signs and Symptoms of Approaching Death

Because each person's dying process is unique to him or her, the outline below is only a general guide. People may exhibit some or all of these signs and symptoms at varying times.

ONE TO THREE MONTHS

- Withdrawal from people and activities
- Communicating less
- Eating and drinking less
- Sleeping more

ONE TO TWO WEEKS

- Disorientation and confusion
- Use of symbolic language ("I want to go home")
- Talking to others not present in the room
- Physical changes:
  - Increase or decrease in pulse
  - Decrease in blood pressure
  - Changes in skin color
  - Irregularities in breathing
  - Changes in body temperature, hot/cold
  - Not eating, taking little or no fluids

DAYS TO HOURS

- Sleeping most of the time
- Surge of energy
- Restlessness
- Difficulty swallowing
- Further discoloration of skin
- Ongoing changes in breathing (long pauses between breaths)
- Rattling breath sounds
- Weak pulse
- Further decrease in blood pressure
- Decreased urine output or no urine
- Eyelids no longer able to close completely

MINUTES

- Shallow breaths with longer pauses
- Mouth open
- Unresponsive

"In this life we cannot do great things. We can only do small things with great love."

— Mother Teresa

Moment of Death

It is important to discuss with family members, caregivers, and friends what to do if they are present at the time of death. No one can accurately predict when death may occur. Some people die when others are present. Some take their last breaths when they are alone.

When the person has died, there will be no breathing or heartbeat. There will be no response to your voice or touch. The eyes may be partly open, and the pupils will be unresponsive. The jaw will relax, and the mouth will open. Sometimes there will be loss of bowel and bladder control.

No matter how well prepared you are, death can still feel like a shock. At the time of death, nothing needs to be done immediately other than calling hospice. There is no need to call 911 or notify the police. You may want to call a trusted friend or a family member to be with you at this time.

What you can do:

- Please contact hospice. A nurse will visit. Please note that other team members may provide assistance as needed.
- When a nurse or other team members visit, some of the things they may do are:
  - Confirm the death
  - Remove any tubes that are present
  - Offer to bathe and prepare the body
  - Dispose of medications
  - Call the funeral home, if you wish
  - Provide support
  - Notify the physician and your hospice team, and arrange for medical equipment to be removed

- People honor the passing of their loved ones in a variety of ways. Some choose to have the funeral home come right away, while other families may choose to wait for a period of time before calling.
- Some of the ways in which you can honor your loved one are: bathing and dressing the body in special clothes, telling stories, lighting a candle, sharing a ritual from his or her spiritual tradition, placing flowers in the room, or playing special music.
- Let the funeral home staff know when you are ready for them to arrive. When they do come, you can decide whether you want to be present when they remove the body or wait in another part of the house. The funeral home will let you know about making arrangements for services.

"Our life is a faint tracing on the surface of mystery."

— Annie Dillard

Care for the Caregiver

Caring for someone who is in the final weeks and days of life can be physically and emotionally demanding. It may feel overwhelming at times and leave you weary in body, mind, and spirit. In addition, some caregivers are often juggling other responsibilities such as work, household duties, caring for other family members, or addressing their own health concerns. Trying to balance another's care with your own needs for rest and nourishment is challenging, but important for your own wellbeing.

What you can do:

- Take a deep breath several times a day. Deep breathing brings more oxygen to every cell and can refresh both body and mind.
- Go outside for a few minutes; smell and feel the fresh air. Take a walk or sit in your garden.
- If you have an exercise routine, try to adhere to it, as this can help decrease stress and boost energy.
- Lie down for 20 minutes or sit in a recliner with your feet up.
- Drink plenty of liquids, especially water.
- Follow a well-balanced diet, eating at regular intervals. Your health and nutrition are just as important as that of the person for which you are caring.
- Determine if calls or visits are helpful or would cause more stress. Limit these as a way of honoring your own needs and private time.
- Ask for help. Often family and friends want to help but do not know how. Keep a list of tasks to be done, such as shopping, going to the post office, walking the dog, or going to the pharmacy.
- Utilize a hospice volunteer visitor for respite or for help with errands.
- Share your concerns or feelings with a trusted friend, your spiritual counselor, or someone from your hospice team.

This booklet (published as *When Death is Near* and *When the Time Comes)* was created by Hospice of Santa Cruz County, a community-based, not-for-profit organization in Scotts Valley, California, that serves Santa Cruz and North Monterey counties. Through a generous grant from The California Endowment, Hospice of Santa Cruz County has moved forward in its ultimate goal of improving the delivery of end-of-life education, hospice, Transitions, and grief support services within the Latino community.

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Provided by

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Montgomery HOSPICE

Staff Mtg

Montgomery HOSPICE

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Hospice at Home
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Fax: (301) 921-4433

Casey House
6001 Muncaster Mill Road
Rockville, MD 20855
Phone: (240) 631-6800
Fax: (240-631-6809

Hospice at Home Services

2016-2017 FEE SCHEDULE

Type of Services	Fee Charges
Routine Home Care – Per Diem rate	$164.00
Registered Nurse Visits Routine Home Visit	$150.00
Medical Social Work Services Routine Home Visit	$ 150.00
Hospice Aide Routine Home Visit	$ 70.00
Admission Visit Registered Nurse and Medical Social Worker	$164.00
Casey House Acute and Non-Acute Care	$800.00

_____ I choose to privately pay for hospice services at the per diem rate of $164.00 per day for home services and $800.00 per day for Casey House services (all inclusive). I understand that this fee includes all services provided by Montgomery Hospice, including 24 hour on call services if I need them. I understand that to be a hospice patient, I will receive weekly visits according to the hospice plan of care. I understand that I will be billed monthly, and upon receipt of the invoice, I agree to pay Montgomery Hospice within 30-45 days.

_____ I choose to privately pay for hospice services on a fee-per visit basis as above for _____days. I understand that to be a hospice patient, I must receive at least one (1) RN visit every two (2) weeks. I understand that I will be billed monthly for all visits that are necessary and that I agree to. I understand that Montgomery Hospice staff is on call 24 hours per day if I need assistance, and that any visits made to me will be billed per the schedule above. Any medications, supplies, and equipment will be my responsibility to pay for separately from Montgomery Hospice's services.

_____ I am not able to pay the fees as above. I am requesting financial assistance from Montgomery Hospice.

Patient Name_____ ID#_____

Signed _____ Date _____
Patient or Patient's representative

Copies to: Patient, Medical Records and Patient Billing

Updated: 1/28/2016

Montgomery HOSPICE

www.montgomeryhospice.org

Hospice at Home
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6001 Muncaster Mill Road
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Phone: (240) 631-6800
Fax: (240-631-6809

Casey House

FEE SCHEDULE

(11/11/11)

Types of Care	Daily Rates
ACUTE INPATIENT CARE	$ 800.00
INPATIENT HOSPICE CARE- NON-ACUTE	$ 800.00

_____ I agree to pay for acute inpatient care at the rate of $800.00 per day for _____ days.

_____ I agree to pay for inpatient hospice care (non-acute) at the rate of $800.00 per day for _____days.

_____ I am not able to pay the fees as above. I am requesting financial assistance from Montgomery Hospice. (For acute inpatient care only)

I understand that I will be billed monthly and that any change in the patient's status may result in a change level of care and therefore a change in fees. If I decide to apply for financial assistance, I agree to complete a financial assessment.

Patient Name_____ ID#_____

Signed_____ Date _____
Patient or Patient's representative

ORIGINAL: Hospice Medical Record YELLOW: Patient PINK: MH Billing

Reviewed: 01/28/16

Videos on the Montgomery Hospice Website

Three are intended for families, two for professionals, and three are about Montgomery Hospice services.

Understanding Hospice Care video

Montgomery Hospice staff members describe hospice services. "This is a journey that we walk with you on." "It's never too early to learn about hospice. We're happy to come to your home and talk with you so that you can make an informed decision later on."

Casey House video

Families talk about Montgomery Hospice Casey House. "Casey House is pleasant and warm." "The staff at Casey House is very knowledgeable and very professional, very comforting."

Video: Three Grief Journeys

Katherine, Gary and Rosemarie talk about their grief journeys, and how Montgomery Hospice supported them.

Maintaining Hope at the End of Life

Professionals talk about hope and communication at end-of-life. "People need dignity. People need honesty."

Conversations about end-of-life care

Cokie Roberts, Dr. Shnider (cardiologist) and Mary Wassman (nurse) discuss importance of hospice services, and encourage physicians and families to discuss hospice. "What you never hear is somebody saying I went to hospice too soon. Quite the contrary. It is always I wish I had done this earlier."

Cokie Roberts talks about Montgomery Hospice's 30th anniversary

"One of the things that has happened in this community that has really improved it is the fact that Montgomery Hospice started here 30 years ago. The care that has meant for my neighbors and my family is just something that cannot be replicated. It is something that is local; it is special and it is terribly, terribly important. I am so grateful."

Montgomery Hospice Sets the Standard for Hospice Care Nationwide

Montgomery Hospice was highlighted in the Hospice Foundation of America's Spirituality and End-of-Life Care program.

Montgomery Hospice Comfort Shawls and Scarves Project

Volunteers make scarves for Montgomery Hospice patients.

Recent Conferences Hosted by Montgomery Hospice

September 20, 2010 *Helping Persons with Complicated and Traumatic Loss*

September 16, 2011 *To Life! Clinically and Culturally Reclaiming the End of Life* (with Ira Byock, MD)

September 6, 2012 *Lessons of Loss: Rewriting Stories of Bereavement*

October 27th, 2012 *The Need for Hospice Care in the African American Community*

May 3, 2013 *Political Implications of the Dementia Tsunami*

November 19, 2013 *African Americans & End-of-Life Care*

September 19, 2014 *The Practice of Presence: Using Compassion-Based Practices in Loss and Grief*

September 24, 2015 *Different Voices, Shared Journeys: Providing Culturally Sensitive Care*

September 16, 2016 *The Impact of Traumatic Loss: New Understandings, New Directions*

MONTGOMERY HOSPICE, INC. AND AFFILIATE

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2015 AND 2014

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INDEPENDENT AUDITORS' REPORT

Board of Directors of
Montgomery Hospice, Inc. and Affiliate
Rockville, Maryland

We have audited the accompanying consolidated financial statements of Montgomery Hospice, Inc. and Affiliate (collectively, the Organization), which comprise the consolidated balance sheets as of December 31, 2015 and 2014, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits 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 consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Organization at December 31, 2015 and 2014, and the results of operations, changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Arlington, Virginia
APRIL 29, 2016

	2015	2014
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 4,947,732	$ 4,966,096
Patient and Other Accounts Receivable, Net of Allowance for Doubtful Accounts of $483,214 and $284,622, Respectively	3,016,839	2,684,404
Contributions and Grants Receivable, Current Portion	38,561	39,277
Other Receivable	65,888	3,146
Prepaid Expenses and Other Current Assets	324,909	317,114
Total Current Assets	8,393,929	8,010,037
CONTRIBUTIONS AND GRANTS RECEIVABLE, NET OF CURRENT PORTION	2,500	15,359
INVESTMENTS	12,606,340	11,884,186
PROPERTY AND EQUIPMENT, NET	2,940,242	2,597,720
Total Assets	$ 23,943,011	$ 22,507,302
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	$ 971,144	$ 1,058,773
Accrued Salaries and Employee Benefits	887,277	1,022,656
Capital Lease Obligations, Current Portion	48,226	59,827
Total Current Liabilities	1,906,647	2,141,256
CAPITAL LEASE OBLIGATIONS, NET OF CURRENT PORTION	-	46,631
DEFERRED RENT	316,620	-
Total Liabilities	2,223,267	2,187,887
NET ASSETS		
Unrestricted:		
Undesignated	14,465,019	13,034,793
Board Designated	1,932,659	1,937,559
Total Unrestricted	16,397,678	14,972,352
Temporarily Restricted	1,015,283	1,000,138
Permanently Restricted	4,306,783	4,346,925
Total Net Assets	21,719,744	20,319,415
Total Liabilities and Net Assets	$ 23,943,011	$ 22,507,302

	2015	2014
UNRESTRICTED REVENUE, GAINS AND OTHER SUPPORT		
Net Patient Service Revenue	$ 22,248,199	$ 20,898,450
Contributions, Grants, and Gifts	1,085,450	767,543
Special Events	236,145	83,665
Interest, Dividends, and Realized Gains, net of Fees	512,016	201,683
Other Revenue	17,477	1,875
Net Assets Released from Restrictions Used for Operations	708,492	746,440
Total Revenue, Gains and Other Support	24,807,779	22,699,656
EXPENSES		
Salaries and Benefits	17,434,086	16,951,065
Purchased Services	569,199	563,194
Durable Medical Equipment, Medical Equipment, and Drugs	2,060,794	2,072,661
Other Expenses	2,324,689	2,627,705
Program Support	36,633	49,558
Depreciation and Amortization	298,115	344,425
Fundraising	146,927	57,658
Interest	18,047	7,620
Total Expenses	22,888,490	22,673,886
EXCESS OF REVENUE, GAINS AND OTHER SUPPORT OVER EXPENSES	1,919,289	25,770
NONOPERATING LOSSES		
Gain on Lease Termination	-	7,919
Unrealized Loss on Investments	(493,963)	(14,429)
Total Nonoperating Losses	(493,963)	(6,510)
Net Increase in Unrestricted Net Assets	1,425,326	19,260
TEMPORARILY RESTRICTED NET ASSETS		
Contributions, Net of Allowances and Discounts	686,529	459,282
Investment Income	34,918	155,989
Net Assets Released from Restrictions for Operations	(706,302)	(746,440)
Increase (Decrease) in Temporarily Restricted Net Assets	15,145	(131,169)
PERMANENTLY RESTRICTED NET ASSETS		
Contributions, Net of Allowances and Discounts	590	991,175
Investment (Loss) Income	(38,542)	4,378
Net Assets Released from Restrictions for Operations	(2,190)	-
(Decrease) Increase in Permanently Restricted Net Assets	(40,142)	995,553
CHANGE IN NET ASSETS	1,400,329	883,644
Net Assets - Beginning of Year	20,319,415	19,435,771
NET ASSETS - END OF YEAR	$ 21,719,744	$ 20,319,415

	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets	$ 1,400,329	$ 883,644
Adjustments to Reconcile Change in Net Assets to		
Net Cash Provided by Operating Activities		
Depreciation and Amortization	298,115	344,425
Loss on Disposal of Fixed Assets	-	85,199
Net Unrealized Loss on Investments	932,291	76,345
Net Realized Gains on Sale of Investments	(632,542)	(138,189)
Gain on Exchange of Land	(357,160)	-
Donated Investments	-	(1,019,756)
Contributions Restricted for Long-Term Purposes	(590)	-
Changes in Assets and Liabilities:		
Patient Accounts Receivable	(332,435)	(30,900)
Contributions and Grants Receivable	13,575	266,761
Other Receivable	(62,742)	45,847
Prepaid Expenses and Other Current Assets	(7,795)	(16,272)
Accounts Payable and Accrued Expenses	(87,629)	138,365
Accrued Salaries and Employee Benefits	(135,379)	(282,819)
Deferred Rent	316,620	(190,619)
Net Cash Provided by Operating Activities	1,344,658	162,031
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sale of Investments	15,266,799	2,858,334
Net Purchase of Investments	(16,288,702)	(3,096,656)
Purchase of Property and Equipment	(283,477)	(195,637)
Net Cash Used in Investing Activities	(1,305,380)	(433,959)
CASH FLOWS FROM FINANCING ACTIVITIES		
Donor-Restricted Contributions for Long-term Purposes	590	-
Payments on Capital Lease Obligations	(58,232)	(40,929)
Net Cash Used in Financing Activities	(57,642)	(40,929)
NET DECREASE IN CASH AND CASH EQUIVALENTS	(18,364)	(312,857)
Cash and Cash Equivalents - Beginning of Year	4,966,096	5,278,953
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 4,947,732	$ 4,966,096
SUPPLEMENTAL DISCLOSURE		
Cash Paid for Interest	$ 11,821	$ 5,884
NONCASH TRANSACTION		
Equipment Acquired by Capital Lease	$ -	$ 108,672
Gain on Exchange of Land	$ 357,160	$ -

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Montgomery Hospice, Inc. (the Hospice) was incorporated in 1979 under the laws of the State of Maryland. The Hospice provides outpatient hospice and inpatient hospice (The Montgomery Hospice Casey House) services to the terminally ill and their families in Montgomery County, Maryland.

Montgomery Hospice Foundation, Inc. (the Foundation) commenced operations in December 1989 as a charitable foundation to solicit and receive all grants, contributions, and special activity revenues received in either the name of the Hospice or the Foundation. The Board of Directors of the Hospice and the Foundation have entered into an agreement providing that all such funds and contributions will be recorded in the accounts of the Foundation and that the Foundation will conduct its operations exclusively for the benefit of the Hospice. Effective July 1, 2014, the Foundation merged with the Hospice.

Palliative Medicine Consultants of Greater Washington, LLC (Palliative Medicine), a wholly owned limited liability company of the Hospice, was established in 2002 to offer a continuum of care throughout the Greater Washington area for patients with advanced illness whose treatment goals emphasize quality of life. Palliative Medicine combines aggressive medical management of pain and other debilitating symptoms with counseling and support for the social, psychological and spiritual needs of patients and families. During 2007, Palliative Medicine activities were discontinued, although the entity was not closed. In October 2013, medical services provided began to be reactivated.

Consolidation

These consolidated financial statements include the accounts of the Hospice and the Palliative Medicine (collectively, the Organization). All inter-company accounts and transactions have been eliminated in the consolidated financial statements.

Income Taxes

The Hospice is a tax-exempt entity as described in Section 501(c)(3) of the Internal Revenue Code (IRC). Palliative Medicine is a limited liability company whose operating results flow through to the Hospice, which is its sole corporate member. Neither of these entities are classified as a private foundation as defined by the Internal Revenue Service.

The IRC provides for taxation of unrelated business income under certain circumstances. The Hospice and its affiliated entities have no significant unrelated business income; however, such status is subject to final determination upon examination of the related income tax returns by the appropriate taxing authorities.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amount of revenues and expenses during the reporting period. Areas subject to management estimates include allowances for contractual adjustments and doubtful accounts related to patient accounts receivable, estimated third-party payor settlements, reserves for workers' compensation claims and reserves for patient care expenses. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with an original maturity of three months or less except for those included in the investment portfolio. The Organization deposits its temporary cash investments in financial institutions. At times, such investments may be in excess of the FDIC insurance limit.

Net Patient Service Revenue, Patient Accounts Receivable and Allowances for Uncollectible Accounts

Medicare and Medicaid Net Patient Revenue and Receivables

Revenue for services rendered to patients covered under the Medicare and Medicaid programs are recorded based on date of service at amounts equal to payment rates specific to the Hospice that are set by the Medicare and Medicaid programs. The payment rates are daily or hourly rates for each of the four levels of care provided by the Hospice (i.e. routine care, general inpatient care, continuous care and respite care). Adjustments are made to revenue for the inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The Hospice estimates the impact of these adjustments based on historical experience, which primarily includes historical claims adjustments, and records it during the period services are rendered as an estimated revenue adjustment and as a reduction to patient accounts receivable.

Additionally, the Hospice reimbursement from Medicare is subject to an inpatient cap limit and an overall payment cap. If inpatient days of hospice care provided exceeds 20% of the total days of hospice care provided for an annual period beginning on November 1, then payments for days in excess of this limit are paid for at the routine home care rate. If overall payments made by Medicare to the Hospice exceeds their hospice cap limit (as calculated by the Medicare fiscal intermediary) for an annual period beginning on November 1, then payments in excess of the hospice cap limit have to be repaid to Medicare. The Organization reviews the adequacy of its hospice cap liability on a periodic basis. The Hospice did not have an overpayment liability at December 31, 2015 or 2014.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Net Patient Service Revenue, Patient Accounts Receivable and Allowances for Uncollectible Accounts (Continued)

Medicare and Medicaid Net Patient Revenue and Receivables (Continued)

Approximately 74% and 72% of net patient service revenue was earned from the Medicare and Medicaid Programs for the years ended December 31, 2015 and 2014, respectively. Due to the significance of Medicare and Medicaid program revenues to the Organization, any change in the reimbursement methodologies employed by the Medicare and Medicaid program for hospice services could significantly impact the financial operations and financial position of the Organization.

Other Third-Party Payor Net Patient Revenue and Receivables

Revenue for services rendered to patients covered by other third-party payors (e.g. commercial insurance carriers, health maintenance organizations, and preferred provider organizations, etc.) is recorded based on date of service at amounts equal to the Organization's established rate or a rate negotiated with the third-party payor. Contractual adjustments are recorded for the difference between the Organization's established rate and the amounts estimated to be realized from third-party payors and are deducted from revenues and patient accounts receivable.

Allowance for Uncollectible Accounts

The Organization maintains a policy for reserving for uncollectible accounts. The Organization calculated the allowance for uncollectible accounts based on a formula applied to the aging of accounts receivable. Accounts are written off when all collection efforts are exhausted.

Contributions Receivable

Pledges are recorded initially and subsequent to initial recognition at fair value. The fair value of contributions receivable is determined by using U.S. Treasury securities rate at various applicable maturity years, quoted on investment basis. Although management uses its best judgment at estimating fair value of the contributions receivable, there are inherent limitations in any valuation technique. Therefore, the value is not necessarily indicative of the amount that could be realized in a current transaction. Future events will also affect the estimates of fair value, and the effect of such events on the estimates of fair value could be material.

Investments

Investments consist of debt and equity securities with readily determinable fair values and are measured at fair value in the consolidated balance sheets. Certificates of deposit are valued at cost which approximate fair value. Investment income or loss includes realized gains and losses, interest, dividends and certain unrealized gains and losses. The investment income or loss on investments that are restricted by donor or law is recorded as increases or decreases to temporarily restricted and permanently restricted net assets.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Acquisitions of property and equipment greater than $2,000 with useful lives greater than one year are recorded at cost and depreciated over their estimated useful lives using the straight-line method. Donated property is recorded at fair market value on the date received. Leasehold improvements are amortized the shorter of the life of the asset or lease term.

Impairment of Long-Lived Assets

The Organization reviews long-lived assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of carrying amount or the fair value less costs to sell. There were no impairment losses recorded for the years ended December 31, 2015 and 2014.

Net Assets

Net assets of the Organization and changes therein are classified and reported as follows:

Unrestricted - Those resources over which the Board of Directors has discretionary control. Designated amounts represent those revenues that the Board has restricted for Casey House Operations.

Temporarily Restricted - Those resources subject to donor imposed restrictions that will be satisfied by actions of the Organization or passage of time.

Permanently Restricted - Those resources subject to a donor imposed restriction that they be maintained permanently by the Organization.

Contributions

Unconditional promises to give cash and other assets are accrued at estimated fair market value at the date each promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction is satisfied, net assets are released and reported as an increase in unrestricted net assets. Donor-restricted contributions whose restrictions are met within the same reporting period as received are recorded as unrestricted contributions.

Excess of Revenue, Gains and Other Support Over Expenses

The consolidated statements of operations and changes in net assets include excess of revenue, gains and other support over expenses. Changes in unrestricted net assets which are excluded from excess of revenue, gains and other support over expenses and losses, consistent with industry practice, include gains on lease termination and unrealized gain (loss) on Investments.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Charity Care and Community Benefit

The mission of the Organization is to enhance life and minimize suffering by offering high quality care and support to individuals with a life-limiting illness and their families and to provide educational services concerning death, dying and grief to individuals in Montgomery County and nearby communities. The Organization provides services to patients regardless of their ability to pay for those services.

The Organization defines and measures this "investment in" and "partnership with" the community primarily through its non-revenue generating bereavement program, palliative care program, in-patient services program, complementary therapy program, pediatric hospice care program and self-pay/financial assistance programs. The Organization provides care to patients who meet certain criteria under its financial assistance policy without charge. Key elements used to determine eligibility include a patient's demonstrated inability to pay based on family size and household income related to federal income poverty guidelines. The Organization's charity care guidelines are 150% of the Federal Poverty Guidelines as published. Because the Organization does not pursue collection of amounts determined to qualify for financial assistance, they are not reported as revenue. The Organization has estimated its direct and indirect costs of providing charity care under its financial assistance policy.

In order to estimate the cost of providing such care, management calculated a cost-to-charge ratio by comparing the per diem rate from the most recently filed cost report to the Organization's gross bill rate. The cost-to-charge ratio is applied to the charity care charges foregone to calculate the estimated direct and indirect cost of providing charity care. Using this methodology, the Organization has estimated the costs foregone for services and supplies furnished under the Organization's financial assistance policy aggregated approximately $452,000 and $506,000 for the years ended December 31, 2015 and 2014, respectively.

Fair Value Measurements

Fair value measurement applies to reported balances that are required or permitted to be measured at fair value under an existing accounting standard. The Organization emphasizes that fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability and establishes a fair value hierarchy. The fair value hierarchy consists of three levels of inputs that may be used to measure fair value as follows:

Level 1 – Inputs that utilize quoted prices (unadjusted) in active markets for identical assets or liabilities that the Organization has the ability to access.

Level 2 – Inputs that include quoted prices for similar assets and liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument. Fair values for these instruments are estimated using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Fair Value Measurements - Continued

Level 3 – Inputs that are unobservable inputs for the asset or liability, which are typically based on an entity's own assumptions, as there is little, if any, related market activity.

In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

Fair Value Option

The Organization elected the fair value option for promises to give. The fair value option election was made to simplify the record keeping. The option allows companies to irrevocably elect fair value as the initial and subsequent measurement attribute for certain financial assets and financial liabilities. Changes in fair value for assets and liabilities for which the election is made will be recognized in earnings as they occur. The fair value option is permitted on an instrument by-instrument basis at initial recognition of an asset or liability or upon an event that gives rise to a new basis of accounting for that instrument.

Reclassifications

Certain prior amounts have been reclassified to conform to the current year presentation. Such reclassification had no effect on net asset amounts previously reported.

Subsequent Events

In preparing these consolidated financial statements, the Organization has evaluated events and transactions for potential recognition or disclosure through APRIL 29, 2016, the date the consolidated financial statements were available for issuance.

NOTE 2 CONCENTRATION OF CREDIT RISK

Financial instruments which subject the Organization to a concentration of credit risk consist of demand deposits placed with financial institutions. At times during the year, the Organization had funds invested with local financial institutions in excess of the Federal Deposit Insurance Corporation limits. The Organization has not experienced any losses on such deposits.

The Organization also grants credit without collateral to its patients, most of whom are insured under third-party payor agreements.

The mix of receivables from patients and third-party payors at December 31 was as follows:

	2015	2014
Medicare	74%	72%
Medicaid	4%	4%
Commercial and Other	22%	24%
Total	100%	100%

NOTE 3 CONTRIBUTIONS RECEIVABLE

The following is a report of contributions receivable due within one year and one to five years as of December 31:

	2015	2014
Amounts Due In:		
Less Than One Year	$ 38,561	$ 39,277
One to Five Years	2,500	15,359
	$ 41,061	$ 54,636

NOTE 4 INVESTMENTS

Investments, stated at fair value, at December 31 include the following:

	2015	2014
Cash and Money Funds	$ 548,755	$ 1,688,178
Equities	2,990,806	-
Fixed Income	7,008,671	1,882,213
Mutual Funds - Equities	1,894,006	4,701,647
Mutual Funds - Fixed Income	-	3,208,066
Certificates of Deposit	164,102	404,082
Total	$ 12,606,340	$ 11,884,186

NOTE 4 INVESTMENTS - CONTINUED

Investment income from cash equivalents and investments is comprised of the following for the years ended December 31:

	2015	2014
Interest and Dividend Income	$ 361,494	$ 334,975
Net Realized Gains on Sales of Securities	632,542	138,189
Change in Net Unrealized Loss	(932,291)	(76,345)
Investment Fees	(47,316)	(49,558)
Total	$ 14,429	$ 347,261

NOTE 5 PROPERTY AND EQUIPMENT

Property and equipment as of December 31 consist of the following:

	2015	2014
Furniture and Equipment	$ 476,874	$ 455,720
Capital Leases	128,672	146,672
Computer Equipment and Software	605,302	605,302
Leasehold Improvements	208,956	-
Land	1,082,200	672,721
Land Improvements	130,904	130,904
Building	2,375,934	2,375,934
	5,008,842	4,387,253
Less: Accumulated Depreciation	(2,068,600)	(1,789,533)
Total Property and Equipment	$ 2,940,242	$ 2,597,720

On December 28, 2015, the Organization completed a real estate exchange with Stanley Martin Homes. Two acres of land with open space easement and a book value of $208,730 were exchanged for two acres of land without open space easement, but with a market value of $565,890. As a result, a land exchange gain of $357,160 was recognized and the Organization's land value increased by the same amount.

NOTE 6 CAPITAL LEASE OBLIGATIONS

The Organization acquired office equipment under non-cancellable lease agreements which expire between 2015 and 2016. The net book value of the equipment at December 31, 2015 and 2014, is as follows:

	2015	2014
Cost	$ 128,672	$ 146,672
Accumulated Depreciation	(86,289)	(43,078)
	$ 42,383	$ 103,594

Depreciation expense amounted to $43,211 and $40,792 for the years ended December 31, 2015 and 2014, respectively. Future minimum lease payments due under this lease are as follows:

Year Ending December 31,	
2016	$ 51,176
Total	51,176
Less Amounts Representing Interest	(2,950)
	48,226
Capital Lease Obligation, Current Portion	(48,226)
Capital Lease Obligation, Net of Current Portion	$ -

NOTE 7 LINE OF CREDIT

The Organization opened a margin account on December 9, 2014, with a financial institution to support working capital needs that was secured by short term investments held at the same financial institution. There were no borrowings against the margin account as of December 31, 2015 or 2014.

NOTE 8 LETTERS OF CREDIT

The Organization has a letter of credit with a bank in the amount of $122,009 and $121,676 as collateral for Maryland State Unemployment Tax as of December 31, 2015 and 2014, respectively. The Organization has a second letter of credit with a bank in the amount of $25,656 that serves as collateral for the security deposit on the office lease.

NOTE 9 TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets consist of the following at December 31:

	2015			
	January 1, 2015	Additions	Releases	December 31, 2015
Purpose Restricted:				
Casey House Operations	$ 686,933	$ 311,425	$ (404,704)	$ 593,654
Clinical Activities	82,965	-	(82,965)	-
General Programs	230,240	410,022	(218,633)	421,629
	$ 1,000,138	$ 721,447	$ (706,302)	$ 1,015,283

	2014			
	January 1, 2014	Additions	Releases	December 31, 2014
Purpose Restricted:				
Casey House Operations	$ 693,880	$ 411,069	$ (418,016)	$ 686,933
Clinical Activities	282,965	-	(200,000)	82,965
General Programs	154,462	204,202	(128,424)	230,240
	$ 1,131,307	$ 615,271	$ (746,440)	$ 1,000,138

NOTE 10 RETIREMENT PLANS

The Organization offers a 403(b) Tax Sheltered Annuity through T. Rowe Price. Eligible employees may contribute to the plan subject to statutory limitations. The Board of Directors may also determine an annual contribution, generally of 1% to 3% of gross earnings, for employees with two years of service who have also worked a minimum of 1,000 hours each year. The Organization made a total contribution of $393,062 and $234,220 to the plan for the years ended December 31, 2015 and 2014, respectively.

NOTE 11 FAIR VALUE MEASUREMENTS

The following investments of the Organization are measured at fair value on a recurring basis and were recorded using the fair value hierarchy at December 31:

	2015			
	Level 1	Level 2	Level 3	Total
Investments:				
Equities	$ 2,990,806	$ -	$ -	$ 2,990,806
Fixed Income	7,008,671	-	-	7,008,671
Mutual Funds - Equities	1,894,006	-	-	1,894,006
Total Investments	8,902,677	-	-	8,902,677
Contributions Receivable, Net	-	-	41,061	41,061
Total	$ 8,902,677	$ -	$ 41,061	$ 8,943,738

	2014			
	Level 1	Level 2	Level 3	Total
Investments:				
Fixed Income	$ 1,882,213	$ -	$ -	$ 1,882,213
Mutual Funds - Equities	4,701,647	-	-	4,701,647
Mutual Funds - Fixed Income	3,208,066	-	-	3,208,066
Total Investments	9,791,926	-	-	9,791,926
Contributions Receivable, Net	-	-	54,636	54,636
Total	$ 9,791,926	$ -	$ 54,636	$ 9,846,562

Level 3 Assets

The following table provides a summary of changes in fair value of the Organization's Level 3 financial assets for the years ended December 31:

Contributions Receivable, Net	2015	2014
Beginning of Year Balance	$ 54,636	$ 321,397
New Pledge Commitments	127,895	109,660
Pledge Payments	(140,970)	(360,946)
Write-offs	(500)	(15,638)
Change in Fair Value	-	163
End of Year Balance	$ 41,061	$ 54,636

NOTE 12 ENDOWMENT FUNDS

The Organization has donor-restricted endowment funds established for purposes of providing income to support the Casey House and Hospice at Home programs. As required by GAAP, net assets of the endowment funds are classified and reported based on the existence or absence of donor-imposed restriction. The Board of Directors of the Organization has interpreted the State of Maryland's Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Organization classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Organization in a manner consistent with the standard of prudence prescribed by UPMIFA and by the donor.

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

- The duration and preservation of the fund
- The purposes of the organization and the donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the organization
- The investment policies of the organization

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or UPMIFA requires the Organization to retain as a fund for perpetual duration. In accordance with GAAP, deficiencies of this nature are reported as a reduction of unrestricted net assets. There were no deficiencies of this nature as of December 31, 2015 and 2014.

Return Objectives and Risk Parameters

Management of the endowment assets is designed to ensure a total return (income plus capital change) necessary to preserve and enhance (in real dollar terms) the principal of the fund and, at the same time, provide a dependable source of support for current programs. The Organization's objective is that total investment returns shall exceed the US Consumer Price Index by four percent (4%). Actual experience in any given year may vary from this amount.

NOTE 12 ENDOWMENT FUNDS (CONTINUED)

Strategies Employed for Achieving Objectives

Reasonable diversification is sought at all times. Experience has shown financial markets and inflation rates are cyclical and, therefore, control of volatility will be achieved through diversification of asset classes and selection of managers of diverse investment styles. The Board of Directors examines the correlation of the investment portfolio and it has historically had positive returns.

Spending Policy

The Organization follows the spending rate of 4% of the average of the portfolio as of December 31st for the three years prior to the current year. The spending for the Casey House endowment for Nurses and Nurses Aides from the Casey Foundation is restricted to only income from the fund and capital gains are not considered to be income. The spending for the other endowment funds includes both income from the fund and capital gains.

Board-Designated Endowment

As of December 31, 2015 and 2014, the Board of Directors had designated $1,931,981 and $1,937,559, respectively, of unrestricted net assets received from Foundation contributions to become part of the Casey House Nursing Endowment.

The following is a summary of endowment funds subject to UPMIFA for the years ended December 31:

	Unrestricted Endowment	Temporarily Restricted	Permanently Restricted	Total
Endowment Net Assets, January 1, 2014	$ 439,540	$ 429,887	$ 3,351,372	$ 4,220,799
Contributions	1,467,420	-	991,175	2,458,595
Investment Gain (Loss), Net	30,599	155,989	4,378	190,966
Appropriations	-	(137,304)	-	(137,304)
Endowment Net Assets, December 31, 2014	1,937,559	448,572	4,346,925	6,733,056
Contributions	-	60,541	590	61,131
Investment Income (Loss), Net	(4,900)	34,918	(38,542)	(8,524)
Appropriations	-	(160,000)	(2,190)	(162,190)
Endowment Net Assets, December 31, 2015	$ 1,932,659	$ 384,031	$ 4,306,783	$ 6,623,473

NOTE 13 FUNCTIONAL EXPENSES

The costs of providing various programs and other activities have been summarized on a functional basis and are provided below for the years ended December 31, 2015 and 2014. Accordingly, overhead expenses have been allocated among the activities benefited based upon position responsibilities.

	2015	2014
Program Services	$ 20,612,110	$20,326,523
Management and General	1,664,162	1,840,042
Fundraising	612,218	507,321
Total	$ 22,888,490	$ 22,673,886

NOTE 14 COMMITMENTS AND CONTINGENCIES

Operating Leases

The Organization had non-cancelable operating leases for office space that would expire in December 2015. In October 2014, a new lease was signed with a commencement date of January 1, 2015, and expiring on December 31, 2025, that terminated the old leases as of December 31, 2014. The effects of the scheduled rent increases and rent abatement are being recognized by the Hospice on a straight-line basis over the life of the lease. The unrecognized portion of rent increases and lease incentives are reflected as deferred rent in the accompanying consolidated balance sheets. The leases contain fixed escalation clauses for increases in the annual minimum rent over the term of the lease and obligates the Organization to pay its pro rata share of the building's operating expenses and real estate taxes. For the years ended December 31, 2015 and 2014, rent expense amounted to $359,467 and $296,864, respectively. Aggregate minimum annual rental payments are as follows:

Year Ending December 31,	
2016	$ 315,564
2017	323,453
2018	331,540
2019	339,828
2020	348,324
Thereafter	1,876,677
Total	$ 3,535,386

NOTE 14 COMMITMENTS AND CONTINGENCIES (CONTINUED)

Contingencies

During the normal course of business, the Organization may be subject to various threatened or asserted claims related to professional liability, employment or other matters. The Hospice has purchased occurrence-based general liability insurance from a commercial insurance carrier. This policy covers claims resulting from incidents that occur during the policy term, regardless of when the claims are reported to the insurance carrier. The Hospice also purchased claims-made professional liability insurance from the same commercial insurance carrier which covers claims when they are first reported to the insurance carrier during the policy term. The Hospice has had continuous claims-made professional liability coverage since September 1, 1998. Cumulative claims made on the policy as of and for the years ended December 31, 2015 and 2014, did not exceed the maximum insurable limits.

The Hospice has also purchased excess umbrella insurance coverage to supplement its professional and general liability insurance policy.

Healthcare Industry

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

SUPPLEMENTARY INFORMATION

CliftonLarsonAllen LLP
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INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION

To the Board of Directors of
Montgomery Hospice, Inc.
Rockville, Maryland

We have audited the consolidated financial statements of Montgomery Hospice, Inc. and affiliates as of and for the years ended December 31, 2015 and 2014, and our report thereon dated APRIL 29, 2016, which expressed an unmodified opinion on those consolidated financial statements, appears on page 1. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheets and consolidating statements of operations and changes in net assets are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Arlington, Virginia
APRIL 29, 2016

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 4,935,000	$ 12,732	$ -	$ 4,947,732
Patient and Other Accounts Receivable, Net of Allowance for Doubtful Accounts of $483,214	3,016,839	-	-	3,016,839
Contributions and Grants Receivable	38,561	-	-	38,561
Other Receivable	65,888	-	-	65,888
Prepaid Expenses and Other Current Assets	324,909	-	-	324,909
Total Current Assets	8,381,197	12,732	-	8,393,929
CONTRIBUTIONS AND GRANTS RECEIVABLE, NET OF CURRENT PORTION	2,500	-	-	2,500
INVESTMENT IN PALLIATIVE MEDICINE CONSULTANTS OF GREATER WASHINGTON, LLC	12,732	-	(12,732)	-
INVESTMENTS	12,606,340	-	-	12,606,340
PROPERTY AND EQUIPMENT, NET	2,940,242	-	-	2,940,242
Total Assets	$ 23,943,011	$ 12,732	$ (12,732)	$ 23,943,011
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts Payable and Accrued Expenses	$ 971,144	$ -	$ -	$ 971,144
Accrued Salaries, Payroll Taxes and Employee Benefits	887,277	-	-	887,277
Capital Lease Obligations, Current Portion	48,226	-	-	48,226
Total Current Liabilities	1,906,647	-	-	1,906,647
DEFERRED RENT	316,620	-	-	316,620
Total Liabilities	2,223,267	-	-	2,223,267
NET ASSETS				
Unrestricted:				
Undesignated	14,465,019	12,732	(12,732)	14,465,019
Board Designated	1,932,659	-	-	1,932,659
Total Unrestricted	16,397,678	12,732	(12,732)	16,397,678
Temporarily Restricted	1,015,283	-	-	1,015,283
Permanently Restricted	4,306,783	-	-	4,306,783
Total Net Assets	21,719,744	12,732	(12,732)	21,719,744
Total Liabilities and Net Assets	$ 23,943,011	$ 12,732	$ (12,732)	$ 23,943,011

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 4,952,971	$ 13,125	$ -	$ 4,966,096
Patient and Other Accounts Receivable, Net of Allowance for Doubtful Accounts of $284,622	2,684,404	-	-	2,684,404
Contributions and Grants Receivable, Current Portion	39,277	-	-	39,277
Other Receivable	3,146	-	-	3,146
Prepaid Expenses and Other Current Assets	317,114	-	-	317,114
Due from Palliative Medicine Consultants	41,740	-	(41,740)	-
Total Current Assets	8,038,652	13,125	(41,740)	8,010,037
CONTRIBUTIONS AND GRANTS RECEIVABLE, NET OF CURRENT PORTION	15,359	-	-	15,359
INVESTMENT IN PALLIATIVE MEDICINE CONSULTANTS OF GREATER WASHINGTON, LLC	(28,615)	-	28,615	-
INVESTMENTS	11,884,186	-	-	11,884,186
PROPERTY AND EQUIPMENT, NET	2,597,720	-	-	2,597,720
Total Assets	$ 22,507,302	$ 13,125	$ (13,125)	$ 22,507,302
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts Payable and Accrued Expenses	$ 1,058,773	$ -	$ -	$ 1,058,773
Accrued Salaries, Payroll Taxes and Employee Benefits	1,022,656	-	-	1,022,656
Due to Hospice	-	41,740	(41,740)	-
Capital Lease Obligations, Current Portion	59,827	-	-	59,827
Total Current Liabilities	2,141,256	41,740	(41,740)	2,141,256
CAPITAL LEASE OBLIGATIONS, NET OF CURRENT PORTION	46,631	-	-	46,631
Total Liabilities	2,187,887	41,740	(41,740)	2,187,887
NET ASSETS				
Unrestricted:				
Undesignated	13,034,793	(28,615)	28,615	13,034,793
Board Designated	1,937,559	-	-	1,937,559
Total Unrestricted	14,972,352	(28,615)	28,615	14,972,352
Temporarily Restricted	1,000,138	-	-	1,000,138
Permanently Restricted	4,346,925	-	-	4,346,925
Total Net Assets	20,319,415	(28,615)	28,615	20,319,415
Total Liabilities and Net Assets	$ 22,507,302	$ 13,125	$ (13,125)	$ 22,507,302

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Eliminations	Total
UNRESTRICTED REVENUE, GAINS AND OTHER SUPPORT				
Net Patient Service Revenue	$ 22,248,199	$ -	$ -	$ 22,248,199
Contributions, Grants, and Gifts	1,085,450	-	-	1,085,450
Special Events	236,145	-	-	236,145
Interest, Dividends, and Realized Gains, Net of Fees	512,016	-	-	512,016
Other Revenue	17,477	-	-	17,477
Net Assets Released from Restrictions Used for Operations	708,492	-	-	708,492
Total Revenue, Gains and Other Support	24,807,779	-	-	24,807,779
EXPENSES				
Salaries and Benefits	17,434,086	-	-	17,434,086
Purchased Services	569,199	-	-	569,199
Durable Medical Equipment, Medical Equipment, and Drugs	2,060,794	-	-	2,060,794
Other Expenses	2,324,689	-	-	2,324,689
Program Support	36,633	-	-	36,633
Depreciation and Amortization	298,115	-	-	298,115
Fundraising	146,927	-	-	146,927
Interest	18,047	393	(393)	18,047
Total Expenses	22,888,490	393	(393)	22,888,490
	22,952,461			
EXCESS (DEFICIT) OF REVENUE, GAINS AND OTHER SUPPORT OVER EXPENSES	1,919,289	(393)	393	1,919,289
NONOPERATING LOSSES				
Unrealized Loss on Investments	(493,963)	-	-	(493,963)
Total Other Nonoperating Losses	(493,963)	-	-	(493,963)
Net Increase (Decrease) in Unrestricted Net Assets	1,425,326	(393)	393	1,425,326
TEMPORARILY RESTRICTED NET ASSETS				
Contributions, Net of Allowances and Discounts	686,529	-	-	686,529
Investment Income	34,918	-	-	34,918
Net Assets Released from Restrictions for Operations	(706,302)	-	-	(706,302)
Increase in Temporarily Restricted Net Assets	15,145	-	-	15,145
PERMANENTLY RESTRICTED NET ASSETS				
Contributions, Net of Allowances and Discounts	590	-	-	590
Investment Loss	(38,542)			(38,542)
Net Assets Released from Restrictions	(2,190)	-	-	(2,190)
Decrease in Permanently Restricted Net Assets	(40,142)	-	-	(40,142)
CHANGE IN NET ASSETS	1,400,329	(393)	393	1,400,329
Net Assets - Beginning of Year	20,319,415	(28,615)	28,615	20,319,415
Paid in Capital Contribution	-	41,740	(41,740)	-
NET ASSETS - END OF YEAR	$ 21,719,744	$ 12,732	$ (12,732)	$ 21,719,744

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Montgomery Hospice Foundation, Inc.	Eliminations	Total
UNRESTRICTED REVENUE, GAINS AND OTHER SUPPORT					
Net Patient Service Revenue	$ 20,898,450	$ -	$ -	$ -	$ 20,898,450
Contributions, Grants, and Gifts	1,561,155	4,704	-	(798,316)	767,543
Special Events	83,665	-	-	-	83,665
Interest, Dividends, and Realized Gains, Net of Fees	201,683	-	-	-	201,683
Other Revenue	1,875	-	-	-	1,875
Net Assets Released from Restrictions Used for Operations	746,440	-	-	-	746,440
Total Revenue, Gains and Other Support	23,493,268	4,704	-	(798,316)	22,699,656
EXPENSES					
Salaries and Benefits	16,952,794	11,158	-	(12,887)	16,951,065
Purchased Services	563,194	-	-	-	563,194
Durable Medical Equipment, Medical Equipment, and Drugs	2,072,661	-	-	-	2,072,661
Other Expenses	2,621,705	6,000	-	-	2,627,705
Program Support	847,874	-	-	(798,316)	49,558
Depreciation and Amortization	344,425	-	-	-	344,425
Fundraising	57,658	-	-	-	57,658
Interest	7,187	433	-	-	7,620
Total Expenses	23,467,498	17,591	-	(811,203)	22,673,886
EXCESS (DEFICIT) OF REVENUE, GAINS AND OTHER SUPPORT OVER EXPENSES	25,770	(12,887)	-	12,887	25,770
NONOPERATING LOSSES					
Gain on Lease Termination	7,919	-	-	-	7,919
Unrealized Loss on Investments	(14,429)	-	-	-	(14,429)
Total Other Nonoperating Losses	(6,510)	-	-	-	(6,510)
Net Increase (Decrease) in Unrestricted Net Assets	19,260	(12,887)	-	12,887	19,260
TEMPORARILY RESTRICTED NET ASSETS					
Contributions, Net of Allowances and Discounts	459,282	-	-	-	459,282
Investment Income	155,989	-	-	-	155,989
Net Assets Released from Restrictions for Operations	(746,440)	-	-	-	(746,440)
Decrease in Temporarily Restricted Net Assets	(131,169)	-	-	-	(131,169)
PERMANENTLY RESTRICTED NET ASSETS					
Contributions	991,175	-	-	-	991,175
Investment Income	4,378	-	-	-	4,378
Increase in Permanently Restricted Net Assets	995,553	-	-	-	995,553
CHANGE IN NET ASSETS	883,644	(12,887)	-	12,887	883,644
Net Assets - Beginning of Year	7,966,395	(15,728)	11,469,376	15,728	19,435,771
Net Assets from Merged Entity	11,469,376		(11,469,376)		-
NET ASSETS - END OF YEAR	$ 20,319,415	$ (28,615)	$ -	$ 28,615	$ 20,319,415

MONTGOMERY HOSPICE, INC. AND AFFILIATE

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2014 AND 2013

MONTGOMERY HOSPICE, INC. AND AFFILIATE
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INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
Montgomery Hospice, Inc. and Affiliate
Rockville, Maryland

We have audited the accompanying consolidated financial statements of Montgomery Hospice, Inc. and Affiliate (collectively, the Organization), which comprise the consolidated balance sheets as of December 31, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits 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 consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Organization at December 31, 2014 and 2013, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Arlington, Virginia
April 29, 2015

MONTGOMERY HOSPICE, INC. AND AFFILIATE
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2014 AND 2013

	2014	2013
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 4,966,096	$ 5,278,953
Patient and Other Accounts Receivable, Net of Allowance for Doubtful Accounts of $284,622 and $313,069, Respectively	2,684,404	2,653,504
Contributions and Grants Receivable, Current Portion	39,277	291,921
Other Receivable	3,146	48,993
Prepaid Expenses and Other Current Assets	317,114	300,842
Total Current Assets	8,010,037	8,574,213
CONTRIBUTIONS AND GRANTS RECEIVABLE, NET OF CURRENT PORTION	15,359	29,476
INVESTMENTS	11,884,186	10,564,263
PROPERTY AND EQUIPMENT, NET	2,597,720	2,723,035
Total Assets	$ 22,507,302	$ 21,890,987
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	$ 1,058,773	$ 920,408
Accrued Salaries and Employee Benefits	1,022,656	1,305,475
Capital Lease Obligations, Current Portion	59,827	29,091
Deferred Rent, Current Portion	-	87,759
Total Current Liabilities	2,141,256	2,342,733
CAPITAL LEASE OBLIGATIONS, NET OF CURRENT PORTION	46,631	9,623
DEFERRED RENT, NET OF CURRENT PORTION	-	102,860
Total Liabilities	2,187,887	2,455,216
NET ASSETS		
Unrestricted:		
Undesignated	13,034,793	14,513,552
Board Designated	1,937,559	439,540
Total Unrestricted	14,972,352	14,953,092
Temporarily Restricted	1,000,138	1,131,307
Permanently Restricted	4,346,925	3,351,372
Total Net Assets	20,319,415	19,435,771
Total Liabilities and Net Assets	$ 22,507,302	$ 21,890,987

See accompanying Notes to Consolidated Financial Statements.

MONTGOMERY HOSPICE, INC. AND AFFILIATE
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014	2013
UNRESTRICTED REVENUE, GAINS AND OTHER SUPPORT		
Net Patient Service Revenue	$ 20,898,450	$ 21,088,768
Contributions, Grants, and Gifts	767,543	1,161,271
Special Events	83,665	87,729
Interest, Dividends, and Realized Gains	251,241	180,591
Other Revenue	1,875	35,789
Net Assets Released from Restrictions Used for Operations	746,440	834,230
Total Revenue, Gains and Other Support	22,749,214	23,388,378
EXPENSES		
Salaries and Benefits	16,951,065	16,381,742
Purchased Services	563,194	608,620
Durable Medical Equipment, Medical Equipment, and Drugs	2,072,661	2,020,730
Other Expenses	2,677,263	2,528,163
Program Support	49,558	42,721
Depreciation and Amortization	344,425	404,587
Fundraising	57,658	67,906
Interest	7,620	6,826
Total Expenses	22,723,444	22,061,295
EXCESS OF REVENUE, GAINS AND OTHER SUPPORT OVER EXPENSES	25,770	1,327,083
NONOPERATING GAINS		
Gain on Lease Termination	7,919	-
Unrealized (Loss) Gain on Investments	(14,429)	222,850
Total Nonoperating (Losses) Gains	(6,510)	222,850
Net Increase in Unrestricted Net Assets	19,260	1,549,933
TEMPORARILY RESTRICTED NET ASSETS		
Contributions, Net of Allowances and Discounts	459,282	425,986
Investment Income	155,989	299,068
Net Assets Released from Restrictions for Operations	(746,440)	(834,230)
Decrease in Temporarily Restricted Net Assets	(131,169)	(109,176)
PERMANENTLY RESTRICTED NET ASSETS		
Contributions, Net of Allowances and Discounts	991,175	71,994
Investment Income	4,378	97,702
Increase in Permanently Restricted Net Assets	995,553	169,696
CHANGE IN NET ASSETS	883,644	1,610,453
Net Assets - Beginning of Year	19,435,771	17,825,318
NET ASSETS - END OF YEAR	$ 20,319,415	$ 19,435,771

See accompanying Notes to Consolidated Financial Statements.

MONTGOMERY HOSPICE, INC. AND AFFILIATE
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets	$ 883,644	$ 1,610,453
Adjustments to Reconcile Change in Net Assets to		
Net Cash Provided by Operating Activities		
Depreciation	344,425	404,587
Loss on Disposal of Fixed Assets	85,199	-
Net Unrealized (Gain) Loss on Investments	76,345	(476,272)
Net Realized Gains on Sale of Investments	(138,189)	(127,498)
Donated Investments	(1,019,756)	(60,973)
Contributions Restricted for Long-Term Purposes	-	(71,994)
Changes in Assets and Liabilities:		
Patient Accounts Receivable	(30,900)	584,141
Contributions and Grants Receivable	266,761	193,009
Other Receivable	45,847	(17,243)
Prepaid Expenses and Other Current Assets	(16,272)	(40,802)
Accounts Payable and Accrued Expenses	138,365	97,918
Accrued Salaries and Employee Benefits	(282,819)	45,982
Deferred Rent	(190,619)	(73,071)
Net Cash Provided by Operating Activities	162,031	2,068,237
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sale of Investments	2,858,334	2,426,259
Purchase of Investments	(3,096,656)	(2,562,135)
Purchase of Property and Equipment	(195,637)	(211,653)
Net Cash Used in Investing Activities	(433,959)	(347,529)
CASH FLOWS FROM FINANCING ACTIVITIES		
Donor-Restricted Contributions for Long-term Purposes	-	71,994
Payments on Capital Lease Obligations	(40,929)	(30,950)
Net Cash (Used in) Provided by Financing Activities	(40,929)	41,044
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(312,857)	1,761,752
Cash and Cash Equivalents - Beginning of Year	5,278,953	3,517,201
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 4,966,096	$ 5,278,953
SUPPLEMENTAL DISCLOSURE		
Cash Paid for Interest	$ 5,884	$ 3,922
NONCASH TRANSACTION		
Equipment Acquired by Capital Lease	$ 108,672	$ -

See accompanying Notes to Consolidated Financial Statements.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Montgomery Hospice, Inc. (the Hospice) was incorporated in 1979 under the laws of the State of Maryland. The Hospice provides outpatient hospice and inpatient hospice (The Montgomery Hospice Casey House) services to the terminally ill and their families in Montgomery County, Maryland.

Montgomery Hospice Foundation, Inc. (the Foundation) commenced operations in December 1989 as a charitable foundation to solicit and receive all grants, contributions, and special activity revenues received in either the name of the Hospice or the Foundation. The Board of Directors of the Hospice and the Foundation have entered into an agreement providing that all such funds and contributions will be recorded in the accounts of the Foundation and that the Foundation will conduct its operations exclusively for the benefit of the Hospice. Effective July 1, 2014 the Foundation merged with the Hospice.

Palliative Medicine Consultants of Greater Washington, LLC (Palliative Medicine), a wholly owned limited liability company of the Hospice, was established in 2002 to offer a continuum of care throughout the Greater Washington area for patients with advanced illness whose treatment goals emphasize quality of life. Palliative Medicine combines aggressive medical management of pain and other debilitating symptoms with counseling and support for the social, psychological and spiritual needs of patients and families. During 2007, Palliative Medicine activities were discontinued, although the entity was not closed. In October 2013, medical services provided began to be reactivated.

Consolidation

These consolidated financial statements include the accounts of the Hospice and the Palliative Medicine (collectively, the Organization). All inter-company accounts and transactions have been eliminated in the consolidated financial statements.

Income Taxes

The Hospice is a tax-exempt entity as described in Section 501(c)(3) of the Internal Revenue Code (IRC). Palliative Medicine is a limited liability company whose operating results flow through to the Hospice, which is its sole corporate member. None of these entities are classified as a private foundation as defined by the Internal Revenue Service.

The IRC provides for taxation of unrelated business income under certain circumstances. The Hospice and its affiliated entities have no significant unrelated business income; however, such status is subject to final determination upon examination of the related income tax returns by the appropriate taxing authorities. The tax returns for the fiscal years ended 2011 through 2013 are open to examination by federal and state authorities

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amount of revenues and expenses during the reporting period. Areas subject to management estimates include allowances for contractual adjustments and doubtful accounts related to patient accounts receivable, estimated third-party payor settlements, reserves for workers' compensation claims and reserves for patient care expenses. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with an original maturity of three months or less except for those included in the investment portfolio. The Organization deposits its temporary cash investments in financial institutions. At times, such investments may be in excess of the FDIC insurance limit.

Net Patient Service Revenue, Patient Accounts Receivable and Allowances for Uncollectible Accounts

Medicare and Medicaid Net Patient Revenue and Receivables

Revenue for services rendered to patients covered under the Medicare and Medicaid programs are recorded based on date of service at amounts equal to payment rates specific to the Hospice that are set by the Medicare and Medicaid programs. The payment rates are daily or hourly rates for each of the four levels of care provided by the Hospice (i.e. routine care, general inpatient care, continuous care and respite care). Adjustments are made to revenue for the inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The Hospice estimates the impact of these adjustments based on historical experience, which primarily includes historical claims adjustments, and records it during the period services are rendered as an estimated revenue adjustment and as a reduction to patient accounts receivable.

Medicare and Medicaid Net Patient Revenue and Receivables

Additionally, the Hospice reimbursement from Medicare is subject to an inpatient cap limit and an overall payment cap. If inpatient days of hospice care provided exceeds 20% of the total days of hospice care provided for an annual period beginning on November 1, then payments for days in excess of this limit are paid for at the routine home care rate. If overall payments made by Medicare to the Hospice exceeds their hospice cap limit (as calculated by the Medicare fiscal intermediary) for an annual period beginning on November 1, then payments in excess of the hospice cap limit have to be repaid to Medicare. The Organization reviews the adequacy of its hospice cap liability on a periodic basis. The Hospice did not have an overpayment liability at December 31, 2014 or 2013.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Net Patient Service Revenue, Patient Accounts Receivable and Allowances for Uncollectible Accounts (Continued)

Medicare and Medicaid Net Patient Revenue and Receivables (Continued)

Approximately 72% and 77% of net patient service revenue was earned from the Medicare and Medicaid Programs for the years ended December 31, 2014 and 2013, respectively. Due to the significance of Medicare and Medicaid program revenues to the Organization, any change in the reimbursement methodologies employed by the Medicare and Medicaid program for hospice services could significantly impact the financial operations and financial position of the Organization.

Other Third-Party Payor Net Patient Revenue and Receivables

Revenue for services rendered to patients covered by other third-party payors (e.g. commercial insurance carriers, health maintenance organizations, and preferred provider organizations, etc.) is recorded based on date of service at amounts equal to the Organization's established rate or a rate negotiated with the third-party payor. Contractual adjustments are recorded for the difference between the Organization's established rate and the amounts estimated to be realized from third-party payors and are deducted from revenues and patient accounts receivable.

Allowance for Uncollectible Accounts

The Organization maintains a policy for reserving for uncollectible accounts. The Organization calculated the allowance for uncollectible accounts based on a formula applied to the aging of accounts receivable. Accounts are written off when all collection efforts are exhausted.

Contributions Receivable

Pledges are recorded initially and subsequent to initial recognition at fair value. The fair value of contributions receivable is determined by using U.S. Treasury securities rate at various applicable maturity years, quoted on investment basis. Although management uses its best judgment at estimating fair value of the contributions receivable, there are inherent limitations in any valuation technique. Therefore, the value is not necessarily indicative of the amount that could be realized in a current transaction. Future events will also affect the estimates of fair value, and the effect of such events on the estimates of fair value could be material.

Investments

Investments consist of debt and equity securities with readily determinable fair values and are measured at fair value in the consolidated balance sheets. Certificates of deposit are valued at cost which approximate fair value. Investment income or loss includes realized gains and losses, interest, dividends and certain unrealized gains and losses. The investment income or loss on investments that are restricted by donor or law is recorded as increases or decreases to temporarily restricted and permanently restricted net assets.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Acquisitions of property and equipment greater than $2,000 are recorded at cost and depreciated over their estimated useful lives using the straight-line method. Donated property is recorded at fair market value on the date received.

Impairment of Long-Lived Assets

The Organization reviews long-lived assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of carrying amount or the fair value less costs to sell. There were no impairment losses recorded for the years ended December 31, 2014 and 2013.

Net Assets

Net assets of the Organization and changes therein are classified and reported as follows:

Unrestricted - Those resources over which the Board of Directors has discretionary control. Designated amounts represent those revenues that the Board has restricted for Casey House Operations.

Temporarily Restricted - Those resources subject to donor imposed restrictions that will be satisfied by actions of the Organization or passage of time.

Permanently Restricted - Those resources subject to a donor imposed restriction that they be maintained permanently by the Organization.

Contributions

Unconditional promises to give cash and other assets are accrued at estimated fair market value at the date each promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction is satisfied, net assets are released and reported as an increase in unrestricted net assets. Donor-restricted contributions whose restrictions are met within the same reporting period as received are recorded as unrestricted contributions.

Excess of Revenue, Gains and Other Support Over Expenses

The consolidated statements of operations and changes in net assets include excess of revenue, gains and other support over expenses. Changes in unrestricted net assets which are excluded from excess of revenue, gains and other support over expenses and losses, consistent with industry practice, include gains on lease termination and unrealized gain (loss) on Investments.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Charity Care and Community Benefit

The mission of the Organization is to enhance life and minimize suffering by offering high quality care and support to individuals with a life-limiting illness and their families and to provide educational services concerning death, dying and grief to individuals in Montgomery County and nearby communities. The Organization provides services to patients regardless of their ability to pay for those services.

The Organization defines and measures this "investment in" and "partnership with" the community primarily through its non-revenue generating bereavement program, palliative care program, in-patient services program, complementary therapy program, pediatric hospice care program and self-pay/financial assistance programs. The Organization provides care to patients who meet certain criteria under its financial assistance policy without charge. Key elements used to determine eligibility include a patient's demonstrated inability to pay based on family size and household income related to federal income poverty guidelines. The Organization's charity care guidelines are 150% of the Federal Poverty Guidelines as published. Because the Organization does not pursue collection of amounts determined to qualify for financial assistance, they are not reported as revenue. The Organization has estimated its direct and indirect costs of providing charity care under its financial assistance policy.

In order to estimate the cost of providing such care, management calculated a cost-to-charge ratio by comparing the per diem rate from the most recently filed cost report to the Organization's gross bill rate. The cost-to-charge ratio is applied to the charity care charges foregone to calculate the estimated direct and indirect cost of providing charity care. Using this methodology, the Organization has estimated the costs foregone for services and supplies furnished under the Organization's financial assistance policy aggregated approximately $506,000 and $435,000 for the years ended December 31, 2014 and 2013, respectively.

Fair Value Measurements

Fair value measurement applies to reported balances that are required or permitted to be measured at fair value under an existing accounting standard. The Organization emphasizes that fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability and establishes a fair value hierarchy. The fair value hierarchy consists of three levels of inputs that may be used to measure fair value as follows:

Level 1 – Inputs that utilize quoted prices (unadjusted) in active markets for identical assets or liabilities that the Organization has the ability to access.

Level 2 – Inputs that include quoted prices for similar assets and liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument. Fair values for these instruments are estimated using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

NOTE 1 ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Fair Value Measurements - Continued

Level 3 – Inputs that are unobservable inputs for the asset or liability, which are typically based on an entity's own assumptions, as there is little, if any, related market activity.

In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

Fair Value Option

The Organization elected the fair value option for promises to give. The fair value option election was made to simplify the record keeping. The option allows companies to irrevocably elect fair value as the initial and subsequent measurement attribute for certain financial assets and financial liabilities. Changes in fair value for assets and liabilities for which the election is made will be recognized in earnings as they occur. The fair value option is permitted on an instrument by-instrument basis at initial recognition of an asset or liability or upon an event that gives rise to a new basis of accounting for that instrument.

Reclassifications

Certain 2013 amounts have been reclassified to conform to the 2014 presentation. These reclassifications had no effect on previously reported net assets.

Subsequent Events

In preparing these consolidated financial statements, the Organization has evaluated events and transactions for potential recognition or disclosure through April 29, 2015, the date the consolidated financial statements were available for issuance.

NOTE 2 CONCENTRATION OF CREDIT RISK

Financial instruments which subject the Organization to a concentration of credit risk consist of demand deposits placed with financial institutions. At times during the year, the Organization had funds invested with local financial institutions in excess of the Federal Deposit Insurance Corporation limits. The Organization has not experienced any losses on such deposits.

The Organization also grants credit without collateral to its patients, most of whom are insured under third-party payor agreements.

NOTE 2 CONCENTRATION OF CREDIT RISK (CONTINUED)

The mix of receivables from patients and third-party payors at December 31 was as follows:

	2014	2013
Medicare	72%	68%
Medicaid	4%	9%
Commercial and Other	24%	23%
Total	100%	100%

NOTE 3 CONTRIBUTIONS RECEIVABLE

The following is a report of contributions receivable due within one year and one to five years as of December 31:

	2014	2013
Amounts Due In:		
Less Than One Year	$ 39,277	$ 291,921
One to Five Years	15,359	29,476
	$ 54,636	$ 321,397

NOTE 4 INVESTMENTS

Investments, stated at fair value, at December 31 include the following:

	2014	2013
Cash and Money Funds	$ 1,688,178	$ 1,562,880
Equities	-	37,447
Fixed Income	1,882,213	2,494,825
Mutual Funds - Equities	4,701,647	4,118,772
Mutual Funds - Fixed Income	3,208,066	1,977,729
Certificates of Deposit	404,082	372,610
Total	$ 11,884,186	$ 10,564,263

Investment income from cash equivalents and investments is comprised of the following for the years ended December 31:

	2014	2013
Interest and Dividend Income	$ 334,975	$ 196,441
Net Realized Gains on Sales of Securities	138,189	127,498
Change in Net Unrealized (Loss) Gain	(76,345)	476,272
Total	$ 396,819	$ 800,211

NOTE 5 PROPERTY AND EQUIPMENT

Property and equipment as of December 31 consist of the following:

	2014	2013
Furniture and Equipment	$ 455,720	$ 1,098,664
Capital Leases	146,672	123,000
Computer Equipment and Software	605,302	886,453
Leasehold Improvements	-	787,877
Land	672,721	650,709
Land Improvements	130,904	127,704
Building	2,375,934	2,375,934
	4,387,253	6,050,341
Less: Accumulated Depreciation	(1,789,533)	(3,327,306)
Total Property and Equipment	$ 2,597,720	$ 2,723,035

NOTE 6 CAPITAL LEASE OBLIGATIONS

The Organization acquired office equipment under non-cancellable lease agreements which expire between 2015 and 2016. The net book value of the equipment at December 31, 2014 and 2013 is as follows:

	2014	2013
Cost	$ 146,672	$ 123,000
Accumulated Depreciation	(43,078)	(87,286)
	$ 103,594	$ 35,714

Depreciation expense amounted to $40,792 and $30,786 for the years ended December 31, 2014 and 2013. Future minimum lease payments due under this lease are as follows:

Year Ending December 31,	
2015	$ 71,648
2016	49,581
Total	121,229
Less Amounts Representing Interest	(14,771)
	106,458
Capital Lease Obligation, Current Portion	(59,827)
Capital Lease Obligation, Net of Current Portion	$ 46,631

NOTE 7 LINES OF CREDIT

The Organization had a revolving line of credit with a bank in the amount of $700,000 that terminated on November 30, 2014 and opened a margin account on December 9, 2014 with another financial institution to support working capital needs and was secured by short term investments held at the same financial institution. The Organization has a second line of credit with a bank in the amount of $31,000 that serves as collateral for the security deposit on the office lease.

NOTE 8 LETTER OF CREDIT

The Organization has a letter of credit with a bank in the amount of $130,291 as collateral for Maryland State Unemployment Tax as of December 31, 2014 and 2013.

NOTE 9 TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets consist of the following at December 31:

	2014			
	January 1, 2014	Additions	Releases	December 31, 2014
Purpose Restricted:				
Casey House Operations	$ 693,880	$ 411,069	$ (418,016)	$ 686,933
Clinical Activities	282,965	-	(200,000)	82,965
General Programs	154,462	204,202	(128,424)	230,240
	$ 1,131,307	$ 615,271	$ (746,440)	$ 1,000,138

	2013			
	January 1, 2013	Additions	Releases	December 31, 2013
Purpose Restricted:				
Casey House Operations	$ 642,950	$ 508,055	$ (457,125)	$ 693,880
Clinical Activities	483,406	-	(200,441)	282,965
General Programs	114,127	216,999	(176,664)	154,462
	$ 1,240,483	$ 725,054	$ (834,230)	$ 1,131,307

NOTE 10 RETIREMENT PLANS

The Organization offers a 403(b) Tax Sheltered Annuity through T. Rowe Price. Eligible employees may contribute to the plan subject to statutory limitations. The Board of Directors may also determine an annual contribution, generally of 1% to 3% of gross earnings, for employees with two years of service who have also worked a minimum of 1,000 hours each year. The Organization made a total contribution of $234,220 and $277,194 to the plan for the years ended December 31, 2014 and 2013, respectively.

NOTE 11 FAIR VALUE MEASUREMENTS

The following investments of the Organization are measured at fair value on a recurring basis and were recorded using the fair value hierarchy at December 31:

	2014			
	Level 1	Level 2	Level 3	Total
Investments:				
Equities	$ -	$ -	$ -	$ -
Fixed Income	1,882,213	-	-	1,882,213
Mutual Funds - Equities	4,701,647	-	-	4,701,647
Mutual Funds - Fixed Income	3,208,066	-	-	3,208,066
Total Investments	9,791,926	-	-	9,791,926
Contributions Receivable, Net	-	-	54,636	54,636
Total	$ 9,791,926	$ -	$ 54,636	$ 9,846,562

	2013			
	Level 1	Level 2	Level 3	Total
Investments:				
Equities	$ 37,447	$ -	$ -	$ 37,447
Fixed Income	2,494,825	-	-	2,494,825
Mutual Funds - Equities	4,118,772	-	-	4,118,772
Mutual Funds - Fixed Income	1,977,729	-	-	1,977,729
Total Investments	8,628,773	-	-	8,628,773
Contributions Receivable, Net	-	-	321,397	321,397
Total	$ 8,628,773	$ -	$ 321,397	$ 8,950,170

Level 3 Assets

The following table provides a summary of changes in fair value of the Organization's Level 3 financial assets for the years ended December 31:

Contributions Receivable, Net	2014	2013
Beginning of Year Balance	$ 321,397	$ 514,406
New Pledge Commitments	109,660	541,564
Pledge Payments	(360,946)	(738,765)
Write-offs	(15,638)	-
Change in Fair Value	163	4,192
End of Year Balance	$ 54,636	$ 321,397

NOTE 12 ENDOWMENT FUNDS

The Organization has donor-restricted endowment funds established for purposes of providing income to support the Casey House and Hospice at Home programs. As required by GAAP, net assets of the endowment funds are classified and reported based on the existence or absence of donor-imposed restriction. The Board of Directors of the Organization has interpreted the State of Maryland's Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Organization classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Organization in a manner consistent with the standard of prudence prescribed by UPMIFA and by the donor.

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

- The duration and preservation of the fund
- The purposes of the organization and the donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the organization
- The investment policies of the organization

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or UPMIFA requires the Organization to retain as a fund for perpetual duration. In accordance with GAAP, deficiencies of this nature are reported as a reduction of unrestricted net assets. There were no deficiencies of this nature as of December 31, 2014 and 2013.

Return Objectives and Risk Parameters

Management of the endowment assets is designed to ensure a total return (income plus capital change) necessary to preserve and enhance (in real dollar terms) the principal of the fund and, at the same time, provide a dependable source of support for current programs. The Organization's objective is that total investment returns shall exceed the US Consumer Price Index by four percent (4%). Actual experience in any given year may vary from this amount.

NOTE 12 ENDOWMENT FUNDS (CONTINUED)

Strategies Employed for Achieving Objectives

Reasonable diversification is sought at all times. Experience has shown financial markets and inflation rates are cyclical and, therefore, control of volatility will be achieved through diversification of asset classes and selection of managers of diverse investment styles. The Board of Directors examines the correlation of the investment portfolio and it has historically had positive returns.

Spending Policy

The Organization follows the spending rate of 4% of the average of the portfolio as of December 31st for the three years prior to the current year. The spending for the Casey House endowment for Nurses and Nurses Aides from the Casey Foundation is restricted to only income from the fund and capital gains are not considered to be income. The spending for the other endowment funds includes both income from the fund and capital gains.

Board-Designated Endowment

As of December 31, 2014 and 2013, the Board of Directors had designated $1,906,960 and $439,540, respectively, of unrestricted net assets received from Foundation contributions to become part of the Casey House Nursing Endowment.

The following is a summary of endowment funds subject to UPMIFA for the years ended December 31:

	Unrestricted Endowment	Temporarily Restricted	Permanently Restricted	Total
Endowment Net Assets, January 1, 2013	$ 439,540	$ 255,932	$ 3,181,676	$ 3,877,148
Contributions	-	-	71,994	71,994
Investment Gain, Net	-	299,068	97,702	396,770
Appropriations	-	(125,113)	-	(125,113)
Endowment Net Assets, December 31, 2013	439,540	429,887	3,351,372	4,220,799
Contributions	1,467,420	-	991,175	2,458,595
Investment Gain, Net	30,599	155,989	4,378	190,966
Appropriations	-	(137,304)	-	(137,304)
Endowment Net Assets, December 31, 2014	$ 1,937,559	$ 448,572	$ 4,346,925	$ 6,733,056

NOTE 13 FUNCTIONAL EXPENSES

The costs of providing various programs and other activities have been summarized on a functional basis and are provided below for the years ended December 31, 2014 and 2013. Accordingly, overhead expenses have been allocated among the activities benefited based upon position responsibilities.

	2014	2013
Program Services	$ 20,326,523	$19,769,452
Management and General	1,889,600	1,731,312
Fundraising	507,321	560,531
Total	$ 22,723,444	$ 22,061,295

NOTE 14 COMMITMENTS AND CONTINGENCIES

Operating Leases

The Organization has non-cancelable operating leases for office space that will expire in December 2015. Through these leases, the Organization received $475,400 of leasehold improvements related to the office space. The effects of the scheduled rent increases and leasehold improvements are being recognized by the Hospice on a straight-line basis over the life of the lease. The unrecognized portion of rent increases and lease incentives are reflected as deferred rent in the accompanying consolidated balance sheets. The leases contain fixed escalation clauses for increases in the annual minimum rent over the term of the lease and obligates the Organization to pay its pro rata share of the building's operating expenses and real estate taxes. In October 2014, a new lease was signed with a commencement date of January 1, 2015 and expiring on December 31, 2025 and terminated the old leases as of December 31, 2014. For the years ended December 31, 2014 and 2013, rent expense amounted to $296,864 and $430,451, respectively. Aggregate minimum annual rental payments are follows:

Year Ending December 31,	
2015	$ 307,868
2016	315,564
2017	323,453
2018	331,540
2019	339,828
Thereafter	2,225,001
Total	$ 3,843,254

NOTE 14 COMMITMENTS AND CONTINGENCIES (CONTINUED)

Contingencies

During the normal course of business, the Organization may be subject to various threatened or asserted claims related to professional liability, employment or other matters. The Hospice has purchased occurrence-based general liability insurance from a commercial insurance carrier. This policy covers claims resulting from incidents that occur during the policy term, regardless of when the claims are reported to the insurance carrier. The Hospice also purchased claims-made professional liability insurance from the same commercial insurance carrier which covers claims when they are first reported to the insurance carrier during the policy term. The Hospice has had continuous claims-made professional liability coverage since September 1, 1998. Cumulative claims made on the policy as of and for the years ended December 31, 2014 and 2013 did not exceed the maximum insurable limits.

The Hospice has also purchased excess umbrella insurance coverage to supplement its professional and general liability insurance policy.

Healthcare Industry

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

SUPPLEMENTARY INFORMATION

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION

To the Board of Directors of
Montgomery Hospice, Inc.
Rockville, Maryland

We have audited the consolidated financial statements of Montgomery Hospice, Inc. and affiliates as of and for the years ended December 31, 2014 and 2013, and our report thereon dated April 29, 2015, which expressed an unmodified opinion on those consolidated financial statements, appears on page 1. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheets and consolidating statements of operations and changes in net assets are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Arlington, Virginia
April 29, 2015

MONTGOMERY HOSPICE, INC. AND AFFILIATE
CONSOLIDATING BALANCE SHEET
DECEMBER 31, 2014
(SEE INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION)

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 4,952,971	$ 13,125	$ -	$ 4,966,096
Patient and Other Accounts Receivable, Net of Allowance for Doubtful Accounts of $284,622	2,684,404	-	-	2,684,404
Contributions and Grants Receivable	39,277	-	-	39,277
Other Receivable	3,146	-	-	3,146
Prepaid Expenses and Other Current Assets	317,114	-	-	317,114
Due from Palliative Medicine Consultants	41,740	-	(41,740)	-
Total Current Assets	8,038,652	13,125	(41,740)	8,010,037
CONTRIBUTIONS AND GRANTS RECEIVABLE, NET OF CURRENT PORTION	15,359	-	-	15,359
INVESTMENT IN PALLIATIVE MEDICINE CONSULTANTS OF GREATER WASHINGTON, LLC	(28,615)	-	28,615	-
INVESTMENTS	11,884,186	-	-	11,884,186
PROPERTY AND EQUIPMENT, NET	2,597,720	-	-	2,597,720
Total Assets	$ 22,507,302	$ 13,125	$ (13,125)	$ 22,507,302
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts Payable and Accrued Expenses	$ 1,058,773	$ -	$ -	$ 1,058,773
Accrued Salaries, Payroll Taxes and Employee Benefits	1,022,656	-	-	1,022,656
Due to Hospice	-	41,740	(41,740)	-
Capital Lease Obligations, Current Portion	59,827	-	-	59,827
Total Current Liabilities	2,141,256	41,740	(41,740)	2,141,256
CAPITAL LEASE OBLIGATIONS, NET OF CURRENT PORTION	46,631	-	-	46,631
Total Liabilities	2,187,887	41,740	(41,740)	2,187,887
NET ASSETS				
Unrestricted:				
Undesignated	13,034,793	(28,615)	28,615	13,034,793
Board Designated	1,937,559	-	-	1,937,559
Total Unrestricted	14,972,352	(28,615)	28,615	14,972,352
Temporarily Restricted	1,000,138	-	-	1,000,138
Permanently Restricted	4,346,925	-	-	4,346,925
Total Net Assets	20,319,415	(28,615)	28,615	20,319,415
Total Liabilities and Net Assets	$ 22,507,302	$ 13,125	$ (13,125)	$ 22,507,302

MONTGOMERY HOSPICE, INC. AND AFFILIATES
CONSOLIDATING BALANCE SHEET
DECEMBER 31, 2013
(SEE INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION)

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Montgomery Hospice Foundation, Inc.	Eliminations	Total
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	$ 2,755,720	$ 9,720	$ 2,513,513	$ -	$ 5,278,953
Patient and Other Accounts Receivable, Net of Allowance for Doubtful Accounts of $313,069	2,653,504	-	-	-	2,653,504
Contributions and Grants Receivable, Current Portion	-	-	291,921	-	291,921
Other Receivable	5,776	6,000	37,217	-	48,993
Prepaid Expenses and Other Current Assets	287,003	-	13,839	-	300,842
Intercompany Investment Transfer	500,000	-	-	(500,000)	-
Due from Palliative Medicine Consultants	31,449	-	-	(31,449)	-
Due from Foundation	1,433,649	-	-	(1,433,649)	-
Total Current Assets	7,667,101	15,720	2,856,490	(1,965,098)	8,574,213
CONTRIBUTIONS AND GRANTS RECEIVABLE, NET OF CURRENT PORTION	-	-	29,476	-	29,476
INVESTMENT IN PALLIATIVE MEDICINE CONSULTANTS OF GREATER WASHINGTON, LLC	(15,728)	-	-	15,728	-
INVESTMENTS	-	-	10,564,263	-	10,564,263
PROPERTY AND EQUIPMENT, NET	2,722,855	1	179	-	2,723,035
Total Assets	$ 10,374,228	$ 15,721	$ 13,450,408	$ (1,949,370)	$ 21,890,987
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts Payable and Accrued Expenses	$ 917,017	$ -	$ 3,391	$ -	$ 920,408
Accrued Salaries, Payroll Taxes and Employee Benefits	1,261,483	-	43,992	-	1,305,475
Due to Hospice	-	31,449	1,433,649	(1,465,098)	-
Capital Lease Obligations, Current Portion	29,091	-	-	-	29,091
Deferred Rent, Current Portion	87,759	-	-	-	87,759
Intercompany Investments Transfer	-	-	500,000	(500,000)	-
Total Current Liabilities	2,295,350	31,449	1,981,032	(1,965,098)	2,342,733
CAPITAL LEASE OBLIGATIONS, NET OF CURRENT PORTION	9,623	-	-	-	9,623
DEFERRED RENT, NET OF CURRENT PORTION	102,860	-	-	-	102,860
Total Liabilities	2,407,833	31,449	1,981,032	(1,965,098)	2,455,216
NET ASSETS					
Unrestricted:					
Undesignated	7,966,395	(15,728)	6,547,157	15,728	14,513,552
Board Designated	-	-	439,540	-	439,540
Total Unrestricted	7,966,395	(15,728)	6,986,697	15,728	14,953,092
Temporarily Restricted	-	-	1,131,307	-	1,131,307
Permanently Restricted	-	-	3,351,372	-	3,351,372
Total Net Assets	7,966,395	(15,728)	11,469,376	15,728	19,435,771
Total Liabilities and Net Assets	$ 10,374,228	$ 15,721	$ 13,450,408	$ (1,949,370)	$ 21,890,987

MONTGOMERY HOSPICE, INC. AND AFFILIATE
CONSOLIDATING STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS
YEAR ENDED DECEMBER 31, 2014
(SEE INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION)

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Montgomery Hospice Foundation, Inc.	Eliminations	Total
UNRESTRICTED REVENUE, GAINS AND OTHER SUPPORT					
Net Patient Service Revenue	$ 20,898,450	$ -	$ -	$ -	$ 20,898,450
Contributions, Grants, and Gifts	1,561,155	4,704	-	(798,316)	767,543
Special Events	83,665	-	-	-	83,665
Interest, Dividends, and Realized Gains	251,241	-	-	-	251,241
Other Revenue	1,875	-	-	-	1,875
Net Assets Released from Restrictions Used for Operations	746,440	-	-	-	746,440
Total Revenue, Gains and Other Support	23,542,826	4,704	-	(798,316)	22,749,214
EXPENSES					
Salaries and Benefits	16,952,794	11,158	-	(12,887)	16,951,065
Purchased Services	563,194	-	-	-	563,194
Durable Medical Equipment, Medical Equipment, and Drugs	2,072,661	-	-	-	2,072,661
Other Expenses	2,671,263	6,000	-	-	2,677,263
Program Support	847,874	-	-	(798,316)	49,558
Depreciation and Amortization	344,425	-	-	-	344,425
Fundraising	57,658	-	-	-	57,658
Interest	7,187	433	-	-	7,620
Total Expenses	23,517,056	17,591	-	(811,203)	22,723,444
EXCESS (DEFICIT) OF REVENUE, GAINS AND OTHER SUPPORT OVER EXPENSES	25,770	(12,887)	-	12,887	25,770
NONOPERATING GAINS (LOSSES)					
Gain on Lease Termination	7,919	-	-	-	7,919
Unrealized Loss on Investments	(14,429)	-	-	-	(14,429)
Total Other Nonoperating Losses	(6,510)	-	-	-	(6,510)
Net Increase (Decrease) in Unrestricted Net Assets	19,260	(12,887)	-	12,887	19,260
TEMPORARILY RESTRICTED NET ASSETS					
Contributions, Net of Allowances and Discounts	459,282	-	-	-	459,282
Investment Income	155,989	-	-	-	155,989
Net Assets Released from Restrictions for Operations	(746,440)	-	-	-	(746,440)
Decrease in Temporarily Restricted Net Assets	(131,169)	-	-	-	(131,169)
PERMANENTLY RESTRICTED NET ASSETS					
Contributions, Net of Allowances and Discounts	991,175	-	-	-	991,175
Investment Income	4,378	-	-	-	4,378
Increase in Permanently Restricted Net Assets	995,553	-	-	-	995,553
CHANGE IN NET ASSETS	883,644	(12,887)	-	12,887	883,644
Net Assets - Beginning of Year	7,966,395	(15,728)	11,469,376	15,728	19,435,771
Net Assets from Merged Entity	11,469,376	-	(11,469,376)	-	-
NET ASSETS - END OF YEAR	$ 20,319,415	$ (28,615)	$ -	$ 28,615	$ 20,319,415

MONTGOMERY HOSPICE, INC. AND AFFILIATES
CONSOLIDATING STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS
YEAR ENDED DECEMBER 31, 2013
(SEE INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION)

	Montgomery Hospice, Inc.	Palliative Medicine Consultants of Greater Washington, LLC	Montgomery Hospice Foundation, Inc.	Eliminations	Total
UNRESTRICTED REVENUE, GAINS AND OTHER SUPPORT					
Net Patient Service Revenue	$ 21,088,768	$ -	$ -	$ -	$ 21,088,768
Contributions, Grants, and Gifts	-	-	1,161,271	-	1,161,271
Intercompany Contribution	794,435	-	-	(794,435)	-
Special Events	-	-	87,729	-	87,729
Interest, Dividends, and Realized Gains	3,480	-	177,111	-	180,591
Other Revenue	10,827	24,000	962	-	35,789
Net Assets Released from Restrictions Used for Operations	-	-	834,230	-	834,230
Total Revenue, Gains and Other Support	21,897,510	24,000	2,261,303	(794,435)	23,388,378
EXPENSES					
Salaries and Benefits	15,940,101	38,635	418,717	(15,711)	16,381,742
Purchased Services	568,551	-	40,069	-	608,620
Durable Medical Equipment, Medical Equipment, and Drugs	2,020,730	-	-	-	2,020,730
Insurance and Other	2,492,804	-	35,359	-	2,528,163
Program Support	-	-	837,156	(794,435)	42,721
Cost Allocations	(90,000)	-	90,000	-	-
Depreciation and Amortization	400,104	-	4,483	-	404,587
Fundraising	-	-	67,906	-	67,906
Interest	5,750	1,076	-	-	6,826
Total Expenses	21,338,040	39,711	1,493,690	(810,146)	22,061,295
EXCESS (DEFICIT) OF REVENUE, GAINS AND OTHER SUPPORT OVER EXPENSES	559,470	(15,711)	767,613	15,711	1,327,083
NONOPERATING GAINS					
Unrealized Gain on Investments	-	-	222,850	-	222,850
Total Other Nonoperating Gains	-	-	222,850	-	222,850
Net Increase (Decrease) in Unrestricted Net Assets	559,470	(15,711)	990,463	15,711	1,549,933
TEMPORARILY RESTRICTED NET ASSETS					
Contributions, Net of Allowances and Discounts	-	-	425,986	-	425,986
Investment Income	-	-	299,068	-	299,068
Net Assets Released from Restrictions for Operations	-	-	(834,230)	-	(834,230)
Decrease in Temporarily Restricted Net Assets	-	-	(109,176)	-	(109,176)
PERMANENTLY RESTRICTED NET ASSETS					
Contributions	-	-	71,994	-	71,994
Investment Income	-	-	97,702	-	97,702
Increase in Permanently Restricted Net Assets	-	-	169,696	-	169,696
CHANGE IN NET ASSETS	559,470	(15,711)	1,050,983	15,711	1,610,453
Net Assets - Beginning of Year	7,406,925	(17)	10,418,393	17	17,825,318
NET ASSETS - END OF YEAR	$ 7,966,395	$ (15,728)	$ 11,469,376	$ 15,728	$ 19,435,771