gentiva

Certificate of Need Application
Hospice Agency

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

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

Signature and Title of Responsible Officer	Date
Deborah Hagopian Deborah Hagopian, RN Executive Director – Administrator Email Address deborah.hagopian@gentivahs.com	January 30, 2025 Telephone Number 253.414.2186
Legal Name of Applicant Odyssey HealthCare Operating B, LP d/b/a Gentiva Address of Applicant 9750 3rd Avenue N.E., Suite 375 Seattle, WA 98115-2022	Provide a brief project description ☐ New Agency ☒ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $ $106,968
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. Pierce County	

Brief Project Description: Odyssey HealthCare Operating B, LP d/b/a Gentiva intends to establish a Medicare and Medicaid certified hospice location licensed to provide all hospice services as federally mandated to all residents of Pierce County. The services will include routine home care, general in-patient care, continuous care and respite care, bereavement, pastoral care, nursing services, home aide services, and 24-hour nurse availability call services.

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Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246- 310-230).

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

Odyssey HealthCare Operating B, LP d/b/a Gentiva
9750 3rd Avenue N.E., Suite 375
Seattle, WA 98115-2022

Odyssey HealthCare LP, LLC
3350 Riverwood Parkway, Suite 1400
Atlanta, GA 30339-3314

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

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

Odyssey HealthCare Operating B, LP d/b/a Gentiva is a Delaware limited partnership registered to do business in Washington. Its UBI number is 602 306 941.

Odyssey Healthcare LP, LLC is a Delaware limited liability company. No UBI number is assigned.

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

Deborah Hagopian, RN
Executive Director – Administrator
Gentiva Hospice
9750 3rd Avenue N.E., Suite 375
Seattle, WA 98115-2022
Deborah.hagopian@gentivahs.com
253.414.2186

4. Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).

Emily R. Studebaker, Esq.
Studebaker Nault, PLLC
11900 N.E. 1st Street, Suite 300
Bellevue, WA 98005
425.279.9929
estudebaker@studebakernault.com

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

See Exhibit 1 – Organizational Structure

6. Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities.

The following identifying information should be included:

- Facility and Agency Name(s)
- Facility and Agency Location(s)
- Facility and Agency License Number(s)
- Facility and Agency CMS Certification Number(s)
- Facility and Agency Accreditation Status
- If acquired in the last three full calendar years, list the corresponding month and year the sale became final
- Type of facility or agency (home health, hospice, other)

See Exhibit 2 – List of Entities Owned

Project Description

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

Odyssey HealthCare Operating B, LP d/b/a Gentiva
9750 3rd Avenue, Suite 375
Seattle, WA 98115

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

Odyssey HealthCare Operating B, LP d/b/a Gentiva ("Gentiva"), located at 9750 3rd Avenue N.E., Suite 375, Seattle, WA 98115-2022 in King County, seeks to add Pierce County to its existing coverage area. Gentiva is currently licensed to serve patients that reside in King County. Gentiva desires to establish an alternate delivery site ("ADS") at a physical location in Pierce County, in the City of Tacoma.

The proposed site will be a fully operational site staffed just like any other ADS. Ultimate supervision of the ADS or "Multiple Location" will rest with the parent location, Gentiva, King County.

"Multiple location" means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the parent hospice location issued the certification number. A multiple location must meet all the conditions of participation applicable to hospices.

1. Multiple locations will be directed, administered and monitored by the parent location, Gentiva, King County, in accordance with regulations and Gentiva policy.

2. Drop sites will not function as multiple locations.

3. Multiple location sites will comply with all applicable policies and procedures as the parent location, Gentiva, King County.

   See Exhibit 8 – Multiple Location Site Control Policy

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

Odyssey HealthCare Operating B, LP d/b/a Gentiva
1102 Broadway, Suite 200
Tacoma, WA 98402

4. Provide a detailed description of the proposed project.

Overview

Gentiva is located at 9750 3rd Avenue N.E., Suite 375, Seattle, WA 98115-2022 in King County and seeks to add Pierce County to its existing coverage area. In October 2024, the Washington State Department of Health ("DOH") 2024-2025 Initial Hospice Numeric Need Methodology identified Pierce County as having a need for an additional provider of hospices services to end-of-life patients and their families. Gentiva is currently licensed to serve patients that reside in King County. Gentiva desires to establish an ADS at a physical location in Pierce County under the provider number in King County to service this CON need.

Gentiva Quality

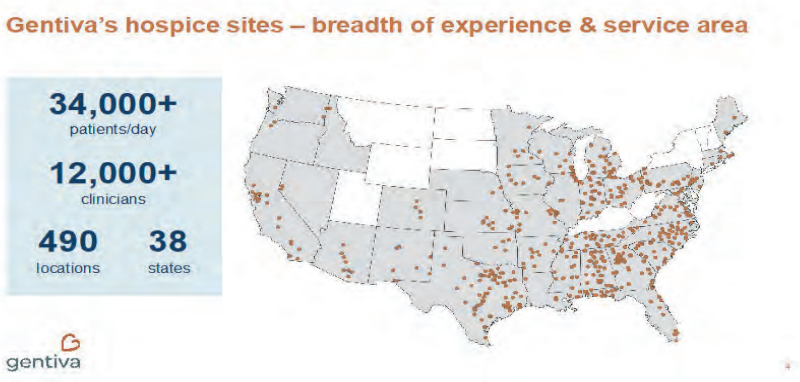
Gentiva has been recognized nationally with several quality awards that make us stand out among other providers. We are very excited to be included among the top award recipients across the nation.

Table 1 – Gentiva Quality Awards

Gentiva Breadth of Experience

Gentiva offers service across the country serving over 34,000 patients and their families each day. With 490 locations in 38 states, Gentiva has extensive experience and knowledge related to new upstart locations in new geographies.

Table 2 – Gentiva Experience



Accredited by Accreditation Commission for Health Care ("ACHC")

Gentiva, King County, is accredited by ACHC. ACHC has deeming authority granted by the Centers for Medicare and Medicaid Services ("CMS"), which determines whether providers meet CMS quality standards and the Medicare Conditions of Participation. Deeming authority means that CMS recognizes that ACHC accreditation standards meet or exceed Medicare standards. ACHC's accreditation is conferred only after a rigorous evaluation performed during an unscheduled in-person visit to a hospice location.

Service to Minority Populations

Gentiva has a strong history of serving minority populations in its communities. Of all patients admitted to Gentiva's locations in the 12 months ending on June 30, 2024, 11.4 percent were African American, and 6.8 percent were Hispanic or Latino. This exceeds the national average admission rate of 8.2 percent for African Americans and 6.7 percent for Hispanic or Latino populations. Pierce County's African American population represents 8.2 percent of the total population; its Hispanic or Latino population represents 13.1 percent of the total population; and its American Indian and Alaska Native population represents 1.9 percent of the total population. See Table 3 – Race and Hispanic Origin. Gentiva is committed to serving all minority populations and looks forward to reaching out and servicing all of the populations of Pierce County.

Table 3 – Race and Hispanic Origin

Race and Hispanic Origin	
White alone, percent	71.9%
Black alone, percent (a)	8.2%
American Indian and Alaska Native alone, percent (a)	1.9%
Asian alone, percent (a)	7.8%
Native Hawaiian and Other Pacific Islander alone, percent (a)	1.9%
Two or More Races, percent	8.2%
Hispanic or Latino, percent (b)	13.1%
White alone, not Hispanic or Latino, percent	62.1%

(1) https://www.census.gov/quickfacts/piercecountywashington

We Honor Veterans Program

With 79,222 Veterans in Pierce County, Veterans make up 8.5 percent of the population. See Table 4 – Veteran Population.

Table 4 – Veteran Population

Population Characteristics	
Veterans, 2019-2023	79,222

(1) https://www.census.gov/quickfacts/fact/table/Piercecountywashington/PST04521

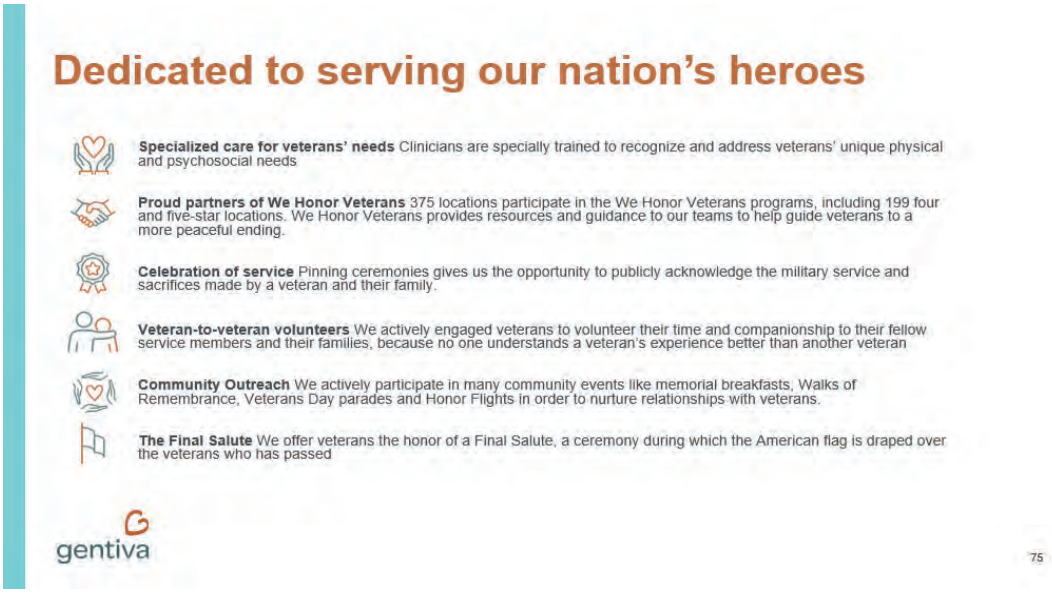
Gentiva recognizes the unique needs of America's Veterans and their families. Gentiva is a dedicated supporter of *We Honor Veterans*, a program of the National Hospice and Palliative Care Organization ("NHPCO") in collaboration with the Department of Veterans Affairs ("VA").

We Honor Veterans is a pioneering program focused on respectful inquiry, compassionate listening, and grateful acknowledgment so that Veterans can be guided through their life stories toward a more peaceful ending. Gentiva, King County is a 3-star partner of the program and would be proud to offer this program to the Veterans of Pierce County. Gentiva's dedication to *We Honor Veterans* includes the following:

- Gentiva employs clinical liaisons to work with VA Medical Centers, the Veterans Benefits Administration, local Veterans' organizations, and long-term care communities in Gentiva's service areas.

- Gentiva identifies hospice patients with military experience using a Veterans military history questionnaire upon admission to hospice care.
- Gentiva devises care plans that consider a Veteran's injuries received in combat, illnesses or diseases contracted while serving, the effects of biological or chemical agents, post-traumatic stress disorder, depression, and substance abuse.
- The Gentiva Hospice Veterans Liaison and staff social workers help eligible Veterans, and their families receive proper recognition from the Military Funeral Honors program.

Table 5 – Gentiva's Dedication to Veterans



Gentiva Medical Direction

Gentiva contracts with a qualified physician as Medical Director overseeing its clinical operations.

Nursing Services

Gentiva employs nurse supervisors and additional nursing staff to meet the needs of all admitted patients.

Dedicated After Hours and Weekend On-Call Personnel

Gentiva's after-hours and weekend on-call personnel are staffed separately from Monday through Friday personnel, which allows nurses to start their shift refreshed and ready to provide the highest level of post-acute care.

24 /7 RN Call Center

Gentiva offers a 24 hour per day, 7 days per week, dedicated call center staffed by RNs to answer questions and provide immediate support for caregivers and patients. Gentiva patients will never have to use an outsourced answering service or wait for a return call.

Spiritual Counseling Services

Gentiva employs chaplains and spiritual counselors to meet the spiritual needs of all patients and their families.

Volunteer Services

Gentiva recruits and trains volunteers to support the care delivery of patients and families. Gentiva operates robust volunteer programs in all locations and uses trained volunteers for a variety of special services including pet therapy and companion visits.

Bereavement Services

Gentiva provides 13 months of bereavement support for bereaved family members of hospice patients.

Nutritional Services

Gentiva provides nutritional services whenever required under a patient's plan of care.

Advance Directives and DNR Orders

Gentiva's policies and procedures comply with state law and rules related to advance directives. Gentiva informs each patient of his/her right to establish an advance directive as part of the advance care planning process, which begins at admission and is reassessed throughout the hospice care process. Gentiva does not restrict admission or limit services based on a patient's self-determination choices. Copies of patient self-determination documents are maintained in the clinical record and the patient's home.

Comprehensive Emergency Management Plan

Gentiva has established an operative plan for emergency preparedness and response in accordance with state and federal requirements. Gentiva ensures plans are based on an assessment of the potential risks and hazards specific to the hospice location. Plans address communication needs during and after the situation and are reviewed annually. Gentiva's policy includes requirements that each location's plan include a provision for special needs shelter and annual review with the appropriate county emergency management authority.

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

Gentiva is proposing to service Pierce County patients and their families with an ADS based in the Tacoma area with the parent provider being Odyssey HealthCare Operating B, LP d/b/a Gentiva, which is based in Seattle, WA. Tacoma is the most populous city in Pierce County, and this will be the most strategic location from which to service all of the residents of Pierce County.

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

Table 6 – Estimated Timeline to Begin Serving Patients

Event	Anticipated Month/Year
CN Approval	9/1/25
Design Complete (If applicable)	n/a
Construction Commenced (if applicable)	n/a
Office Lease Executed	9/2/25
Office Fully Equipped	12/31/25
Staff Hired and Trained	3/1/26
Agency Prepared for Survey	5/1/26
Agency Providing Medicare and Medicaid hospice services in proposed county.	7/1/26

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

Table 7 – Services Offered

☑	Skillled Nursing	☑	Durable Medical Equipment
☑	Home Health Aide	☐	IV Services
☑	Physical Therapy	☑	Nutritional Counseling
☑	Occupational Therapy	☑	Bereavement Counseling
☑	Speech Therapy	☑	Symptom and Pain Management
☑	Respiratory Services	☑	Phatmacy Services
☑	Medical Social Services	☑	Respite Care
☐	Palliative Care	☑	Spirtual Counseling
☐	Other (Please Describe)		

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

Gentiva currently services patients and families in King County. Both Medicare and Medicaid services are provided.

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

This application proposes to expand the service area of Gentiva to Pierce County upon licensure approval. The services Gentiva proposes to provide in Pierce County upon licensure approval will be consistent with those services Gentiva provides in King County.

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

Gentiva provides adult hospice services to end of life regardless of age, race, color, national origin, religion, sex (inclusive of gender identity and sexual orientation), disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other area protected by law (See Exhibit 6 – Non-Discrimination Policy), and will ensure that all populations have access to services through it's Charity Care Policy (see Exhibit 4). This includes patients with any diagnosis designated by the attending physician that indicates a life expectancy of 6 months or less.

11. Provide a copy of the letter of intent that was already submitted according to WAC246-310-080 and WAC 246-310-290(3).

See Exhibit 9 – Letter of Intent

12. Confirm that the agency will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing agency, provide the existing agency's license number and Medicare and Medicaid numbers.

IHS.FS. 60330209

Medicare #: 50-1541

Medicaid #: 2035575

Certificate of Need Review Criteria
A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

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

Table 8 – Historical Utilization

County (King) - Odyssey	2022	2023	2024
Total Number of Admissions	50	111	141
Total Number Patient Days	7680	7739	10304
Average Daily Census	21	21	28

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

Table 9 – Projected Utilization

County (King) - Odyssey - Existing	2022	2023	2024	2025 Proj	2026 Proj	2027 Proj	2028 Proj
Total Number of Admissions	50	111	141	161	171	181	192
Total Number Patient Days	7680	7739	10304	11636	12366	13096	13826
Average Daily Census	21	21	28	32	34	36	38

County (Pierce) ADS	2022	2023	2024	2025 Proj	2026 Proj	2027 Proj	2028 Proj
Total Number of Admissions	0	0	0	0	18	150	220
Total Number Patient Days	0	0	0	0	913	11498	18250
Average Daily Census	0	0	0	0	7	31	50

Assumptions: Projected ADC growth is historically based. The anticipated growth for Pierce is 3.0 ADC per month. We continue with modest projected growth assumptions based upon historical growth for Gentiva, King County through 2028.

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

Patient access to hospice care is critical in any market. The DOH 2024-2025 Initial Hospice Numeric Need Methodology identified Pierce County as having a need for an additional hospice provider. Adding an additional provider would increase access and allow patients and families greater flexibility in their healthcare choices.

Current research shows that availability of qualified staff in Pierce County is average. Lack of qualified staff can restrict patient access to hospice services. In order to recruit and retain qualified associates, Gentiva ensures it provides a good work/life balance. Qualified associates enjoy a comprehensive benefits package, including 401(k) with match, competitive compensation, flexible schedules, PTO, floating holidays, and holiday pay. Gentiva also offers extensive training to grow skills, as well as tuition reimbursement.

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

The DOH's 2024-2025 Initial Hospice Numeric Need Methodology has established need for an additional hospice provider in Pierce County, WA. Gentiva's application seeks to address that unmet need for additional hospice services identified by the DOH's 2024-2025 Initial Hospice Numeric Need Methodology. That determination and the attached Exhibit 10 demonstrate that this application is not an unnecessary duplication of services for Pierce County.

See Exhibit 10 – DOH Hospice Need Methodology

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

With the establishment of an ADS in Tacoma, Pierce County, WA, we believe we will be able to effectively service all Pierce County patients and their families with the parent

provider being Odyssey HealthCare Operating B, LP d/b/a Gentiva, which is based in Seattle, WA. Tacoma is the most populous city in Pierce County, and this will be the most strategic location from which to service the residents and their families.

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

The DOH's 2024-2025 Initial Hospice Numeric Need Methodology has established need for an additional hospice provider in Pierce County, WA. Gentiva's application seeks to address that unmet need for additional hospice services identified by the DOH's 2024-2025 Initial Hospice Numeric Need Methodology.

Gentiva makes its services available to all patients without discrimination (See Exhibit 6 - Non-Discrimination Policy). As noted in earlier sections of this application, Gentiva has a strong history of serving minority and underserved populations in its communities, including without limitation, African Americans, Hispanic and Latino populations, and Veterans. As noted above, Gentiva's patients admitted in the 12 months ending on June 30, 2024, for African American and Hispanic and Latino patients exceed the national average.

In evaluating this criteria, the DOH has generally reviewed an applicant's admission policies, willingness to serve Medicare and Medicaid patients, and ability to serve patients that cannot afford services. Gentiva is currently serving Medicare and Medicaid patients in King County and, if the application is approved, will serve Medicare and Medicaid patients in Pierce County. In addition, Gentiva is providing copies of its Admission Policy (Exhibit 3), Charity Care Policy (Exhibit 4), and Non-Discrimination Policy (Exhibit 6).

7. Provide a copy of the following policies:

•Admissions policy

See Exhibit 3 – Admission Policy

•Charity care or financial assistance policy

See Exhibit 4 – Charity Care Policy

•Patient Rights and Responsibilities policy

See Exhibit 5 – Patient Rights and Responsibilities Policy

•Non-discrimination policy

See Exhibit 6 – Non-Discrimination Policy

Suggested additional policies include any others believed to be directly related to patient access (death with dignity, end of life, advanced care planning)

See Exhibit 7 – Death with Dignity Policy

See Exhibit 8 – Multiple Location Site Control Policy

8. If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:

•All applicable review criteria and standards with the exception of numeric need have been met;
•The applicant commits to serving Medicare and Medicaid patients; and
•A specific population is underserved; or
•The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.
Note: The department has sole discretion to grant or deny application(s)submitted under this subsection.

This section is non-applicable since Washington State has determined Pierce County has a numeric need.

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

Financial feasibility of a hospice project is based on the criteria in WAC 246-310-220.

1. Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:

•Utilization projections. These should be consistent with the projections provided under the Need section. **Include all assumptions.**

See Exhibit 13 – P&L's

•Pro Forma revenue and expense projections for at least the first three full calendar years of operation using at a minimum the following Revenue and Expense categories identified at the end of this question. **Include all assumptions.**

See Exhibit 13a – P&L – Pierce County

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

See Exhibit 15 – Balance Sheet

•For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.

See Exhibit 13b- P&L – Gentiva King + Pierce

2. Provide the following agreements/contracts:

•Management agreement.

Non-Applicable

•Operating agreement

Non-Applicable

•Medical director agreement

See Exhibit 18 – Medical Director Agreement

•Joint Venture agreement

Non-Applicable

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

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

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

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

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

The attached draft Lease Agreement and executed Letter of Intent between J2 Investments ("Lessor") and Odyssey Healthcare Operating B, LP (Lessee") demonstrates control of the site located at 1102 Broadway, Suite 200, Tacoma, WA 98402.

See Exhibit 12 – Draft Lease Agreement and Executed Letter of Intent.

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

Table 10 – Estimated Capital Expenditure

Item	Cost	Assumptions
a. Land Purchase	$0.00	n/a
b. Utilities to Lot Line	$0.00	n/a
c. Land Improvements	$0.00	n/a
d. Building Purchase	$0.00	n/a
e. Residual Value of Replace Facility	$0.00	n/a
f. Building Construction	$0.00	n/a
g. Fixed Equipment (not already included in the construction contract)	$0.00	n/a
h. Moveable Equipment	$35,000.00	Based upon historical branch establishment
i. Architect and Engineering Fees	$0.00	n/a
j. Consulting/Legal/Application Fees	-	-
1. Consulting	$0.00	n/a
2. Legal	$50,000.00	Based upon previous CON submissions
3. Application Fees	$21,968.00	Based upon DOH Washington Hospice Application Fees
k. Site Preparation	$0.00	n/a
l. Supervision and Inspection of Site	$0.00	n/a
m. Any Costs Associated with Securing Financing	-	n/a
1. Land	$0.00	n/a
2. Building	$0.00	n/a
3. Equipment	$0.00	n/a
4. Other	$0.00	n/a
n. Washington Sales Tax	$0.00	n/a
Total Estimated Capital Expenditure	$106,968.00	-

5. Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

Gentiva has provided the estimated capital cost identified.

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

All costs associated with the startup of the ADS are included in the proforma. See Exhibits 13a, 13b, 13c, and 15.

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

Gentiva has provided 100% of the estimated capital expenditures/start-up costs noted above.

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

The project will have a total of $106,968 (See Table 12) of capital impact in the question above and will produce the jobs shown in the FTE calculation. See Exhibit 16 - Employee Detail.

Hospice provides stabilizing support to families and provides assistance to those who are alone without family support. The overall healthcare operating costs within Pierce County will be reduced from these unmet admissions being admitted to Gentiva.

The hospice benefit is primarily a Medicare benefit paid by the federal program directly. Many beneficiaries are dual eligible beneficiaries of both Medicaid and Medicare. Gentiva Hospice services will reduce the costs for these Medicaid beneficiaries for the county by providing supportive services and reducing acute admissions.

A 2022 study of hospice costs from 2002 – 2016 found $7,727 savings for CMS for patients served by hospice compared to the control group not served by hospice for the last three months of their lives. See Exhibit 22 - Jama Health Forum.

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

Hospice services in Pierce County are covered by Medicare and Medicaid services, as well as many private/commercial insurers. As a result, the only impact to costs and charges for health services in the planning area will be a reduction in overall Medicare spending, a resultant savings to the Medicare program. See Exhibit 21 - NORC Study – Value of Hospice Care. Additionally, there will be no construction costs because of this project.

10. Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."

Table 11 – Projected Payor Mix – Pierce Only

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	99%	99%
Medicaid	1%	1%
Private pay	0%	0%
Total	100%	100%

11. If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.

Table 12 – Historical Payor Mix – Gentiva, King County + Pierce

	KSE + Pierce							
			Historical			Projected		
		2022	2023	2024	2025	2026	2027	2028
	Revenue							
	Medicare (Including Managed Care)	1,248,872	1,584,910	2,191,329	2,683,123	3,359,996	6,275,076	7,698,276
	Medicaid (Including Managed Care)	-	18,959	19,561	1,948	2,320	3,956	4,693
	Private pay	10,140	5,534	910	-	-	-	-
	Other (tri-Care, VA, LNI)	10	-	(5,329)	(15,971)	(19,598)	(36,518)	(43,979)

Note: Negative figures on Line 8 are projected adjustments for Room and Board with skilled nursing home patients.

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

Moveable equipment, furnishings, and computers are estimated to be $35,000 and are listed as a capital expenditure on Table 10.

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

This project will be funded from cash on hand. The bank accounts are maintained at Truist Bank.

See Exhibit 19 – Letter of Financial Commitment
See Exhibit 23 – Truist Bank Letter and Account Balance

14. If this project will be debt financed through a financial institution, provide are payment schedule showing interest and principal amount for each year over which the debt will be amortized.

This project will not be financed. It will be funded utilizing cash on hand.

15. Provide the most recent audited financial statements for:
- The applicant, and
- Any parent entity responsible for financing the project.

See Exhibit 20 – Unaudited Financial Statements - Financials are not audited at this level of operation.

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

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

1. Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.

See Exhibit 16 - Employee Detail (Field/Clinical Model); and
See Exhibit 17 - Employee Detail (Administrative Model)

2. If this application proposes the expansion of an **existing** agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.

This application proposes an ADS location based in Tacoma, Pierce County, WA that operates with its own contingency of staff. Exhibit 14 details the FTE's proposed for that location. See Exhibit 14 – FTE's – Historical and Projected.

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

Executive Director/Administrator	1/Location
PCM Patient Care Manager	1/Location
Registered Nurse	1RN/12 Patients
Social Workers	1SW/45 Patients
Aides (CNA)	1CNA/12 Patients
Chaplain	2 Chaplain/60Patients
Volunteer/Bereavement Coordinator	1VC/BC/80 Patients

Assumptions used to project the number and types of FTE for this project: The staffing levels noted above are not fixed, and may vary and be adjusted depending upon a number of factors, such as the intensity of care required for a patient and the family, growth of the patient census, travel time to patient homes, safety issues, percentage of facility-based patients, etc. Many factors are utilized to determine staffing needs and ratios. What is provided above is the initial staffing levels for the project developed with reference to the NHPCO Hospice Staffing Framework (See Exhibit 26 - NHPCO Hospice Staffing Framework) that is adjusted to ensure the highest quality patient care will be delivered.

> [The hospice] framework differs from previously published staffing ratios and guidelines in that recommended ranges for caseloads are not provided. Instead, using the analysis process delineated in the framework, each hospice may assess a number of variables and outcome measures to identify whether there are opportunities to tailor staffing to meet the needs of their organization.

See Exhibit 26 - NHPCO Hospice Staffing Framework, at 2 (March 2024).

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

Gentiva's staffing model is designed to efficiently and effectively service patients. By leveraging a strategic combination of skilled professionals, optimized scheduling, and

technology, we will ensure that each patient receives high-quality care without compromising on service standards. This model allows us to maintain a sustainable workload for Gentiva's nursing staff of 12:1 while meeting the individual patient needs.

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

Dr. Eric Sohn Regional Medical Director/Contracted/MD00037099
See Exhibit 18 – Medical Director Agreement

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

Non-Applicable as the medical director is contracted.

7. Identify key staff by name and professional license number, if known. If not yet known, provide a timeline for staff recruitment and hiring (nurse manager, clinical director, etc.)

Key staff have not been identified at this time. Recruiting will begin for an Executive Director upon award of a CON and establishment of the office. The Executive Director will work with Gentiva's denovo team and staff recruiting division to advertise and begin the selection process for all positions. See Table 6 – Estimated Timeline to Serve Patients, which includes timeline for hiring personnel.

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

Table 13 – Names and License Numbers for Current Staff

Number	First Name	Last Name	Position	License Type	License #
51011592	Danielle	Drazic	Registered Nurse	RN	RN 61241362
51010160	Mardeliza	Britt	Registered Nurse	RN	RN 61572109
51008401	Getachew	Haile	Registered Nurse On Call	RN	RN 61220787
50061684	Bashir	Abumenjel	Registered Nurse On Call	RN	RN 61033298
50062132	Deborah	Hagopian	Administrator RN	RN	RN 60678614
51016931	Liliya	Semenyuk	Registered Nurse	RN	RN 61009762
51014830	Carrie	Norrah	Social Worker MSW	LW	LW 00008373
51006951	Kaleb	Bruce	Patient Care Manager	RN	RN 61279212
51007905	Amy	Elligsen	Registered Nurse Admissions	RN	RN 00106897
50076859	Tetsuomi	Honda	Registered Nurse	RN	RN 00147278
50076849	Andrew	Grossman	Nurse Practitioner	AP	AP60282819 & RN60102308
51015789	Noemi	Mendoza	Aide	NC	NC 61600118
51011235	Yodit	Werede	Aide	NC	NC 60101620

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

Current research shows that availability of qualified staff in Pierce County is market average. Lack of qualified staff can restrict access to patient care. Many organizations talk about the importance of a good work/life balance, but Gentiva makes it a foundation of Gentiva's care. New team members will work with, and learn from, passionate team members who have come to Gentiva to make a difference in people's lives. Gentiva offer's

all Gentiva's associates training to learn new skills and empower them with the autonomy to decide how best to use those skills.

All associates and potential associates are vetted through extensive background checks as well as state and federal exclusion lists. In order to recruit and retain qualified personnel, qualified associates enjoy a comprehensive benefits package, including 401(k) with match, competitive compensation, flexible schedules, PTO, floating holidays, and holiday pay. We also offer extensive training to grow skills, as well as tuition reimbursement.

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

Gentiva's operations run 24 hours per day, 7 days per week, 365 days per year, ensuring that patients have access to Gentiva's services at any time by calling Gentiva's main number. During business hours (Monday to Friday, 8:00am – 5:00pm), Gentiva's team is readily available to assist patients with accessing the care they need. Outside of these hours, Gentiva's dedicated nursing staff will answer calls, triage patient needs, and dispatch an on-call nurse to the patient's bedside as necessary.

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

At Gentiva, patient and family satisfaction is Gentiva's top priority. We continuously seek feedback on the care we provide, ensuring that family decision-makers and Gentiva's care partners in facilities where Gentiva's patients reside are included in the process. We deliver surveys to Gentiva's referral sources and ask for candid feedback as part of Gentiva's quarterly quality assurance and performance improvement process. Additionally, we engage a third-party service to administer surveys and collect real-time data for prompt feedback. When we fall short of meeting Gentiva's customers' needs, we conduct a root cause analysis and collaborate with Gentiva's clinical leaders and compliance team to ensure no vital steps are missed in the care of Gentiva's hospice patients.

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

DME – State Serv
Pharmacy – Enclara
Med Supplies – Medline
Therapy Services – Centerwell Home Health

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

Existing ancillary and support agreements are expected to remain in place and will be unchanged.

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

Pierce County will be a new area of service for Gentiva. Community relationships are essential to establishing a hospice operation that reaches the community to ensure the provision of and access to hospice for all who desire the service. This, of course, includes not just the medical professionals, but groups who may have contact with the elderly or others who may be entering the death and dying phase of their life. Community education is a critical aspect to understanding hospice services. This ongoing education serves to dispel myths associated with hospice care that may be barriers, especially for the underserved communities.

Gentiva intends to establish relationships with the following entities to provide ancillary support and services to its patients:

- Hospitals
- Skilled Nursing Facilities
- Assisted Living Facilities
- Independent Living Facilities
- Physicians
- Urgent Care Centers
- Social Workers
- Dialysis Centers
- Home Health Organization
- Personal Care Operations
- Insurance/Health Maintenance Organizations
- American Cancer Society
- Heart Association
- Alzheimer's Society
- Churches and Funeral Homes
- Public Libraries
- VA Facilities
- Senior Centers
- Durable Medical Equipment Companies
- Laboratory Centers
- Community/Job/Senior Fairs

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

The Hearthstone at Green, 7720 E Green Lake Way N, Seattle, WA 98103
Briarwood Health Center, 100 Timber Ridge Way, NW Issaquah, WA 98205
University of Washington, 1959 NE Pacific St., Seattle, WA 98195
Shoreline Health and Rehabilitation, 2818 NE 145 St, Shoreline, WA 98155
Valley View Talbot, 4430 Talbot Rd S, Renton, WA 98055
Parkshore, 1630 43rd Ave E, Seattle, WA 98112
Aegis Living and Memory Care, 2200 E Madison St, Seattle, WA 98112

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

Other than the addition of working relationships as noted in #14 above and #17 below, no existing working relationships will change.

17. For a **new** agency, provide the names of healthcare facilities with which the hospice agency anticipates it would establish working relationships.

While not a new agency, as Gentiva is expanding into a new planning area, it anticipates establishing working relationships with the following facilities:

CHI Virginia Mason, 1717 South J Street, Tacoma, WA 98405
MultiCare Health System, 315 Martin Luther King Jr. Way, Tacoma, WA 98405
ALF Facilities +
Merrill Gardens, 5 S G St, Tacoma, WA 98405
Brookdale, 3615 South 23rd Street, Tacoma, WA 98405
Cogir at the Narrows, 8201 6th Avenue, Tacoma, WA 98406
Kings Manor, 8609 Portland Avenue, Tacoma, WA 98445
Weatherly Inn, 606 Columbia Street N.W. Ste 101, Olympia, WA 98501
Gencare, 4970 Main Street, Tacoma, WA 98407
The Village, 4707 South Orchard Street, Tacoma, WA 98466
Spring Ridge, 6856 E Portland Avenue, Tacoma, WA 98404
Skilled Nursing Facilities +
Frank Tobey Jones. 5340 N Bristol St, Tacoma, WA 98407
Heartwood Extended, 1649 E 72nd St, Tacoma, WA 98404
Aglity Health, 5520 Bridgeport Way W, University Place, WA 98467
The Oaks, 11411 Bridgeport Way SW, Lakewood, WA 98499
Avamere Heritage, 3625 East B St, Tacoma, WA 98404
Promedica, 5601 S Orchard St, Tacoma, WA 98409

18. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)

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

No facility or practitioner associated with this application has a history of the actions listed above.

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

Providing continuity of care and avoiding fragmentation in care delivery is something that Gentiva does well across the country and in the communities it serves. The Gentiva affiliated companies, year to date, have served multiple different referral sources across 38 states.

As noted above, there is a need for an additional hospice provider in Pierce County and, as noted in other sections of this application, Gentiva already provides services in King County. Gentiva works closely with local healthcare providers in the continuum of care to ensure that patients and families receive the highest levels of support and coordinated service. This includes hospitals, skilled nursing facilities, assisted living facilities and physicians. Each of these referral sources exhibits confidence in Gentiva's abilities to promote best practices, continuity, and unwarranted fragmentation in services. Gentiva takes pride in providing care for each patient on an individual level based on their specific needs. Gentiva will develop relationships with local providers in Pierce County.

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC246-310-230.

Gentiva would serve the existing healthcare system in the same manner as the other current hospice agencies in the planning area. Gentiva prides itself on providing excellent hospice care to the communities we serve. Gentiva also prides itself in being a valuable resource for not only the community's existing health care system, but also for ancillary services, such as the American Cancer Society, Veterans Clinics and Organizations, civic organizations, and local community colleges and schools.

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

The Applicant does not have a pattern of condition-level findings.

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

Not Applicable

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

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

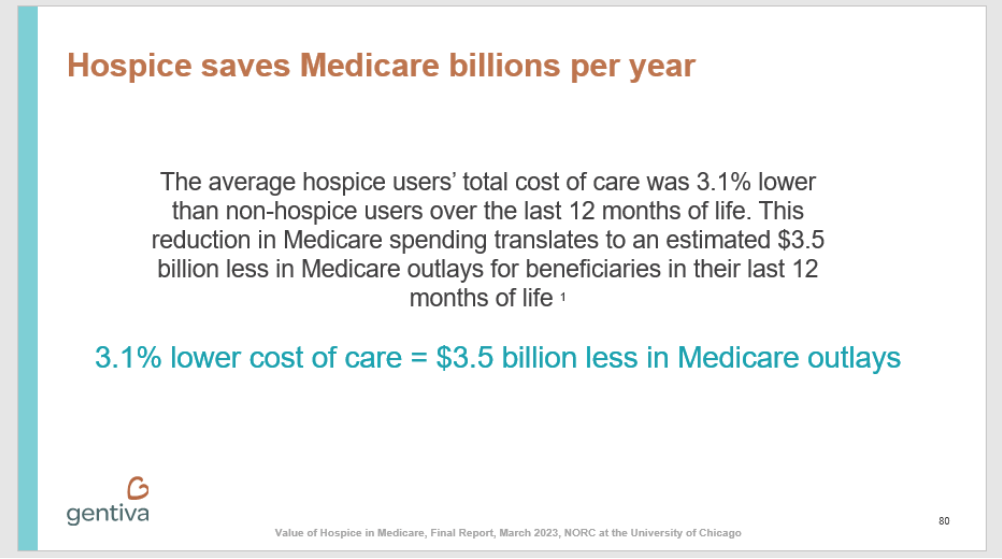
Value of Hospice Care

Key Findings NORC Study March 2023 (Note: NORC Study was commissioned and endorsed by NHPCO and NAHC. See study summary under Attachment F)

- In the last year of life, the total costs of care for Medicare beneficiaries who elected hospice were 3.1 percent lower than the adjusted spending of beneficiaries who did not use hospice.

- Medicare spending in the 12 months preceding death is consistently lower for beneficiaries with lengths of stay of 15 days or more, compared to beneficiaries who did not elect hospice, regardless of disease group.

Table 14 - Hospice Saves Medicare Billions



Hospital Avoidance Program Reduces Unnecessary Hospitalizations

Unnecessary hospitalizations utilize critical and limited health care resources. Gentiva's proprietary Hospital Avoidance Program engages in frequent and regular telephone contacts with the caregivers of high-risk patients. Calls are made by clinicians, and frequency is based upon the acuity of each patient's diagnoses and symptoms. Hospital avoidance allows Gentiva's clinical staff and nurse case managers an opportunity to intervene before a potential health or symptom crises results in the need for urgent care or hospitalization.

Outreach Coordination Program Maintains Contact with High-Risk Individuals

Uncoordinated medical care for patients with chronic illnesses has been estimated to cost nearly $88,000 per person. Gentiva's Outreach Coordination Program focuses on the continuum of care for patients to ensure the right level of care is delivered at the right time. The program results in improved outcomes and cost reduction through identification and intervention in potential health or symptom crises. The program always honors the patient's and family's choice of provider, even if it is not Gentiva.

Table 15 – Gentiva Clinical Contact/Outreach Coordination Program

1. Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.

The alternative to Gentiva's proposal versus a "no project" would be not offering hospice care to those identified as having a need in Pierce County. As mentioned above, hospice care not only benefits the patients and their grieving families but also provides reduced emergency room visits and cost-containment benefits. See Table 16.

A second alternative would be the granting of a CON to a provider other than Gentiva. Gentiva believes that it is the best hospice option for Pierce County as has been outlined in the section labeled "Hospice Agency Superiority."

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

Table 16 – No Action vs Action Comparison (Patient Access & Capital Costs)

	Patient Access to Hospice Services	Capital Costs
Discussion	The DOH 2024-2025 Initial Hospice Numeric Need Methodology show the need for an additional hospice provider within Pierce County in order to meet the number of projected deaths in the coming years.	Are capital costs a consideration related to the implementation of the project?
No Action Proposal Rejected by Applicant	No action would have meant that patients and families of Pierce County would potentially not have access to choice Medicare/Medicaid hospice providers.	No action would of course mean "zero" capital cost expenditures.
Action Proposal as Accepted by Applicant	Gentiva's proposed alternate delivery site would afford more patients access to the Medicare and Medicaid hospcie benefit and help to insure the unmet need is met going forward.	This project has a capital cost projection Of $106,968.
Summary:	The action proposal would be more benefical than the no action proposal for the patients and families of Pierce County allowing the unmet need to be fulfilled by a new provider.	The proposed capital costs for the project are offset by the significant Medicare savings that will result by increasing hospice access in Pierce County. With just 38 project patients served where the need is unmet, this represents a $292,600 savings to Medicare potentially in the first full year of operations. (See Exhibit 23 - JAMA Health Forum Study)

Table 17 – No Action vs Action Comparison (Legal Restrictions & Staffing Impacts)

	Legal Restrictions	Staffing Impacts
Discussion	What impact will legal restrictions have related to the implementation of this project?	What impact will staffing have on the implementation of this project?
No Action Proposal Rejected by Applicant	Legal restrictions play a role in hospice access by limiting the number of providers. This has potentially both positive and a negative impacts on proivders and patients. Since DOH monitors and publishes need, as long as providers make application for the need territory, there are no negataive effects. No action in this instance would mean that the 'need" that has been identified would continue to go unmet.	Current research show that availability of registered nurses in the Pierce County area is average. This means that we do not anticipate staffing issues in the region.
Action Proposal as Accepted by Applicant	With DOH 2024-2025 Initial Hospice Numeric Need Methodology showing need, Gentiva hopes to be able to service/meet the unmet need of patients and their families in Pierce County	Gentiva believes that recruiting will not be an issue in Pierce County due to the availability of nurses.
Summary:	Legal implications will not have an effect on the project due to the fact that DOH 2024-2025 Initial Hospice Numeric Need Methodology shows need.	Gentiva's excellent benefit packages and competitive salary pacakges, as well as Gentiva's commitment to quality patient care, will potentially be benefical to the recruitment of RN's and that staffing will not be an issue with the project.

Table 18 – No Action vs Action Comparison (Quality of Care & Cost/Efficiency of Operations)

	Quality of Care	Cost or Operation Efficiency
Discussion	What impact will the project have on quality of care?	What impact will the project have on costs or operational efficiency?
No Action Proposal Rejected by Applicant	A no-action move in regards to this project means that the DOH 2024-2025 Initial Hospice Numeric Need Methodology showing need wil continue to go unmet. Quality of care will be impacted negatively as a result of patients and families not having access to hospice care.	A no-action move in regards to this project means that the DOH 2024-2025 Initial Hospice Numeric Need Methodology showing need wil continue to go unmet, negavtively impacting how Medicare dollars are spent.
Action Proposal as Accepted by Applicant	Gentiva strives with the programs to maintian and increase quality wherever they can. With our live 24/7/365 call center, we are able to have a clinican available to patients and families at the touch of a phone. Our hospital avoidance program has been instrumental in reducung ER vists and readmission to hospitals.	With 38 projected patients served, this represents a $292,600 savings to Medicare potentially in the first full year of operations. (See Exhibit 23 - JAMA Health Forum Study)
Summary:	Its clear that a new hospice provider in Pierce County will add to the quality of patient care that is delivered to patients and their families versus a no- action move related to this project.	A non-action proposal would not be the best feasible cost option for Pierce County, the State of Washington, nor the US Federal Governement.

3. If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):

•The costs, scope, and methods of construction and energy conservation are reasonable; and
•The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

This project is not anticipated to involve construction.

4. Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment, and which promote quality assurance and cost effectiveness.

Hospice services have been demonstrated to be a cost-effective service for patients. As noted in earlier sections of this application, the total costs of care for Medicare beneficiaries who elect hospice were 3.1 percent lower than the adjusted spending of beneficiaries who did not use hospice.

Gentiva's Hospital Avoidance Program and Outreach Coordination Program focuses on ensuring patients receive the appropriate level of care, obtain improved outcomes, and reduce costs by avoiding potentially costly and unnecessary urgent care visits or hospitalizations.

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

From the letters of intent filed, it appears that there are multiple applicants applying for this certificate of need. WAC 246-310-290(11)(a) provides a set of five measurements DOH uses to compare two or more competing applications where the number of applicants exceeds the projected need.

Under the first measurement, DOH must determine which applicant would most improve the service to the planning area. Approval of Gentiva's application would most improve service to the planning area. As noted in more detail in other parts of this application, Gentiva's Hospital Avoidance Program and Outreach Coordination Program focuses on ensuring patients receive the appropriate level of care, obtain improved outcomes, and reduce costs by avoiding potentially costly and unnecessary urgent care visits or hospitalizations. Gentiva's operations run 24 hours per day, 7 days per week, 365 days per year, ensuring that patients have access to Gentiva's services at any time by calling Gentiva's main number. This number is not simply an answering service, but is staffed with licensed RNs. This ensures that when a family has a need, and they make a call, they are talking with a hospice registered nurse right away. During business hours (Monday to Friday, 8:00am – 5:00pm), Gentiva's team is readily available to assist patients with accessing the care they need. Outside of these hours, Gentiva's dedicated nursing staff will answer calls, triage patient needs, and dispatch an on-call nurse to the patient's bedside as necessary.

Unlike some of the other applicants seeking to establish a new agency in the planning area, Gentiva already provides hospice services in neighboring King County and has established relationships with ancillary service providers that it can better leverage to provide a fuller spectrum of care to Pierce County residents. In addition, unlike some applicants seeking to expand services from King County to Pierce County, Gentiva intends to establish a local ADS at 1102 Broadway, Suite 200, Tacoma, WA 98402. This will allow it to better serve the residents of Pierce County compared to a hospice agency located outside of the county.

Under the Second measurement, DOH must determine which applicant would best serve the specific populations of the planning area. In addition to the reasons Gentiva would most improve services to the planning area, Gentiva has a strong history of serving minority populations, including Washington's African American, Hispanic and Latino, American Indian, Alaska Native, and Veteran populations. In addition, Gentiva has demonstrated its ability to serve Medicare and Medicaid patients, and to serve patients that cannot afford services. As noted above, Gentiva's patients admitted in the 12 months ending on June 30, 2024, for African American and Hispanic and Latino patients exceed the national average. This experience will allow Gentiva to better serve the population of Pierce County, including its minority and underserved populations.

The third measurement is which applicant will have the least impact on existing programs. As noted above, Gentiva currently operates a hospice agency in neighboring King County and has established relationships with local service providers. In addition, Gentiva has 490 locations in 38 states and serves over 34,000 patients and families each day. Gentiva's

extensive experience and knowledge as well as its local relationships demonstrate that it would have the least impact on existing programs.

The fourth measurement is which hospice agency provides the greatest breadth and depth of hospice services. As noted above, Gentiva's services will include routine home care, general in-patient care, continuous care and respite care, 13 months of bereavement support for family members, pastoral care, nutritional services, nursing services, home aide services, 24-hour nurse availability call services, and companion visits. This demonstrates that Gentiva's services are expansive and would be most likely to provide Pierce County residents with the greatest breath and depth of hospice services.

The fifth measurement is a quantitative comparison of publicly available quality data. We understand that this comparison will be made on the basis of the most recent CMS quality data publicly available as of the beginning of the review. As noted above, Gentiva has received numerous awards recognizing the quality of care it provides. Gentiva has received the HEALTHCAREfirst CAHPS Honors & Honors Elite recognition, Homecare Homebase Hospice Quality Excellence Award, Homecare KPI Excellence Award, and SHPBest Superior Performer Caregiver Satisfaction Award. See Table 1. In addition, Gentiva is accredited by ACHC, which has deeming authority granted by CMS.

Several letters of support have been received from individuals within the community. See Exhibit 25 – Letters of Support.

Additionally, CMS added the hospice quality reporting program ("HQRP") in fiscal year 2022. The data source for the quality measures are hospice claims so providers do not need to submit any data to CMS for measure compliance or calculation. The Hospice Care Index ("HCI") is a claims-based measure concept based on multiple indicators. CMS states that the addition of the HCI measure to the HQRP will offer a more comprehensive and holistic view of hospice providers.

The 10 indicators include the following:

- Indicator one: continuous home care or general inpatient provided
- Indicator two: gaps in skilled nursing visits
- Indicator three: early live discharges
- Indicator four: late live discharges
- Indicator five: burdensome transitions (type 1) - live discharges from hospice followed by hospitalization and subsequent hospice readmission
- Indicator six: burdensome transitions (type 2) - live discharges from hospice followed by hospitalization with the patient dying in the hospital
- Indicator seven: per-beneficiary Medicare spending
- Indicator eight: skilled nursing care minutes per routine home care day
- Indicator nine: skilled nursing minutes on weekends
- Indicator ten: visits near death

Source: https://www.nhpco.org/wp-content/uploads/HCI_Resource.pdf.

Reporting data was not available for 4 of the applicants in Washington State. Gentiva, King County, scores a 9 out of 10 on the most recent HCI score that is available from the CMS Hospice Care Compare website. Gentiva, King County also scores higher than the national averages in all 3 categories. Additionally, Gentiva scores higher than the Washington State averages in 2 of 3 categories, and only slightly lower in the third category. A comparison of each is noted below. https://www.medicare.gov/care-compare/

Table 19 — Hospice Care Index Scores (Quality Comparisons)

	National Avg	WA Avg	Gentiva King County *	Eden Kirkland	Aleca	Heart n Soul	Moments
% of pts who got assessed on all 7 HIS quality measures	91.8%	95.6%	98.9%	Not Available	Not Available	Not Available	Not Available
% of pts who received a visit from RN or SW on at least 2 of last 3 days of life	47.7%	54.4%	70.1%	Not Available	Not Available	Not Available	Not Available
Hospice Care Index Score (0-10) (Higher is better)	8.80%	9.30%	9.00%	Not Available	Not Available	Not Available	Not Available

* Care Compare shows Gentiva King County as "Kindred 50-1541"

Care Compare Consumer Assessment of Healthcare Providers and Systems.

Care Compare has an additional quality measure called the Consumer Assessment of Healthcare Providers and Systems ("CAHPS"). The CAHPS Hospice Survey gathers information on the experiences of hospice patients and their informal caregivers' perspectives of their loved ones' care. The CAHPS Hospice Survey started national implementation in January 2015.

The CAHPS Hospice Survey samples primary caregivers of deceased hospice patients who meet survey criteria. Survey administration occurs several months after the death. The survey includes the following key topics: starting hospice care, help for the patients' symptoms, communication with the hospice team, caregivers' own experiences with hospice care services, an overall rating of hospice care, and willingness to recommend the hospice. There are currently three approved modes of survey administration: mail only, telephone only, and mixed mode (mail followed by telephone). https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/cahps-hospice.

CAHPS Hospice Survey Star Ratings

CAHPS Hospice Survey Star Ratings provide consumers with an easy-to-understand method for summarizing CAHPS Hospice Survey measure scores and make comparisons between hospices more straightforward. Beginning with the August 2022 refresh of Care Compare, a Family Caregiver Survey Rating Summary Star Rating is publicly reported for all hospices with 75 or more completed surveys over the reporting period. Star Ratings are updated every other quarter. https://www.hospicecahpssurvey.org/globalassets/hospice-cahps4/home-page/cahps_hospice_survey_fact_sheet_january-2024.pdf.

Unfortunately, the CAHPS Survey lags from a reporting standpoint and is contingent upon 75 or more completed surveys as noted above. Gentiva, along with the other 4 hospice applicants for Pierce County do not have reported CAHPS data on the Care Compare website. However, Gentiva, monitors the CAHPS surveys that have been submitted via HEALTHCAREfirst. These are not publicly reported surveys and are not official unless the threshold noted above has been met. Additionally, the results noted below are essentially real time, and do not lag or average for several quarters as does the reporting on the Care Compare website. The results below are an average from the time period January 2024 -

August 2024. Gentiva exceeds the national and Washington State averages in all 7 areas except for one, and that figure being only 2% lower than the national averages.

Table 20 – HEALTHCAREfirst Survey Results*

	National Avg	WA Avg	Gentiva King
Star Rating			N/A
Communication with family	81%	81%	88%
Getting timely help	77%	75%	85%
Treating patient with respect	90%	91%	91%
Emotional and spiritual support	90%	91%	97%
Help for pain and symptoms	74%	73%	91%
Training family to care for patient	75%	74%	91%
Willing to recommend this hospice	84%	86%	82%

***This report has been produced by HEALTHCAREfirst and does not represent official CAHPS Hospice Survey Results.**

Multiple Applications in One Year

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

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

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

2. If the answer to the previous question is yes, clarify:

•Are these applications being submitted under separate companies owned by the same applicant(s); No

•Are these applications being submitted under a single company/applicant? Yes

•Will they be operated under some other structure? Describe in detail.

No – same structure. If the application for Clallam County is approved, Gentiva will operate the proposed site as a fully operational site staffed just like any other ADS. Ultimate supervision of the Clallam County ADS or "Multiple Location" will rest with the parent location, Gentiva, King County, as described in earlier parts of this application. See Exhibit 8 – Multiple Location Site Control Policy.

3. Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of **this project** in the first three full calendar years of operation. Provide pro forma balance sheets for the **applicant,** assuming approval of this project showing the first three full calendar years of operation. In addition, provide a pro forma balance sheet for the **applicant** assuming approval of **all proposed projects** in this year's review cycles showing the first three full calendar years of operation.

See Exhibit 15 – Balance Sheet

4. In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements **may** be required.

•If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.
•If your applications propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.

See Exhibit 13c – P&L Gentiva King + Pierce + Clallam

gentiva

Exhibit 1 - Organizational Structure

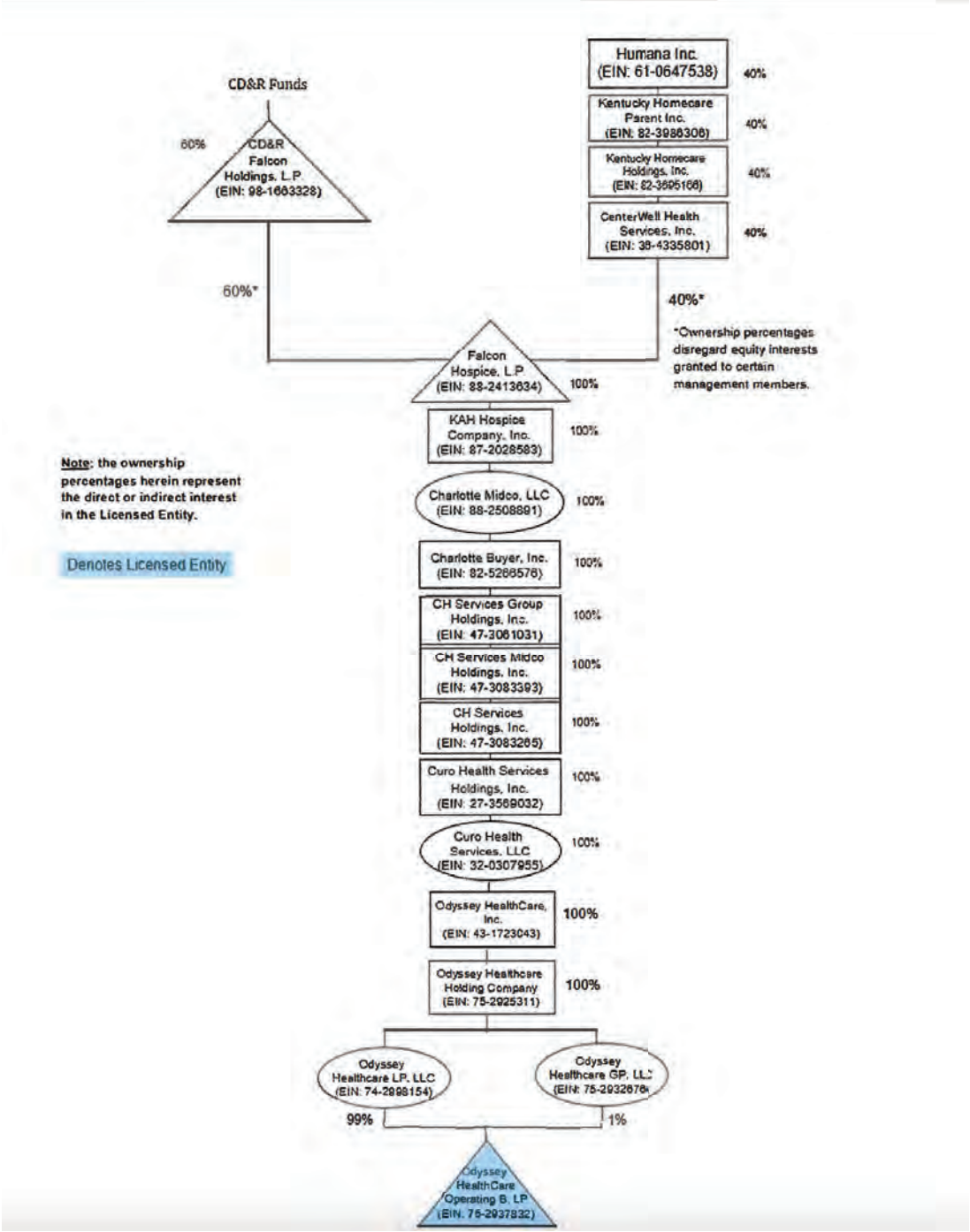


Exhibit 2 – List of Entities Owned (Page 1 of 9)
(Note: All Heartland locations were acquired effective 11/1/23)

Company Name	Site Name	te Level (Parent, Branch, etc.) Nar	Site Street Address 1	Site Street Adress 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	2431 W. Main St	STE 1102	Dothan	AL	36301-1250	N/A	1922535400	102G707021; RRDY9475	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	1321 Murfreesboro Pike	Suite 510	Nashville	TN	37217-2619	N/A	1770085573	0600	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	950 S Dillard Street	Suite A	Winter Garden	FL	34787-3912	N/A	1679195028	MH561	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	144 S Thomas St	STE 202	Tupelo	MS	38801-5337		1346935129	2U7197	
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	39425 Garfield Road	Suite 24	Clinton Township	MI	48038-4651		1477240190	M17798	
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	9775 Crosspoint BLVD	STE 118A	Indianapolis	IN	46256-3376		1699463299	IN5986	
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	10200 W Innovation Drive	STE 400	Milwaukee	WI	53226-3276	N/A	1710768213	K101022320	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	3975 Fair Ridge Drive	STE 1255	Fairfax	VA	22033-2924	N/A	1326829821	6Q5189	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	2050 Corporate Centre Drive	Suite 220-A	Myrtle Beach	SC	29577-7428	N/A	1033990544	O972	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	750 Holiday Drive	Suite 110, Fosbr Plaza I	Pittsburgh	PA	15220-2769	N/A	1396526802		N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	460 Norristown Road	Suite 101	Blue Bell	PA	19422-2323	N/A	1467233734	6C8123	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	6500 Busch Boulevard	Suite 210	Columbus	OH	43229-1728	N/A	1881391597	H987750	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	12101 Woodcrest Executive Drive	Suite 102-A	Saint Louis	MO	63141-5008	N/A	1275314783		N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Parent-Palliative	7001 Johnnycake Road	Suite 204-A	Windsor Mill	MD	21244-2420	N/A	1992586408		N/A
SouthernCare, Inc.	Heartland Hospice (Northbrook)	Parent-Palliative	1110 West Lake Cook Road	Suite 130-A	Buffalo Grove	IL	60089-1965	N/A	1790566206	F101032860	N/A
Odyssey HealthCare Holding Company	Heartland Hospice (Woodbury)	Parent-Palliative	1385 Chews Landing Road	STE A	Laurel Springs	NJ	08021-2760	N/A	1477334985	6E1479	N/A
IH Physician Services, PC	IH Physician Services, PC	Parent-Palliative	100 Pavilion Way	STE E4 & E5	Southern Pines	NC	28387-4559	N/A	1447959093	O484	
TEXAS PALLIATIVE SERVICES PA	TEXAS PALLIATIVE SERVICES PA	Parent-Palliative	8277 Belleview Dr	Ste 275	Plano	TX	75024-0358		1528841020	6N3271	
Mid-South Palliative Services, LLC	Emerald Coast Palliative Care	Parent-Palliative	2190 Airport Blvd	Suite 2850-A	Pensacola	FL	32504-8918	HCC12187	1306351275	TA977	N/A
Illumia Health, LLC	Illumia Health	Parent-Palliative	3700 Embassy Parkway Ext	STE 130	Akron	OH	44333-8384		1740024397		
ABC Hospice, LLC	Gentiva	Parent-Hospice	510 Austin Ave.	STE 341	Waco	TX	76701-2117	012591	1215156021	67-1594	ACHC; EXP 02/14/26
American Hospice, Inc.	Gentiva	Parent-Hospice	210 West Park Drive	STE 107	Livingston	TX	77351-8338	013607	1407047590	67-1609	ACHC; EXP 03/05/26
Angel Heart Hospice, LLC	New Century Hospice of Austin	Parent-Hospice	9430 Research Blvd.	Suite II-100	Austin	TX	78759-5874	17517	1013901719	67-1502	ACHC; EXP 07/03/26
At Home Healthcare and Hospice, LLC	Gentiva	Parent-Hospice	1051 Culpepper Dr. SW	STE #100	Conyers	GA	30094-5986	122-0292-H	1104031863	11-1668	ACHC; EXP 06/21/27
Avalon Hospice Minnesota, LLC	Gentiva	Parent-Hospice	1821 University Avenue W	STE 252	Saint Paul	MN	55104-2872	413667	1902343353	24-1611	ACHC; EXP 10/13/23
Avalon Hospice Ohio, LLC	Gentiva II	Parent-Hospice	4010 Executive Park Drive	Suite 225	Cincinnati	OH	45241-4010	0247HSP	1316484785	36-1704	ACHC; EXP 03/09/27
Bethany Hospice, LLC	Gentiva	Parent-Hospice	2913 Williams Drive	STE 320	Georgetown	TX	78628-2740	009947	1295899284	67-1517	ACHC; EXP 02/17/26
Carrollton Home Care, LLC	Gentiva	Parent-Hospice	2800 Breezewood Avenue	Suite 100	Fayetteville	NC	28303-5282	HC1331; NP3441	1528015369	34-1576	ACHC; EXP 06/16/26
Central Arizona Home Health Care, Inc.	Gentiva I	Parent-Hospice	3107 Clearwater Drive	STE B	Prescott	AZ	86305-7167	HSPC3752	1174575781	03-1564	Pending
Community Home Care & Hospice, LLC	Gentiva	Parent-Hospice	2841 Daisy Lane	Suite E	Wilson	NC	27896-6948	HOS2241; HC343	1134176993	34-1585	ACHC; EXP 05/31/23
Community Home Care & Hospice, LLC	Gentiva	Parent-Hospice	1712 W Howard Avenue		Tarboro	NC	27886-3409	HOS4887	1043677107	34-1581	ACHC; EXP 10-18-24
Community Home Care & Hospice, LLC	Gentiva	Parent-Hospice	126 Executive Drive	STE 110	Wilkesboro	NC	28697-7571	HOS0407	1003236258	34-1506	ACHC; EXP 03/11/27
Community Home Care of Vance County, LLC	Gentiva	Parent-Hospice	946 W Andrews Avenue	Suite S	Henderson	NC	27536-2500	HOS2561; HC346	1841247335	34-1589	ACHC; EXP 11/16/26
Community Hospice of the Carolinas, LLC	Gentiva	Parent-Hospice	10100 N Ambassador Dr	Ste 100B	Kansas City	MO	64153-2313	289-HO	1477176345	26-1701	ACHC; 03/17/2026
Community Hospice, LLC	Gentiva	Parent-Hospice	1423 South Glenburnie Road	Suite A	New Bern	NC	28562-2603	HOS2302; HC343	1891736336	34-1586	ACHC; EXP 06/13/23
Cosmos Hospice of Corpus Christi, LLC	New Century Hospice of South Texas	Parent-Hospice	4550 Corona Dr.		Corpus Christi	TX	78411-4306	017441	1033397815	67-1607	ACHC; EXP 01/05/27
Cosmos Hospice of San Antonio, LLC	New Century Hospice of San Antonio	Parent-Hospice	8207 Callaghan Rd	STE #353	San Antonio	TX	78230-4735	17455	1467621078	67-1612	ACHC; EXP 09/29/26
Curo Health Services, LLC	Heartland Hospice (Tucson)	Parent-Hospice	3112 North Swan Road		Tucson	AZ	85712-1227	HSPC1987	1427757913	03-1548	
Curo Health Services, LLC	Heartland Hospice (Ft. Wayne)	Parent-Hospice	2720 Dupont Commerce Ct	Suite 210	Fort Wayne	IN	46825-2364	22006341-1	1013616515	15-1521	
Curo Health Services, LLC	Heartland Hospice (Indianapolis)	Parent-Hospice	931 East 86th Street	Suite 208	Indianapolis	IN	46240-1852	21-003154-1	1740989243	15-1573	ACHC exp 10/4/27
Curo Health Services, LLC	Heartland Hospice (NW Indiana)	Parent-Hospice	5265 Commerce Blvd	STE A	Crown Point	IN	46307-5327	0015077	1194424697	15-1648	
Curo Health Services, LLC	Heartland Hospice (Des Moines)	Parent-Hospice	1701 48th Street	Suite 220	West Des Moines	IA	50266-6723	Pending	1043911753	16-1616	ACHC; EXP 08/15/2025
Curo Health Services, LLC	Heartland Hospice (Davenport)	Parent-Hospice	5139 Utica Ridge Road		Davenport	IA	52807-3062	321568	1164123873	16-1568	ACHC EXP; 2/8/27
Curo Health Services, LLC	Heartland Hospice (Wichita)	Parent-Hospice	2872 N Ridge Road	Suite 122	Wichita	KS	67205-1144	Exempt	1013618180	17-1528	ACHC; 11/12/2027
Curo Health Services, LLC	Heartland Hospice (Baltimore)	Parent-Hospice	7001 Johnnycake Road	STE 204	Windsor Mill	MD	21244-2420	H1533	1558060061	21-1533	
Curo Health Services, LLC	Heartland Hospice (Kansas City)	Parent-Hospice	4731 S Cochise Dr	Suite 120	Independence	MO	64055-6975	305-1HO	1891494308	26-1572	ACHC; EXP 11/06/27
Curo Health Services, LLC	Heartland Hospice (St. Louis)	Parent-Hospice	12101 Woodcrest Executive Dr	Ste 102	St. Louis	MO	63141-5047	110-22HO	1437858941	26-1574	
Curo Health Services, LLC	Heartland Hospice (Lincoln)	Parent-Hospice	3801 Union Dr	Suite 202	Lincoln	NE	68516-6652	HOSPICE 75	1255030763	28-1555	
Curo Health Services, LLC	Heartland Hospice (Albuquerque)	Parent-Hospice	4001 Indian School Road NE	Suite 300	Albuquerque	NM	87110-3853	3114	1235830860	32-1547	
Curo Health Services, LLC	Heartland Hospice (Raleigh)	Parent-Hospice	4515 Falls of Neuse Road	Suite 420	Raleigh	NC	27609-6374	HOS2281	1982303491	34-1587	12/28/2026
Curo Health Services, LLC	Heartland Hospice (Charleston)	Parent-Hospice	7410 Northside Drive	Suite 250	North Charleston	SC	29420-4292	HPC-0264	1740989060	42-1546	ACHC; Exp 6-29-27
Curo Health Services, LLC	Heartland Hospice (Greenville)	Parent-Hospice	421 SE Main St	Suite 100	Simpsonville	SC	29681-2967	HCP-0263	1588363899	42-1558	ACHC; Exp. 8/15/27
Curo Health Services, LLC	Heartland Hospice (Myrtle Beach)	Parent-Hospice	2050 Corporate Centre Drive	Suite 220	Myrtle Beach	SC	29577-7428	HCP-0265	1306545629	42-1545	ACHC; EXP 02/13/2027
Curo Health Services, LLC	Heartland Hospice (Fairfax)	Parent-Hospice	3975 Fair Ridge Drive	Suite 125S	Fairfax	VA	22033-2924	Exempt	1447959762	49-1565	
Curo Health Services, LLC	Heartland Hospice (Newport News)	Parent-Hospice	41 Old Oyster Point Road	Suite D	Newport News	VA	23602-7177	Exempt	1528767845	49-1575	
Curo Health Services, LLC	Heartland Hospice (Richmond)	Parent-Hospice	10800 Midlothian Turnpike	Suite 303	North Chesterfield	VA	23235-4700	Exempt	1265131585	49-1567	
Curo Health Services, LLC	Heartland Hospice (Roanoke)	Parent-Hospice	2840 Electric Rd. SW	Suite 106A	Roanoke	VA	24018-3551	Exempt	1720787047	49-1617	
Curo Health Services, LLC	Heartland Hospice (Virginia Beach)	Parent-Hospice	5041 Corporate Woods Drive	Ste 200	Virginia Beach	VA	23462-4375	Exempt	1184121489	49-1545	

Exhibit 2 – List of Entities Owned (Page 2 of 9)

Company Name	Site Name	e Level (Parent, Branch, etc.)	Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
Family Hospice, Ltd.	Gentiva	Parent-Hospice		7500 Jefferson St. NE	STE 210	Albuquerque	NM	87109-4384	7013	1033127147	32-1520	Pending
Family Hospice, Ltd.	Gentiva	Parent-Hospice		7557 Rambler Road	STE 560	Dallas	TX	75231-4142	004059	1033129887	45-1527	ACHC; EXP 01/20/27
Family Hospice, Ltd.	Gentiva	Parent-Hospice		2824 Terrell Road	STE 500	Greenville	TX	75402-5529	008082	1821043852	45-1722	ACHC; EXP 02/03/26
Family Hospice, Ltd.	Gentiva	Parent-Hospice		1515 West Calle Sur Street	STE 129	Hobbs	NM	88240-0998	6716	1972511061	32-1513	ACHC; EXP 03/31/24
Family Hospice, Ltd.	Gentiva	Parent-Hospice		7202 Slide Road	STE 301	Lubbock	TX	79424-2557	005035	1720098585	45-1520	ACHC; EXP 02/23/27
Family Hospice, Ltd.	Gentiva	Parent-Hospice		1911 Corporate Drive	STE 104	San Marcos	TX	78666-6171	004098	1790795524	45-1640	ACHC; EXP 12/17/2025
Family Hospice, Ltd.	Gentiva	Parent-Hospice		116 West Concho Avenue		San Angelo	TX	76903-6416	006693	1609822295	45-1697	ACHC; EXP 12/06/25
Family Hospice, Ltd.	Gentiva	Parent-Hospice		4040 Broadway Street	STE 305 & 306	San Antonio	TX	78209-6353	004072	1265441190	45-1563	ACHC; EXP 03/27/26
Family Hospice, Ltd.	Gentiva	Parent-Hospice		2626 South 37th Street	STE B	Temple	TX	76504-7136	004135	1588674352	45-1542	ACHC; EXP 05/5/2026
Freedom Hospice, LLC	Gentiva	Parent-Hospice		4111 S. Darlington Ave.	STE 650	Tulsa	OK	74135-6348	HO4208	1295819050	37-1657	ACHC; EXP 07/12/24
Gilbert's Hospice Care, LLC	Gentiva	Parent-Hospice		301B West College Street		Booneville	MS	38829-3314	103	1851397921	25-1594	ACHC; EXP 06/08/24
Gilbert's Hospice Care, LLC	Gentiva	Parent-Hospice		104 Court Street		Batesville	MS	38606-2213	084	1104176486	25-1579	ACHC; EXP 12/01/24
Gilbert's Hospice Care, LLC	Gentiva	Parent-Hospice		403 Hospital Road		Starkville	MS	39759-2164	105	1477875441	25-1597	ACHC; EXP 05/07/24
Healthfield Hospice Services, LLC	Gentiva	Parent-Hospice		2525 Highway 34 E		Newnan	GA	30265-1329	038-0310-H	1851323964	11-1675	ACHC; EXP 10/19/26
Healthfield Hospice Services, LLC	Gentiva	Parent-Hospice		200 Business Center Drive	STE 218	Stockbridge	GA	30281-9025	075-229-H	1932137783	11-1528	ACHC; EXP 04/26/25
Heritage Health & Hospice Care, LLC	Gentiva	Parent-Hospice		6800 West Loop South	Suite 200	Bellaire	TX	77401-4536	15346	1447381470	67-1626	ACHC; EXP 03/07/25
Hospice Care of Kansas, LLC	Gentiva	Parent-Hospice		1819 Main Street		Parsons	KS	67357-3367	Not Required	1609924638	17-1556	ACHC; EXP 1/24/25
Hospice Care of Kansas, LLC	Gentiva	Parent-Hospice		9229 E. 37th Street N.	STE 104	Wichita	KS	67226-2003	Not Required	1790833382	17-1542	ACHC; EXP 06/03/27
Hospice of Texas, LLC	Gentiva	Parent-Hospice		1031 Andrews Highway	Suite 203	Midland	TX	79701-3914	020204	1366083305	97-1637	ACHC; 03/11/27
Hospice of Minnesota, LLC	Gentiva I	Parent-Hospice		4140 Richard Ave	Building 6 Suite 320	Hermantown	MN	55811-3309	413588	1073177986	24-1612	ACHC; EXP 03/25/27
Hospice Family Care, Inc.	Gentiva II	Parent-Hospice		201 W. Guadalupe Rd.	Suite 308	Gilbert	AZ	85233-3334	HSPC0044	1518943919	03-1537	ACHC; EXP 07/12/27
Hospice Family Care, Inc.	Gentiva II	Parent-Hospice		310 S Williams Blvd	STE 300	Tucson	AZ	85711-4484	HSPC0030	1760467575	03-1519	ACHC; EXP 07/02/27
Hospice of Maine, LLC	Gentiva	Parent-Hospice		238 State Street	Suite 16	Brewer	ME	04412-1519	39644	1477025286	20-1523	ACHC; EXP 12/23/25
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Parent-Hospice		401 E 23rd St. STE C		Panama City	FL	32405-7616	5001096	1952337149	10-1537	Pending
IntegraCare Hospice of Abilene, LLC	Gentiva	Parent-Hospice		4400 Buffalo Gap Rd	STE 1200	Abilene	TX	79606-8717	14755	1114205408	45-1751	ACHC; EXP 04/23/2026
IntegraCare of Athens-Hospice, LLC	Gentiva	Parent-Hospice		5409 Plaza Drive		Texarkana	TX	75503-1662	13432	1275858631	45-1583	ACHC; EXP 08/27/26
IntegraCare of West Texas-Hospice, LLC	Gentiva	Parent-Hospice		3232 Hobbs Avenue	STE A	Amarillo	TX	79109-3224	012961	1063643054	45-1663	ACHC; EXP 02/24/26
International Tutoring Services, LLC	Hospice Plus	Parent-Hospice		2777 N. Stemmons Freeway	Suite 1100	Dallas	TX	75207-2513	009235	1164466397	45-1780	ACHC; EXP 09/24/27
Iowa Hospice, LLC	Gentiva	Parent-Hospice		831 North Griffith Road		Carroll	IA	51401-2025	Not Required	1306946900	16-1582	ACHC; EXP 02/18/25
Iowa Hospice, LLC	Gentiva	Parent-Hospice		5399 Chimra Road		Panora	IA	50216-8738	Not Required	1821075201	16-1575	ACHC; EXP 12/07/26
Iowa Hospice, LLC	Gentiva	Parent-Hospice		1370 Lake Street		Spirit Lake	IA	51360-1100	Not Required	1033381736	16-1586	ACHC Exp 12/8/2024
KAH Development 8, LLC	Gentiva I	Parent-Hospice		3855 North Ocoee St	Suite 200	Cleveland	TN	37312-4457	358	1124470588	44-1603	ACHC; EXP 09/24/23
Kindred Hospice Missouri, LLC	Gentiva	Parent-Hospice		1616 Southridge Drive	Suite 201	Jefferson City	MO	65109-5677	297-3HO	1346719473	26-1684	ACHC; EXP 10/06/26
Legacy Hospice of Colorado Springs, LLC	Gentiva I	Parent-Hospice		6270 Lehman Drive	Suite 150	Colorado Springs	CO	80918-1435	17L201	1295071702	06-1583	ACHC; EXP 09/26/23
Legacy Hospice, LLC	Gentiva	Parent-Hospice		380 Perry Street	Unit 210	Castle Rock	CO	80104-2485	17I598	1003044835	06-1570	ACHC; EXP 02/23/24
Lighthouse Hospice - Coastal Bend, LLC	Gentiva	Parent-Hospice		210 South Carancahua	STE 200	Corpus Christi	TX	78401-3040	011168	1649321928	67-1580	ACHC; EXP 12/17/25
Loving Peace Hospice, Inc.	Gentiva	Parent-Hospice		2815 Old Jacksonville Road	Suite 202	Springfield	IL	62704-6419	2003153	1811393564	14-1666	ACHC; EXP 04/20/24
New Beacon Healthcare Group, LLC	SouthernCare New Beacon - Anniston	Parent-Hospice		1419 Leighton Avenue	Unit A	Anniston	AL	36207-3800	E0801	1346279320	01-1508	ACHC; EXP 10/27/23
New Beacon Healthcare Group, LLC	SouthernCare New Beacon - N. Birmingh	Parent-Hospice		5582 Apple Park Dr		Birmingham	AL	35235-8616	E3706	1770512741	01-1501	ACHC; EXP 09/29/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon - Jasper	Parent-Hospice		3835 Watermelon Rd	Suites B & C	Northport	AL	35473-5001	E6401	1376572255	01-1506	ACHC; EXP 12/14/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon - Scottsboro	Parent-Hospice		1602 S. Broad Street		Scottsboro	AL	35768-2611	E3601	1588693550	01-1512	ACHC; EXP 10/13/23
New Century Hospice Delaware, LLC	Gentiva I	Parent-Hospice		53 Baxter Blvd		Portland	ME	04101-1827	39630	1720601693	20-1525	ACHC; EXP 1/4/26
New Century Hospice of Richmond, LLC	Gentiva I	Parent-Hospice		10333 Southpoint Landing Blvd	Suite 211	Fredericksburg	VA	22407-8042	HSP-18205	1619399227	49-1602	ACHC; EXP 08/16/24
New Century Hospice, Inc.	New Century Hospice of Dallas	Parent-Hospice		740 E. Campbell Rd.	STE 470	Richardson	TX	75081-6749	017435	1407929037	67-1588	ACHC; EXP 05/30/26
New Century Hospice, Inc.	Heartland Hospice (Newark)	Parent-Hospice		750 Prides Crossing	Suite 110	Newark	DE	19713-6107	HSPC-008	1942909437	08-1506	ACHC; EXP 07/22/25
New Century Hospice, Inc.	Heartland Hospice (McAlester)	Parent-Hospice		500 Village Blvd	Ste C	McAlester	OK	74501-2078	HO4170	1912606435	37-1625	ACHC; Exp 4/28/25
New Century Hospice, Inc.	Heartland Hospice (Shawnee)	Parent-Hospice		2802 N. Kickapoo Avenue		Shawnee	OK	74804-1798	HO4007	1720787245	37-1514	ACHC; 11/20/24
Odyssey HealthCare of Kansas City, LLC	Gentiva	Parent-Hospice		20101 E. Jackson Dr.		Independence	MO	64057-1956	178-16HO	1073514600	26-1534	ACHC; EXP 07/14/23
Odyssey HealthCare of Kansas City, LLC	Gentiva	Parent-Hospice		6735 Rosehill Road	STE 200	Lenexa	KS	66215-4624	Not Required	1467782516	17-1569	09/14/2025
Odyssey HealthCare of Marion County, LLC	Gentiva	Parent-Hospice		6161 Blue Lagoon Drive	STE 170	Miami	FL	33126-2045	50370970	1114159902	10-1548	ACHC; EXP 10/12/23
Odyssey HealthCare of Marion County, LLC	Gentiva	Parent-Hospice		4776 New Broad St.	STE 200	Orlando	FL	32814-6423	50370963	1528439700	10-1540	ACHC; EXP 01/11/24
Odyssey HealthCare of Savannah, LLC	Gentiva	Parent-Hospice		2280 East Victory Drive	STE A	Savannah	GA	31404-3957	025-213-H	1477554947	11-1615	ACHC; EXP 09/18/26
Odyssey HealthCare of South Texas, LLC	Gentiva	Parent-Hospice		410-A N. Ed Carey Drive		Harlingen	TX	78550-7960	012130	1255332961	45-1667	ACHC; EXP 11/23/26
Odyssey HealthCare Operating A, LP	Gentiva I	Parent-Hospice		85 West Algonquin Road	STE 100	Arlington Heights	IL	60005-4420	2002228	1124029848	14-1608	ACHC; EXP 07/28/23
Odyssey HealthCare Operating A, LP	Gentiva	Parent-Hospice		7320 North Mopac Expressway	STE 300	Austin	TX	78731-2338	007845	1760483671	45-1715	ACHC; EXP 03/13/26
Odyssey HealthCare Operating A, LP	Gentiva	Parent-Hospice		1141 East Main Street	STE 208	Batesville	AR	72501-3014	AR5839	1295185239	04-1539	ACHC; EXP 12/14/26
Odyssey HealthCare Operating A, LP	Gentiva	Parent-Hospice		3129 College St	Suite 150	Beaumont	TX	77701-4682	007790	1821099714	45-1638	ACHC; EXP 02/07/26
Odyssey HealthCare Operating A, LP	Gentiva	Parent-Hospice		5001 East Commercenter Drive	STE 200	Bakersfield	CA	93309-1655	070000582	1740281633	05-1740	ACHC; EXP 10/12/24
Odyssey HealthCare Operating A, LP	Gentiva	Parent-Hospice		2400 Crockett Drive	STE 300	Brownwood	TX	76801-5912	011763	1275543316	45-1707	ACHC; EXP 03/11/26
Odyssey HealthCare Operating A, LP	Gentiva	Parent-Hospice		205 Grandview Ave	STE 304	Camp Hill	PA	17011-1708	16711601	1316921323	39-1671	ACHC; EXP 03/31/27

Exhibit 2 – List of Entities Owned (Page 3 of 9)

Company Name	Site Name	e Level (Parent, Branch, etc.)	Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		100 E Peach Street	STE 350	El Dorado	AR	71730-5812	AR5840	1710339825	04-1531	ACHC; EXP 03/15/24
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		5000 Hopyard Rd	STE 301	Pleasanton	CA	94588-3145	550000790	1881899250	55-1562	ACHC; EXP 05/04/24
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		7826 Bois D Arc Drive	Unit A	El Paso	TX	79925-7735	007770	1194726083	45-1705	ACHC; EXP 03/26/26
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		915 North Washington Street	STE B-1	Forest City	AR	72335-2824	AR5949	1720438765	04-1510	ACHC; EXP 08/17/24
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		2212 Malvern Avenue	STE 3-B	Hot Springs	AR	71901-8043	AR5950	1265882294	04-1537	Pending
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		4500 Kruse Way	STE 100	Lake Oswego	OR	97035-2562	16-1000	1144221128	38-1547	ACHC; EXP 03/04/27
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		301 Natural Resources Dr	STE 102	Little Rock	AR	72205-1417	AR5285	1750382750	04-1561	ACHC; EXP 08/19/25
OdysseyHealthCare Operating A, LP	Gentiva II	Parent-Hospice		2127 Memorial Blvd	Suite A	Springfield	TN	37172-3953	346	1649271578	44-1553	ACHC; EXP 05-11-25
OdysseyHealthCare Operating A, LP	Gentiva I	Parent-Hospice		800 Enterprise Drive	STE 111	Oak Brook	IL	60523-4201	2002848	1033449301	14-1610	ACHC; EXP 10/20/26
OdysseyHealthCare Operating A, LP	Gentiva I	Parent-Hospice		444 Regency Parkway Drive	STE 200	Omaha	NE	68114-3779	HOSPICE 32	1265433247	28-1528A	Pending
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		5315 Campbells Run Road	STE 190	Pittsburgh	PA	15205-9005	161299	1437150430	39-1612	ACHC; EXP 06/02/24
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		36947 Cook Street, Bldg 10	STE 102	Palm Desert	CA	92211-6078	080000724	1043211931	05-1716	ACHC; EXP 02/24/27
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		4820 Business Center Drive	STE 175	Fairfield	CA	94534-1901	550001170	1952542177	55-1585	ACHC; EXP 06/28/27
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		3801 W. Main Street	STE A	Russellville	AR	72801-2313	AR5837	1467802405	04-1528	ACHC; EXP 05/03/25
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		301 E Vanderbilt Way	Suite 25(	San Bernardino	CA	92408-3512	080000736	1053312033	05-1593	ACHC; EXP 03/10/27
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		5080 Shoreham Place	Suite 10(	San Diego	CA	92122-5931	080000595	1346241056	05-1717	ACHC; EXP 04/20/25
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		4440 South Piedras Drive	STE 125	San Antonio	TX	78228-1241	007712	1437150141	45-1682	ACHC; EXP 05/05/25
OdysseyHealthCare Operating A, LP	Gentiva	Parent-Hospice		210 N. State Line Avenue	STE 502	Texarkana	AR	71854-5912	AR5953	1003266040	04-1532	Pending
OdysseyHealthCare Operating A, LP	Heartland Hospice (Monterey)	Parent-Hospice		2511 Garden Road	STE A250	Monterey	CA	93940-5330	70000418	1871292367	05-1692	ACHC EXP; 8/17/25
OdysseyHealthCare Operating A, LP	Heartland Hospice (Santa Clara)	Parent-Hospice		181 Metro Drive	Suite 54(	San Jose	CA	95110-1346	70000419	1215636709	05-1690	ACHC EXP; 8/8/25
OdysseyHealthCare Operating A, LP	Heartland Hospice (Sylvania)	Parent-Hospice		1718 Indian Wood Circle	Suite A	Maumee	OH	43537-2269	0093HSP	1598466138	36-1582	ACHC EXP; 5/13/25
OdysseyHealthCare Operating A, LP	Heartland Hospice (Cleveland)	Parent-Hospice		4807 Rockside Road	STE 110	Independence	OH	44131-2140	0130HSP	1023717535	36-1584	ACHC; EXP 10/12/24
OdysseyHealthCare Operating A, LP	Heartland Hospice (Columbus)	Parent-Hospice		6500 Busch Boulevard	STE 210	Columbus	OH	43229-1728	0139HSP	1104525617	36-1620	ACHC; EXP 10/6/25
OdysseyHealthCare Operating A, LP	Heartland Hospice (Dayton)	Parent-Hospice		580 Lincoln Park Boulevard	STE 320	Kettering	OH	45429-3493	0121HSP	1659070175	36-1589	ACHC EXP; 9/29/25
OdysseyHealthCare Operating A, LP	Heartland Hospice (Portsmouth)	Parent-Hospice		205 North Street		Lucasville	OH	45648-0400	0129HSP	1184325870	36-1610	ACHC EXP; 3/19/25
OdysseyHealthCare Operating A, LP	Heartland Hospice (Cincinnati)	Parent-Hospice		3960 Red Bank Road	STE 140	Cincinnati	OH	45227-3421	0065HSP	1386343804	36-1560	ACHC EXP; 10/3/24
OdysseyHealthCare Operating A, LP	Heartland Hospice (Fremont)	Parent-Hospice		907 W State Street	STE A	Fremont	OH	43420-2548	0111HSP	1598465320	36-1595	ACHC EXP; 7/11/27
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		575 Research Dr.	STE A	Athens	GA	30605-2779	029-202-H	1427040765	11-1612	ACHC; EXP 09/17/27
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		4700 Hardy Street	STE X	Hattiesburg	MS	39402-1300	037	1699776245	25-1536	ACHC; EXP 11/18/24
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		1321 N. Northwood Center Ct.	STE A	Coeur D Alene	ID	83814-4944	Not Required	1225487648	13-1576	ACHC; EXP 07/29/23
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		106 Riverview Drive		Flowood	MS	39232-8908	097	1306847868	25-1590	ACHC; EXP 08-10-25
OdysseyHealthCare Operating B, LP	Gentiva I	Parent-Hospice		625 Kenmoor Avenue SE	STE 115	Grand Rapids	MI	49546-2395	1041000121	1528347572	23-1627	ACHC; EXP 08/19/27
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		1326 N Whitman Lane		Liberty Lake	WA	99019-7594	IHS.FS.60308060	1205183878	50-1534	ACHC; EXP 11/16/23
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		2800 Dauphin Street	STE 103	Mobile	AL	36606-2400	E4906	1184625717	01-1605	ACHC; EXP 07/27/24
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		242 Old New Brunswick Road	STE 410	Piscataway	NJ	08854-3754	22800	1497756993	31-1545	ACHC; EXP 8/16/2027
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		808 Moorefield Park Drive	Moorefield II, #113	Richmond	VA	23236-3683	HSP-21688	1265433718	49-1568	ACHC; EXP 12/28/23
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		9750 3rd Ave NE	STE 375	Seattle	WA	98115-2022	IHS.FS.60330209	1689906125	50-1541	ACHC; EXP 10/30/26
OdysseyHealthCare Operating B, LP	Gentiva I	Parent-Hospice		25925 Telegraph Road	STE 102	Southfield	MI	48033-2527	1041000057	1164423703	23-1564	ACHC; EXP 10/28/26
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		5544 Greenwich Rd	STE 302	Virginia Beach	VA	23462-6563	HSP-21664	1346241981	49-1562	ACHC; EXP 12/02/23
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		10150 West National Avenue	STE 140	West Allis	WI	53227-2145	553	1538160163	52-1559	ACHC; EXP 1/18/25
OdysseyHealthCare Operating B, LP	Gentiva	Parent-Hospice		2374 Post Road	STE 206	Warwick	RI	02886-2270	HSP01635	1699776187	41-1511	ACHC; EXP 11/30/26
PeoplefirstHomeCare & Hospice of Indiana, LL	Gentiva II	Parent-Hospice		9775 Crosspoint Boulevard	STE 118	Indianapolis	IN	46256-3376	22-011593-1	1336337625	15-1601	ACHC; EXP 03/25/23
PeoplefirstHomeCare & Hospice of Massachu	Gentiva	Parent-Hospice		130 Rumford Avenue	STE 211	Auburndale	MA	02466-1370	7016	1437397569	22-1591	ACHC; EXP 01/06/26
PeoplefirstHomeCare & Hospice of Ohio, LLC	Gentiva	Parent-Hospice		4401 Rockside Road	STE 214	Independence	OH	44131-2147	0219HSP	1720444177	36-1679	ACHC; EXP 12/14/26
PeoplefirstHomeCare & Hospice of Ohio, LLC	Gentiva	Parent-Hospice		112 Harcourt Road	STE 3	Mount Vernon	OH	43050-3944	0162-HSP	1922238203	36-1635	ACHC; EXP 07/06/27
Regency Hospice of Georgia, LLC	Gentiva	Parent-Hospice		1690 University Parkway		Aiken	SC	29801-6340	HPC-0085	1003864869	42-1552	ACHC; EXP 08/10/23
Regency Hospice of Georgia, LLC	Regency Southern Care	Parent-Hospice		3730 Washington Road	Suite 100	Augusta	GA	30907-4196	036-0242-H	1760440424	11-1637	ACHC; EXP 03/23/27
Regency Hospice of Northwest Florida, Inc.	Gentiva I	Parent-Hospice		7282 Plantation Road	Suite 302	Pensacola	FL	32504-6331	50370972	1730326828	10-1551	ACHC; EXP 06/18/24
Southern Care, Inc.	Gentiva II	Parent-Hospice		1965 Boardman Road	Suite B	Jackson	MI	49202-1979	1041000079	1093753188	23-1592	ACHC; EXP 10/25/26
Southern Care, Inc.	Gentiva II	Parent-Hospice		400 Lakemont Park Boulevard	Suite 300	Altoona	PA	16602-5967	16571601	1700826211	39-1657	ACHC; EXP 09/15/23
Southern Care, Inc.	Gentiva	Parent-Hospice		2706 West Oxford Loop	Suite 100	Oxford	MS	38655-5715	203	1326088154	25-1671	ACHC; Exp 06/04/25
Southern Care, Inc.	Gentiva	Parent-Hospice		925 Tommy Munro Dr	STE J	Biloxi	MS	39532-2134	039	1053350850	25-1537	ACHC; EXP 04/29/25
Southern Care, Inc.	Gentiva	Parent-Hospice		17316 Airline Hwy	Suite P	Prairieville	LA	70769-3377	296	1235179060	19-1570	ACHC; EXP 05/18/27
Southern Care, Inc.	Southern Care Greenville	Parent-Hospice		501 E. Commerce St.		Greenville	AL	36037-2313	E0703	1639112410	01-1655	ACHC; EXP 08/23/23
Southern Care, Inc.	Gentiva	Parent-Hospice		706 Highway 51 North		Brookhaven	MS	39601-2366	062	1851330641	25-1561	ACHC; EXP 05/02/25
Southern Care, Inc.	Southern Care Indianapolis	Parent-Hospice		1907 South Liberty Drive	STE 102	Bloomington	IN	47403-5146	21-002998-1	1750329132	15-1572	ACHC; EXP 07/06/24
Southern Care, Inc.	Gentiva	Parent-Hospice		1990 South Frontage Road	Suite I	Vicksburg	MS	39180-5232	061	1861430837	25-1559	ACHC; 4/13/24
Southern Care, Inc.	Gentiva II	Parent-Hospice		1911 W. Centre Ave	Suite 1	Portage	MI	49024-5367	1041000077	1114965688	23-1591	ACHC; EXP 12/08/26
Southern Care, Inc.	Gentiva II	Parent-Hospice		1119 Park Avenue	Suite 7	Meadville	PA	16335-3107	16811601	1093741282	39-1681	ACHC; EXP 08/27/23
Southern Care, Inc.	Gentiva	Parent-Hospice		278 Commercial Drive		Newton	MS	39345-9564	043	1982622015	25-1541	ACHC; EXP 05/29/25

Exhibit 2 – List of Entities Owned (Page 4 of 9)

Company Name	Site Name	te Level (Parent, Branch, etc.)	Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
SouthernCare, Inc.	Gentiva II	Parent-Hospice		11835 Fishing Point Dr.	STE 102B	Newport News	VA	23606-3070	HSP-18228	1720458508	49-1622	ACHC; EXP 04/07.23
SouthernCare, Inc.	Gentiva	Parent-Hospice		2307 South Tucker Street		Pittsburg	KS	66762-6530	N/A	1063459535	17-1562	ACHC; EXP 05/09.27
SouthernCare, Inc.	Gentiva II	Parent-Hospice		5330 Peters Creek Rd., NW	Suite D1	Roanoke	VA	24019-3853	HSP-18130	1902848443	49-1582	ACHC; EXP 02/16.24
SouthernCare, Inc.	SouthernCare South Bend	Parent-Hospice		1626 E. Day Road		Mishawaka	IN	46545-3469	22-003723-1	1740228832	15-1582	ACHC; EXP 10/18.23
SouthernCare, Inc.	Gentiva	Parent-Hospice		590 Boardwalk Blvd.	Suite BO-590	Bossier City	LA	71111-4384	2203784630	1740229178	19-1580	ACHC; EXP 06/28.27
SouthernCare, Inc.	Gentiva II	Parent-Hospice		420 Neff Avenue	Suite 110	Harrisonburg	VA	22801-5435	HSP-18139	1033151550	49-1590	ACHC; EXP 04/16.24
SouthernCare, Inc.	Gentiva	Parent-Hospice		5375 SW 7th Street	STE 500	Topeka	KS	66606-2553	N/A	1295773273	17-1546	ACHC; EXP 06/06.27
SouthernCare, Inc.	SouthernCare Youngstown	Parent-Hospice		970 Windham Court	Suite 9	Youngstown	OH	44512-5082	0140HSP	1104864198	36-1617	ACHC; EXP 10/12.26
SouthernCare, Inc.	Heartland Hospice (Augusta)	Parent-Hospice		4487 Columbia Road	STE 103	Martinez	GA	30907-4255	121-0254-H	1720787211	11-1610	ACHC; 6/5/2027
SouthernCare, Inc.	Heartland Hospice (Brunswick)	Parent-Hospice		664 Scranton Road	Unit 103	Brunswick	GA	31520-1946	063-0256-H	1720787229	11-1644	
SouthernCare, Inc.	Heartland Hospice (Macon)	Parent-Hospice		5400 Riverside Drive	STE 200	Macon	GA	31210-0816	011-0261-H	1316646508	11-1603	
SouthernCare, Inc.	Heartland Hospice (Rockford)	Parent-Hospice		6000 E State Street	STE 1	Rockford	IL	61108-2521	2003273 (IL) 2022	1073212577	14-1617	ACHC; Exp 6/14/2027
SouthernCare, Inc.	Heartland Hospice (Fairview Heights)	Parent-Hospice		333 Salem Place	STE 165	Fairview Heights	IL	62208-1341	2003269	1154020659	14-1636	
SouthernCare, Inc.	Heartland Hospice (Frankfort)	Parent-Hospice		20960 S Frankfort Square Road	Unit C	Frankfort	IL	60423-5127	2003270	1316646813	14-1619	
SouthernCare, Inc.	Heartland Hospice (Northbrook)	Parent-Hospice		1110 W Lake Cook Road	STE 130	Buffalo Grove	IL	60089-1965	2003272	1124727623	14-1586	ACHC; EXP 04/24.27
SouthernCare, Inc.	Heartland Hospice (Allentown)	Parent-Hospice		951 Marcon Boulevard	STE 3	Allentown	PA	18109-9350	16371601	1457050973	39-1637	
SouthernCare, Inc.	Heartland Hospice (Chadds Ford)	Parent-Hospice		5 Christy Drive	STE 103	Chadds Ford	PA	19317-9667	16841601	1275232795	39-1684	
SouthernCare, Inc.	Heartland Hospice (Philadelphia)	Parent-Hospice		460 Norristown Road	STE 101	Blue Bell	PA	19422-2323	157099	1801595327	39-1570	ACHC: 8/12/25
SouthernCare, Inc.	Heartland Hospice (York)	Parent-Hospice		3417 Concord Road	STE C	York	PA	17402-9001	16381601	1710686233	39-1638	ACHC; 9/27/2025
SouthernCare, Inc.	Heartland Hospice (Erie)	Parent-Hospice		719 Indiana Drive		Erie	PA	16505-4409	16761601	1538868054	39-1676	ACHC; 9/30/25
SouthernCare, Inc.	Heartland Hospice (Pittsburgh)	Parent-Hospice		750 Holiday Drive	Suite 110, Foster Plaza I	Pittsburgh	PA	15220-2769	161099	1700585221	39-1610	
The American Heartland Hospice Corporation	Gentiva	Parent-Hospice		12125 Woodcrest Executive Dr	Suite 220	Saint Louis	MO	63141-5010	189-12HO	1649265166	26-1550	ACHC; EXP 02/16.24
TNMO Healthcare, LLC	Gentiva	Parent-Hospice		7315 Lee Highway	Suite 131	Chattanooga	TN	37421-1560	368	1003867458	44-1576	ACHC; Exp 05/31/2026
TNMO Healthcare, LLC	Gentiva	Parent-Hospice		2024 S. Maiden Lane	Suite 202	Joplin	MO	64804-0319	183-14HO	1609827468	26-1585	ACHC; EXP 05/21.24
TNMO Healthcare, LLC	Gentiva	Parent-Hospice		7135 Charlotte Pike	STE 200	Nashville	TN	37209-5017	369	1407807688	44-1545	ACHC; EXP 07/18.24
Trinity Hospice of Texas, LLC	Gentiva	Parent-Hospice		937 FM 1821	STE A-100	Mineral Wells	TX	76067-9133	11458	1831158203	45-1703	ACHC; EXP 03/13.26
Vista Hospice Care, LLC	Gentiva III	Parent-Hospice		6845 East U.S. Highway 36	STE 410	Avon	IN	46123-8104	22-004875-1	1447505144	15-1594	Pending
Vista Hospice Care, LLC	Gentiva II	Parent-Hospice		8000 W. 78th Street	STE 210	Edina	MN	55439-2549	402999	1750736625	24-1601	ACHC; EXP 08/06.23
Vista Hospice Care, LLC	Gentiva	Parent-Hospice		9484 Double R Boulevard	STE A	Reno	NV	89521-2993	1795-HPC-36	1043265341	29-1507	ACHC; EXP 03/09.25
Vista Hospice Care, LLC	Gentiva	Parent-Hospice		1476 West 18th Street		Rochester	IN	46975-7939	21-009878-1	1699118513	15-1562	ACHC; EXP 04/01.23
VistaCare of Boston, LLC	Gentiva	Parent-Hospice		275 Martine Street	STE 202	Fall River	MA	02723-1518	707C	1639450513	22-1594	ACHC; EXP 10/12.26
VistaCare of Boston, LLC	Gentiva	Parent-Hospice		2 Tupper Road	Unit 3	Sandwich	MA	02563-5323	7VF8	1366119562	22-1620	ACHC; Pending
VistaCare USA, LLC	Gentiva	Parent-Hospice		1120 Sanctuary Parkway	STE 250	Alpharetta	GA	30009-7629	033-113-H	1043257934	11-1544	ACHC; EXP 8/18/24
VistaCare USA, LLC	Gentiva I	Parent-Hospice		1777 Sentry Parkway West	STE 110	Blue Bell	PA	19422-2211	162299	1164478103	39-1622	ACHC; EXP 10/08.26
VistaCare USA, LLC	Gentiva	Parent-Hospice		700 Brookstone Centre Parkway	Suite 100	Columbus	GA	31904-9225	106-233-H	1801834593	11-1560	ACHC; EXP 02/10.2025
VistaCare USA, LLC	Gentiva I	Parent-Hospice		5401 Vogel Road	STE 740	Evansville	IN	47715-7834	23-009765-1	1700894987	15-1558	ACHC; EXP 05/05.24
VistaCare USA, LLC	Gentiva I	Parent-Hospice		2 Easton Oval	Suite 110	Columbus	OH	43219-6036	0084HSP	1366498305	36-1573	ACHC; EXP 03/22.25
VistaCare USA, LLC	Gentiva	Parent-Hospice		15 Brendan Way	STE 100	Greenville	SC	29615-3562	HPC-0058	1013962034	42-1534	ACHC; EXP 08/06.27
VistaCare USA, LLC	Gentiva I	Parent-Hospice		37 South Park Boulevard	Bldg 1	Greenwood	IN	46143-8838	22-003901-1	1952319113	15-1586	ACHC 11-26-2026
VistaCare USA, LLC	Gentiva I	Parent-Hospice		1701 E Market Street		Jeffersonville	IN	47130-4755	21-009766-1	1629086707	15-1557	ACHC; EXP 08/17.26
VistaCare USA, LLC	Gentiva	Parent-Hospice		730 N Dean Rd	STE 300	Auburn	AL	36830-4304	E5702	1326091273	01-1602	ACHC; EXP 12/18.26
VistaCare USA, LLC	Gentiva I	Parent-Hospice		4134 S. 7th Street		Terre Haute	IN	47802-4123	22-004763-1	1720034432	15-1592	ACHC; EXP 11/26.25
VistaCare USA, LLC	Gentiva	Parent-Hospice		105 Jim Mason Court	Suite 100	Warner Robins	GA	31088-9241	011-111-H	1891733580	11-1559	ACHC; EXP 01/04.27
Wiregrass Hospice of South Carolina, LLC	Gentiva	Parent-Hospice		4975 Lacross Road	STE 200A	North Charleston	SC	29406-6531	HPC-0007	1780849026	42-1503	ACHC; EXP 06/09/27
Wiregrass Hospice of South Carolina, LLC	Gentiva	Parent-Hospice		136 Roxboro Road		Oxford	NC	27565-2642	HOS4791	1336584622	34-1599	ACHC; EXP 05/12/27
Wiregrass Hospice of South Carolina, LLC	Gentiva	Parent-Hospice		101 North Pine St	STE 215	Spartanburg	SC	29302-1685	HPC-0103	1861445835	42-1571	ACHC; EXP 11/30/26
Wiregrass Hospice, LLC	Gentiva	Parent-Hospice		432 East Shotwell St.		Bainbridge	GA	39819-4058	043-084-H	1063448645	11-1556	ACHC; EXP 02/03/27
Wiregrass Hospice, LLC	Gentiva	Parent-Hospice		2550 Acton Road	STE 110	Birmingham	AL	35243-4248	E3733	1184897092	01-1675	ACHC; EXP 01/15/23
Wiregrass Hospice, LLC	Gentiva	Parent-Hospice		750 E Spring Street	STE B-1	Cookeville	TN	38501-4528	331	1720081409	44-1520	ACHC; EXP 10/26/23
Wiregrass Hospice, LLC	Gentiva	Parent-Hospice		2431 W Main Street	STE 1102	Dothan	AL	36303-1250	E3501	1770519324	01-1522	ACHC; EXP 07/19/24
Wiregrass Hospice, LLC	Gentiva	Parent-Hospice		5000 Bradford Drive NW	STE 3A	Huntsville	AL	35805-1937	E4505	1568635472	01-1674	ACHC; EXP 02/10/26
Hospice of Mesilla Valley, LLC	Gentiva	Parent-Hospice		665 E. University Avenue	Building 1	Las Cruces	NM	88005-3363	3679	1073070967	32-1581	ACHC; EXP 10/01/23
Odyssey HealthCare Holding Company	Heartland Hospice (Broward)	Parent-Hospice		150 S Pine Island Road	STE 540	Plantation	FL	33324-2667	5012096	1013617786	10-1502	
Odyssey HealthCare Holding Company	Heartland Hospice (Jacksonville)	Parent-Hospice		8130 Baymeadows Way West	STE 201	Jacksonville	FL	32256-7451	50370971	1093415762	10-1549	
Odyssey HealthCare Holding Company	Heartland Hospice (Ann Arbor)	Parent-Hospice		777 E Eisenhower Pkwy	Suite 230	Ann Arbor	MI	48108-3273	1041000062	1174224612	23-1572	ACHC; EXP 4/5/27
Odyssey HealthCare Holding Company	Heartland Hospice (Bay City)	Parent-Hospice		1320 Waldo Avenue	Suite 300	Midland	MI	48642-5898	1041000046	1306546080	23-1550	
Odyssey HealthCare Holding Company	Heartland Hospice (Flint)	Parent-Hospice		3031 Airpark Drive North		Flint	MI	48507-3471	1041000075	1932809613	23-1589	ACHC; EXP 3/30/27
Odyssey HealthCare Holding Company	Heartland Hospice (Grand Rapids)	Parent-Hospice		695 Kenmoor Avenue SE	Suite B	Grand Rapids	MI	49546-2375	1041000069	1114627890	23-1582	
Odyssey HealthCare Holding Company	Heartland Hospice (Mason)	Parent-Hospice		2150 Association Drive	Suite 200	Okemos	MI	48864-5498	1041000074	1013617794	23-1588	ACHC; EXP 5/18/27
Odyssey HealthCare Holding Company	Heartland Hospice (Monroe)	Parent-Hospice		1070 N Monroe Street	Suite B	Monroe	MI	48162-3113	1041000098	1811697584	23-1609	

Exhibit 2 – List of Entities Owned (Page 5 of 9)

Company Name	Site Name	e Level (Parent, Branch, etc.)	Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
Odyssey HealthCare Holding Company	Heartland Hospice (Southfield)	Parent-Hospice		26211 Central Park Boulevard	Suite 60(	Southfield	MI	48076-4107	1041000060	1649970328	23-1569	
Odyssey HealthCare Holding Company	Heartland Hospice (West Branch)	Parent-Hospice		564 Progress Street		West Branch	MI	48661-9382	1041000001	1467152140	23-1576	
Odyssey HealthCare Holding Company	Heartland Hospice (Rochester)	Parent-Hospice		821 3rd Avenue SE	Suite 15	Rochester	MN	55904-7300	396340	1801596580	24-1579	
Odyssey HealthCare Holding Company	Heartland Hospice (Woodbury)	Parent-Hospice		1385 Chews Landing Road		Laurel Springs	NJ	08021-2760	22925	1992405674	31-1550	
Odyssey HealthCare Holding Company	Heartland Hospice (Eau Claire)	Parent-Hospice		3410 Oakwood Mall Drive	Suite 40(	Eau Claire	WI	54701-2608	2068	1235839929	52-1618	
Odyssey HealthCare Holding Company	Heartland Hospice (Fond du Lac)	Parent-Hospice		N6650 Rolling Meadows Drive	Suite 1	Fond Du Lac	WI	54937-9471	2014	1558061242	52-1579	
Odyssey HealthCare Holding Company	Heartland Hospice (Green Bay)	Parent-Hospice		1145 W. Main Ave	Suite 20(	De Pere	WI	54115-9345	2005	1366143810	52-1569	
Odyssey HealthCare Holding Company	Heartland Hospice (Madison)	Parent-Hospice		2801 Crossroads Drive	STE 200(	Madison	WI	53718-7994	2031	1710687405	52-1592	
Odyssey HealthCare Holding Company	Heartland Hospice (Milwaukee)	Parent-Hospice		10200 W Innovation Drive	Suite 40(	Milwaukee	WI	53226-4826	2003	1851092316	52-1568	
Odyssey HealthCare Holding Company	Heartland Hospice (Central WI)	Parent-Hospice		3233A Business Park Dr	STE 203	Stevens Point	WI	54482-8861	2065	1265132963	52-1617	
East Rockets HH, LLC	Heartland Home Health (Ft. Wayne)	Parent-Home Health		2720 Dupont Commerce Ct	Suite 13(	Fort Wayne	IN	46825	22006341-1	1588364806	15-7205	
East Rockets HH, LLC	Heartland Home Health (Cleveland)	Parent-Home Health		4807 Rockside Road	Suite 11(	Independence	OH	44131-2140	0464HHS	1710674163	36-7634	ACHC; EXP 11/08/25
East Rockets HH, LLC	Heartland Home Health (Columbus)	Parent-Home Health		6500 Busch Boulevard	Suite 21(	Columbus	OH	43229-1728	0292HHS	1760182083	36-7557	ACHC; EXP 12/18/24
East Rockets HH, LLC	Heartland Home Health (Portsmouth)	Parent-Home Health		205 North St	P.O. Box400	Lucasville	OH	45648-0400	0064HHS	1104526771	36-7633	ACHC EXP: 2/4/25
East Rockets HH, LLC	Heartland Home Health (Pittsburgh)	Parent-Home Health		750 Holiday Drive	Foster Plaza #9, Ste 110	Pittsburgh	PA	15220-2769	718805	1801596127	39-7188	
Midwest Rockets HH, LLC	Heartland Home Health (Wichita)	Parent-Home Health		2872 N Ridge Road	Suite 12(	Wichita	KS	67205-1144	A-087-025	1902506579	17-7202	
Midwest Rockets HH, LLC	Heartland Home Health (Ann Arbor)	Parent-Home Health		1300 Eisenhower Place	#1390	Ann Arbor	MI	48108	Exempt	1427759547	23-7423	ACHC; EXP 02/14/27
Midwest Rockets HH, LLC	Heartland Home Health (Bay City)	Parent-Home Health		1320 Waldo Ave	Suite 30(	Midland	MI	48642-5898	Exempt	1093400319	23-7162	ACHC; EXP 04/26/27
Midwest Rockets HH, LLC	Heartland Home Health (Flint)	Parent-Home Health		3031 Airpark Drive N		Flint	MI	48507-3471	Exempt	1417658519	23-7336	ACHC; EXP 5/9/27
Midwest Rockets HH, LLC	Heartland Home Health (Grand Rapids)	Parent-Home Health		695 Kenmoor Ave SE	Suite B	Grand Rapids	MI	49546-2375	Exempt	1952002057	23-7331	
Midwest Rockets HH, LLC	Heartland Home Health (Mason)	Parent-Home Health		2150 Association Drive	STE 200	Okemos	MI	48864	Exempt	1093416190	23-7333	ACHC; EXP 3/23/27
Midwest Rockets HH, LLC	Heartland Home Health (West Branch)	Parent-Home Health		564 Progress Street		West Branch	MI	48661-9382	Exempt	1073214177	23-7435	
Midwest Rockets HH, LLC	Heartland Home Health (Shawnee)	Parent-Home Health		2802 N Kickapoo Avenue		Shawnee	OK	74804-1798	HC7163	1407557101	37-7158	
Mid-South Home Care Services, LLC	Empatia Palliative Care	Branch-Palliative		2800 Dauphin Street	Suite 10(	Mobile	AL	36606-2400	N/A	1407361371	102G707021; RRDY9475	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Branch-Palliative		2550 Acton Road	Suite 11(	Birmingham	AL	35243-4248	N/A	1922535400	102G707021	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Branch-Palliative		10220 Waterville Street		Whitehouse	OH	43571-9705	N/A	1881391597	H987750	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Branch-Palliative		1320 Waldo Avenue	Suite 30(	Midland	MI	48642-5898	N/A	1477240190	MI17797	N/A
Mid-South Home Care Services, LLC	Empatia Palliative Care	Branch-Palliative		26211 Central Park Boulevard	Suite 60(	Southfield	MI	48076-4107	N/A	1477240190	MI17798	N/A
IH Physican Services, PC	IH Physician Services, PC	Branch-Palliative		4515 Falls of Neuse Road	Suite 42(	Raleigh	NC	27609-6374	N/A	1447959093	O484	N/A
Illumia Health, LLC	Illumia Health	Branch-Palliative		7887 Washington Village Drive	STE 350/	Dayton	OH	45459-3900		1740024397		
Angel Heart Hospice, LLC	New Century Hospice of Austin	Branch-Hospice		451 E. Central Texas EXPY	STE #C	Harker Heights	TX	76548-1982	017517	1013901719	67-1502	ACHC; EXP 07/03/26
Angel Heart Hospice, LLC	New Century Hospice of Austin	Branch-Hospice		705 N US HIGHWAY 281	STE 201	Marble Falls	TX	78654-5124	17517	1013901719	67-1502	ACHC; EXP 07/03/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		533 S. Fayetteville Street		Asheboro	NC	27203-5701	HOS3075	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		126 E. Elizabeth Street	Suite A	Clinton	NC	28328-4018	HC1844	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		1231 North Main Street		Lillington	NC	27546-8286	HOS2048	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		497 Olde Waterford Way	Suite 20(	Belville	NC	28451-4183	HOS3010	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		2600 North Elm St	Ste. B	Lumberton	NC	28358-3011	HOS2060	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		1428 ELLEN ST	Unit A	Monroe	NC	28112-5286	HOS3116	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		1198 Rockingham Road		Rockingham	NC	28379-4501	HOS3007	1528015369	34-1576	ACHC; EXP 06/16/23
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		1836 Doctors Drive		Sanford	NC	27330-5057	HOS2034	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		1024 Albemarle Road	Suite 90(	Troy	NC	27371-8684	HOS3199	1528015369	34-1576	ACHC; EXP 06/16/26
Carrolton Home Care, LLC	Gentiva	Branch-Hospice		301 Liberty Street	Suite 20(	Whiteville	NC	28472-3714	HOS3011	1528015369	34-1576	ACHC; EXP 06/16/26
Community Home Care & Hospice, LLC	Gentiva	Branch-Hospice		2309 Wayne Memorial Drive		Goldsboro	NC	27534-1725	HC2361	1134176993	34-1585	ACHC; EXP 05/31/23
Community Home Care & Hospice, LLC	Gentiva	Branch-Hospice		1003 Red Banks Road	STE B	Greenville	NC	27858-5908	HOS2996	1134176993	34-1585	ACHC; EXP 05/31/23
Community Home Care & Hospice, LLC	Gentiva	Branch-Hospice		2479 Hurt Drive		Rocky Mount	NC	27804-7976	HOS2424	1134176993	34-1585	ACHC; EXP 05/31/23
Community Home Care & Hospice, LLC	Gentiva	Branch-Hospice		52 Anna Louise Lane		Roanoke Rapids	NC	27870-8648	HOS3009	1134176993	34-1585	ACHC; EXP 05/31/23
Community Home Care of Vance County, LLC	Gentiva	Branch-Hospice		2730 Tucker Street	Suite 600	Burlington	NC	27215-8860	HOS3063	1841247335	34-1589	ACHC; EXP 11/16/26
Community Home Care of Vance County, LLC	Gentiva	Branch-Hospice		208 Buttemut Lane		Clayton	NC	27520-5857	HOS2135; NP281	1841247335	34-1589	ACHC; EXP 11/16/26
Community Home Care of Vance County, LLC	Gentiva	Branch-Hospice		7714 Chapel Hill Road		Cary	NC	27513-6256	HOS2223	1841247335	34-1589	ACHC; EXP 11/16/26
Community Home Care of Vance County, LLC	Gentiva	Branch-Hospice		1308 Davie Avenue		Statesville	NC	28677-3514	HOS3273	1841247335	34-1589	ACHC; EXP 11/16/26
Community Hospice, LLC	Gentiva	Branch-Hospice		1601 N. Road Street	Suite B	Elizabeth City	NC	27909-3417	HOS3301	1891736336	34-1586	ACHC; EXP 06/13/23
Community Hospice, LLC	Gentiva	Branch-Hospice		115 Airport Road		Kinston	NC	28501-1603	HOS2984	1891736336	34-1586	ACHC; EXP 06/13/23
Community Hospice, LLC	Gentiva	Branch-Hospice		662 West Corbett Avenue		Swansboro	NC	28584-8450	HOS3006	1891736336	34-1586	ACHC; EXP 06/13/23
Community Hospice, LLC	Gentiva	Branch-Hospice		222 W. Stewart Parkway	Suite 100	Washington	NC	27889-4994	HOS2516	1891736336	34-1586	ACHC; EXP 06/13/23
Community Hospice, LLC	Gentiva	Branch-Hospice		200 Green Street	Suite 203	Williamston	NC	27892-2066	HOS3008	1891736336	34-1586	ACHC; EXP 06/13/23
Cosmos Hospice of Corpus Christi, LLC	New Century Hospice of South Texas	Branch-Hospice		1819 N. Frontage Road		Beeville	TX	78102-2937	17441	1033397815	67-1607	ACHC; EXP 01/05/27
Cosmos Hospice of Corpus Christi, LLC	New Century Hospice of South Texas	Branch-Hospice		1501 East Mockingbird Lane	STE 301 B	Victoria	TX	77904-2153	17441	1033397815	67-1607	ACHC; EXP 01/05/27
Cosmos Hospice of San Antonio, LLC	New Century Hospice of San Antonio	Branch-Hospice		2210 Bandera Hwy	Suite B-2	Kerrville	TX	78028-6609	17455	1467621078	67-1612	ACHC; EXP 09/29/26
Cosmos Hospice of San Antonio, LLC	New Century Hospice of San Antonio	Branch-Hospice		206 N. Smith St.		Pleasanton	TX	78064-3536	17455	1467621078	67-1612	ACHC; EXP 09/29/26
Curo Health Services, LLC	Heartland Hospice (Marion)	Branch-Hospice		3001 S Valley Avenue		Marion	IN	46953-3410	Under Parent 21-0	1740989243	15-1573	ACHC exp 10/4/27

Exhibit 2 – List of Entities Owned (Page 6 of 9)

Company Name	Site Name	e Level (Parent, Branch, etc.)	Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
Curo Health Services, LLC	Heartland Hospice (South Bend)	Branch-Hospice		230 W. Catalpa Drive	Suite D	Mishawaka	IN	46545-8322	Under Parent 220(	1013616515	15-1521	
Curo Health Services, LLC	Heartland Hospice (Cedar Rapids)	Branch-Hospice		1540 Midland Court NE	Suite 100	Cedar Rapids	IA	52402-1922	Under Parent 821	1164123873	16-1568	ACHC EXP: 2/8/27
Curo Health Services, LLC	Heartland Hospice (Festus)	Branch-Hospice		533 Bailey Rd		Crystal City	MO	63019-1701	Under Parent 110-	1437858941	26-1574	
Curo Health Services, LLC	Heartland Hospice (Butler)	Branch-Hospice		601 W Nursery Street		Butler	MO	64730-1872	Under Parent 111-	1891494308	26-1572	
Curo Health Services, LLC	Heartland Hospice (Sedalia)	Branch-Hospice		150 S. Limit Avenue	Suite 400	Sedalia	MO	65301-3617	Under Parent 111-	1891494308	26-1572	
Curo Health Services, LLC	Heartland Hospice (Washington)	Branch-Hospice		1715 Heritage Hills Dr.,		Washington	MO	63090-4621	Under Parent 110-	1437858941	26-1574	
Curo Health Services, LLC	Heartland Hospice (Wentzville)	Branch-Hospice		1097 Wentzville Parkway		Wentzville	MO	63385-3537	Under Parent 110-	1437858941	26-1574	
Curo Health Services, LLC	Heartland Hospice (Suffolk)	Branch-Hospice		1500 Breezeport Way	Suite 400	Suffolk	VA	23435-3730	Exempt	1164121489	49-1545	
Curo Health Services, LLC	Heartland Hospice (Charlottesville)	Branch-Hospice		2410 Old Ivy Road	Suite 350	Charlottesville	VA	22903-5084	Exempt	1265131585	49-1567	
Curo Health Services, LLC	Heartland Hospice (Lynchburg)	Branch-Hospice		7806 Timberlake Rd		Lynchburg	VA	24502-2602	Exempt	1720787047	49-1617	
Curo Health Services, LLC	Heartland Hospice (Warrenton)	Branch-Hospice		493 Blackwell Road	Suite 319	Warrenton	VA	20186-2639	Exempt	1447959762	49-1565	
Curo Health Services, LLC	Heartland Hospice (Moline)	Branch-Hospice		1701 River Drive	STE 104	Moline	IL	61265-1322	2003271 (IL)	1164123873	16-1568	
Family Hospice, Ltd.	Gentiva	Branch-Hospice		2708 North Prince Street		Clovis	NM	88101-4462	6716AS2	1972511061	32-1513	ACHC; EXP 03/31/24
Family Hospice, Ltd.	Gentiva	Branch-Hospice		400 North Pennsylvania Avenue	STE 500	Roswell	NM	88201-4720	6716AS1	1972511061	32-1513	ACHC; EXP 03/31/24
Freedom Hospice, LLC	Gentiva	Branch-Hospice		1310 S. York Street		Muskogee	OK	74403-7650	HO4208 (AAO)	1295819050	37-1657	ACHC; EXP 07/12/24
Gilbert's Hospice Care, LLC	Gentiva	Branch-Hospice		144 S. Thomas St.	STE 201	Tupelo	MS	38801-5337	103	1851397921	25-1594	ACHC; EXP 06/08/24
Gilbert's Hospice Care, LLC	Gentiva	Branch-Hospice		128 West Washington St		Kosciusko	MS	39090-3633	105	1477875441	25-1597	
Heritage Health & Hospice Care, LLC	Gentiva	Branch-Hospice		2615 Calder Street	Suite 660	Beaumont	TX	77702-1955	15346	1447381470	67-1626	ACHC; EXP 03/07/25
Heritage Health & Hospice Care, LLC	Gentiva	Branch-Hospice		1022 S John Redditt Drive		Lufkin	TX	75904-4364	15346	1447381470	67-1626	ACHC; EXP 03/07/25
Heritage Health & Hospice Care, LLC	Gentiva	Branch-Hospice		10707 Corporate Drive	Ste. 200	Stafford	TX	77477-4001	15346	1447381470	67-1626	ACHC; EXP 03/07/25
Heritage Health & Hospice Care, LLC	Gentiva	Branch-Hospice		322 Spring Hill Dr.	STE B100	Spring	TX	77386-3401	15346	1447381470	67-1626	ACHC; EXP 03/07/25
Hospice Care of Kansas, LLC	Gentiva	Branch-Hospice		120 North Main Street		Hutchinson	KS	67501-5219	N/A	1790833382	17-1542	ACHC; EXP 06/03/27
Hospice Care of Kansas, LLC	Gentiva	Branch-Hospice		900 E 1st Street	Suite A	McPherson	KS	67460-3616	N/A	1790833382	17-1542	ACHC; EXP 06/03/27
Hospice Care of Kansas, LLC	Gentiva	Branch-Hospice		1603 Main Street		Winfield	KS	67156-4931	N/A	1790833382	17-1542	ACHC; EXP 06/03/27
Hospice Care of Kansas, LLC	Gentiva	Branch-Hospice		1003 East Albert Ave		Salina	KS	67401-6611	N/A	1790833382	17-1542	ACHC; EXP 06/03/27
Hospice Family Care, Inc.	Gentiva II	Branch-Hospice		1175 E. Cottonwood Lane	Suite 1	Casa Grande	AZ	85122-2968	HSPC7053	1023401924	03-1537	ACHC; EXP 07/12/24
Hospice Family Care, Inc.	Gentiva II	Branch-Hospice		275 W. Continental Road	Suite 195	Green Valley	AZ	85622-3626	HSPC6479	1609288190	03-1519	ACHC; EXP 07/02/24
Hospice Family Care, Inc.	Gentiva II	Branch-Hospice		8245 N Silverbell Rd	STE 167B	Tucson	AZ	85743-7381	HSPC7456	1043677438	03-1519	ACHC; EXP 07/02/24
Hospice Family Care, Inc.	Gentiva II	Branch-Hospice		13540 W Camino del Sol	Suite 1	Sun City	AZ	85375-4435	HSPC6444	1063824530	03-1537	ACHC; EXP 07/12/24
Hospice of Maine, LLC	Gentiva	Branch-Hospice		24 Stone Street	STE 106	Augusta	ME	04330-5209	39644	1477025286	20-1523	
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Branch-Hospice		1330 South Boulevard		Chipley	FL	32428-1846	5001096	1952337149	10-1537	Pending
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Branch-Hospice		550 Redstone Ave. West	STE 310	Crestview	FL	32536-6429	5001096	1952337149	10-1537	Pending
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Branch-Hospice		1301 Eglin Parkway	Unit D	Shalimar	FL	32579-1208	5001096	1952337149	10-1537	Pending
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Branch-Hospice		3015 Jefferson Street	STE C	Marianna	FL	32446-2300	5001096	1952337149	10-1537	Pending
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Branch-Hospice		200 Grand Blvd	STE 205-A	Miramar Beach	FL	32550-1884	5001096	1952337149	10-1537	Pending
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Branch-Hospice		5536 Stewart Street		Milton	FL	32570-4304	5001096	1952337149	10-1537	Pending
Hospice of the Emerald Coast, Inc.	Emerald Coast Hospice	Branch-Hospice		2190 Airport Blvd	Suite 2850	Pensacola	FL	32504-8987	5001096	1952337149	10-1537	Pending
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		524 E Lamar Blvd	Ste 152	Arlington	TX	76011-3929	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		9701 Wesley Street	STE 204 (main) & 205 (a	Greenville	TX	75402-3754	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		836 Southpark Circle	Suite D	Athens	TX	75752-6922	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		571 W. Main Street	Suite 240	Lewisville	TX	75047-3628	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		3218 North 4th Street		Longview	TX	75605-5143	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		1575 Redbud Blvd.	Suite 201	McKinney	TX	75069-3226	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		302 N. Jefferson Avenue	Suite 101	Mount Pleasant	TX	75455-3935	009235	1164466397	45-1780	ACHC; EXP 09/24/24
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		100 Willow Creek Pkwy	Suite B	Palestine	TX	75801-4387	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		100 W. Lamberth Road	Suite C	Sherman	TX	75092-2671	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		608 N. Rockwall Ave.,	STE 608	Terrell	TX	75160-2117	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		112 E. Line Street	Suite 202	Tyler	TX	75702-5760	009235	1164466397	45-1780	ACHC; EXP 09/24/24
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		820 Ferris Ave	Suite 251	Waxahachie	TX	75165-2590	009235	1164466397	45-1780	ACHC; EXP 09/24/27
International Tutoring Services, LLC	Hospice Plus	Branch-Hospice		4210 Kell Blvd	Suite 204	Wichita Falls	TX	76309-4802	009235	1164466397	45-1780	ACHC; EXP 09/24/27
Legacy Hospice of Colorado Springs, LLC	Gentiva I	Branch-Hospice		1320 Fortino Blvd.	Suite C	Pueblo	CO	81008-2081	17W350	1801467758	06-1583	ACHC; EXP 09/26/23
Loving Peace Hospice, Inc.	Gentiva	Branch-Hospice		205 N. Williamsburg Drive	Suite D	Bloomington	IL	61704-7721	2003153	1811393564	14-1666	ACHC; EXP 04/20/24
New Beacon Healthcare Group, LLC	SouthernCare New Beacon - Alabaster	Branch-Hospice		122 7th Avenue NE	Suite D	Alabaster	AL	35007-9121	E5912	1770512741	01-1501	ACHC; EXP 09/29/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Alexander Ci	Branch-Hospice		124 Aliant Parkway		Alexander City	AL	35010-3158	E6209	1346279320	01-1508	ACHC; EXP 10/27/23
New Beacon Healthcare Group, LLC	SouthernCare New Beacon S. Birmingha	Branch-Hospice		1280 Columbiana Road	Suite 110	Vestavia Hills	AL	35216-1605	E3739	1376572255	01-1506	ACHC; EXP 12/14/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Clanton	Branch-Hospice		201 Medical Center Drive		Clanton	AL	35045-2329	E1107	1770512741	01-1501	ACHC; EXP 09/29/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Cullman	Branch-Hospice		417 Main Street		Hanceville	AL	35077-5459	E2211	1588693550	01-1512	ACHC; EXP 10/13/23
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Decatur	Branch-Hospice		1316 Somerville Rd. SE	Suite 4	Decatur	AL	35601-4309	E5209/ BL : 2023-	1588693550	01-1512	ACHC; EXP 10/13/23
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Demopolis	Branch-Hospice		927 Hwy 80 West		Demopolis	AL	36732-4102	E4606	1376572255	01-1506	ACHC; EXP 12/14/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Gadsden	Branch-Hospice		412 South 5th Street		Gadsden	AL	35901-5102	E2810	1346279320	01-1508	ACHC; EXP 10/27/23

Exhibit 2 – List of Entities Owned (Page 7 of 9)

Company Name	Site Name	e Level (Parent, Branch, etc.)	Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Huntsville	Branch-Hospice		200 West Side Square	Suite 440	Huntsville	AL	35801-4864	E4519	1588693550	01-1512	ACHC; EXP 10/13/23
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Montgomery	Branch-Hospice		7067 Sydney Curve	Suite B	Montgomery	AL	36117-3509	E5115	1770512741	01-1501	ACHC; EXP 09/29/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Quad Cities	Branch-Hospice		239 Azalea Drive		Florence	AL	35630-1733	E3913	1588693550	01-1512	ACHC; EXP 10/13/23
New Beacon Healthcare Group, LLC	SouthernCare New Beacon Selma	Branch-Hospice		900 Church Street	STEs 1, 2, 3	Selma	AL	36701-4550	E2408	1376572255	01-1506	ACHC; EXP 12/14/26
New Beacon Healthcare Group, LLC	SouthernCare New Beacon - Sylacauga	Branch-Hospice		1300 Talladega Highway		Sylacauga	AL	35150-1628	E6114	1770512741	01-1501	ACHC; EXP 09/29/26
New Century Hospice, Inc.	New Century Hospice of Dallas	Branch-Hospice		301 Hospital Drive	Suite 101	Corsicana	TX	75110-2471	17435	1407929037	67-1588	ACHC; EXP 05/30/26
New Century Hospice, Inc.	New Century Hospice of Dallas	Branch-Hospice		4150 International Plaza	STE 100	Fort Worth	TX	76109-4819	17435	1407929037	67-1588	ACHC; EXP 05/30/26
Odyssey HealthCare of Flint, LLC	Gentiva	Branch-Hospice		6270 State Street		Saginaw	MI	48603	1041000023	1346247244	23-1524	ACHC; EXP 08/17/26
Odyssey HealthCare of Marion County, LLC	Gentiva	Branch-Hospice		1717 North Clyde Morris Blvd.	STE 130	Daytona Beach	FL	32117-5532	50370970	1114159902	10-1548	ACHC; EXP 10/12/23
Odyssey HealthCare of Marion County, LLC	Gentiva	Branch-Hospice		103400 Overseas Hwy	STE 235	Key Largo	FL	33037-2849	50370970	1114159902	10-1548	ACHC; EXP 10/12/23
Odyssey HealthCare of Marion County, LLC	Gentiva	Branch-Hospice		1320 SE 25th Loop	STE 101	Ocala	FL	34471-1024	50370970	1114159902	10-1548	ACHC; EXP 10/12/23
Odyssey HealthCare of Marion County, LLC	Gentiva	Branch-Hospice		160 Cypress Point Parkway	Suite D104	Palm Coast	FL	32164-8445	50370970	1114159902	10-1548	ACHC; EXP 10/12/23
Odyssey HealthCare of Marion County, LLC	Gentiva	Branch-Hospice		1975 South John Young Parkway	Suite 203	Kissimmee	FL	34741-0605	50370963	1942971346	10-1540	ACHC; EXP 01/11/24
Odyssey HealthCare of Marion County, LLC	Gentiva	Branch-Hospice		929 North Spring Garden Ave	STE 145	Deland	FL	32720-0916	50370970	1114159902	10-1548	
Odyssey HealthCare of Savannah, LLC	Gentiva	Branch-Hospice		114 South Main Street		Statesboro	GA	30458-5246	025-213-H	1477554947	11-1615	ACHC; EXP 09/16/26
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		12777 Jones Road	Suite 375 (main) & 395	Houston	TX	77070-4627	007790	1821099714	Pending	ACHC; EXP 03/07/25
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		1525 Lakeville Drive	Suite 218	Kingwood	TX	77339-2079	007790	1821099714	Pending	ACHC; EXP 03/07/25
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		18333 Egret Bay Blvd	Suite 560	Houston	TX	77058-6408	007790	1821099714	Pending	ACHC; EXP 03/07/25
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		770 Factory Street	STE 1	Conway	AR	72032-4327	AP6285	1750382750	04-1561	ACHC; EXP 08/19/25
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		8608 Dollarway Road	STE A	White Hall	AR	71602-2867	AP6285	1750382750	04-1561	ACHC; EXP 08/19/25
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		1201 West Gibson Street		Jasper	TX	75951-4807	007790	1821099714	45-1638	ACHC; EXP 02/07/26
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		26 Nesbitt Rd.	STE 200	New Castle	PA	16105-3417	161299	1437150430	39-1612	ACHC; EXP 06/02/24
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		16070 Tuscola Rd	STE 204	Apple Valley	CA	92307-1691	080000736	1235705575	05-1593	ACHC; EXP 03/10/27
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		4020 South Demaree Street	STE B	Visalia	CA	93277-9543	070000582	1740281633	05-1740	ACHC; EXP 10/12/24
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		295 Featherston Street		Waldron	AR	72958-8900	AP5837	1467802405	04-1528	ACHC; Pending
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		1891 Santa Barbara Drive	Suite 201	Lancaster	PA	17601-4106	16711601	1316921323	39-1671	ACHC; EXP 03/31/27
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		22461 I-30	STE 302	Bryant	AR	72022-2382		1265882294	04-1537	
Odyssey HealthCare Operating A, LP	Gentiva	Branch-Hospice		244 Highway 65 North	STE 8	Clinton	AR	72031-6677			04-1539	
Odyssey HealthCare Operating A, LP	Heartland Hospice (Burlingame)	Branch-Hospice		1575 Bayshore Highway	Suite 200	Burlingame	CA	94010-1616	UnderParent700	1215636709	05-1690	ACHC EXP; 8/8/25
Odyssey HealthCare Operating A, LP	Heartland Hospice (Capitola)	Branch-Hospice		824 Bay Avenue	STE 40	Capitola	CA	95010-2104	UnderParent700	1871292367	05-1692	ACHC EXP; 8/17/25
Odyssey HealthCare Operating A, LP	Heartland Hospice (Akron)	Branch-Hospice		231 Springside Drive	STE 140	Akron	OH	44333-4516	UnderParent013	1023717535	36-1584	ACHC; EXP 10/12/24
Odyssey HealthCare Operating A, LP	Heartland Hospice (Circleville)	Branch-Hospice		116 Morris Road	STE B	Circleville	OH	43113-1685	UnderParent013	1104525617	36-1620	ACHC EXP; 10-6-25
Odyssey HealthCare Operating A, LP	Heartland Hospice (Jackson)	Branch-Hospice		120 Twin Oaks Drive	Unit B	Jackson	OH	45640-9506	UnderParent012	1184325870	36-1610	ACHC; EXP 3/19/25
Odyssey HealthCare Operating A, LP	Heartland Hospice (Marion)	Branch-Hospice		685 Delaware Avenue	STE 300	Marion	OH	43302-5073	UnderParent013	1104525617	36-1620	ACHC EXP; 10/6/25
Odyssey HealthCare Operating A, LP	Heartland Hospice (Sidney)	Branch-Hospice		650 N Vandemark Road	STE D	Sidney	OH	45365-3575	UnderParent012	1659070175	36-1589	ACHC EXP; 9/29/25
Odyssey HealthCare Operating A, LP	Heartland Hospice (Washington Court H	Branch-Hospice		208 North Fayette Street		Washington Court Hou	OH	43160-1306	UnderParent013	1104525617	36-1620	ACHC EXP; 10/6/25
Odyssey HealthCare Operating A, LP	Heartland Hospice (Youngstown)	Branch-Hospice		1240 Boardman-Canfield Road	STE 4C	Boardman	OH	44512-4044	UnderParent013	1023717535	36-1584	ACHC; EXP 10/12/24
Odyssey HealthCare Operating A, LP	Heartland Hospice (Toledo)	Branch-Hospice		10220 Waterville Street		Whitehouse	OH	43571-9705	UnderParent011	1598465320	36-1595	ACHC EXP; 7/11/27
Odyssey HealthCare Operating B, LP	Gentiva	Branch-Hospice		9805 Millwood Circle	STE D	Daphne	AL	36527-5452	E0209	1184625717	01-1605	ACHC; EXP 07/27/24
Odyssey HealthCare Operating B, LP	Gentiva	Branch-Hospice		1100 Sherwood Park Drive NE	STE 120	Gainesville	GA	30501-3426	029-202-H	1427040765	11-1612	ACHC; EXP 09/17/24
Odyssey HealthCare Operating B, LP	Gentiva	Branch-Hospice		595 Old Wagner Road	STE E	Petersburg	VA	23805-9307	HSP-21158	1265433718	49-1568	ACHC; EXP 12/28/23
Odyssey HealthCare Operating B, LP	Gentiva	Branch-Hospice		1610 NE Eastgate Blvd	STE 610	Pullman	WA	99163-5609	IHS.FS.60308060	1205183878	50-1534	ACHC; EXP 11/16/23
Odyssey HealthCare Operating B, LP	Gentiva	Branch-Hospice		203 Bulifants Blvd	Ste B	Williamsburg	VA	23188-5742	HSP-21194	1346241981	49-1562	ACHC; EXP 12/02/23
Odyssey HealthCare Operating B, LP	Gentiva I	Branch-Hospice		39425 Garfield Rd	STE 22	Clinton Township	MI	48038-4651	1041000057	1164423703	23-1564	ACHC; EXP 10/28/26
Peoplefirst Home Care & Hospice of Ohio, LLC	Gentiva	Branch-Hospice		7887 Washington Village Drive	STE 350	Dayton	OH	45459-3986	0162-HSP	1922238203	36-1635	ACHC; EXP 07/06/24
Peoplefirst Home Care & Hospice of Ohio, LLC	Gentiva	Branch-Hospice		1201 Delaware Ave		Marion	OH	43302-6419	0162-HSP	1922238203	36-1635	ACHC; EXP 07/06/24
Regency Hospice of Georgia, LLC	Gentiva	Branch-Hospice		205 East Main Street		Chesterfield	SC	29709-1717	HPC-0085	1003864869	42-1552	ACHC; EXP 08/10/23
Regency Hospice of Georgia, LLC	Regency Southern Care	Branch-Hospice		4255 Wade Green Road NW	Suite 110	Kennesaw	GA	30144-1810	036-0242-H	1760440424	11-1637	ACHC; EXP 03/23/27
Regency Hospice of Georgia, LLC	Gentiva	Branch-Hospice		2170 Ashley Phosphate Road	Suite 110	North Charleston	SC	29406-4160	HPC-0085	1003864869	42-1552	ACHC; EXP 08/10/23
Regency Hospice of Georgia, LLC	Gentiva	Branch-Hospice		960 Pamplico Highway	Suite K	Florence	SC	29505-6244	HPC-0085	1003864869	42-1552	ACHC; EXP 08/10/23
Regency Hospice of Georgia, LLC	Gentiva	Branch-Hospice		750 Executive Center Drive	Suite 207	Greenville	SC	29615-4582	HPC-0085	1003864869	42-1552	ACHC; EXP 08/10/23
Regency Hospice of Georgia, LLC	Regency Southern Care	Branch-Hospice		350 S. Main Street	P. O. Box 494	Hiawassee	GA	30546-0494	036-0242-H	1760440424	11-1637	ACHC; EXP 03/23/27
Regency Hospice of Georgia, LLC	Gentiva	Branch-Hospice		5046 Highway 17 Bypass S	Suite 206	Myrtle Beach	SC	29588-4503	HPC-0085	1003864869	42-1552	ACHC; EXP 08/10/26
Regency Hospice of Georgia, LLC	Regency Southern Care	Branch-Hospice		143 S. Hwy 319	Suite 1	Moultrie	GA	31768-7991	036-0242-H	1760440424	11-1637	ACHC; EXP 03/23/27
Regency Hospice of Georgia, LLC	Gentiva	Branch-Hospice		1740 Village Park Drive	STE 1740	Orangeburg	SC	29118-2547	HPC-0085	1003864869	42-1552	ACHC; EXP 08/10/23
Regency Hospice of Georgia, LLC	Regency Southern Care	Branch-Hospice		7 Allen Cail Drive	Ste. A & B	Statesboro	GA	30458-2100	036-0242-H	1760440424	11-1637	ACHC; EXP 03/23/27
Regency Hospice of Georgia, LLC	Regency Southern Care	Branch-Hospice		1006 Mount Vernon Road	Suite B	Vidalia	GA	30474-3029	036-0242-H	1760440424	11-1637	ACHC; EXP 03/23/27
Regency Hospice of Georgia, LLC	Gentiva	Branch-Hospice		200 Center Point Circle	STE 100	Columbia	SC	29210-5895				
Regency Hospice of Northwest Florida, Inc.	Gentiva I	Branch-Hospice		1045 US Hwy 331 South	Unit C	De Funiak Springs	FL	32435-3379	50370972	1730326828	10-1551	ACHC; EXP 06/18/24
Regency Hospice of Northwest Florida, Inc.	Gentiva I	Branch-Hospice		124 E Miracle Strip Pkwy	Suite 301 & 302	Mary Esther	FL	32569-1990	50370972	1730326828	10-1551	ACHC; EXP 06/18/24

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Company Name	Site Name	e Level (Parent, Branch, etc.)	Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
SouthernCare, Inc.	SouthernCare Youngstown	Branch-Hospice		3575 Forest Lake Drive	Suite 550	Uniontown	OH	44685-8115	0140HSP	1104864198	36-1617	ACHC; EXP 10/12/25
SouthernCare, Inc.	SouthernCare Evergreen	Branch-Hospice		116 Edwina Street		Evergreen	AL	36401-3319	E2009	1639112410	01-1655	ACHC; EXP 08/23/2
SouthernCare, Inc.	SouthernCare Atmore	Branch-Hospice		3421 HWY 21	STE 110	Atmore	AL	36502-4669	E2706	1639112410	01-1655	ACHC; EXP 08/23/2
SouthernCare, Inc.	SouthernCare Mobile	Branch-Hospice		3938 A Government Blvd	Suite 103	Mobile	AL	36693-4383	E4923	1639112410	01-1655	ACHC; EXP 08/23/2
SouthernCare, Inc.	Gentiva II	Branch-Hospice		941 Glenwood Station	Unit 204	Charlottesville	VA	22901-5719	HSP-18221	1033151550	49-1590	ACHC; EXP 04/16/24
SouthernCare, Inc.	SouthernCare Daphne	Branch-Hospice		1819 N McKenzie S	Bldg 1	Foley	AL	36535-2326	E0218	1639112410	01-1655	ACHC; EXP 08/23/2
SouthernCare, Inc.	Gentiva	Branch-Hospice		25550 Juban Road	Suite C	Denham Springs	LA	70726-6149	296-A	1235179060	19-1570	ACHC; EXP 05/18/24
SouthernCare, Inc.	SouthernCare Dothan	Branch-Hospice		2576 Montgomery Hwy	Suite 2	Dothan	AL	36303-2633	E3508	1639112410	01-1655	ACHC; EXP 08/23/2
SouthernCare, Inc.	SouthernCare Enterprise	Branch-Hospice		300 N. Edwards St.		Enterprise	AL	36330-2508	E1607	1639112410	01-1655	ACHC; EXP 08/23/2
SouthernCare, Inc.	SouthernCare Grove Hill	Branch-Hospice		179-B Jackson Street		Grove Hill	AL	36451-3009	E1306	1639112410	01-1655	ACHC; EXP 08/23/2
SouthernCare, Inc.	SouthernCare South Bend	Branch-Hospice		2312 South Dixon Road	Suite 200	Kokomo	IN	46902-6423	21-003723-1	1740228832	15-1582	ACHC; EXP 10/18/23
SouthernCare, Inc.	SouthernCare South Bend	Branch-Hospice		935 Mezzanine Drive	Suite B	Lafayette	IN	47905-8645	21-003723-1	1740228832	15-1582	ACHC; EXP 10/18/23
SouthernCare, Inc.	Gentiva	Branch-Hospice		98 Glen Oaks Drive		Lucedale	MS	39452-5857	039	1053350850	25-1537	ACHC; EXP 04/29/25
SouthernCare, Inc.	SouthernCare South Bend	Branch-Hospice		3415 West Fox Ridge Lane		Muncie	IN	47304-5204	21-003723-1	1740228832	15-1582	ACHC; EXP 10/18/23
SouthernCare, Inc.	SouthernCare Youngstown	Branch-Hospice		9501 US Highway 250 N	Suite 2	Milan	OH	44846-8377	0140HSP	1104864198	36-1617	ACHC; EXP 10/12/25
SouthernCare, Inc.	Gentiva	Branch-Hospice		4803 29th Avenue	STE 2	Meridian	MS	39305-2675	043	1982622015	25-1541	ACHC; EXP 05/29/25
SouthernCare, Inc.	SouthernCare Youngstown	Branch-Hospice		2291 W. Fourth Street	Suite G	Ontario	OH	44906-1261	0140HSP	1104864198	36-1617	ACHC; EXP 10/12/25
SouthernCare, Inc.	SouthernCare Indianapolis	Branch-Hospice		3602 Northgate Court	Suite 27	New Albany	IN	47150-6417	21-002998-1	1750329132	15-1572	ACHC; EXP 07/06/24
SouthernCare, Inc.	Gentiva	Branch-Hospice		215 Telly Road		Picayune	MS	39466-5363	039	1053350850	25-1537	ACHC; EXP 04/29/25
SouthernCare, Inc.	Gentiva	Branch-Hospice		6858 Swinnea Road, Rutland Place	STE 6A	Southaven	MS	38671-8493	203	1326088154	25-1671	ACHC; EXP 06/04/25
SouthernCare, Inc.	Gentiva	Branch-Hospice		218 Oxford Road	Suite A	New Albany	MS	38652-3115	203	1326088154	25-1671	ACHC; Exp 06/04/25
SouthernCare, Inc.	SouthernCare Indianapolis	Branch-Hospice		4624 S. Spring Hill Junction Rd.		Terre Haute	IN	47802-4584	21-002998-1	1750329132	15-1572	ACHC; EXP 07/06/24
SouthernCare, Inc.	SouthernCare Youngstown	Branch-Hospice		6545 West Central Ave.	Suite 103	Toledo	OH	43617-1034	0140HSP	1104864198	36-1617	ACHC; EXP 10/12/25
SouthernCare, Inc.	SouthernCare South Bend	Branch-Hospice		9205 Broadway	STE B	Merrillville	IN	46410-7061	21-003723-1	1740228832	15-1582	ACHC; EXP 10/18/23
SouthernCare, Inc.	SouthernCare Youngstown	Branch-Hospice		100 Welday Avenue	Suite G	Wintersville	OH	43953-3779	0140HSP	1104864198	36-1617	ACHC; EXP 10/12/25
SouthernCare, Inc.	Gentiva II	Branch-Hospice		245 Holston Road	Suite A	Wytheville	VA	24382-4486	HSP-18219	1902848443	49-1582	ACHC; EXP 02/16/21
SouthernCare, Inc.	Heartland Hospice (Kingsland/Camden	Branch-Hospice		2475 Village Drive	STE 110	Kingsland	GA	31548-6729	UnderParent063	1720787229	11-1644	
SouthernCare, Inc.	Heartland Hospice (Springfield)	Branch-Hospice		1999 Wabash Avenue	STE 105	Springfield	IL	62704-5375	UnderParent	1154020659	14-1636	
SouthernCare, Inc.	Heartland Hospice (Carlisle)	Branch-Hospice		1200 Walnut Bottom Road	STE 302	Carlisle	PA	17015-7767	UnderParent1638	1710686233	39-1638	
SouthernCare, Inc.	Heartland Hospice (Chambersburg)	Branch-Hospice		1976 Scotland Avenue		Chambersburg	PA	17201-1450	UnderParent1638	1710686233	39-1638	
SouthernCare, Inc.	Heartland Hospice (Reading)	Branch-Hospice		2201 Ridgewood Road	STE 108	Wyomissing	PA	19610-1190	UnderParent1637	1457050973	39-1637	
SouthernCare, Inc.	Heartland Hospice (Irwin)	Branch-Hospice		3520 Route 130	Building 3	Irwin	PA	15642-1438	UnderParent1610	1700585221	39-1610	
SouthernCare, Inc.	Heartland Hospice (Johnstown)	Branch-Hospice		999 Eisenhower Boulevar	STE H	Johnstown	PA	15904-3347	UnderParent1610	1700585221	39-1610	
SouthernCare, Inc.	Heartland Hospice (Seven Fields)	Branch-Hospice		2200 Garden Drive	STE 200C	Seven Fields	PA	16046-7869	UnderParent1610	1700585221	39-1610	
SouthernCare, Inc.	Heartland Hospice (Somerset)	Branch-Hospice		1590 N Center Avenue	STE 103	Somerset	PA	15501-7019	UnderParent1610	1700585221	39-1610	
The American Heartland Hospice Corporation	Gentiva	Branch-Hospice		4783 Flat River Road	STE 100B	Farmington	MO	63640-7401	189-11HO	1649265166	26-1550	ACHC; EXP 02/16/24
The American Heartland Hospice Corporation	Gentiva	Branch-Hospice		16 The Plaza		Troy	MO	63379-1365	189-11HO	1649265166	26-1550	ACHC; EXP 02/16/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		1700 West Market Street	Suite C	Bolivar	TN	38008-1651	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		3095 East Andrew Johnson Highway	Suite A-1	Greeneville	TN	37745-0961	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		603 Congress Pkwy N	Suite B	Athens	TN	37303-1617	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		432 W. Fir Road	Suite A	Carthage	MO	64836-3707	183-13HO	1609827466	26-1585	ACHC; EXP 05/21/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		700 West Main Street		Livingston	TN	38570-1720	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		226 Uffelman Drive		Clarksville	TN	37043-4974	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		645 S. Main Street	Suite 102	Crossville	TN	38555-5069	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		216 E. College Street	BLDG D, Suite C	Dickson	TN	37055-1845	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		1901 Cook St		Dyersburg	TN	38024-1882	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		101 Creekstone Boulevard	Suite 101	Franklin	TN	37064-6509	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		394 West Main Street	Suite A3 & A4	Hendersonville	TN	37075-3345	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		174 Murray Guard Dr	Suite A	Jackson	TN	38305-3742	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		208 Sunset Drive	Suite 365	Johnson City	TN	37604-2572	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		2004 American Way	Suite 101	Kingsport	TN	37660-5892	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		9729 Cogdill Road	Suite 301	Knoxville	TN	37932-3426	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		1407 North Locust Avenue	Suite 103	Lawrenceburg	TN	38464-2277	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		115 Winwood Drive	Suite 102	Lebanon	TN	37087-1343	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		2650 Thousand Oaks Blvd	Suite 2400	Memphis	TN	38118-2479	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		28 Snow Hollow Lane		Mc Minnville	TN	37110-7592	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		305 Calvary Drive		Morristown	TN	37813-2149	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		1639 Medical Center Parkway	Suite 101	Murfreesboro	TN	37129-2593	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		101 E. Main Street		Neosho	MO	64850-0570	183-13HO	1609827468	26-1585	ACHC; EXP 05/21/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice		1101 E Wood St		Paris	TN	38242-4326	369	1407807688	44-1545	ACHC; EXP 07/18/24

Exhibit 2 – List of Entities Owned (Page 9 of 9)

Company Name	Site Name	e Level (Parent, Branch, etc.) Nar	Site Street Address 1	Site Street Address 2	Site Street City Name	Street State C	Site Street Zip	License	NPI	Medicare	Accreditation Org and Exp Date
TNMO Healthcare, LLC	Gentiva	Branch-Hospice	115 Allensville Rd.	STE A	Sevierville	TN	37876-3122	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice	305 1/2 South Jackson Street		Tullahoma	TN	37388-3476	369	1407807688	44-1545	ACHC; EXP 07/18/24
TNMO Healthcare, LLC	Gentiva	Branch-Hospice	830 Hatcher Lane		Columbia	TN	38401-3528	369	1407807688	44-1545	ACHC; EXP 07/18/24
Vista Hospice Care, LLC	Gentiva	Branch-Hospice	1761 E. College Parkway	Suite 113	Carson City	NV	89706-7954	6429-HPC-13	1043265341	29-1507	ACHC; EXP 03/09/25
VistaCare USA, LLC	Gentiva	Branch-Hospice	127 Straight Drive		Anderson	SC	29625-1523	HPC-0058	1013962034	42-1534	ACHC; EXP 08/06/27
VistaCare USA, LLC	Gentiva	Branch-Hospice	6458 Spring Street	STE 100	Douglasville	GA	30134-1871	033-113-H	1043257934	11-1544	ACHC; EXP 10/18/24
VistaCare USA, LLC	Gentiva l	Branch-Hospice	3788 N. Newton Street		Jasper	IN	47546-2963	21-009765-1	1700894987	15-1558	ACHC; EXP 05/05/24
VistaCare USA, LLC	Gentiva l	Branch-Hospice	1210 Northbrook Drive	STE 220	Trevose	PA	19053-2518	162299	1164478103	39-1622	ACHC; EXP 10/08/26
VistaCare USA, LLC	Gentiva	Branch-Hospice	201 East Lamar Street	STE B	Americus	GA	31709-3632	Under Parent	1801834593	11-1560	ACHC; 2/10/2025
Wiregrass Hospice of South Carolina, LLC	Gentiva	Branch-Hospice	5250 Woodside Executive Court		Aiken	SC	29803-3816	HPC-0103	1861445835	42-1571	ACHC; EXP 11/30/26
Wiregrass Hospice of South Carolina, LLC	Gentiva	Branch-Hospice	223 S Herlong Avenue	STE 120	Rock Hill	SC	29732-1089	HPC-0103	1861445835	42-1571	ACHC; EXP 11/30/26
Wiregrass Hospice, LLC	Gentiva	Branch-Hospice	801 Noble Street	STE 924	Anniston	AL	36201-5698	E0804	1184897092	01-1675	ACHC; EXP 01/15/23
Wiregrass Hospice, LLC	Gentiva	Branch-Hospice	1015 1st Ave SW	STE B	Cullman	AL	35055-4201	E2204	1568635472	01-1674	ACHC; EXP 02/10/26
Wiregrass Hospice, LLC	Gentiva	Branch-Hospice	1032 Boll Weevil Circle	STE D	Enterprise	AL	36330-1319	E1606	1770519324	01-1522	ACHC; EXP 07/19/24
Wiregrass Hospice, LLC	Gentiva	Branch-Hospice	3230 Florence Blvd		Florence	AL	35634-2539	E3905	1568635472	01-1674	ACHC; EXP 02/10/23
Wiregrass Hospice, LLC	Gentiva	Branch-Hospice	74 Industrial Parkway		Jasper	AL	35501-8961	E6403	1184897092	01-1675	ACHC; EXP 01/15/23
Wiregrass Hospice, LLC	Gentiva	Branch-Hospice	200 Interstate Park Dr.	Bldg. 200, Suite 220	Montgomery	AL	36109-5465	E1106	1184897092	01-1675	ACHC; EXP 01/15/23
Wiregrass Hospice, LLC	Gentiva	Branch-Hospice	3225 Rainbow Drive	STE 256	Rainbow City	AL	35906-5861	E2804	1568635472	01-1674	ACHC; EXP 02/10/26
Odyssey HealthCare Holding Company	Heartland Hospice (Aventura)	Branch-Hospice	134 S Dixie Highway	Suite 207	Hallandale	FL	33009-5435	Under Parent 5012	1013617786	10-1502	
Odyssey HealthCare Holding Company	Heartland Hospice (Homestead)	Branch-Hospice	9500 S Dadeland Blvd	Suite 802	Miami	FL	33156-2850	Under Parent 5012	1013617786	10-1502	
Odyssey HealthCare Holding Company	Heartland Hospice (Bad Axe)	Branch-Hospice	1171 S Van Dyke	Suites C&D	Bad Axe	MI	48413-9615	Under Parent 1041	1306546080	23-1550	
Odyssey HealthCare Holding Company	Heartland Hospice (Fremont)	Branch-Hospice	1053 West Main Street		Fremont	MI	49412-1408	Under Parent 1041	1114627890	23-1582	
Odyssey HealthCare Holding Company	Heartland Hospice (Kalamazoo)	Branch-Hospice	8075 Creekside Drive	Suite 120	Portage	MI	49024-5390	Under Parent 1041	1114627890	23-1582	
Odyssey HealthCare Holding Company	Heartland Hospice (Mt. Pleasant)	Branch-Hospice	1627 E Broomfield Street		Mount Pleasant	MI	48858-5429	Under Parent 1041	1306546080	23-1550	
Odyssey HealthCare Holding Company	Heartland Hospice (Traverse City)	Branch-Hospice	4000 Eastern Sky Drive	Suite 2	Traverse City	MI	49684-7351	Under Parent 1041	1114627890	23-1582	
Odyssey HealthCare Holding Company	Heartland Hospice (Northfield)	Branch-Hospice	2111 New Road	Suite 100	Northfield	NJ	08225-1512	23192	1992405674	31-1550	
Odyssey HealthCare Holding Company	Heartland Hospice (Kenosha)	Branch-Hospice	1143 Warwick Way	Suite 1	Racine	WI	53406-5661	Under Parent 2003	1851092316	52-1568	
East Rockets HH, LLC	Heartland Home Health (Marion)	Branch-Home Health	685 Delaware Ave	STE 300	Marion	OH	43302-5073	Under Parent 0292	1760182083	36-7557	ACHC EXP; 12/18/24
East Rockets HH, LLC	Heartland Home Health (Irwin)	Branch-Home Health	3520 Route 130	Building 3	Irwin	PA	15642-1438	Under Parent 7188	1801596127	39-7188	
Curo Health Services, LLC	Heartland Hospice (Beltsville)	Parent-Hospice	12304 Baltimore Ave	Suite A	Beltsville	MD	20705-1314	HOSPICE-003	1184323693	21-1542	10/31/2027
Midwest Rockets HH, LLC	Heartland Home Health (Green Bay)	Parent-Home Health	1145 W. Main Avenue	Suite 205	De Pere	WI	54115-9345	218	1043910870	52-7233	
Midwest Rockets HH, LLC	Heartland Home Health (Milwaukee)	Parent-Home Health	10200 W Innovation Drive	Suite 400	Milwaukee	WI	53226-4826	280	1033819867	52-7238	
Odyssey HealthCare of Flint, LLC	Gentiva	Parent-Hospice	4458 Oakbridge Drive	STE B & D	Flint	MI	48532-5490	1041000023	1346247244	23-1524	ACHC; EXP 08/17/26

Exhibit 3 – Admission Policy

ADMISSION CRITERIA AND PROCESS
Policy No. 4-021

PURPOSE

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

POLICY

Gentiva – Hospice Division (the hospice) will admit adult patients with a life-limiting illness that meets the eligibility criteria. The term "limited life expectancy" is equivalent to the term "life limiting illness" or other similar terms in the policies and procedures, which means a medical prognosis of 6 months or less.

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

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs (medical and non-medical) can be adequately met in the patient's place of residence. (See Policy No. 1-024 Scope of Services.)

The unit of care in hospice services is the patient and family/caregiver. Hospice recognizes that care and support of the patient affects the family/caregiver. Hospice will strive to help the patient and family/caregiver not only with physical symptoms and problems of the terminal illness of the patient, but also with emotional and psychosocial stresses.

Hospice will offer medical care of the patient and psychosocial, spiritual, and financial guidance and support to the patient and family/caregiver. If the patient is hospitalized or goes to a nursing home or other facility; hospice will continue to communicate and support the family/caregiver. Bereavement support will be available for family/caregiver members for at least up to one (1) year after the patient's death, as needed or requested.

The hospice reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if the hospice cannot meet his/her needs, as applicable. Referral sources will be notified when patient needs cannot be met and are not being admitted to the hospice.

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

Refer to Policy No. 4-098 Intake Process for specific referral and intake process information.

Admission Criteria

1. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.
2. Referrals containing verbal orders are given to the designated professional for verification and documentation of verbal orders. (See Policy No. 4-028 Verification of Physician Orders)
3. The patients identified who have a need for a support care person will be referred to the social worker for the development of a specific plan.

4. The patient must have a life-limiting illness with a life expectancy of six (6) months or less if the disease follows its normal course, as determined by the attending physician and hospice Medical Director using standard clinical prognosis criteria and LCD's if applicable.
5. The patient must desire hospice services and be aware of the diagnosis and prognosis.
6. The focus of care desired must be palliative versus curative. Under applicable payer sources, concurrent curative treatment may be allowed.
7. The patient and family/caregiver desire hospice care, agree to participate in the plan of care, and sign the consent form for hospice care.
8. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.
9. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.
10. The patient must reside within the geographical area for which the hospice provider has been approved.
11. The patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement, as applicable.
12. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

PROCEDURE

1. The hospice will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.
2. The Administrator and/or Executive Director/designee will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source or based on the information regarding the patient's condition or as ordered by the physician (or other authorized independent practitioner).
3. Assignment of appropriate hospice personnel to conduct the assessment of patient's eligibility for admission will be based on:
    a. Patient's geographical location
    b. Complexity of patient's hospice care needs/level of care required
    c. Hospice personnel's education and experience
    d. Hospice personnel's special training and/or competence to meet patient's needs
    e. Urgency of identified need for assessment
4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay.
    a. Such notification and approval will be documented.

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

5. A hospice Registered Nurse (RN) will make an initial clinical contact prior to the patient's hospital discharge, if possible or appropriate for patients referred during a hospital stay.
6. An initial home visit will be made by the hospice RN within the timeframe requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner). The purpose of the initial visit will be to:
   a. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.
   b. Explain the patient's rights and responsibilities and grievance procedure. (See Policy No. 2-002 Patient Bill of Rights.)
   c. Provide the patient with a copy of the Notice of Privacy Practices.
   d. Assess the family/caregiver's ability to provide care.
   e. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.
   f. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.
   g. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.
   h. Provide services as needed and ordered by physician (or other authorized independent practitioner) and incorporate additional needs into the hospice plan of care.
   i. Give patient information about durable power of attorney for health care if the patient has not already done so.
7. In the infrequent event the patient is not competent to sign and date his/her election statement and the legal representative is unable to be present during the admission visit, either a Registered Nurse (RN), Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN) or Social Worker as permitted by state regulation may provide an informational visit, review the election statement with the legal representative and obtain signature. See Policy 4-023 Hospice Election Statement for additional information.
8. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:
   a. Level of services required and frequency criteria
   b. Eligibility (according to organization admission criteria)
   c. Source of payment
9. If eligibility criteria are met the patient and family/caregiver will be provided with various educational materials providing sufficient information on:
   a. Nature and goals of care and/or service

b. Hours during which care, or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)
c. Access to care after hours
d. Financial liability to the patient, if any, for care
e. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement
f. Safety information
g. Infection control information
h. Emergency preparedness plans
i. Available community resources
j. Complaint/grievance process
k. Advance Directives
l. Availability of spiritual counseling in accordance with religious preference
m. Hospice personnel to be involved in care
n. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

10. The hospice registered nurse will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.
11. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.
12. The patient or his/her representative will sign the required forms indicating election of hospice care and receipt of patient rights and privacy information.
    a. If a different clinician has completed a visit and obtained signatures on the required forms prior to the hospice registered nurse visit, collaboration of visits and services will be documented.
13. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.
14. The hospice registered nurse will assist the family in understanding changes in the patient's status related to the progression of an end-stage disease.
15. The hospice registered nurse will educate the family in techniques for providing care.
16. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.
17. The hospice registered nurse will complete an initial assessment within 48 hours after the election of the hospice care (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.) The initial assessment will assess the patient's immediate physical, psychosocial, emotional, and spiritual status related to the

terminal illness and related conditions. The initial assessment is necessary to gather the essential information necessary to begin the plan of care and provide the immediate necessary care and services. (See Policy No. 4-041 Initial Hospice Assessment.)

18. The Case Manager (or admitting registered nurse) will then notify the attending physician and core members of the interdisciplinary group of the initial assessment findings, the identification of patient needs and the recommended services to meet those needs. The plan of care will be reviewed prior to care being delivered.
19. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days (to include weekends and holidays) after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, patient/family/caregiver, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See Policy No. 4-042 Comprehensive Assessment.)
20. A clinical record will be initiated for each patient admitted for hospice services.
21. If a patient does not meet the admission criteria or cannot be cared for by the hospice, the Administrator/Executive Director or designee, Medical Director and referral source should be notified and appropriate referrals to other sources of care made on behalf of the patient.
22. The following individuals should be notified of non-admits:
    a. Patient
    b. Physician
    c. Referral Source (if not physician)
23. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Administrator/Executive Director will be notified. All care, service, and discharge decisions must be made in by the IDG.
24. Staff shall also follow this process and criteria in respect to all readmissions.

Addendum A: State Specific Requirements

The policy statements listed below reflect additional state specific requirements that must be followed in addition to the organizational policy. When the organizational policy and state-specific requirements are conflicting, the most stringent should be followed.

State	State Requirement	State Regulatory Reference
Alabama	1. Ensure that a summary of prior treatments is made available at the time of admission or within 48 hours thereafter. 2. Permit a hospice patient to withdraw consent for hospice care at any time.	Ala. Admin. Code r. 420-5-17-.14
Arizona	1. Before admitting an individual as a patient, The hospice will: a. Obtain the name of the individual's physician. b. Obtain documentation that the individual has a diagnosis by a physician that indicates that the individual has a specific, progressive, normally irreversible disease that is likely to cause the individual's death in six months or less. c. Obtain documentation from the individual or the individual's representative acknowledging that: i. Hospice services include palliative care and supportive care and is not curative, and ii. The individual or individual's representative has received a list of services to be provided by the hospice and a list of patient rights. 2. At time of admission, the hospice will ensure a physician or registered nurse assesses the patient's medical, social, nutritional, and psychological needs and, as applicable, obtains informed consent or general consent for the hospice services to be provided. 3. Before or at the time of admission, the hospice will ensure a personnel member qualified according to policies and procedures assesses the social and psychological needs of a patient's family, if applicable.	A.A.C. R9-10-607
Arkansas	While patients are accepted for services based on their hospice care needs, the patient's ability to pay for such services, whether through state or federal assistance programs, private insurance, or personal assets is a factor that will be considered.	Ark. Admin. Code 007.05.16-8(D)

Colorado	A. For purposes of determining eligibility and admission for hospice services in Colorado, "Terminally Ill" means that the individual has a medical prognosis that includes a limited life expectancy of days, weeks or months if the illness runs its anticipated course. Palliative care patients may fall outside of a payer's coverage guidelines for the hospice benefit. B. Notwithstanding the above, the hospice will defer to the requirements of the relevant payer source, as well as other state and federal regulations and guidelines where applicable, for purposes of the definition of "terminally ill" used by those payers and other state and federal agencies (see e.g., Policies: 1-027 – Medicare Hospice Benefit; 1-028 – Medicaid Hospice Benefit; 4-021 – Admission Criteria and Process, especially *Admission Criteria* section 11; and 4-022 – Certification of Terminal Illness, section 8). Payers and other state and federal agencies generally employ a more limited definition of "terminal illness."	6 CCR 1011-1 Ch. 21, 2.13
Connecticut	The hospice will ensure that the patient is provided prior notification of any delay in the start of service. Such notification shall include the anticipated start of service date and the agency's plan while the patient is on the waiting list.	Conn. Agencies Regs. § 19-13-D72(a)(1)(F)
Delaware	A. Admission is limited to those patients who are no longer receiving treatment for cure. B. The hospice will not admit any persons under the age of eighteen (18) years. C. At the time of admission to the hospice and thereafter, a patient/family must be under the care of a physician who shall be responsible for medical care. D. Admission is limited to those patients who have a family member or designated person who is able and willing to assume the role of primary care giver.	16 Del. Admin. Code § 4468(5.3.2) 16 Del. Admin. Code § 4468(5.3.5) 16 Del. Admin. Code § 4468(5.3.7) 16 Del. Admin. Code § 4468(5.3.8)
Georgia	A. The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: 1. The patient has identified a primary caregiver. In the absence of a primary caregiver, the hospice must develop a detailed plan for meeting the daily care and safety needs of the patient. 2. The hospice will ensure the development of an initial plan of care, within 24 hours of admission to the hospice, based on the initial assessment and with appropriate input from a physician or registered nurse to meet the immediate needs of the patient. 3. The hospice will ensure that no terminally ill patient is excluded from participation in or denied benefits of any hospice care because of an inability to pay for such hospice care.	Ga Comp. R. & Regs. 111-8-37-.14

Illinois	A. Each patient has an attending physician. The hospice will have each patient or his/her representative complete and sign a form indicating the name of the attending physician responsible for his/her care. B. Fully discloses in writing to any hospice patient, or to any hospice patient's family or representative, prior to the patient's admission, the hospice services available from the hospice program and the hospice services for which the hospice patient may be eligible under the patient's third-party payer plan (that is, Medicare, Medicaid, the Veterans Administration, private insurance or other plans).	77 Ill. Adm. Code 280.2070
Indiana	A. The hospice shall prepare and update as necessary a disclosure document to be presented to each potential patient of the hospice program. B. The disclosure document shall contain at least the following: 1. A description of all hospice services provided by the hospice program, including the: i. types of nursing services; ii. other services; iii. specific services available during the progressive stages of the terminal illness and thereafter; and iv. a statement that the extent of hospice services and supplies are dispensed based on the hospice program patient's individual needs as determined by the interdisciplinary team. 2. An explanation of the hospice program's internal complaint resolution process. 3. A statement that the hospice program patient has the right to participate in the planning of the patient's care. 4. A statement that a hospice program patient may refuse any component of hospice services offered by the hospice program. 5. A statement that a hospice employee may provide supplies to a hospice program patient; or the hospice program patient's family in addition to the supplies provided by the hospice program, but the employee may only be reimbursed for the supplies by providing a written receipt to the hospice program patient or the hospice program patient's family. 6. A statement that the hospice program patient may request the hospice program to provide, on a monthly basis, an itemized statement of services and supplies delivered to the patient, as submitted to the patient's payor.	Ind. Code Ann. § 16-25-7-1 / 16-25-7-2

	7. The toll-free number established by the state department under Indiana Code 16-25-5-4 to receive complaints from hospice program patients and the family members of hospice program patients regarding the hospice program.	
Louisiana	The hospice will also: 1. Ensure that admission decisions are based upon medical, physical and psychosocial information provided by the patient's attending licensed medical practitioner, the patient/family and the interdisciplinary team. 2. Include in its admission criteria: a. The ability of the hospice to provide core services on a 24-hour basis and provide for or arrange for non-core services on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions. b. Certification of terminal illness (CTI) signed by the attending licensed medical practitioner and the medical director of the agency; however, the CTI shall not be signed by an Advanced Practice Registered Nurse. c. Informed consent signed by patient or representative who is authorized in accordance with state law to elect the hospice care, which will include the purpose and scope of hospice services. 3. Ensure that an assessment visit is made by a registered nurse, who will assess the patient's needs with emphasis on pain and symptom control. This assessment shall occur within 48 hours of referral for admission, unless otherwise ordered by physician or unless a request for delay is made by patient/family. 4. Ensure that documentation at admission is retained in the clinical record and includes: a. Signed consent forms; b. Signed patient's rights statement; c. Clinical data including physician order for care; d. Patient release of information; e. Patient's signed designation of attending licensed medical practitioner; f. Orientation of patient/caregiver, which includes:	LAC 48:I:8219; LAC 48:I:8235(C)(2) & (D)(1)(a)

	i. Advanced directives and LaPOST; ii. Agency services; iii. Patient's rights; and iv. Agency contact procedures; and g. For an individual who is terminally ill, certification of terminal illness signed by the medical director or the physician member of the IDT and the individual's attending physician. 5. Not accept orders to assess or admit from any source other than licensed physician or authorized physician representative (e.g., hospital discharge planner). Although the hospice may provide care to relatives of employees, the order to admit to the hospice must be initiated by the primary attending physician. 6. Only admit patients in its defined service area, which is the area for which the hospice location is licensed and approved to provide services by the State and/or CMS, as applicable.	
Missouri	The following is added to item 5 under Policy – Admission Criteria: "Chemotherapeutic agents and radiation may be administered as palliative therapy only."	19 CSR 30-35.010(1)(B)
New Jersey	A. The hospice shall provide the following information to the patient and family/caregiver: 1. Information about the services covered under the hospice benefit and to receive information about the scope of services that the hospice will provide and specific limitations on those services. 2. In writing: i. The names and professional status of personnel providing and/or responsible for care; ii. The frequency of home visits to be provided; iii. The hospice's daytime and emergency telephone numbers; and iv. Notification regarding the filing of written complaints with the New Jersey Department of Health, Office of Assessment and Survey. B. The hospice shall not require a patient or family member of a patient to sign admission papers during such times as the patient's or family member's religious beliefs prohibit them from signing the papers.	N.J.A.C. § 8:42C-5.1(b)(3)—(4) N.J.A.C. § 8:42C-6.3(a)(1)

South Carolina	The hospice will ensure that: A. Individuals admitted are not likely to endanger themselves or others as determined by a physician or other authorized healthcare provider. B. If a patient or potential patient has a communicable disease, the hospice shall seek advice from a physician or other authorized healthcare provider in order to: a. Ensure the hospice has the capability to provide adequate care and prevent the spread of that condition and that the staff members/volunteers are adequately trained; b. Transfer the patient to an appropriate facility, if necessary.	S.C. Code Regs. 61-78, Section 800, Part 801 S.C. Code Regs. 61-78, Section 1200
Tennessee	A. The hospice will only admit patients who meet the eligibility criteria, which includes being a non-hospice patient that has been determined to need palliative care only. B. A diagnosis must be entered in the admission records of the hospice for every person admitted for care or treatment.	TENN. COMP. R. & REGS: 1200-08-27-.05(1)(e), (8)
Wisconsin	* For full regulatory text, see pages 12-14	W.S.A. 50.94 Wis. Adm. Code § 131.13(24) Wis. Adm. Code § 131.17 Wis. Adm. Code § 131.18

Policy No. 4-021 (WISCONSIN)

State Specific Admission Criteria and Process

The policy statements listed below reflect additional state specific requirements that must be followed in addition to the organizational policy. When the organizational policy and state-specific requirements are conflicting, the most stringent should be followed.

1. Eligibility for Hospice Services
    a. For purposes of determining eligibility and admission for hospice services in Wisconsin, "Terminal illness" means a medical prognosis by a Doctor of Medicine or osteopathy that an individual's life expectancy is less than 12 months.
    b. Notwithstanding the above, the hospice will defer to the requirements of the relevant payer source, as well as other state and federal regulations and guidelines where applicable (see Section III below – Surrogate Decision Maker for Hospice Admission; The hospice Policies: 1-027 – Medicare Hospice Benefit; 1-028 – Medicaid Hospice Benefit; 4-021 – Admission Criteria and Process, especially *Admission Criteria* section 11; and 4-022 – Certification of Terminal Illness, section 8).
2. Admission Policies and Acknowledgement
    a. The hospice shall inform the patient and his or her representative, if any, of the admission policies that include all of the following:
        i. Clearly define the philosophy of the program (see the hospice Policy 1-001).
        ii. Limit admission to individuals with terminal illness (see the hospice Policy 4-021).
        iii. Clearly define the hospice's limits in providing services and the settings for service provision (see the hospice Policy 1-024).
        iv. Ensure protection of patient rights (see the hospice Policies 2-002 and 2-003).
        v. Provide clear information about services available for the prospective patient and his or her representative, if any (see the hospice Policies 1-026, 2-004, and 4-021).
        vi. Allow an individual to receive hospice services whether or not the individual has executed an advance directive (see the hospice Policies 1-015 and 2-032).
3. At the time of the patient's admission, the hospice shall provide a copy of Policy 4-076 *Discharge from Hospice Program* and any addenda to the patient or patient's representative, if any, as part of the acknowledgement and authorization process.
4. The person seeking admission to the hospice shall be recognized as being admitted after:
    a. Completion of the initial determination of whether the hospice is generally able to meet the patient's needs (see the hospice Policy 4-021); and
    b. Completion of a Wisconsin service agreement, in its entirety including services to be provided as appropriately identified in the initial assessment, in which:
        i. The person or the person's representative, if any, acknowledges, in writing, that he or she has been informed about admission policies and services;
        ii. The hospice agrees to provide care for the person; and

iii. The person or the person's representative, if any, authorizes services in writing.

iv. Once the hospice has admitted a patient to the program, and the patient or the patient's representative, if any, has signed the acknowledgement and authorization for services under Section (C)(2) above, the hospice is obligated to provide care to that patient.

5. Surrogate Decision Maker for Hospice Admission

   a. As used in this section:

      i. "Hospice care" means palliative care, respite care, short-term care or supportive care.

      ii. "Incapacitated" means unable to receive and evaluate information effectively or to communicate decisions to such an extent that a person lacks the capacity to manage his or her health care decisions.

      iii. "Physician" means a person licensed to practice medicine and surgery under Wisconsin Ch. 448(d).

      iv. "Terminal condition" means an incurable condition caused by injury, disease or illness that according to reasonable medical judgment will produce death within 6 months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

6. A person who is determined to be incapacitated under Section H below, does not have a valid living will or valid power of attorney for health care, and has not been adjudicated incompetent in Wisconsin may be admitted to a hospice only if all of the following requirements are met:

   a. An individual who is specified in Section C below signs all of the following:

      i. On behalf of the person who is incapacitated, an informed consent for the receipt of hospice care by the person who is incapacitated.

      ii. A statement certifying that it is his or her belief, to the best of his or her knowledge, that, if able to do so, the person who is incapacitated would have selected hospice care.

7. A physician certifies that the person who is incapacitated has a terminal condition and that the physician believes that the individual under Section (B)(1) is acting in accordance with the views or beliefs of the person who is incapacitated.

8. The following individuals, in the following order of priority, may act under Section (B)(1):

   a. The spouse or domestic partner under Wisconsin Ch. 770 of the person who is incapacitated.

   b. An adult child of the person who is incapacitated.

   c. A parent of the person who is incapacitated.

   d. An adult sibling of the person who is incapacitated.

   e. A close friend or a relative of the person who is incapacitated, other than as specified in Sections (C)(1)-(4), to whom all of the following apply:

i. The close friend or other relative is aged at least 18 and has maintained sufficient regular contact with the person who is incapacitated to be familiar with the person's activities, health and beliefs.

ii. The close friend or other relative has exhibited special care and concern for the incapacitated person.

9. The individual who acts under Section (B)(1) may make all health care decisions related to receipt of hospice care by the person who is incapacitated.

10. The person who is incapacitated or the individual under Section (D) may object to or revoke the election of hospice care at any time.

11. A person who disagrees with a hospice decision made under this Policy may apply under W.S.A. 54.50 for temporary guardianship of the person who is incapacitated. In applying for the temporary guardianship, such a person has the burden of proving that the person who is incapacitated would not have consented to admission to a hospice or hospice care.

12. The individual who acts under Section (B)(1) shall, if feasible, provide to all other individuals listed under Section (C) notice of the proposed admission of the person who is incapacitated to a hospice and of the right to apply for temporary guardianship under section (F). If it is not feasible for the individual to provide this notice before admission of the person who is incapacitated to a hospice, the individual who acts under Section (B)(1) shall exercise reasonable diligence in providing the notice within 48 hours after the admission.

13. A determination that a person is incapacitated may be made only by 2 physicians or by one physician and one licensed psychologist, as defined in W.S.A. 455.01(4), who personally examine the person and sign a statement specifying that the person is incapacitated. Mere old age, eccentricity or physical disabilities, singly or together, are insufficient to determine that a person is incapacitated. Whoever determines that the person is incapacitated may not be a relative, as defined in W.S.A. 242.01(11), of the person or have knowledge that he or she is entitled to or has claim on any portion of the person's estate. A copy of the statement shall be included in the records of the incapacitated person in the hospice to which he or she is admitted.

Exhibit 4 – Charity Care Policy

Gentiva
Enterprise Compliance Program

WAIVERS: PAYMENTS, CO-PAYMENTS, COINSURANCE, AND/OR DEDUCTIBLES
ECP 14.0

Policy

- The Company's policy is to bill for patient out-of-pocket payments, co-payments, coinsurance, and/or deductibles and to make good faith efforts to collect such amounts.
- Waivers of payments, co-payments, coinsurance, and/or deductibles owed by a patient occur only as authorized by the criteria set forth in this policy. Failure to adhere to this policy may subject the Company to liability and violation of the Company's Compliance Program.
- If the Company determines a patient is financially unable to pay out-of-pocket payments, co-payments, coinsurance, and/or deductibles, the Company may cease billing and/or collection efforts with respect to the patient's out-of-pocket obligations upon receipt of a patient's financial hardship documentation.
- It is permissible to bill Medicare coinsurance to other third-party payers such as other insurance plans for Medicare patients. Agencies may also bill other third parties but not patients for services denied by Medicare.
- Under no circumstances will the Company engage in the following activities with respect to waivers of payments, co-payments, coinsurance, and/or deductibles:
    - Advertise to the public that:
        - Medicare or private insurance is accepted as payment in full.
        - Patients will not incur out-of-pocket expenses.
    - Collect payments, co-payments, coinsurance, and/or deductibles only when the beneficiary has Medicare supplemental insurance coverage.
    - Charge Medicare beneficiaries' higher rates to offset payments, co-payments, coinsurance, and/or deductible waivers.
    - Fail to collect payments, co-payments, coinsurance, and/or deductibles from a specific group of Medicare patients such as: Medicare patients of a particular physician/allowed practitioner for reasons unrelated to indigence or managed care contracting to obtain referrals.
    - Fail to attempt to collect payments, co-payments, coinsurance, and/or deductibles for a period of time before a waiver was approved.
- Company Associates do not advertise the availability of waivers of payments, co-payments, coinsurance, and/or deductibles in any way except to advise individual patients or physicians/allowed practitioners of a limited availability for waivers with prior documentation from the patient demonstrating financial hardship.
- Notice of payments, co-payments, coinsurance, and/or deductibles will be included in the financial responsibilities' information on the consent and addenda as applicable and to the best of the agency's knowledge at the time of notice.

WAIVERS: PAYMENTS, CO-PAYMENTS, COINSURANCE, AND/OR DEDUCTIBLES
ECP 14.0

- Waiver of payments, co-payments, coinsurance, and/or deductibles is granted only after all other measures have been exhausted such as payment plans, and only if patients demonstrate they have a financial hardship.
- Financial waivers are granted for a period of one year from the date of final approval. If renewal of an existing waiver is requested a new Confidential Financial Worksheet and associated documents must be completed and submitted for approval 45 days prior to the existing waiver's expiration date.
- This policy is superseded by contractual requirements placed upon the Company that affect waiver of payments, co-payments, coinsurance, and/or deductibles.
- The Compliance Officer/designee are responsible for ensuring waivers are approved in accordance with this policy.

Waiver Approval Process

- Initial recommendations to commit the Company to waive payments, co-payments, coinsurance, and/or deductibles are made on a case-by-case basis by the Administrator/Executive Director and the Area Vice President of Operations.
- Each patient requesting waiver of payments, co-payments, coinsurance, and/or deductibles must initially and on an annual basis complete a Confidential Financial Worksheet.
- Decisions to waive payments, co-payments, coinsurance, and/or deductibles are based on financial information supplied by the patient on the Confidential Financial Worksheet.
    - In general, financial hardship is demonstrated by a household income that is less than 200% of the current Federal poverty level. The Company uses the annual update of the United States Department of Health and Human Services Poverty Guidelines in establishing eligibility for a payment, co-payment, coinsurance, and/or deductible waiver.
- Confidential Financial Worksheets and supporting documentation are submitted for review to the Compliance Department via email to financialwaivers@gentivahs.com, if possible, prior to the Start of Care date. Patient care should not be withheld pending approval.
- The Compliance Officer/designee makes the final waiver decision based on supporting documentation provided by the patient.
- Decisions to waive payments, co-payments, coinsurance, and/or deductibles must be:
    - Documented
    - Based on uniform objective criteria
    - Granted in accordance with the Company's charitable intent

WAIVERS: PAYMENTS, CO-PAYMENTS, COINSURANCE, AND/OR DEDUCTIBLES
ECP 14.0

- A partial waiver is considered for patients that do not qualify for a full waiver of payments, copayments, coinsurance, and/or deductibles using the Confidential Financial Worksheet. The Company reserves the right to modify and/or change waiver criteria without prior notice.
- It is Company policy to not grant retroactive payment, co-payment, coinsurance, and/or deductible waivers. In limited situations., retroactive waivers may be requested in the following manner. The patient must:
    - Provide detailed reasons for financial waiver consideration.
    - Complete a Confidential Financial Worksheet and accompanying documentation.

Patient Notification

- The Administrator/Executive Director is responsible for ensuring patients are notified verbally and in writing of waiver decisions.
- Written notification for approval or denial is mailed to patients no later than five business days following the waiver determination.
- If the request for a waiver is denied, the Company follows normal collection procedures and reminds patients of their financial responsibility.
- No one has a "right" to waivers of payments, co-payments, coinsurance, and/or deductibles. The Company reserves the right to disapprove waiver requests without explanation.

Recordkeeping

- Completed Confidential Financial Worksheets, supporting documentation and the Patient Notification for Financial Waiver Letter will be uploaded to the patient record for all requests for a financial waiver.

Resources

- Financial Waiver Request Forms
    - Confidential Financial Worksheet
    - Patient Notification for Financial Waiver Letters
    - Poverty Guidelines
    - Sliding Scale for Financial Waivers
- Standard Operating Procedures: Financial Waivers

Exhibit 5 – Patient Rights and Responsibilities Policy

PATIENT BILL OF RIGHTS
Policy No. 2-002

PURPOSE

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

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights as described. The rights contained within this policy include the basic rights of the patient.

A patient may designate someone to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the hospice.

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

PROCEDURE

1. The Patient Bill of Rights statement defines the right of the patient to:
    a. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the hospice and must not be subjected to discrimination or reprisal for doing so
    b. Receive an investigation by the hospice of complaints made by the patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for the patient's property by anyone furnishing services on behalf of the hospice; the existence of the complaint and the resolution of the complaint must be documented
    c. Be advised in advance of the right to participate in planning the care or service and in planning changes in the care and service; have the right to refuse care or treatment
    d. Confidentiality of the clinical records maintained by the hospice
    e. Patients have the right to receive effective pain management, choose attending physician, receive information regarding the scope of services and services under the hospice benefit and be free from mistreatment, neglect or verbal, mental, sexual, physical abuse and misappropriation of patient property.
    f. Access to care/service is provided regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law. Patients also agree to accept hospice caregivers based upon the same standards of nondiscrimination.
    g. Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service and as changes occur, including fees for services/products provided, direct pay responsibilities, and notification of insurance coverage
    h. Receive in writing, prior to the start of care, the telephone numbers for the State specified Hotline, including hours of operation, and the purpose of the hotlines to receive complaints or questions about the hospice

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

j. Have the right to have the patient's person and property treated with consideration, respect, and full recognition of the patient's individuality and personal needs

2. Upon admission, the admitting clinician/technician will provide each patient or his/her representative with a written copy of the Patient Bill of Rights.
3. The Patient Bill of Rights document will include the contact information for accrediting bodies (if applicable), the state contact number, as well as the hospice's Compliance Helpline number of 1-800-359-7412 to voice complaints.
4. The Patient Bill of Rights will be explained and distributed to the patient prior to the initiation of organization services. This explanation will be in a language he/she can reasonably be expected to understand.
5. The admitting clinician will document that the patient has received a copy of the Patient Bill of Rights
    a. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made
    b. In the event a communication barrier exists, special devices or interpreters will be made available
    c. Written information will be provided to patients in the predominant languages of the population served
6. When the patient's representative signs the Patient Bill of Rights form, an explanation of that relationship must be documented and kept on file in the clinical record.
7. The family or guardian may exercise the patient's rights when a patient is incompetent or a minor.
8. In the case of the patient who has not been adjudged incompetent by the State court, any person designated in accordance with State law may exercise the patient's rights to the extent provided by the law.
9. All organization personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually.

Addendum A: State Specific Requirements

The policy statements listed below reflect additional state specific requirements that must be followed in addition to the organizational policy. When the organizational policy and state-specific requirements are conflicting, the most stringent should be followed.

State	State Requirement	State Regulatory Reference
Arkansas	The hospice will ensure that each patient or patient's representative is informed of the patients' rights identified in Policy 2-002 and: 1. The patient and property shall be treated with dignity and respect by all that provide services; 2. The right to receive an explanation of the informed consent and election statement that is signed by the patient or patient's representative for the provision of hospice care; 3. The right to participate in the decision-making process regarding where care is to be delivered and the options available; 4. The right to receive a timely response from the hospice agency regarding any request for services; 5. The right to privacy and confidentiality; 6. The right to be informed of the name of the hospice agency, services offered by the agency, services being provided to the patient, and how to contact that agency during all hours; 7. The right to be informed that a hospice may not discontinue or diminish care because of the lack of a payor source; and The hospice shall provide each patient and patient's representative with a list affirming the patient's and patient's representative's responsibility to: 1. Assist in developing and maintaining a safe environment, when possible; 2. Treat all agency staff with respect; 3. Participate in the development and update of the plan of care; and 4. Adhere to the plan of care as developed by the agency and assist in the care as necessary. 5. Services the hospice does not cover.	Ark. Admin. Code 007.05.16-7(A) Ark. Admin. Code 007.05.16-7(B)

Arizona	The hospice will follow current procedure (see Policy 2-002) and will also ensure that patients that do not speak English or who are disabled become aware of patient rights.	A.A.C. R9-10-603(C)(1)(e)
California	The hospice will follow current procedure (see Policy 2-002) and will also comply with the following California requirements: 1. Such policies shall ensure that each patient receiving care shall have the following rights and responsibilities: a. To be informed by the licensee of the provisions of the law regarding complaints and procedures for registering complaints confidentially, including, but not limited to, the address and telephone number of the local district office of the Department.	California Standards of Quality Hospice Care 2005, Section 6.6 A.1.j
Colorado	The hospice will follow current procedure (see Policy 2-002) and will also comply with the following Colorado requirements: 1. In addition to the rights enumerated in existing hospice policy, the hospice also affirms the following patient rights and responsibilities: a. The right to be informed of the hospice concept, admission criteria, services to be provided, and options available; b. The right to withdraw from the program at any time; and c. The responsibility to provide accurate information which may be useful to the hospice in delivering appropriate care. 2. The hospice responsibilities will include but not be limited to: a. Providing quality care to individuals regardless of race, religion, sex, age, and/or physical or mental disabilities or ability to pay; b. Training all employees and volunteers adequately for the type of service they provide; c. Providing care that is ethical, is in the best interest of the patient, and is respectful of the patient/family life values, religious preference, dignity, individuality, privacy in treatment and personal needs; and d. To the extent the hospice serves such populations, assuring special attention to patients who are infants, small children and adolescents in regard to their right to privacy, choice and dignity.	6 CCR 1011-1 Ch. 21, 5.3 and 5.4
Connecticut	Patients shall also have the following rights: 1. To receive a description of available services, unit charges and billing mechanisms, and to be given oral and written	Conn. Agencies Regs. § 19-13-D78

	notice of any changes in such no later than 30 working days from the date the agency becomes aware of a change; 2. To receive an explanation of the agency's policy on uncompensated care; 3. To receive an explanation of the agency's criteria for admission to service and discharge from service; 4. To receive information about the disciplines that will furnish care, the frequency of visits proposed, and the person supervising the patients' care and the manner in which that person may be contacted; 5. To receive information about the patient's responsibility for participation in the development and implementation of the plan of care; 6. The right of the patient or designated representative to be fully informed of the patient's health condition, unless contraindicated by a physician in the clinical record; 7. The right of the patient to have his or her property treated with respect; 8. An explanation of the confidential treatment of all patient information retained by the agency and the requirement for written consent for release of information to persons not otherwise authorized under law to receive it; 9. To receive information on a policy regarding patient access to the clinical record; and 10. To receive information on the procedure for registering complaints with the Commissioner of Public Health and information regarding the availability of the Medicare toll-free hotline, including telephone number, hours of operation for receiving complaints or questions about local home health agencies.	
Delaware	The hospice will ensure that: 1. The rights of patients shall be consistent with Titles 16 and 31 of the Delaware Code and the Department of Health and Social Services Regulations regarding Patient's Rights.	16 Del. Admin. Code § 4468(5.5)
Georgia	The hospice will ensure: 1. That patients and their families receive hospice care and palliative care for persons with advanced and progressive diseases, when offered, in a manner that respects and protects their dignity and ensures all patients' rights delineated in Ga Comp. R. & Regs. 111-8-37-.10.	Ga Comp. R. & Regs. 111-8-37-.10

	2. The hospice will provide to the patient, the patient's representative, and/or the patient's legal guardian oral and written explanations of the rights of the patient and the patient's family unit while receiving hospice care for the terminally ill and palliative care for persons with advanced and progressive diseases. The explanation of rights will be provided at the time of admission into the hospice. 3. At the time of admission, the hospice will provide to the patient, the patient's representative, and the patient's legal guardian the contact information, including the website address of the Department, for reporting complaints about hospice care to the Department. 4. The hospice shall post the following information in a public area at the facility: a. A copy of the patient rights as outlined in Rule 111-8-37-.10(1) in a public area at the facility; and b. Contact information, including the website address of the Department, for reporting complaints about hospice care to the Department.	
Illinois	The hospice will ensure that: 1. It has written policies and procedures that support, enhance and protect the human, civil, constitutional and statutory rights of all patients. Rights will include: a. The right to informed consent that specifies the type of care and services that will be provided in the hospice program. b. The right to information regarding diagnosis and prognosis and any change in either. c. The right to review and participate in his or her plan of care. d. The right to privacy.	77 Ill. Adm. Code 280.2050
Louisiana	In addition to the rights in existing policy 2-002, the hospice will l ensure that the patient has the right to: 1. Be cared for by a team of professionals who provide high quality comprehensive hospice services as needed and appropriate for patient/family; 2. Have a clear understanding of the availability of hospice services and the hospice team 24 hours a day, seven days a week; 3. Receive appropriate and compassionate care, regardless of diagnosis, race, age, gender, creed, disability, sexual	LAC 48:I:8231(A) and (C)-(D) LAC 48:I:8235(D)(2)

	orientation, place of residence, or the ability to pay for the services rendered 4. Be fully informed regarding patient status in order to participate in the POC. The hospice professional team will assist patient/family in identifying which services and treatments will help attain these goals; 5. 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 appropriate to patient/family personal wishes; 6. Be treated with respect and dignity; 7. Have patient/family trained in effective ways of caring for patient; 8. Confidentiality with regard to provision of services and all patient records, including information concerning patient/family health status, as well as social, and/or financial circumstances. The patient information and/or records may be released only with patient/family's written consent, and/or as required by law; 9. Voice grievances concerning patient care, treatment, and/or respect for person or privacy without being subject to discrimination or reprisal, and have any such complaints investigated by the hospice; and 10. Be informed of any fees or charges in advance of services for which patient/family may be liable. Patient/family has the right to access any insurance or entitlement program for which patient may be eligible. In addition, the patient has the responsibility to the best of their ability to: 1. Participate in developing the POC and update as his or her condition/needs change; 2. Provide hospice with accurate and complete health information; 3. Remain under a doctor's care while receiving hospice services; and 4. Assist hospice staff in developing and maintaining a safe environment in which patient care can be provided. Unless the hospice policy or other applicable law requires a longer time period, clinical records shall be maintained for at least six years from the date of discharge, unless there is an audit or litigation affecting the records. Records for individuals under the	

	age of majority shall be kept in accordance with current state and federal law. **Hospice Responsibility to the Patient** The hospice will ensure: 1. It is in compliance with the Louisiana Minimum Standards for licensure of hospice agencies and all applicable federal, state, and local law at all times; 2. It provides all core services directly by the hospice and any non-core services required to meet the patient/family needs; 3. It acts as the patient advocate in medical decisions affecting the patient; 4. It protects the patient from unsafe skilled and unskilled practices; 5. It protects the patient from being harassed, bribed, and/or any form of mistreatment by any employee or volunteer of the agency; 6. It provides patient information on the patient's rights and responsibilities; 7. It provides patient information on advanced directives in compliance with all applicable federal, state, and local laws; 8. It protects and assures that patient's rights are not violated; 9. It focuses on enabling the patient remaining in the familiar surroundings of his/her place of residence as long as possible and appropriate; 10. It encourages the patient/family to participate in developing the plan of care and provision of hospice services; 11. With the permission of the patient, it includes in the plan of care specific goals for involving the patient/family; 12. It makes appropriate referrals for family members outside the hospice's service area for bereavement follow-up; 13. Whenever a hospice program manages and/or delivers care in a facility, it ensures than an appropriate standard of care is provided to the patient in the facility, regardless of whether or not hospice is responsible for the direct provision of those services;	

	14. It ensures that any facility where hospice care is provided meets appropriate licensing requirements and any payor source requirements when applicable; and 15. It ensures that any facility in which hospice care is provided has the following: a. Areas that are designed and equipped for the comfort and privacy of each patient and family member; b. Physical space for private patient/family visiting; c. Accommodations for family members to remain with the patient throughout the night; d. Accommodations for family privacy after a patient's death; e. Décor which is homelike in design and function; and f. Patients must be permitted to receive visitors at any hour, including small children.	
Michigan	The hospice will ensure that: 1. The patient bill of rights will be available to the patient and family/caregiver upon request before and following the patient's admission. 2. The patient bill of rights will be posted in a public place at the hospice. 3. Upon the request of a patient or a prospective patient, the hospice will disclose in writing any policies related to a patient or the services a patient may receive involving life-sustaining or non-beneficial treatment from the hospice. **Patient Responsibilities:** 1. A patient is responsible for following health facility rules and regulations affecting the patient care and conduct: a. A patient is responsible for providing a complete and accurate medical history. b. A patient is responsible for making it known whether he or she clearly comprehends a contemplated course of action and the things he or she is expected to do. c. A patient is responsible for following the recommendations and advice prescribed in a course of treatment by the physician. d. A patient is responsible for providing information about unexpected complications that arise in an expected course of treatment.	1978 PA 368, MCL §§ 333.20201, 333.20203 & 333.20403 Mich. Admin. Code R 325.13110 1978 PA 368, MCL §§ 333.20202 & 333.20203 Mich. Admin. Code R 325.13104 & R 325.13110

	e. A patient is responsible for being considerate of the rights of other patients or residents and health facility personnel and property. f. A patient is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations 2. An individual shall not be civilly or criminally liable for failure to comply with Section A above, and Section A shall not be construed to expand or diminish other remedies at law available to a patient under the Michigan Public Health Code or the statutory and common law of Michigan. 3. A patient and family/caregiver unit will be given a copy of this policy before the patient's admission. This policy will be posted in a public place at the hospice and will be available to the patient and family/caregiver unit following the patient's admission upon request.	
Minnesota	1. No later than the time hospice services are initiated, the hospice will give a written copy of the hospice bill of rights, as required by Minnesota Statutes, section 144A.751, to each hospice patient or responsible person. 2. In addition to the text of the bill of rights in Minnesota Statutes, section 144A.751, subdivision 1, the written notice to the patient will include the following: a. A statement, printed prominently in capital letters, as follows: IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU HOSPICE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR OLDER MINNESOTANS; b. The telephone number, mailing address, and street address of the Office of Health Facility Complaints; The telephone number and address of the Office of the Ombudsman for Older Minnesotans; c. The licensee's name, address, telephone number, and name or title of the person to whom problems or complaints may be directed; and d. If the hospice provider operates a residential hospice facility, the written notice to each residential hospice patient must include the	Minn. R. 4664.0030 Minn. Stat. § 144A.751

	number and qualifications of the personnel, including both staff persons and volunteers, employed by the provider to meet the requirements of part 4664.0390 on each shift at the residential hospice facility. 3. The hospice will provide to hospice patients or responsible persons within 48 hours of admission a written notice of charges for services. 4. The hospice will provide written notice of changes in charges for services, according to Minnesota Statutes, section 144A.751, subdivision 1, clause (17). The notice will include the name, address, and telephone number of the Office of the Ombudsman for Older Minnesotans. 5. The hospice will obtain written acknowledgment of the hospice patient's receipt of the bill of rights and notice of charges for services, or if unable to obtain written acknowledgment, document oral acknowledgment of receipt, including the date of the acknowledgment. The acknowledgment must be obtained from the hospice patient or the hospice patient's responsible person. 6. The hospice will retain in the hospice patient's record documentation of compliance with patient bill of rights requirements. 7. The hospice will not require a person to surrender his or her rights as a condition of receiving hospice care. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. 8. The copy of the patient bill of rights provided to the patient will contain the address and telephone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long-Term Care will be included in notices of change in provider fees and in notices where hospice providers initiate transfer or discontinuation of services.	
Missouri	The hospice will: 1. Submit to the Missouri Department of Health and Senior Services for approval a bill of rights that will be equally applicable to all clients. 2. Protect and promote the exercise of patient rights.	MO. REV. STAT. § 197.264.1 19 CSR 30-35.010(1)(F)

	3. In addition to the rights in existing hospice policy (see Policy 2-002), each client will also have the following rights: a. To be fully informed about his/her care alternatives available from the hospice, including choice of service providers, charges and payment resources; b. To be a full participant in the development of his/her plan of care; c. To be treated with dignity and respect; d. The patient and family's right for respect of property and person; e. To be informed in advance about the care to be furnished; f. To be informed in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished; g. To be informed in advance of any change in the plan of care before the change is made; h. To be informed of the hospice's policy for disclosure of clinical records; and i. To be informed in writing of the extent to which payment may be required from the patient and any changes in liability within 30 days of the hospice becoming aware of the new amount of the liability. 4. The hospice will ensure that each of its clients can fully receive each provision of its approved bill of rights.	
Nebraska	The hospice will ensure that the attached Nebraska Patient Bill of Rights is equally applicable to all patients. The hospice will protect and promote the exercise of these rights.	Neb. Admin. R & Regs. 175 § 16-006.06 & .06(B).
New Jersey	1. The hospice shall comply with existing Policy 2-002 with regard to patient rights, and shall establish and implement written policies and procedures regarding the rights of patients and the implementation of these rights as set forth below. 2. The hospice shall post a complete statement of these rights, including the right to file a complaint with the New Jersey Department of Health, at a location in the hospice that is accessible to and seen by patients and the public, and shall distribute such statement to all staff and contracted personnel.	N.J.A.C. § 8:42C-5.1

	3. The hospice shall make these patient rights available in any language which is spoken as the primary language by more than 10 percent of the population in the hospice program's service area. 4. The hospice shall ensure that all verified violations involving anyone furnishing services on behalf of the hospice are reported to State and local authorities having jurisdiction within five working days of becoming aware of the violation. 5. In addition to the rights outlined in 2-002, each patient shall be entitled to the following rights, none of which shall be abridged or violated by the hospice or any of its staff: a. To treatment and services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment. b. To be given a verbal and written notice in a language and manner that the patient understands, prior to the initiation of care, of these patient rights and any additional policies and procedures established by the agency involving patient rights and responsibilities. If the patient is unable to respond, the notice shall be given to a family member or an individual who is a legal representative of the patient. i. The hospice shall obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities. ii. If a patient has been adjudged incompetent under State law by a court with jurisdiction, the rights of the patient are exercised by the person appointed pursuant to State law to act on the patient's behalf. iii. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. c. To receive information about the services covered under the hospice benefit and to receive information about the scope of services that the	

	hospice will provide and specific limitations on those services. d. To be informed in writing of the following: i. The services available from the hospice; ii. The names and professional status of personnel providing and/or responsible for care; iii. The frequency of home visits to be provided; iv. The hospice's daytime and emergency telephone numbers; and v. Notification regarding the filing of complaints with the Department's 24-hour Complaint Hotline at 1-800-792-9770, or in writing to the Office of Assessment and Survey. e. To receive, in terms that the patient understands, an explanation of his or her plan of care, expected results, and reasonable alternatives. if this information would be detrimental to the patient's health, or if the patient is not able to understand the information, the explanation shall be provided to a family member or an individual who is a legal representative of the patient and documented in the patient's medical record. f. To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and health care personnel. i. The hospice shall make efforts to secure a professional, objective interpreter for hospice-patient communications, including those involving the notice of patient rights. g. To receive the care and health services that have been ordered. h. To receive effective pain management and symptom control from the hospice for conditions related to the terminal illness, in accordance with N.J.A.C. 8:43E–6. i. To choose his or her attending physician or APN.	

	j. To be involved in the planning of his or her hospice care and treatment. k. To refuse services, including medication and treatment, provided by the hospice and to be informed of available hospice treatment options, including the option of no treatment, and of the possible benefits and risks of each option. l. To refuse to participate in experimental research. If he or she chooses to participate, his or her written informed consent shall be obtained. m. To receive full information about financial arrangements, including, but not limited to: i. Fees and charges, including any fees and charges for services not covered by sources of third party payment; ii. Copies of written records of financial arrangements; iii. Notification of any additional charges, expenses, or other financial liabilities in excess of the predetermined fee; and iv. Description of agreements with third-party payors and/or other payors and referral systems for patients' financial assistance. n. To express grievances regarding care and services by anyone who is furnishing services on behalf of the hospice to the hospice's staff and governing authority without fear of reprisal, and to receive an answer to those grievances within a reasonable period of time. o. To be free from mistreatment, neglect and mental, verbal, sexual and physical abuse and from exploitation, including corporal punishment, injuries of unknown source and misappropriation of patient property. p. To be free from restraints, unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. q. To be free from seclusion, of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. r. To be assured of confidential treatment of his or her medical health record, and to approve or	

	refuse in writing its release to any individual outside the hospice, except as required by law or third-party payment contract. s. To be treated with courtesy, consideration, respect, and recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy and confidentiality concerning patient treatment and disclosures. t. To be assured of respect for the patient's personal property. u. To retain and exercise to the fullest extent possible all the constitutional, civil, and legal rights to which the patient is entitled by law, including religious liberties, the right to independent personal decisions, and the right to provide instructions and directions for health care in the event of future decision making incapacity in accordance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H–53 et seq., and any rules which may be promulgated pursuant thereto. v. To be informed by the hospice of and receive written information concerning the hospice's policies on advance directives, including a description of applicable State law. w. To be transferred to another hospice provider only for one of the reasons delineated in the Standards for Licensure of Residential Health Care Facilities Located with, and Operated by, Licensed Health Care Facilities, at N.J.A.C. 8:43-4.16(g). x. To discharge himself or herself from treatment by the hospice 6. The hospice shall implement and comply with the requirements of Section E.2., above.	
Rhode Island	The hospice shall ensure that: 1. Applicable "rights of patients", pursuant to the provisions of R.I. Gen. Laws § 23-17-19.1 (see 2-002-RI. a, incorporated herein by this reference), are preserved for each patient. 2. The patient shall be offered treatment without discrimination as to creed, or gender identity or expression.	R.I. Gen. Laws § 23-17-19.1 216-RICR-40-10-11.5.11

	3. No charge shall be made for furnishing a health record or part of a health record to a patient, his or her attorney or authorized representative if the record or part of the record is necessary for the purpose of supporting an appeal under any provision of the Social Security Act, 42 U.S.C. § 301 et seq., and the request is accompanied by documentation of the appeal or a claim under the provisions of the Workers' Compensation Act, R.I. Gen. Laws Chapters 28-29 through 28-38. Additionally, charges shall not be made if the record is requested for immunization records required for school admission or by the applicant or beneficiary or individual representing an applicant or beneficiary for the purposes of supporting a claim or appeal under the provision of the Social Security Act or any federal or state needs-based benefit program such as Medical Assistance, Rite Care, Temporary Disability Insurance (TDI) or unemployment compensation. 4. The patient/patient's designated agent/family are provided with written information concerning the hospice's policies on advance directives, including a description of any applicable state law. The hospice shall make a copy of the Patient's Rights, including the provisions of R.I. Gen. Laws § 23-17-19.1 (see 2-002-RI.a), available to patients/patient's designated agent/families.	
South Carolina	The hospice will ensure: 1. That patients and their families receive hospice care in a manner that respects and protects their dignity and ensures all patients' rights delineated in S.C. Code Regs. 61-78, Section 1100. 2. The hospice shall not retaliate against a patient should the patient exercise his or her right to complain about a violation of his or her rights, e.g., increasing charges, decreasing the services received; taking away any privileges; use of abuse, threatening language, or trying to force a patient to discontinue hospice care or leave the hospice facility	S.C. Code Regs. 61-78, Section 1100
Tennessee	The hospice acknowledges and shall ensure that each patient has at least the following rights, in addition to those in existing company policy: 1. To privacy in treatment and personal care. 2. To be free from mental and physical abuse. Should this right be violated, then the hospice will notify the Tennessee Department of Health within five (5) business days. Suspected abuse of a patient shall be reported	TENN. COMP. R. & REGS: 1200-08-27-.12

	immediately to the Tennessee Department of Human Services, Adult Protective Services as required by T.C.A. §71-6-101 et seq. and The hospice policy (see Policy 2-035). 3. To refuse treatment. The patient must be informed of the consequences of that decision. A refusal and its reason must be reported to the physician and documented in the medical record. 4. To refuse experimental treatment and drugs. The patient's or health care decision maker's written consent for participation in research must be obtained and retained in the medical record. 5. To have their records kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision maker. 6. To self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.	
Texas	1. Comply with the provisions of the Texas Human Resources Code, Chapter 102, Rights of the Elderly, which applies to a patient sixty years of age or older. 2. At the time of admission, provide the patient with a written statement that informs the patient that a complaint against the hospice may be directed to the Texas Department of Aging and Disability Services (DADS)/Health and Human Services Commission (HHSC), DADS'/HHSC Consumer Rights and Services Division, P.O. Box 149030, Austin, TX 78714-9030, toll free 1-800-458-9858.	TX H&S Code § 142.009; 40 TAC § 97.282
Virginia	1. The patient or his designee shall be given a copy of the hospice program's procedures for filing a complaint at the time of admission to service. The hospice program shall provide each patient or his designee with the name, mailing address, and telephone number of the: a. hospice program contact person b. State Ombudsman and c. Complaint Unit of the OLC 2. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.	12VAC5-391-240

	3. Upon admission, the admitting clinician/technician will provide each patient or his/her representative with a written copy of the Patient Bill of Rights. 4. The Patient Bill of Rights will be explained and distributed to the patient prior to the initiation of organization services. This explanation will be in a language he/she can reasonably be expected to understand. 5. The admitting clinician will document that the patient has received a copy of the Patient Bill of Rights. a. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made. b. In the event a communication barrier exists, if possible, special devices or interpreters will be made available. c. Written information will be provided to patients in the predominant languages of the population served. 6. When the patient's representative signs the Patient Bill of Rights form, an explanation of that relationship must be documented and kept on file in the clinical record. 7. The family or guardian may exercise the patient's rights when a patient is incompetent or a minor. 8. All organization personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually. (See "Orientation" Policy No. 8-022.)	
Washington	The hospice will ensure patients shall have the right to: 1. Receive effective symptom control and quality services for services identified in the plan of care. 2. Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services. 3. Receive a statement advising of the right to ongoing participation in the development of the plan of care. 4. Receive a statement advising of the right to have access to the Washington state Department of Health's listing of licensed hospice agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations.	WAC 246-335-635; RCW 70.127.140

	5. Receive a listing of the total services offered and those being provided to the patient. 6. Receive the name of the individual responsible for supervising the patient's care and the manner in which that individual may be contacted. 7. To be treated with courtesy, respect, and privacy. 8. To be free from verbal, mental, sexual, and physical abuse, neglect, exploitation, discrimination, and the unlawful use of restraints or seclusion. 9. Have property treated with respect. 10. Privacy of personal information and health care related records and confidentiality of personal information. 11. To be informed of what the hospice agency charges for services, to what extent payment may be expected from health insurance, public programs, or other sources, and what charges the patient may be responsible for paying. 12. Receive a fully itemized billing statement upon request, including the date of each service and the charge. 13. Be informed about advance directives and POLST and the agency's scope of responsibility. 14. Be informed of the agency's policies and procedures regarding the circumstances that may cause the agency to discharge a patient. 15. Be informed of the agency's policies and procedures for back-up care when services cannot be provided as scheduled. 16. Receive a description of the agency's process for patients and family to submit complaints to the hospice agency about the services and care they are receiving and to have those complaints addressed without retaliation. 17. Be informed of the Washington State Department of Social and Health Services end harm hotline number to report suspected abuse of children or vulnerable adults. The hospice will ensure Patient Rights are implemented and updated as appropriate.	

Exhibit 6 – Non-Discrimination Policy

Gentiva
Enterprise Compliance Program

NON-DISCRIMINATION
ECP 9.0

Policy

- The office adheres to an equal opportunity policy for all persons seeking admission as patients pursuant to:
  - Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and 45 C.F.R. Part 80
  - Section 504, Rehabilitation Act of 1973 as amended (29 U.S.C. 794) and 45 C.F.R. Part 84
  - Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.) and 45 C.F.R. Part 91
- The Company operates in compliance with all federal and state laws and regulations related to non-discrimination in employment and service provision.
- Patients are accepted for service and receive services as ordered by their physician/allowed practitioner without regard to age, race, color, national origin, religion, sex (inclusive of gender identity and sexual orientation), disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law or decision regarding advance directives. Patients are accepted for service in accordance with Company admission policies.

General Information

- Adherence to the above listed policies is mandatory. Failure to comply with non-discrimination policies may result in disciplinary action including termination of employment/contracts.
- Questions related to employment practices will be referred to the Human Resources Department. Questions related to service delivery will be referred to the Corporate Clinical Operations Department.
- The National Section 504 Coordinator will be advised regarding issues of alleged discrimination in service or employment based on disabilities. The Chief Compliance Officer serves as the National Section 504 Coordinator.
- Individuals referred for care who do not meet the policy for acceptance of patients will be advised of the reasons for non-admission (for example, the requested procedure cannot be provided safely in the home setting) and will be offered reasonable assistance in obtaining services from another organization.
- The physician/allowed practitioner will be advised on the disposition of the service request for patients referred by a physician/allowed practitioner and not admitted. Reasons for non-admission will be documented for statistical purposes.
- Patients will be treated with dignity and respect for their persons and property. This includes the use of appropriate forms of address such as Mr., Mrs., Ms., or other titles/names the patient prefers and specifically requests.

NON-DISCRIMINATION
ECP 9.0

- The office does not limit admission to programs or the provision of service based on patient age except to programs designed and operated specifically for pediatric populations.
- No restriction or limitation of admissions for services or treatment exists based on membership or affiliation with a fraternal organization, religious organization, or because of disease entity. Only such factors as may relate to patient safety and the office ability to provide required services will be considered for patient admissions.
- All patients will be treated with respect and consideration in the provision of services. Such factors as age, race, color, national origin, religion, sex, disability, or being a qualified disabled veteran, or a qualified veteran of the Vietnam era, or any other category protected by law are considerations only insofar as they contribute to the development of plans to meet patient needs effectively (for example, physiological effects of aging that affect drug metabolism). Such factors will not be used by any Associate or subcontractor as a basis for rejecting patients for care or for limiting properly authorized services to the patient.
- Except when another site is preferred by the patient or dictated by the nature of the service, care is administered in the patient's place of residence.
- In some Home Health cases, equipment required to implement the Medicare therapy plan cannot be brought into a patient home. Even though the patient is homebound services may be performed in a facility where the equipment is available. The services are billed as home health services to Medicare.

Exhibit 7– Death with Dignity Policy

Death with Dignity/Medical Aid in Dying
Policy No. 4-055

PURPOSE

To provide general guidelines regarding Death with Dignity/Medical Aid in Dying practice.

DEFINITION

Death with Dignity (DWD), or Medical Aid in Dying (MAID), for purposes of this policy, means a process by which terminally ill patients may end their lives legally in certain states, through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. This process may also be known as Physician-Assisted Death, Physician Aid in Dying, End of Life Option, or Physician-Assisted Suicide. This policy only applies to the following states: California, Colorado, New Jersey, Maine, New Mexico, Oregon, and Washington.

POLICY

Gentiva – Hospice Division (the hospice) is committed to providing excellent care and services to the patient and family during the dying process and period of bereavement, regardless of the patient's decision to participate in Death with Dignity (DWD)/Medical Aid in Dying (MAID), the language of which may vary by state. The hospice does not participate in any state's DWD/MAID program and does not allow any hospice employee or contractor to participate in any state's DWD/MAID program while acting within the course and scope of his or her capacity as a hospice employee or contractor. This would include staff distribution of Death with Dignity literature or Death with Dignity physician recommendations.

1. Hospice employees will notify the clinical manager of the patient's intention to participate in DWD/MAID. The clinical manager will notify the Gentiva Chief Medical Officer or respective National Medical Director.
2. The Case Manager will notify the attending physician and core members of the interdisciplinary group of the patient's intention to participate in DWD/MAID and initiate the DWD/MAID plan of care problem statement.
3. The patient will designate an attending physician, in accordance with the respective state's legal requirements. If the attending physician is a contract physician or an employee of the hospice that information should be included in the above-required, the hospice notification.
4. Physicians employed by or contracted with the hospice, including the hospice Medical Director, may not prescribe, order, prepare, or administer an aid-in-dying drug to the patient while acting within their role as a hospice employee or contracted physician.
5. Physicians employed by or contracted with the hospice, including the hospice Medical Director, do not participate as either an attending (prescribing) or consulting provider, while acting within their role as a hospice employee or contracted physician. They may not sign the death certificate or participate in any documentation (including the completion of any state required documentation as an acting consulting medical provider required to be completed as part of the Death with Dignity process) of the patient's death while acting within their role as a hospice employee or contracted physician.
6. The patient otherwise has the right to seek out an attending physician, who is not acting within his or her role as a hospice employee or contracted physician, to aid in the patient's participation in a state-sanctioned DWD/MAID program. This physician, who must not be acting within the scope of his or her role as a hospice employee or contractor, is solely responsible for satisfying all applicable state-specific DWD/MAID program laws, regulations,

and/or reporting or documentation requirements, including (but not limited to): meeting all document and signature requirements for patient consent to participate in any state-sanctioned DWD/MAID program; completing the patient's death certificate; securing any consulting physician or mental health professional, as may be required under state law; satisfying any documentation requirements related to diagnosis, prognosis, and determination that the patient is qualified to give informed consent and has been properly counseled in accordance with state-specific requirements; and ensuring that any consulting physician or mental health professional has met all relevant state-specific obligations and documentation requirements.

7. Hospice employees and contractors will provide and maintain appropriate palliative care during the dying and bereavement process. Employees and contractors may be present to offer support and comfort to the patient and family in the normal course of hospice care. Hospice staff and volunteers may not be present in the patient room at the moment of ingestion but may be present in the patient residence at time of ingestion.
8. Hospice employees and contractors will neither participate in nor assist in the preparation and administration of the lethal medications associated with DWD/MAID process. Hospice staff may not place a rectal catheter for the purpose of self-administration of DWD medications.
9. Hospice staff will not transport any medications associated with the DWD/MAID process from the pharmacy to the patient's residence.
10. Hospice staff and volunteers will not witness a patient's written request for medication that the patient may self-administer to end their life.
11. Hospice employees and contractors have the right to refrain from participating in the care of a patient that has elected DWD/MAID for any reason and without consequence. If a hospice employee or contractor chooses to not participate, a replacement clinician will be identified as soon as possible.

Addendum A: State Specific Requirements

The policy statements listed below reflect additional state specific requirements that must be followed in addition to the organizational policy. When the organizational policy and state-specific requirements are conflicting, the most stringent should be followed.

State	State Death with Dignity/Medical Aid in Dying Requirement	State Legal Reference
California	The attending physician is responsible for completing all relevant attending physician checklists and compliance forms and submitting all applicable forms, including the consulting physician compliance form, to the State Department of Public Health. If the patient's death is not the result of ingesting aid-in-dying drugs, the hospice RN will educate the deceased patient's family about the disposal of such medications. This education will include the following: A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.	Cal. Health & Safety Code § 443.5(a)(11) Cal. Health & Safety Code, Part 1.85, §443.20; Effective 6/9/2016
Colorado	The attending physician or the hospice medical director must sign the death certificate of patient who obtained and self-administered aid-in-dying medication. Within 30 days of writing a prescription for aid-in-dying medication, the attending physician is responsible for completing and submitting any state-required compliance forms. If the patient's death is not the result of ingesting aid-in-dying drugs, the hospice RN will educate the deceased patient's family about the disposal of such medications. This education will include the following: A person who has custody or control of any unused aid-in-dying drugs prescribed to the state DWD Act after the death of the patient shall personally return the unused medical aid-in-dying medication to the attending physician who prescribed the medical-aid-in-dying medication or by lawful means in accordance with the state's household medication take-back program or any other state or federally-approved take-back program authorized under the federal Secure and Responsible Drug Disposal Act of 2010.	C.R.S.A. § 25-48-109; 6 CCR 1009-4:II; C.R.S.A. § 25-48-120; Effective 12/16/2016
Maine	The patient has the right to information regarding all treatment options reasonably available for the care of the patient, including, but not limited to, information in response to specific questions about the foreseeable risks and benefits of medication, without a physician's withholding requested information regardless of the purpose of the questions or the nature of the information. A health care provider may prohibit its employees, independent contractors or other persons or entities, including other health care	Maine Death with Dignity Act, Ch. 271 Public Law; Effective September 19, 2019

	providers, from participating in activities under the DWD Act while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider. A health care provider that prohibits its employees, independent contractors or other persons or entities from participating in the DWD Act shall first give notice of the policy prohibiting participation under the DWD Act to those employees, independent contractors or other persons or entities. A health care provider that fails to provide notice to those employees, independent contractors or other persons or entities in compliance with this paragraph may not enforce such a policy against those employees, independent contractors or other persons or entities. A prohibiting health care provider is not allowed to prohibit an employee, independent contractor, or other person from: • Participating, or entering into an agreement to participate, in activities under this Act while on premises that are not owned or under the management or direct control of the prohibiting health care provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider; or • Participating, or entering into an agreement to participate, in activities under this Act as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting health care provider. If the patient's death is not the result of ingesting aid-in-dying drugs, the hospice RN will educate the deceased patient's family about the disposal of such medications. This education will include the following: A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to the DWD Act after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest facility qualified to dispose of controlled substances, or, if such delivery is impracticable, personally dispose of the unused medications by any lawful means, in accordance with any guidelines adopted by the Maine Department of Health and Human Services.	
New Jersey	Any medication dispensed pursuant to the DWD Act that a qualified terminally ill patient chooses not to self-administer shall be disposed of by lawful means, including, but not limited to, disposing of the medication consistent with State and federal guidelines concerning disposal of prescription medications, or surrendering the medication to a prescription medication drop-off receptacle. The patient shall designate a person who shall be responsible for the lawful disposal of the medication. The existing policies and procedures utilized by a health care facility shall, to the maximum extent possible, govern the taking of any action by a health care professional pursuant to the DWD Act on the premises owned	New Jersey, Medical Aid in Dying for the Terminally Ill Act, P.L. 2019, Ch. 59; Effective August 1, 2019

	or controlled by the facility, except as otherwise may be prescribed by regulation of the Commissioner of Health. Pursuant to applicable state regulation hospice registered nurses are able to pronounce death.	
New Mexico	"Medical Aid in Dying" means the medical practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to bring about a peaceful death • Two licensed health care providers, one of which must be a physician, must confirm the terminal illness. Individuals enrolled in hospice are deemed terminal and do not require a second confirmation. Individuals are not eligible for medical aid in dying solely because of age or disability. • The prescribing provider must inform the requesting individual about all of their end-of life care options, including hospice and pain and symptom management. • If the provider has concerns about the individual's mental capacity or ability to make an informed decision, they must make a referral to a mental health professional for an assessment. Medication cannot be prescribed until their mental capacity is affirmed. • Two people must witness the required "Request to End My Life in a Peaceful Manner" form. Only one witness can be a relative. • There is a 48-hour waiting period before the medical aid in dying prescription can be filled for a qualified individual (dying patient), which a provider can waive if the patient is unlikely to survive the 48-hour waiting period. • The qualified individual can withdraw their request for medication, not take the medication once they have it, or otherwise change their mind at any point. • The underlying illness will be listed as the cause of death on the death certificate. • Prescribing health care providers must comply with medical record documentation requirements and make required data available to the New Mexico Department of Health. • The New Mexico Department of Health is required to collect specified data and issue a publicly available annual report. Identifying information about qualified individuals and health care providers is kept confidential. • Providers who participate and comply with all aspects of the law are given civil and criminal immunity and other professional and employment-related protections. • No health care provider, health care entity, or pharmacist is required to participate in medical aid in dying. For those choosing not to participate, appropriate notice to the public and a referral of the qualified individual to a participating provider or to an	Section of Chapter 30, Article 2 NMSA 1978; Elizabeth Whitefield End-of-Life Options Act; Effective June 20, 2021

	individual or entity that can provide assistance to those seeking medical aid in dying are required. • Self-administration does not include administration by intravenous (IV) injection or infusion by any person, including the patient's provider, family member, or the patient themselves.	
Oregon	Within seven calendar days of writing a prescription for an aid-in-dying drug, the attending physician is responsible for submitting by mail the patient's written request for medication to end life, the relevant attending physician's compliance form, the consulting physician's compliance form, and psychiatric/psychological consultant's compliance form (if applicable). Within 10 calendar days of the patient's ingestion of lethal medication or death by any other cause, the attending physician is responsible for completing and submitting the Oregon Death with Dignity Act Attending Physician Interview form. No guidance related to the disposal of unused aid-in-dying medication was located in the state's DWD Act or implementing regulations.	OAR 333-009-0010; Effective 10/27/1997
Washington	A valid request for medication under this chapter shall be in substantially the form described in RCW 70.245.220, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request. One of the witnesses shall be a person who is not: • A relative of the patient by blood or by law; • A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or • An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident. The patient's attending qualified medical provider at the time the request is signed shall not be a witness Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means. The attending qualified medical provider is responsible for certifying the patient's death certificate within 5 calendar days from the date of death and send the completed forms to the state within 30 calendar days after the date of death. The hospice shall submit to the department of health its policies related to access to care regarding end of life care. The information shall include: • A section for the public with specific information about which end-of-life services are and are not generally available at each agency or facility; and (b) the contact information for the agency or facility	Wash. Rev. Code Ann. § 70.245.140; RCW 70.245.030 RCW 70.127.290 Washington Department of Health, Death with Dignity Act, Frequently Asked Questions, available at https://www.doh.Wa.gov/

	in case patients have specific questions about services available at the hospice. If a hospice makes changes to any of the policies listed under subsection (1), it shall submit a copy of the changed policy to the department of health within 30 days after the agency or facility approves the changes. A copy of the policies provided to the department of health under subsection (1) of this section must be posted to the website of each agency or facility providing hospice services as defined in RCW 70.127.010 in a location where the policies are readily accessible to the public without a required login or other restriction.	

Exhibit 8 – Multiple Location Site Control Policy

MULTIPLE LOCATION SITE CONTROL
Policy No. 1-020

PURPOSE

To ensure that documentation, communication, coordination and retrieval of information at Multiple Location Site (MLS) locations is treated in the same manner as that in the parent location

POLICY

"Multiple location" means a Medicare-approved location from which the Hospice provides the same full range of hospice care and services that is required of the parent hospice location issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices.

1. Multiple locations will be directed, administered and monitored by the parent location in accordance with regulations and Company policy.
2. Drop Sites will not function as multiple locations.
3. Multiple Location Sites (MLS) will comply with all applicable policies and procedures as the parent location.

PROCEDURE

1. The hospice will maintain policy and procedure manuals electronically so they are accessible by the parent and all multiple location sites.
2. Organization personnel at all locations will be introduced to applicable policies and procedures during the orientation process. Changes in policies and procedures will be communicated to personnel at all locations through the use of personnel meetings, newsletters, or other available means of communication.
3. Multiple location sites will maintain patient clinical/service records in the identical manner of the parent location including entries into the record and protection of protected health information.
4. Personnel assigned to multiple location sites will attend personnel meetings and educational in-services to ensure that communication of significant information is accomplished.
5. The Administrator of the parent office:
   a. Maintains ongoing oversight and communication with the multiple location staff ensuring that

      each hospice location provides the same full range of services that is required of the parent

      agency.

   b. Assigns an Executive Director to each hospice location.
6. The parent agency is responsible for continually monitoring and managing all services provided at all of its locations through the Quality Assessment and Performance Improvement (QAPI) Program to ensure that services are delivered in a safe and effective manner and ensure that each patient and family receives the necessary care and services outlined in the Plan of Care.
7. The Hospice:
   a. Maintains original clinical records for active patients at the location providing care when

   b. permitted by state regulation.
   c. Establishes a personnel and clinical record system that ensures all employee and patient records are available at the parent agency when requested by a surveyor.
   d. Develops all contracts for services under arrangement with the assistance of the parent office.

8. If organization intends to add a location, it must notify CMS, the state survey agency and any other affiliated regulatory entity in writing of the proposed location and if the location will participate in Medicare and/or Medicaid.

Drop Sites

1. If the parent office establishes drop sites for the convenience of clinicians, such sites will be for the purposes of picking up supplies and forms, preparing documentation for submission to the parent office, making phone calls related to patient care, etc.
2. No personnel or clinical records will be maintained in a drop site; services will not be provided or advertised from the drop site; admissions will not be taken at the drop site; and care will not be coordinated from the drop site.
3. Do not:
   a. Attach signs with the company name to drop sites unless a listing is required by the lease.
   b. Advertise the telephone number for the hospice agency unless for the sole purpose of allowing patients and referral sources to use a local phone number instead of a long distance phone number.
4. Since the drop site is not staffed with personnel, the phone must be forwarded to the parent agency's number.
5. The site must comply with any additional state requirements applying to such locations.
6. If it proves necessary to maintain records or to deliver services from such a site, application will be made for approval as a multiple location prior to such conversion, if the location is subject to certification or licensure.
7. Drop sites may also be referred to as work stations, charting location, etc., based upon individual state agency verbiage. Regardless of state agency identification verbiage, any location not licensed and certified as a multiple location site must adhere to the guidelines for drop sites.

MULTIPLE LOCATION SITE CONTROL
Policy No. 1-020

Addendum A: State Specific Requirements

The policy statements listed below reflect additional state specific requirements that must be followed in addition to the organizational policy. When the organizational policy and state-specific requirements are conflicting, the most stringent should be followed.

State	State Requirement	State Regulatory Reference
Georgia	A. All locations will be owned and operated by the same governing body and conduct business under the same set of by-laws and the same trade name; B. Each location will be responsible to the same governing body and central administration managed together under the same set of policies and procedures C. The governing body and central administration demonstrate the capacity to adequately manage all locations and ensure the quality of care at all locations as evidenced by a prior history of satisfactory compliance with hospice regulations and appropriate staffing; D. Supervision and oversight at additional locations is sufficient to ensure that hospice care and services meet the needs of patients and the patients' family units; E. The medical director assumes responsibility for the medical component of the hospice's patient care at all locations; F. Additional locations provide the same full range of services and the same level and quality of care including timely responses, that is provided by the primary location; G. Each patient is assigned to a specific hospice care team responsible for ongoing assessment, planning, monitoring, coordination, and provision of care, which has ready access to the patient's clinical record; H. All hospice patients' clinical records that are requested by the Department at the time of inspection will be available at the hospice's primary location; and I. All locations will maintain the same Medicare provider number, as applicable.	Ga Comp. R. & Regs. 111-8-37-.04
Illinois	A. The hospice exerts the supervision and control necessary at each location to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings; B. Each location provides the same full range of services that is required of the hospice to which the license was issued; C. Each patient will be assigned to a specific hospice care team responsible for ongoing assessment, planning, monitoring, coordination and provision of care;	77 Ill. Adm. Code 280.2000

	D. The hospice medical director assumes overall responsibility for the medical component of the hospice's patient care program at all locations; E. Each location is responsible to the same governing body and central administration that governs the hospice to which the license was issued, and the governing body and central administration will be able to manage the location adequately and to assure quality of care at the location; and F. All hospice patients' clinical records requested by a surveyor will be available at the hospice site to which the license was issued.	
Louisiana	The hospice will comply with the applicable requirements of LAC 48:I:8241 regarding establishment and operations of Branch Offices, including: 1. No branch office will be opened without written approval from the Louisiana Department of Health & Hospitals. 2. Each branch will serve the same or part of the geographic area approved for the parent. 3. All services provided by the parent agency must be available in the branch. 4. Each branch office shall have a registered nurse immediately available to be on site, or on site in the branch office at all times during stated operating hours. 5. Original personnel files will be kept at the parent agency, but (subject to Policy 1-018) shall be made available to federal/state surveyors during any review upon request. 6. The branch site shall retain all Clinical Records for its patients. Duplicate records need not be maintained at the parent agency, but (subject to Policy 1-018) shall be made available to federal/state surveyors during any review upon request. 7. A statement of personnel policies will be maintained in each branch for staff usage.	LAC 48:I:8241
Missouri	A. The hospice will ensure that branch offices are located sufficiently close to share administration and supervision and services in a manner that renders it unnecessary for it to be separately certificated. 1. In all cases, the satellite office must be located within 100 miles of the parent office. B. If hospice has its parent office in a state which does not have a reciprocal agreement with Missouri on hospice certification, then hospice will maintain a branch office in Missouri. Such branch office will maintain all records required by the Missouri Department of Health and Senior Services for survey and will be certificated as a hospice.	MO. REV. STAT. § 197.254.7; § 197.258.1 19 CSR 30-35.010(1)(K)

	C. If hospice represents to the public that it has a branch office, there will be a designated interdisciplinary group with documented group meetings and telephone reception during normal business hours. D. The standard of care and clinical services will be the same out of the satellite/branch offices as the parent office.	
Tennessee	A. The hospice parent office shall develop and maintain administrative controls of the branch office(s) and house the administrative functions of the home care organization. The parent office shall be ultimately responsible for human resource activities and all financial and contractual agreements for hospice, including both parent and branch offices. B. The administrator and director of nursing for hospice shall be primarily located in the parent office. The hospice administrator and director of nursing shall make on-site supervisory visits to each branch office at least quarterly. C. The parent office of hospice shall have a clearly defined process to ensure that effective interchange occurs between the parent and branch regarding various functions, including branch staffing requirements, branch office patient census, total visits provided by the branch, complaints, incident reports and referrals. D. The hospice branch office(s) shall maintain the same name and standards of practice as the parent office, including forms, policies, procedures and service delivery standards. The parent office shall maintain documentation of integration between the parent office and its branch offices. The parent office of a home care organization shall maintain regular administrative contact with its branch offices at least weekly. Documentation of this contact shall be maintained by the parent office. The parent office shall receive weekly written staffing reports from its branch offices, including, but not limited to, information regarding staffing needs, staffing patterns and staff productivity. E. hospice shall ensure that each branch office meets the criteria above and is sufficiently close to share administrative services with the parent office. 1. A branch office shall be deemed to be sufficiently close if it is within one hundred (100) miles of the parent office. 2. A branch office that is greater than one hundred (100) miles from a parent office may be considered a branch office by the Tennessee Board for Licensing Health Care Facilities (the "Board"), if it otherwise meets the applicable criteria. 3. A branch office of a home care organization existing as of May 11, 1998, that is more than one hundred (100) miles from the parent office of such home care organization and that has been previously approved as a branch office by the Board, may continue to be classified as a branch office, if it otherwise meets the applicable criteria.	TENN. CODE ANN.: § 68-11-202(e) TENN. COMP. R. & REGS: 1200-08-27-.04(8)

	F. If hospice provides hospice services at more than one location, it will ensure that: 1. Each location provides the same full range of services that is required of the hospice issued license (parent); 2. Each location is responsible to the same governing body and central administration that governs the hospice issued license (parent), and the governing body and central administration are able to adequately manage each location; 3. Clinical records are maintained for all patients, regardless of where services are provided; and 4. All hospice patients' clinical records requested by the surveyor will be available at the hospice site issued the license (parent). G. If hospice is unable to comply with these requirements at an additional location, it will apply and become separately licensed.	
Texas	The hospice will comply with existing policy (see Policies 1-020 and 8-003) as well as the Texas specific requirements below related to alternate delivery sites. A. According to the Texas Administrative Code (TAC), what is traditionally known as a "branch" under hospice policy, procedure and practice is known as an "alternate delivery site" (ADS) in Texas. Under the TAC, an ADS is a facility or site, including a residential unit or an inpatient unit: 1. That is owned or operated by an agency providing hospice services; 2. That is not the hospice's parent agency; 3. That is located in the geographical area served by the hospice; and 4. From which the hospice provides hospice services. B. The hospice will post the ADS license from the Texas Department of Aging and Disability Services (DADS)/ Health and Human Services Commission (HHSC) in a conspicuous place on the licensed ADS premises. C. The hospice and an ADS must meet the following requirements: 1. The hospice Administrator or alternate Administrator/Branch Director, or supervising nurse (a/k/a Director of Nursing) or alternate supervising nurse must conduct an on-site supervisory visit to the ADS at least monthly. The hospice may visit the ADS more frequently considering the size of the service area provided by the hospice. The supervisory visits may be documented and include the date of the visit, the content of the consultation, the individuals in attendance, and the recommendations of the staff. 2. Hospice will approve all ADS policies and procedures. This approval must be documented and filed with the hospice and the ADS. D. Hospice will ensure that:	TX H&S Code § 142.0085 26 TAC §§558.322

	1. The Hospice's organizational chart will be maintained in writing, describe the organizational structure, either in the form of a chart or narrative, and will include a description of all services provided by the agency, the governing body, the administrator, supervising nurse, advisory committee, interdisciplinary team, and staff, as appropriate, based on services provided by the agency; and the lines of authority and the delegation of responsibility down to and including the client care level. Additionally, the lines of authority and professional and administrative control will be clearly delineated in the hospice's organizational structure and in practice and must be traced to the parent agency. The hospice will continually monitor and manage all services provided by its ADS to ensure that services are delivered in a safe and effective manner and to ensure that a patient and the patient's family receives the necessary care and services outlined in the plan of care	

gentiva

Exhibit 9 – Letter of Intent

gentiva

December 30, 2024

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

Via Email: ERIC.HERNANDEZ@DOH.WA.GOV
FLSCON@DOH.WA.GOV

RE: Letter of Intent – Odyssey HealthCare Operating B, LP (dba Gentiva)
Projected Need Pierce County

Dear Mr. Hernandez,

Odyssey HealthCare Operating B, LP (dba Gentiva) respectfully submits this letter of intent to apply for a certificate of need to establish a hospice agency. In accordance with WAC 246-310-080, please find the following information:

1. Description of Services Provided. Gentiva proposes to expand our service area from King County into Pierce County establishing a Medicare and Medicaid licensed alternate delivery site of our in-home hospice Parent Provider 50-1541, NPI 1689906125.
2. Estimated Cost of the Proposed Project. The estimated cost of the proposed hospice agency is $107,000.00.
3. Identification of Service Area. The service area of the hospice agency will be Pierce County, Washington.

Thank you for your support. We look forward to serving hospice patients in Pierce County.

Please feel free to contact me with any questions or concerns.

Sincerely,

Deborah Hagopian, RN
Executive Director – Administrator
Gentiva Hospice – King County/Seattle
Deborah.hagopian@gentivahs.com
253.414.2186

3350 Riverwood Parkway, Suite 1400, Atlanta, Georgia 30339
www.gentivahs.com

Department of Health
2024-2025 Initial Hospice Numeric Need Methodology
Distributed October 10, 2024

WAC246-310-290(8)(a) Step 1:

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

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.

WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Hospice admissions ages 0-64	
Year	Admissions
2021	3,883
2022	3,331
2023	3,399
	average: 3,538

Deaths ages 0-64	
Year	Deaths
2021	18,015
2022	17,201
2023	16,708
	average: 17,308

Use Rates	
0-64	20.44%
65+	54.75%

Hospice admissions ages 65+	
Year	Admissions
2021	27,885
2022	28,503
2023	26,755
	average: 27,714

Deaths ages 65+	
Year	Deaths
2021	50,717
2022	52,002
2023	49,130
	average: 50,616

Department of Health
2024-2025 Initial Hospice Numeric Need Methodology
Distributed October 10, 2024

WAC246-310-290(8)(b) Step 2:
Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

0-64				
County	2021	2022	2023	2021-2023 Average Deaths
Adams	23	25	30	**26**
Asotin	43	45	74	**54**
Benton	536	566	414	**505**
Chelan	256	225	158	**213**
Clallam	185	179	190	**185**
Clark	1,078	1,002	1,058	**1,046**
Columbia	11	12	15	**13**
Cowlitz	401	311	310	**341**
Douglas	45	45	89	**60**
Ferry	21	22	26	**23**
Franklin	110	79	179	**123**
Garfield	4	2	5	**4**
Grant	208	190	243	**214**
Grays Harbor	236	223	309	**256**
Island	116	117	146	**126**
Jefferson	54	59	58	**57**
King	4,892	4,902	4,217	**4,670**
Kitsap	489	462	556	**502**
Kittitas	88	78	76	**81**
Klickitat	50	50	58	**53**
Lewis	186	191	248	**208**
Lincoln	24	24	35	**28**
Mason	168	152	202	**174**
Okanogan	92	106	112	**103**
Pacific	59	69	72	**67**
Pend Oreille	55	44	47	**49**
Pierce	2,574	2,518	2,320	**2,471**
San Juan	24	12	37	**24**
Skagit	334	258	282	**291**
Skamania	25	20	48	**31**
Snohomish	1,563	1,468	1,637	**1,556**
Spokane	1,842	1,603	1,340	**1,595**
Stevens	114	107	141	**121**
Thurston	763	709	626	**699**
Wahkiakum	7	9	8	**8**
Walla Walla	138	157	110	**135**
Whatcom	443	467	475	**462**
Whitman	59	65	63	**62**
Yakima	699	628	694	**674**

65+				
County	2021	2022	2023	2021-2023 Average Deaths
Adams	92	91	84	**89**
Asotin	188	227	236	**217**
Benton	1,610	1,739	1,332	**1,560**
Chelan	870	873	617	**787**
Clallam	906	935	1,019	**953**
Clark	3,705	3,709	3,399	**3,604**
Columbia	43	37	40	**40**
Cowlitz	1,100	989	1,033	**1,041**
Douglas	174	205	270	**216**
Ferry	63	60	105	**76**
Franklin	261	234	364	**286**
Garfield	24	24	20	**23**
Grant	523	533	616	**557**
Grays Harbor	590	683	762	**678**
Island	504	548	732	**595**
Jefferson	295	298	349	**314**
King	11,896	12,448	10,961	**11,768**
Kitsap	1,832	1,895	1,909	**1,879**
Kittitas	241	261	317	**273**
Klickitat	164	130	175	**156**
Lewis	723	753	811	**762**
Lincoln	76	67	120	**88**
Mason	461	414	646	**507**
Okanogan	324	341	407	**357**
Pacific	239	235	295	**256**
Pend Oreille	119	127	164	**137**
Pierce	6,264	6,412	5,695	**6,124**
San Juan	91	78	134	**101**
Skagit	1,190	1,215	1,168	**1,191**
Skamania	56	60	89	**68**
Snohomish	4,478	4,833	4,660	**4,657**
Spokane	4,810	4,603	3,990	**4,468**
Stevens	304	336	423	**354**
Thurston	2,285	2,419	2,175	**2,293**
Wahkiakum	25	24	54	**34**
Walla Walla	595	598	567	**587**
Whatcom	1,674	1,653	1,552	**1,626**
Whitman	278	233	237	**249**
Yakima	1,644	1,682	1,603	**1,643**

Department of Health
2024-2025 Initial Hospice Numeric Need Methodology
Distributed October 10, 2024

WAC246-310-290(8)(c) Step 3.
Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

0-64		
County	2021-2023 Average Deaths	Projected Patients: 20.44% of Deaths
Adams	26	5
Asotin	54	11
Benton	505	103
Chelan	213	44
Clallam	185	38
Clark	1,046	214
Columbia	13	3
Cowlitz	341	70
Douglas	60	12
Ferry	23	5
Franklin	123	25
Garfield	4	1
Grant	214	44
Grays Harbor	256	52
Island	126	26
Jefferson	57	12
King	4,670	955
Kitsap	502	103
Kittitas	81	16
Klickitat	53	11
Lewis	208	43
Lincoln	28	6
Mason	174	36
Okanogan	103	21
Pacific	67	14
Pend Oreille	49	10
Pierce	2,471	505
San Juan	24	5
Skagit	291	60
Skamania	31	6
Snohomish	1,556	318
Spokane	1,595	326
Stevens	121	25
Thurston	699	143
Wahkiakum	8	2
Walla Walla	135	28
Whatcom	462	94
Whitman	62	13
Yakima	674	138

65+		
County	2021-2023 Average Deaths	Projected Patients: 54.75% of Deaths
Adams	89	49
Asotin	217	119
Benton	1,560	854
Chelan	787	431
Clallam	953	522
Clark	3,604	1,974
Columbia	40	22
Cowlitz	1,041	570
Douglas	216	118
Ferry	76	42
Franklin	286	157
Garfield	23	12
Grant	557	305
Grays Harbor	678	371
Island	595	326
Jefferson	314	172
King	11,768	6,444
Kitsap	1,879	1,029
Kittitas	273	149
Klickitat	156	86
Lewis	762	417
Lincoln	88	48
Mason	507	278
Okanogan	357	196
Pacific	256	140
Pend Oreille	137	75
Pierce	6,124	3,353
San Juan	101	55
Skagit	1,191	652
Skamania	68	37
Snohomish	4,657	2,550
Spokane	4,468	2,446
Stevens	354	194
Thurston	2,293	1,256
Wahkiakum	34	19
Walla Walla	587	321
Whatcom	1,626	890
Whitman	249	137
Yakima	1,643	900

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WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

0-64								
County	Projected Patients	2021-2023 Average Population	2024 projected population	2025 projected population	2026 projected population	2024 potential volume	2025 potential volume	2026 potential volume
Adams	5	18,382	18,748	18,931	19,076	5	5	6
Asotin	11	16,591	16,360	16,244	16,150	11	11	11
Benton	103	177,393	180,477	182,019	183,656	105	106	107
Chelan	44	62,984	63,139	63,217	63,358	44	44	44
Clallam	38	52,399	52,704	52,857	53,039	38	38	38
Clark	214	429,086	437,545	441,774	445,732	218	220	222
Columbia	3	2,713	2,615	2,566	2,534	2	2	2
Cowlitz	70	88,027	88,206	88,295	88,438	70	70	70
Douglas	12	35,501	35,746	35,869	36,040	12	12	12
Ferry	5	5,047	4,886	4,806	4,794	5	4	4
Franklin	25	90,044	92,587	93,859	95,174	26	26	27
Garfield	1	1,570	1,569	1,569	1,565	1	1	1
Grant	44	86,185	87,363	87,952	88,582	44	45	45
Grays Harbor	52	57,788	57,179	56,875	56,714	52	51	51
Island	26	64,048	64,464	64,672	64,972	26	26	26
Jefferson	12	20,192	20,040	19,964	20,079	12	12	12
King	955	1,984,180	2,003,368	2,012,962	2,022,512	964	968	973
Kitsap	103	222,634	222,729	222,776	223,024	103	103	103
Kittitas	16	38,910	39,653	40,024	40,367	17	17	17
Klickitat	11	17,103	16,874	16,759	16,746	11	11	11
Lewis	43	64,018	64,432	64,639	64,828	43	43	43
Lincoln	6	7,794	7,775	7,765	7,769	6	6	6
Mason	36	50,196	50,594	50,793	51,105	36	36	36
Okanogan	21	31,737	31,392	31,219	31,139	21	21	21
Pacific	14	15,464	15,346	15,287	15,287	14	13	13
Pend Oreille	10	9,602	9,485	9,427	9,408	10	10	10
Pierce	505	794,221	801,483	805,114	808,657	510	512	514
San Juan	5	11,668	11,640	11,626	11,711	5	5	5
Skagit	60	100,998	101,846	102,270	102,688	60	60	61
Skamania	6	9,121	8,875	8,752	8,728	6	6	6
Snohomish	318	717,100	725,839	730,209	734,203	322	324	326
Spokane	326	449,365	452,277	453,733	455,179	328	329	330
Stevens	25	35,550	35,071	34,832	34,983	24	24	24
Thurston	143	244,360	248,369	250,374	252,633	145	146	148
Wahkiakum	2	2,930	2,903	2,890	2,890	2	2	2
Walla Walla	28	50,370	50,382	50,388	50,438	28	28	28
Whatcom	94	186,794	189,395	190,696	192,079	96	96	97
Whitman	13	42,503	42,531	42,545	42,566	13	13	13
Yakima	138	219,982	220,690	221,044	221,446	138	138	139

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WAC246-310-290(8)(f) Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	2024 Unmet Need Admissions*	2025 Unmet Need Admissions*	2026 Unmet Need Admissions*	Statewide ALOS	2024 Unmet Need Patient Days*	2025 Unmet Need Patient Days*	2026 Unmet Need Patient Days*
Adams	17	17	18	**59.79**	1,003	1,015	1,079
Asotin	34	38	42	**59.79**	2,045	2,294	2,514
Benton	(3)	29	59	**59.79**	(168)	1,722	3,556
Chelan	(258)	(244)	(230)	**59.79**	(15,438)	(14,565)	(13,766)
Clallam	219	225	231	**59.79**	13,070	13,451	13,805
Clark	(346)	(261)	(171)	**59.79**	(20,698)	(15,594)	(10,247)
Columbia	1	2	2	**59.79**	69	98	121
Cowlitz	(85)	(71)	(54)	**59.79**	(5,055)	(4,217)	(3,226)
Douglas	(368)	(363)	(358)	**59.79**	(21,997)	(21,694)	(21,427)
Ferry	12	14	14	**59.79**	732	830	850
Franklin	12	20	28	**59.79**	704	1,220	1,694
Garfield	6	6	6	**59.79**	337	332	333
Grant	99	111	124	**59.79**	5,890	6,638	7,390
Grays Harbor	91	100	106	**59.79**	5,420	5,967	6,347
Island	(114)	(107)	(102)	**59.79**	(6,789)	(6,420)	(6,088)
Jefferson	65	70	73	**59.79**	3,866	4,168	4,335
King	(638)	(398)	(151)	**59.79**	(38,143)	(23,782)	(8,999)
Kitsap	6	43	80	**59.79**	353	2,588	4,771
Kittitas	28	32	36	**59.79**	1,688	1,885	2,130
Klickitat	18	22	25	**59.79**	1,091	1,336	1,498
Lewis	8	16	24	**59.79**	476	943	1,429
Lincoln	30	31	31	**59.79**	1,790	1,838	1,867
Mason	(199)	(190)	(183)	**59.79**	(11,893)	(11,386)	(10,951)
Okanogan	68	74	79	**59.79**	4,087	4,443	4,698
Pacific	87	90	92	**59.79**	5,202	5,392	5,488
Pend Oreille	20	23	26	**59.79**	1,219	1,396	1,533
Pierce	139	275	417	**59.79**	8,287	16,445	24,907
San Juan	(38)	(36)	(35)	**59.79**	(2,299)	(2,181)	(2,111)
Skagit	(99)	(81)	(61)	**59.79**	(5,944)	(4,831)	(3,642)
Skamania	13	16	18	**59.79**	798	975	1,069
Snohomish	(1,016)	(893)	(759)	**59.79**	(60,756)	(53,421)	(45,394)
Spokane	(608)	(526)	(441)	**59.79**	(36,340)	(31,444)	(26,353)
Stevens	98	108	112	**59.79**	5,866	6,467	6,702
Thurston	16	57	95	**59.79**	943	3,382	5,658
Wahkiakum	3	3	4	**59.79**	172	205	223
Walla Walla	87	93	98	**59.79**	5,220	5,554	5,862
Whatcom	(687)	(659)	(631)	**59.79**	(41,075)	(39,402)	(37,738)
Whitman	89	92	95	**59.79**	5,301	5,473	5,685
Yakima	149	172	197	**59.79**	8,881	10,274	11,802

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

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WAC246-310-290(8)(g) Step 7:
Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

				Step 7 (Patient Days / 365) = Unmet ADC		
County	2024 Unmet Need Patient Days*	2025 Unmet Need Patient Days*	2026 Unmet Need Patient Days*	2024 Unmet Need ADC*†	2025 Unmet Need ADC*	2026 Unmet Need ADC*
Adams	1,003	1,015	1,079	3	3	3
Asotin	2,045	2,294	2,514	6	6	7
Benton	(168)	1,722	3,556	(0)	5	10
Chelan	(15,438)	(14,565)	(13,766)	(42)	(40)	(38)
Clallam	13,070	13,451	13,805	36	37	38
Clark	(20,698)	(15,594)	(10,247)	(57)	(43)	(28)
Columbia	69	98	121	0	0	0
Cowlitz	(5,055)	(4,217)	(3,226)	(14)	(12)	(9)
Douglas	(21,997)	(21,694)	(21,427)	(60)	(59)	(59)
Ferry	732	830	850	2	2	2
Franklin	704	1,220	1,694	2	3	5
Garfield	337	332	333	1	1	1
Grant	5,890	6,638	7,390	16	18	20
Grays Harbor	5,420	5,967	6,347	15	16	17
Island	(6,789)	(6,420)	(6,088)	(19)	(18)	(17)
Jefferson	3,866	4,168	4,335	11	11	12
King	(38,143)	(23,782)	(8,999)	(104)	(65)	(25)
Kitsap	353	2,588	4,771	1	7	13
Kittitas	1,688	1,885	2,130	5	5	6
Klickitat	1,091	1,336	1,498	3	4	4
Lewis	476	943	1,429	1	3	4
Lincoln	1,790	1,838	1,867	5	5	5
Mason	(11,893)	(11,386)	(10,951)	(32)	(31)	(30)
Okanogan	4,087	4,443	4,698	11	12	13
Pacific	5,202	5,392	5,488	14	15	15
Pend Oreille	1,219	1,396	1,533	3	4	4
Pierce	8,287	16,445	24,907	23	45	68
San Juan	(2,299)	(2,181)	(2,111)	(6)	(6)	(6)
Skagit	(5,944)	(4,831)	(3,642)	(16)	(13)	(10)
Skamania	798	975	1,069	2	3	3
Snohomish	(60,756)	(53,421)	(45,394)	(166)	(146)	(124)
Spokane	(36,340)	(31,444)	(26,353)	(99)	(86)	(72)
Stevens	5,866	6,467	6,702	16	18	18
Thurston	943	3,382	5,658	3	9	16
Wahkiakum	172	205	223	0	1	1
Walla Walla	5,220	5,554	5,862	14	15	16
Whatcom	(41,075)	(39,402)	(37,738)	(112)	(108)	(103)
Whitman	5,301	5,473	5,685	14	15	16
Yakima	8,881	10,274	11,802	24	28	32

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.
†unmet need for 2024 is calculated by dividing by 366 days due to it being a leap year.

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WAC246-310-290(8)(h) Step 8:
Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

	Step 7 (Patient Days / 365) = Unmet ADC			Step 8 - Numeric Need	
County	2024 Unmet Need ADC*†	2025 Unmet Need ADC*	2026 Unmet Need ADC*	Numeric Need?	Number of New Agencies Needed?**
Adams	3	3	3	FALSE	FALSE
Asotin	6	6	7	FALSE	FALSE
Benton	(0)	5	10	FALSE	FALSE
Chelan	(42)	(40)	(38)	FALSE	FALSE
Clallam	36	37	38	*TRUE*	*1*
Clark	(57)	(43)	(28)	FALSE	FALSE
Columbia	0	0	0	FALSE	FALSE
Cowlitz	(14)	(12)	(9)	FALSE	FALSE
Douglas	(60)	(59)	(59)	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	2	3	5	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	16	18	20	FALSE	FALSE
Grays Harbor	15	16	17	FALSE	FALSE
Island	(19)	(18)	(17)	FALSE	FALSE
Jefferson	11	11	12	FALSE	FALSE
King	(104)	(65)	(25)	FALSE	FALSE
Kitsap	1	7	13	FALSE	FALSE
Kittitas	5	5	6	FALSE	FALSE
Klickitat	3	4	4	FALSE	FALSE
Lewis	1	3	4	FALSE	FALSE
Lincoln	5	5	5	FALSE	FALSE
Mason	(32)	(31)	(30)	FALSE	FALSE
Okanogan	11	12	13	FALSE	FALSE
Pacific	14	15	15	FALSE	FALSE
Pend Oreille	3	4	4	FALSE	FALSE
Pierce	23	45	68	*TRUE*	*1*
San Juan	(6)	(6)	(6)	FALSE	FALSE
Skagit	(16)	(13)	(10)	FALSE	FALSE
Skamania	2	3	3	FALSE	FALSE
Snohomish	(166)	(146)	(124)	FALSE	FALSE
Spokane	(99)	(86)	(72)	FALSE	FALSE
Stevens	16	18	18	FALSE	FALSE
Thurston	3	9	16	FALSE	FALSE
Wahkiakum	0	1	1	FALSE	FALSE
Walla Walla	14	15	16	FALSE	FALSE
Whatcom	(112)	(108)	(103)	FALSE	FALSE
Whitman	14	15	16	FALSE	FALSE
Yakima	24	28	32	FALSE	FALSE

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**The numeric need methodology projects need for whole hospice agencies only - not partial hospice agencies. Therefore, the results

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290(7)(b) Agencies

Application & Release Year	2024
Supply year 1	2021
Supply year 3	2023
Statewide ALOS	59.79
Default Admits = 35 ADC	213.7

			Supply Years									
			2021			2022			2023			
Provider	County	Certificate Year	Survey	CN Yet?	# Used	Survey	CN Yet?	# Used	Survey	CN Yet?	# Used	Notes
Olympic Medical Center	Clallam	2019		213.7	213.7							Third year 2021
Providence Health & Services	Clark	2019	18	213.7	213.7							Third year 2021
Envision Hospice	King	2019	74	213.7	213.7							Third year 2021
Continuum Care of Snohomish	Snohomish	2019	342	213.7	342.0							Third year 2021
Envision Hospice	Snohomish	2019	1	213.7	213.7							Third year 2021
Glacier Peak Healthcare (Alpha)	Snohomish	2019	117	213.7	213.7							Third year 2021
Heart of Hospice	Snohomish	2019		213.7	213.7							Third year 2021
The Pennant Group (Puget Sound Hospice)	Thurston	2019	19	213.7	213.7							Third year 2021
Continuum Care of King	King	2020		213.7	213.7		213.7	213.7				Third year 2022
Envision Hospice	Kitsap	2020	61	213.7	213.7	120	213.7	213.7				Third year 2022
EmpRes Healthcare Group	Whatcom	2020	26	213.7	213.7	65	213.7	213.7				Third year 2022
The Pennant Group (Puget Sound Hospice)	Grays Harbor	2021	6	213.7	213.7	31	213.7	213.7	71	213.7	213.7	Third year 2023
EmpRes Healthcare Group	King	2021		213.7	213.7		213.7	213.7	20	213.7	213.7	Third year 2023
Seasons (AccentCare)	King	2021		213.7	213.7		213.7	213.7	20	213.7	213.7	Third year 2023
The Pennant Group (Puget Sound Hospice)	Mason	2021	0	213.7	213.7	100	213.7	213.7	16	213.7	213.7	Third year 2023
Envision Hospice	Pierce	2021	121	213.7	213.7	85	213.7	213.7		213.7	213.7	Third year 2023
Providence Health & Services	Pierce	2021	2	213.7	213.7	98	213.7	213.7	176	213.7	213.7	Third year 2023
EmpRes Healthcare Group	Snohomish	2021		213.7	213.7		213.7	213.7	13	213.7	213.7	Third year 2023
Seasons (AccentCare)	Snohomish	2021		213.7	213.7		213.7	213.7	8	213.7	213.7	Third year 2023
MultiCare Health	Thurston	2021		213.7	213.7		213.7	213.7		213.7	213.7	Third year 2023
Stride Health Care (Advanced Hospice North	Chelan	2022					213.7	213.7	29	213.7	213.7	Third year 2024
The Pennant Group (Puget Sound Hospice)	King	2022					213.7	213.7	7	213.7	213.7	Third year 2024
Y.B.G. Healthcare	King	2022					213.7	213.7	25	213.7	213.7	Third year 2024
Continuum Care of Snohomish	Pierce	2022				0	213.7	213.7	112	213.7	213.7	Third year 2024
Seasons (AccentCare)	Pierce	2022					213.7	213.7		213.7	213.7	Third year 2024
The Pennant Group (Puget Sound Hospice)	Pierce	2022					213.7	213.7	187	213.7	213.7	Third year 2024
Stride Health Care (Advanced Hospice North	Douglas	2023							1	213.7	213.7	Third year 2025
Wesley Homes Hospice	Pierce	2023	50		50.0	41		41.0	12	213.7	213.7	Third year 2025
Providence Health & Services	Spokane	2023							45	213.7	213.7	Third year 2025
Family Hospice Services	King	2024								213.7	213.7	Third year 2026, adjustment in 2023 as proxy
Shalom Hospice of Puget Sound	Kitsap	2024								213.7	213.7	Third year 2026, adjustment in 2023 as proxy
EmpRes Healthcare Group	Spokane	2024								213.7	213.7	Third year 2026, adjustment in 2023 as proxy
MultiCare Health	Spokane	2024								213.7	213.7	Third year 2026, adjustment in 2023 as proxy

Source
Self-Report Provider Utilization Surveys for Years 2021-2023
Prepared by DOH Program Staff

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Survey Data

Agency Name	License Number	County	Year	0-64	65+
Harbors Home Health & Hospice	IHS.FS.00000306	Grays Harbor	2021	2	2
Harbors Home Health & Hospice	IHS.FS.00000306	Grays Harbor	2022	40	172
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2023	31	166
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2021	0	6
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2022	0	31
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2023	4	67
Evergreen Health	IHS.FS.00000278	Island	2023	2	4
EvergreenHealth	IHS.FS.00000278	Island	2021	0	4
EvergreenHealth	IHS.FS.00000278	Island	2022	0	4
Hospice of the Northwest	IHS.FS.00000437	Island	2023	13	152
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2022	3	29
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2023	3	33
Providence Hospice Snohomish	IHS.FS.00000418	Island	2021	7	36
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2021	22	111
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2022	16	132
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2021	39	299
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2022	22	254
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2023	20	227
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2021	14	162
Jefferson Hospice	IHS.FS.00000349	Jefferson	2023	14	158
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Jefferson	2022	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2021	1	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2023	1	27
AccentCare	IHS.FS.61428561	King	2023	2	18
Caroline Kline Galland	IHS.FS.60103742	King	2022	39	472
Continuum Care of King LLC	IHS.FS.61058934	King	2021	0	0
Continuum Care of King LLC	IHS.FS.61058934	King	2023	21	692
Continuum Care of Snohomish	IHS.FS.61010090	King	2022	17	452
Continuum Care of Snohomish, LLC	IHS.FS.61010090	King	2021	9	309
Eden Hospice at King County, LLC	IHS.FS.61293991	King	2023	3	17
Envision Hospice of Washington, LLC	IHS.FS.60952486	King	2021	1	73
Envision Hospice of Washington, LLC	IHS.FS.60952486	King	2022	3	69
Evergreen Health	IHS.FS.00000278	King	2023	275	2399
EvergreenHealth	IHS.FS.00000278	King	2021	259	2082
EvergreenHealth	IHS.FS.00000278	King	2022	320	2379
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2021	31	387
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2022	30	405
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2023	21	278
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2021	42	281
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2023	51	331
Kline Galland Hospice	IHS.FS.60103742	King	2021	42	410
Kline Galland Hospice	IHS.FS.60103742	King	2023	37	486
Multicare Hospice	IHS.FS.60639376	King	2021	21	141
Multicare Hospice	IHS.FS.60639376	King	2022	23	100
MultiCare Hospice	IHS.FS.60639376	King	2023	22	159
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2021	1	116
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2022	1	67
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2023	67	1
Providence Hospice of Seattle	IHS.FS.00000336	King	2021	402	2664
Providence Hospice of Seattle	IHS.FS.00000336	King	2022	361	2215
Providence Hospice of Seattle	IHS.FS.00000336	King	2023	314	2141
Puget Sound Hospice	IHS.FS.61369722	King	2023	0	7
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2021	4	129
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2022	2	93
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2023	15	15
Y.B.G. Healthcare LLC DBA Heart and Soul Hospice	IHS.FS.61379202	King	2022	0	0
Y.B.G. Healthcare LLC DBA Heart and Soul Hospice	IHS.FS.61379202	King	2023	0	25
Envision Hospice of Washington, LLC	IHS.FS.60952486	Kitsap	2021	6	55
Envision Hospice of Washington, LLC	IHS.FS.60952486	Kitsap	2022	3	117
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2021	356	371
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2022	30	405
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2023	52	460
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2021	11	138
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2023	11	171
Multicare Hospice	IHS.FS.60639376	Kitsap	2021	16	140
Multicare Hospice	IHS.FS.60639376	Kitsap	2022	24	168
MultiCare Hospice	IHS.FS.60639376	Kitsap	2023	19	160
Kittitas Valley Healthcare Hospice	IHS.FS.00000320	Kittitas	2021	15	115
Kittitas Valley Healthcare Hospice	IHS.FS.00000320	Kittitas	2023	6	141
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2022	8	148
Inspiring Hospice Partners of Oregon, LLC (Heart of Hospice)	IHS.FS.60741443	Klickitat	2021	3	20
Inspiring Hospice Partners of Oregon, LLC (Heart of Hospice)	IHS.FS.60741443	Klickitat	2022	5	20

Source:
Self-Report Provider Utilization Surveys for Years 2021-2023
Prepared by DOH Program Staff

Department of Health
2024-2025 Initial Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Inspiring Hospice Partners of Oregon, LLC (Heart of Hospice)	IHS.FS.60741443	Klickitat	2023	0	0
Klickitat Valley Health - Hospice	IHS.FS.00000361	Klickitat	2021	3	28
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2022	5	44
Klickitat Valley Health Hospice	IHS.FS.00000361	Klickitat	2023	4	36
Providence Hospice	IHS.FS.60201476	Klickitat	2021	7	34
Providence Hospice	IHS.FS.60201476	Klickitat	2022	3	26
Providence Hospice	IHS.FS.60201476	Klickitat	2023	1	20
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Lewis	2022	21	247
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2021	19	221
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2023	18	320
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2021	19	200
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2022	31	155
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2023	21	131
Enhabit Hospice	IHS.FS.61165576	Lincoln	2021	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2021	1	2
Hospice of Spokane	IHS.FS.00000337	Lincoln	2022	0	1
Hospice of Spokane	IHS.FS.00000337	Lincoln	2023	0	2
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Lincoln	2022	1	16
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Lincoln	2023	8	31
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2021	4	10
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Mason	2022	5	53
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2021	12	47
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2023	9	73
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2021	25	300
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2022	23	176
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2023	25	198
Puget Sound Hospice	IHS.FS.61032138	Mason	2021	0	0
Puget Sound Hospice	IHS.FS.61032138	Mason	2022	0	100
Puget Sound Hospice	IHS.FS.61032138	Mason	2023	0	16
Enhabit Hospice	IHS.FS.61165576	Okanogan	2021	19	183
Enhabit Hospice	IHS.FS.61165576	Okanogan	2022	20	129
Enhabit Hospice	IHS.FS.61165576	Okanogan	2023	17	113
Harbors Home Health & Hospice	IHS.FS.00000306	Pacific	2021	2	2
Harbors Home Health & Hospice	IHS.FS.00000306	Pacific	2022	12	99
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2023	6	99
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2021	12	55
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2022	8	55
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2023	12	69
Continuum Care of Snohomish	IHS.FS.61010090	Pierce	2022	0	0
Continuum Care of Snohomish, LLC	IHS.FS.61010090	Pierce	2023	26	86
Envision Hospice of Washington, LLC	IHS.FS.60952486	Pierce	2021	8	113
Envision Hospice of Washington, LLC	IHS.FS.60952486	Pierce	2022	1	84
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2021	141	1081
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2022	136	2118
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2023	60	988
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2021	21	156
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2023	23	138
Multicare Hospice	IHS.FS.60639376	Pierce	2021	145	914
Multicare Hospice	IHS.FS.60639376	Pierce	2022	156	818
MultiCare Hospice	IHS.FS.60639376	Pierce	2023	176	1058
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2021	0	1
Providence Hospice of Seattle	IHS.FS.00000336	Pierce	2021	1	1

Source:
Self-Report Provider Utilization Surveys for Years 2021-2023
Prepared by DOH Program Staff

Department of Health

2024-2025 Initial Hospice Numeric Need Methodology

Final Death Data Released October 3, 2024

	0-64			65+		
County	2021	2022	2023	2021	2022	2023
ADAMS	23	25	30	92	91	84
ASOTIN	43	45	74	188	227	236
BENTON	536	566	414	1610	1739	1332
CHELAN	256	225	158	870	873	617
CLALLAM	185	179	190	906	935	1019
CLARK	1078	1002	1058	3705	3709	3399
COLUMBIA	11	12	15	43	37	40
COWLITZ	401	311	310	1100	989	1033
DOUGLAS	45	45	89	174	205	270
FERRY	21	22	26	63	60	105
FRANKLIN	110	79	179	261	234	364
GARFIELD	4	2	5	24	24	20
GRANT	208	190	243	523	533	616
GRAYS HARBOR	236	223	309	590	683	762
ISLAND	116	117	146	504	548	732
JEFFERSON	54	59	58	295	298	349
KING	4892	4902	4217	11896	12448	10961
KITSAP	489	462	556	1832	1895	1909
KITTITAS	88	78	76	241	261	317
KLICKITAT	50	50	58	164	130	175
LEWIS	186	191	248	723	753	811
LINCOLN	24	24	35	76	67	120
MASON	168	152	202	461	414	646
OKANOGAN	92	106	112	324	341	407
PACIFIC	59	69	72	239	235	295
PEND OREILLE	55	44	47	119	127	164
PIERCE	2574	2518	2320	6264	6412	5695
SAN JUAN	24	12	37	91	78	134
SKAGIT	334	258	282	1190	1215	1168
SKAMANIA	25	20	48	56	60	89
SNOHOMISH	1563	1468	1637	4478	4833	4660
SPOKANE	1842	1603	1340	4810	4603	3990
STEVENS	114	107	141	304	336	423
THURSTON	763	709	626	2285	2419	2175
WAHKIAKUM	7	9	8	25	24	54
WALLA WALLA	138	157	110	595	598	567
WHATCOM	443	467	475	1674	1653	1552
WHITMAN	59	65	63	278	233	237
YAKIMA	699	628	694	1644	1682	1603

Department of Health
2023-2024 Initial Hospice Numeric Need Methodology
0-64 Population Projection

County	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021-2023 Average Population
Adams	18,015	18,199	18,382	18,565	18,748	18,931	19,076	19,221	19,365	19,510	19,655	18,382
Asotin	16,822	16,706	16,591	16,475	16,360	16,244	16,150	16,056	15,962	15,868	15,774	16,591
Benton	174,308	175,851	177,393	178,935	180,477	182,019	183,656	185,293	186,929	188,566	190,203	177,393
Chelan	62,829	62,907	62,984	63,062	63,139	63,217	63,358	63,499	63,640	63,781	63,922	62,984
Clallam	52,094	52,247	52,399	52,552	52,704	52,857	53,039	53,221	53,402	53,584	53,766	52,399
Clark	420,628	424,857	429,086	433,316	437,545	441,774	445,732	449,690	453,649	457,607	461,565	429,086
Columbia	2,812	2,763	2,713	2,664	2,615	2,566	2,534	2,501	2,469	2,436	2,404	2,713
Cowlitz	87,848	87,937	88,027	88,116	88,206	88,295	88,438	88,581	88,725	88,868	89,011	88,027
Douglas	35,255	35,378	35,501	35,624	35,746	35,869	36,040	36,211	36,383	36,554	36,725	35,501
Ferry	5,208	5,127	5,047	4,967	4,886	4,806	4,794	4,781	4,769	4,756	4,744	5,047
Franklin	87,500	88,772	90,044	91,315	92,587	93,859	95,174	96,489	97,805	99,120	100,435	90,044
Garfield	1,570	1,570	1,570	1,569	1,569	1,569	1,565	1,561	1,558	1,554	1,550	1,570
Grant	85,007	85,596	86,185	86,774	87,363	87,952	88,582	89,212	89,841	90,471	91,101	86,185
Grays Harb	58,396	58,092	57,788	57,484	57,179	56,875	56,714	56,554	56,393	56,233	56,072	57,788
Island	63,633	63,840	64,048	64,256	64,464	64,672	64,972	65,273	65,573	65,874	66,174	64,048
Jefferson	20,345	20,269	20,192	20,116	20,040	19,964	20,079	20,195	20,310	20,426	20,541	20,192
King	1,964,992	1,974,586	1,984,180	1,993,774	2,003,368	2,012,962	2,022,512	2,032,062	2,041,611	2,051,161	2,060,711	1,984,180
Kitsap	222,540	222,587	222,634	222,681	222,729	222,776	223,024	223,273	223,521	223,770	224,018	222,634
Kittitas	38,168	38,539	38,910	39,282	39,653	40,024	40,367	40,709	41,052	41,394	41,737	38,910
Klickitat	17,332	17,217	17,103	16,988	16,874	16,759	16,746	16,733	16,721	16,708	16,695	17,103
Lewis	63,604	63,811	64,018	64,225	64,432	64,639	64,828	65,016	65,205	65,393	65,582	64,018
Lincoln	7,814	7,804	7,794	7,785	7,775	7,765	7,769	7,773	7,776	7,780	7,784	7,794
Mason	49,799	49,998	50,196	50,395	50,594	50,793	51,105	51,417	51,730	52,042	52,354	50,196
Okanogan	32,082	31,910	31,737	31,564	31,392	31,219	31,139	31,059	30,978	30,898	30,818	31,737
Pacific	15,581	15,523	15,464	15,405	15,346	15,287	15,287	15,287	15,286	15,286	15,286	15,464
Pend Oreil	9,718	9,660	9,602	9,543	9,485	9,427	9,408	9,388	9,369	9,349	9,330	9,602
Pierce	786,960	790,591	794,221	797,852	801,483	805,114	808,657	812,200	815,742	819,285	822,828	794,221
San Juan	11,697	11,682	11,668	11,654	11,640	11,626	11,711	11,796	11,882	11,967	12,052	11,668
Skagit	100,150	100,574	100,998	101,422	101,846	102,270	102,688	103,106	103,525	103,943	104,361	100,998
Skamania	9,366	9,243	9,121	8,998	8,875	8,752	8,728	8,704	8,680	8,656	8,632	9,121
Snohomish	708,361	712,731	717,100	721,470	725,839	730,209	734,203	738,197	742,192	746,186	750,180	717,100
Spokane	446,453	447,909	449,365	450,821	452,277	453,733	455,179	456,625	458,071	459,517	460,963	449,365
Stevens	36,029	35,790	35,550	35,311	35,071	34,832	34,983	35,134	35,285	35,436	35,587	35,550
Thurston	240,351	242,356	244,360	246,365	248,369	250,374	252,633	254,892	257,150	259,409	261,668	244,360
Wahkiakur	2,957	2,943	2,930	2,917	2,903	2,890	2,890	2,891	2,891	2,892	2,892	2,930
Walla Wall	50,358	50,364	50,370	50,376	50,382	50,388	50,438	50,488	50,537	50,587	50,637	50,370
Whatcom	184,193	185,493	186,794	188,095	189,395	190,696	192,079	193,462	194,844	196,227	197,610	186,794
Whitman	42,475	42,489	42,503	42,517	42,531	42,545	42,566	42,587	42,608	42,629	42,650	42,503
Yakima	219,274	219,628	219,982	220,336	220,690	221,044	221,446	221,848	222,251	222,653	223,055	219,982

Department of Health
2024-2025 Initial Hospice Numeric Need Methodology
Methodology By County

COUNTY: Pierce **Select from drop down menu*

Pierce County Only

Population information (OFM)

Ages	County	2020	2021	2022	2023	2024	2025	2026	2021-2023 Avgerage
0 - 64	Pierce	786,960	790,591	794,221	797,852	801,483	805,114	808,657	794,221
Ages	County	2020	2021	2022	2023	2024	2025	2026	2021-2023 Avgerage
65 +	Pierce	133,433	139,235	145,038	150,840	156,642	162,444	168,469	145,038

WAC 246-310-290(8)(a) Step 1:

		2021	2022	2023	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,883	3,331	3,399	3,538	20.44%
	Total deaths	18,015	17,201	16708	17,308	

		2021	2022	2023	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,885	28,503	26,755	27,714	54.75%
	Total deaths	50,717	52,002	49,130	50,616	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2021	2022	2023	2024	2025	2026	
Planning area historical resident deaths (OFM)	2		2,574	2,518	2,320				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	2,471							
Projected patient deaths: 20.44%	3	505							
Average population (OFM)	4	794,221							
Projected population	N/A		790,591	794,221	797,852	801,483	805,114	808,657	
Potential volume	N/A		503	505	507	510	512	514	

Ages 65+	Step	Result	2021	2022	2023	2024	2025	2026	
PA historical resident deaths (OFM)	2		6,264	6,412	5,695				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	6,124							
Projected patient deaths: 54.75%	3	3,353							
Average population (OFM)	4	145,038							
Projected population	N/A		139,235	145,038	150,840	156,642	162,444	168,469	
Potential volume	N/A		3,219	3,353	3,487	3,621	3,755	3,895	

All Ages	Step	Result	2021	2022	2023	2024	2025	2026	
Combined age cohorts	5		3,721	3,858	3,994	4,131	4,267	4,409	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	3,992							
Unmet need	5		(271)	(134)	2	139	275	417	
Unmet need patient days (statewide ALOS)	6	59.79	(16,186)	(8,028)	130	8,287	16,445	24,907	
Unmet Average Daily Census (ADC)	7		(44)	(22)	0	23	45	68	
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	1	1	

Exhibit 11 – Financial Assumptions

1	WA Revenue Rate								
2		Tacoma-Lakewood, WA Wage Inde	1.2513						
3		Tier 1 Fixed	76.37						
4		Tier 1 Variable	148.25						
5			**256.64**						
6		Tier 2 Fixed	60.15						
7		Tier 2 Variable	116.77						
8			**202.14**						
9									
10		CLALLAM, WA Wage Index	0.9364						
11		Tier 1 Fixed	76.37						
12		Tier 1 Variable	148.25						
13			**210.89**						
14		Tier 2 Fixed	60.15						
15		Tier 2 Variable	116.77						
16			**166.10**						
17									
18		Annual CMS Rate Inc	2.50%						
19									
20		Annual CMS Rate Inc	2.50%						
21					KSE				
22	WA Labor Avg Salaries (Monthly)				Labor Avg Salaries (Monthly)				
23		RN	$ 8,297			RN	$ 9,948		
24		Aide	$ 3,947			Aide	$ 5,200		
25		SW	$ 6,565			SW	$ 7,800		
26		Chaplain	$ 5,647			Chaplain	$ 5,720		
27		BC/VC	$ 4,759			BC/VC	$ 4,759		
28		Sales	$ 7,250			Sales	$ 7,833		
29		ED	$ 9,896			ED	$ 12,667		
30		PCM/PCC	$ 8,040			PCM/PCC	$ 11,458		
31		MRS/OC	$ -			MRS/OC	$ -		
32									
33		Annual Merit Increase	2.00%						
34									
35		Lease/Rent (Monthly)	$ 8,836						
36									
37		Inflation	3.00%						
38									
39									
40		Admit Growth	6.00%						
41		ADC Growth	5.75%						
42									
43									
44									
45	COR WA:								
46	Taxes/Benefits								
47		Payroll Taxes	9.03%						
48		Workers Comp/PLGL	2.20%						
49		Health Insurance	4.58%						
50		401K & Other	1.73%						
51	Total Other Benefits								
52									
53	Contract Services								
54		Medical Director	$7.64						
55		Transportation	$2.13						
56		OPS	$1.35						

LEASE AGREEMENT

THIS LEASE AGREEMENT (this "Lease") is entered into this _____ day of_____, 2024 (the "Effective Date"), by and between J2 INVESTMENTS ("Lessor"), and ODYSSEY HEALTHCARE OPERATING B, LP ("Lessee").

Recitals:

Lessor owns the Property (as defined below) and Lessee wishes to lease the Leased Premises in order to operate the administrative office of its hospice agency licensed in the State of Washington to provide hospice, and related services in Tacoma, WA (the "Office"). Lessor desires to lease the Leased Premises to Lessee pursuant to the terms and conditions of this Lease.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and other good and valuable consideration, it is agreed:

Agreement:

1. Lease of Premises. Lessor, in consideration of the covenants and agreements to be performed by Lessee, and upon the terms and conditions hereinafter stated, does hereby rent and lease unto Lessee certain premises comprised of approximately 4,062 rentable square feet of space, known as Suite 200 (the "Leased Premises") located at 1102 Broadway, Tacoma, WA 98402, commonly known as the Columbia Bank Building (the "Property"). In consideration of the Rent (as defined below) to be paid by Lessee to Lessor, and agreements set forth herein, Lessor hereby leases to Lessee the Leased Premises, together with all structures, facilities, and other improvements now or to be erected thereon by Lessor, rights of access, and easements thereto, including ingress and egress over and across the Property.

2. Term. The term of this Lease shall be for sixty-one (61) months (the "Initial Term"). The term shall commence on April 1, 2025 (the "Commencement Date"), and end on the last day of the sixty-first (61st) month of the Initial Term, unless sooner terminated in accordance with the terms of this Lease. Lessee shall have access to space fifteen (15) days prior to Commencement Date to install phone and data lines. After the commencement of the Initial Term, Lessor and Lessee shall execute a commencement letter to be provided by Lessee. Between the Effective Date and the Commencement Date, all of the provisions of this Lease shall be in full force and effect except for Lessee's obligation to pay Rent.

3. Rent.

a. Base Rent. Lessee shall pay to Lessor during the Initial Term, Base Rent (herein so called) in the amount of:

Period	Annual Base Rent	Base Rent per Month
Month 1 (RENT ABATED)	$0.00	$0.00
Month 2 – Month 13	$113,736.00	$9,478.00
Month 14 – Month 25	$117,148.08	$9,762.34
Month 26 – Month 37	$120,662.52	$10,055.21
Month 38 – Month 49	$124,282.44	$10,356.87
Month 50 – Month 61	$128,010.84	$10,667.57

Rent is due in advance on or before the fifth (5th) day of each calendar month during the Term. The Rent for any partial calendar months included in the Lease Term shall be prorated on a daily basis.

b. Additional Rent. Lessee shall pay to Lessor during the Initial Term as additional rent, Lessee's Proportionate Share (defined below) of Excess Operating Expenses (defined below) as set forth below. The Base Rent and additional rent are sometimes referred to herein as "Rent".

i. For the purposes of this Paragraph 4.b, the following terms are defined as follows:

1. "Base Year" means the calendar year ending December 31, 2025.

2. "Lessee's Proportionate Share" means a fraction, the numerator of which is the number of square feet within the Premises and the denominator of which is the number within the Building, as reasonably determined by Lessor. Lessee's Proportionate Share is 4.51%.

3. "Excess Operating Expenses" means the amount by which the Operating Expenses for the Project for any calendar year during the Term after the Base Year exceed the Operating Expenses incurred by Lessor during the Base Year.

4. "Project" means the Building, parking areas, drives, land, and other improvements appurtenant to the Building.

5. "Operating Expenses" means all reasonable costs, expenses, and obligations incurred or payable by Lessor in connection with the operation, management, repair or maintenance of the Project, including without limit an administrative supervision fee (but not a management fee) in an amount not to exceed four percent (4%) of the total Operating Expenses (excluding any insurance costs), utility costs incurred by Lessor (including electricity, gas, water, sewer, and other utility costs), insurance premiums for the insurance required to be carried by Lessor pursuant to this Lease, and real property taxes and assessments on the Project payable by Lessor as set forth in this Lease. There shall be excluded from Operating Expenses (i) the original capital costs of the Building and the original equipment serving the same, (ii) the capital costs of improvements, replacements, additions and alterations of the common areas and/or the capital costs for any expansion or remodeling of the Building, (iii) administrative charges except as permitted above, management fees, leasing commissions and professional fees and disbursements, (iv) expenses incurred due to the negligence or willful misconduct of Lessor or any occupant of the Building, their respective agents or employees, (v) expenses related to or reimbursable by an individual occupant of the Building or to a particular occupant's space, (vi) reserves for repairs or replacements, (vii) costs incurred for repairs or replacements due to faulty construction or workmanship or due to the utilization of improper equipment or materials, (viii) costs and interest thereon related to violations by Lessor or the Building or any occupant of the Building (other than Lessee) of any governmental law, rule, regulation or order (including, without limitation, all environmental laws and regulations), (ix) advertising and promotional expenditures, and seasonal decorations, (x) costs incurred for repairs or replacements necessitated by fire or other casualty, (xi) costs incurred

by Lessor in complying with its obligations under the Lease, (xii) principal and interest payments related to any financing of the Building, (xiii) costs incurred in connection with any environmental clean-up or remediation of Hazardous Materials (as defined herein) unless caused by the act or omission of Lessee, (xiv) any overhead or profit increments to any subsidiary or affiliate of Lessor for services on or to the Building, (xv) all costs and expenses associated with the operation of the business of the entity which constitutes Lessor as the same are distinguished from the costs of operation of the Building, and/or (xvi) any other cost or expense not specifically defined herein which, under generally acceptable accounting principles, would not be considered to be an operating expense of the Building or which is not reasonable and customary for similar class buildings in Port Angeles, WA.

ii. Prior to the commencement of each calendar year of the Term following the Base Year, Lessor shall provide Lessee with a written estimate of Lessee's Proportionate Share of Excess Operating Expenses, if any, for the Project for the ensuing year. Lessee shall pay such estimated amount to Lessor in equal monthly installments, in advance, on the first day of each month. Within sixty (60) days following each calendar year, Lessor shall present Lessee with an annual itemization of all Operating Expenses for such calendar year and the amount of the Excess Operating Expenses and shall, upon Lessee's written request, furnish to Lessee copies of any paid bills for said expenses. If Lessee's actual Proportionate Share of Excess Operating Expenses is less than the estimated payments for such year, Lessor shall refund the excess to Lessee simultaneously with Lessor's delivery of the annual statement. If Lessee's Proportionate Share of Excess Operating Expenses is greater than the estimated payments for such year, Lessee shall remit the balance due to the Lessor within thirty (30) days after receiving said statement. Notwithstanding the foregoing, Lessee shall have no obligation to remit any such balance if Lessee does not receive the annual itemization within one hundred twenty (120) days following the end of such year, or if Lessor does not furnish Lessee upon Lessee's request with copies of any paid bills evidencing Operating Expenses.

iii. With respect to any calendar year or partial calendar year in which the Building is not occupied to the extent of 100% of the rentable area thereof (including the Base Year), the Operating Expenses which fluctuate with occupancy for such period shall, for the purposes hereof, be increased to the amount which would have been incurred had the Building been occupied to the extent of 100% of the rentable area thereof.

iv. Lessee and its agents shall be entitled to examine, copy, and audit Lessor's books upon fifteen (15) days prior notice to Lessor given within two (2) years after the calendar year subject to the audit. Lessee may not refrain from payment pending receipt of any such audit results. If an audit reveals an overpayment by Lessee, the overpayment shall be promptly refunded to Lessee. If the audit shows that any statement rendered by Lessor is overstated by more than three percent (3%), Lessor shall pay Lessee, in addition to any overpayment, the costs of such audit. If any amount payable under this subparagraph 3.b.iv. is not paid by Lessor within thirty (30) days after receipt of an invoice, Lessee may offset such amount against Rent.

4. **Taxes.** Lessee shall be solely responsible for the payment of any taxes, fees, and assessments imposed or assessed upon Lessee's income, business operations, equipment, fixtures, and other personal property or assets.

5. **Possession and Use of the Leased Premises.** Lessee shall be entitled to possession on the Effective Date and shall yield possession back to Lessor at the time and date of the expiration or termination of this Lease. Lessee agrees during the Term of this Lease to use the Leased Premises solely for purposes of operating the Office. Lessee's use and occupancy of the Leased Premises shall at all times comply with applicable laws, ordinances, rules, and regulations of governmental authorities.

6. **Alterations.** Lessee shall make no alterations, additions, or improvements (collectively, "Alterations") to the Leased Premises without the prior written consent of Lessor, not to be unreasonably withheld, conditioned or delayed. All Alterations made by, for, or at the direction of Lessee shall, when made become the property of Lessor and shall remain upon and be surrendered with the Leased Premises at the expiration or termination of this Lease. Notwithstanding anything contained herein to the contrary, Lessee is permitted to install IT data infrastructure provided that same is reasonably consistent with the operation of the Office and does not materially negatively affect the structure of the Leased Premises, and Lessee shall have the right, but not the obligation, to remove same at the expiration or earlier termination of the Term.

7. **Utilities, Janitorial Expenses.** Lessor shall be responsible for all charges for water, sewer, garbage, gas, electricity, and other services and utilities used by Lessee on the Leased Premises during the Term of this Lease. Lessor shall provide janitorial services to the Leased Premises.

8. **Care and Maintenance of the Leased Premises.** Except as set forth below in this Section 8 or elsewhere, Lessor shall be responsible for making all necessary renovations, improvements, and repairs to the Leased Premises in order that Lessee may operate the Office at the Leased Premises. As a condition precedent to Lessor's obligations hereunder, Lessee shall provide notice to Lessor of any repairs that are necessary and shall allow Lessor and its representatives reasonable access, both during and outside of regular business hours, to the Leased Premises. All such renovations, repairs, and improvements that are or become affixed to the Leased Premises shall be the property of Lessor. Lessor shall keep the roof, structural parts of the floor, walls, and other structural parts of the Property, and the Leased Premises in good repair. Lessor shall maintain and make necessary repairs to the sanitary sewer system, plumbing, water pipes, and electrical wiring as well as the heating, ventilating, and air conditioning equipment. Lessee shall not knowingly permit or allow the Leased Premises to be damaged or depreciated in value by any act or negligence of Lessee, its agents, employees, invitees, or guests.

9. **Insurance.** Lessor shall maintain in effect at all times during the Term fire and extended coverage insurance insuring the Leased Premises in an amount equal to the full replacement value of the Leased Premises. Lessor shall have no obligation to insure any property or equipment of Lessee and Lessee shall procure and maintain at its expense throughout the Term a policy or policies of commercial property insurance, issued on an "all risks" basis, and insuring the full replacement cost of its furniture, equipment, supplies, and other property owned, leased, held, or possessed by it and contained in the Leased Premises. Lessee also shall procure and maintain at its expense throughout the Term a policy or policies of commercial general liability insurance, insuring Lessee against any and all liability for injury to or death of a person or persons and for damage to property occasioned by or arising out of the condition, use, or occupancy of the Leased Premises, or arising out of the activities of Lessee, its agents, contractors, employees, or guests in the Leased Premises. Lessee agrees to list Lessor as an additional insured under its commercial general liability policy. Lessor and Lessee each shall have included in all policies of property insurance respectively obtained by them a waiver by the insurer of all rights of subrogation against the other in connection with any loss or damage thereby insured against. To the full extent permitted by law, each of Lessor and Lessee

waives all right of recovery against the other for, and agrees to release the other from liability for, loss or damage to the extent that such loss or damage is covered by valid and collectible insurance in effect at the time of such loss or damage, and the proceeds of such insurance are actually collected.

10. Lessee's Default.

(a) The following events shall be deemed to be events of default by Lessee under this Lease: (i) Lessee shall fail to pay any installment of Rent or any other charge or assessment against Lessee pursuant to the terms hereof within five (5) days after the due date thereof and if said default shall continue for ten (10) days after written notice thereof shall have been given to Lessee by Lessor; (ii) Lessee shall fail to comply with any term, provision, covenant, or warranty made under this Lease by Lessee other than the payment of the Rent or any other charge or assessment payable by Lessee, and does not cure such failure within a reasonable time not to exceed thirty (30) days after written notice thereof to Lessee; (iii) Lessee or any guarantor of this Lease shall file a petition under any Section or Chapter of the federal Bankruptcy Code, as amended, or under similar law or statute of the United States or any state thereof, or there shall be filed against Lessee or any guarantor of this Lease a petition of bankruptcy or insolvency or a similar proceeding, or Lessee or any guarantor shall be adjudged bankrupt or insolvent in proceedings filed against Lessee or any such guarantor; or (iv) Lessee shall do or permit to be done anything which creates a lien upon the Leased Premises that is not released or bonded off within thirty (30) days after Lessee receives notice thereof.

(b) In the event of the occurrence of an Event of Default as defined in subsection 10(a), above, Lessor shall provide written notice to Lessee, and Lessee shall have thirty (30) days in which to cure the default; provided, however, in the event of default by non-payment, Lessee shall cure such default within ten (10) days of Lessor's notice of same. Upon Lessee's failure to cure, Lessor shall have the right, in its sole discretion, to pursue any remedy at law or in equity, including but not limited to one or more of the following: (i) terminate this Lease, in which event Lessee shall immediately surrender the Leased Premises to Lessor; (ii) terminate Lessee's right of possession without terminating this Lease, and retake and relet the Leased Premises; and/or (iii) accelerate and demand payment of all Rent and other charges due and payable, and such Rent and other charges which represent Lessor's reasonable determination of what would be due and payable over the remainder of the Term of this Lease. Notwithstanding the foregoing, if the nature of the default is such that it cannot be cured within said thirty (30) day period, Lessee shall not be in default hereunder if Lessee shall commence to cure such breach and thereafter rectify and cure such breach with due diligence.

11. Lessor's Default. If Lessor fails to perform any of Lessor's obligations under this Lease, Lessee gives Lessor written notice setting forth in reasonable detail the nature of the default, and such default continues for either (a) five (5) days after the giving of the notice in the case of a default that materially negatively affects Lessee's use and enjoyment of the Leased Premises, or (b) thirty (30) days after the giving of the notice in all other cases, Lessee, without thereby waiving the default, and in addition to any other right or remedy of Lessee, shall have the right (but shall not be obligated) to terminate this Lease upon providing written notice to Lessor. Notwithstanding the foregoing, if the nature of the default is such that it cannot be cured within said thirty (30) day period, Lessor shall not be in default hereunder if Lessor shall commence to cure such breach and thereafter rectify and cure such breach with due diligence.

12. Quiet Enjoyment. Lessor warrants that it has full right and authority to enter into this Lease and perform its obligations hereunder, and Lessor covenants that during the Term of this Lease Lessor shall not cause or suffer anything to be done which will impair Lessee's leasehold interest and rights hereunder. Lessor shall defend Lessee in the enjoyment and peaceful possession of the Leased Premises during the Term.

13. **Destruction.**

(a) Partial Destruction of the Leased Premises. If the Leased Premises shall be partially destroyed by fire, or other casualty, whereby the Leased Premises shall be rendered unusable only in part, Lessor shall cause the damage to be repaired, and this Lease shall remain in full force and effect.

(b) Total Destruction of the Leased Premises. If by reason of fire or other casualty the Leased Premises shall be rendered wholly unusable, or if the damage results from a cause not covered by fire and extended coverage insurance that Lessor is required to maintain pursuant to the terms of this Lease, Lessee shall have the option to terminate this Lease by providing Lessor with Notice thereof within thirty (30) days after the casualty, in which event this Lease shall cease as of the date of said damage or destruction.

14. **Hazardous Materials.** Lessee shall not bring onto the Leased Premises any Hazardous Materials (as defined below) except in compliance with all requirements of any constituted public authority and all federal, state, and local codes, statutes, ordinances, rules and regulations, and laws, whether now in force or hereafter adopted relating to Lessee's use of the Leased Premises, or relating to the storage, use, disposal, processing, distribution, shipping or sales of any hazardous, flammable, toxic, or dangerous materials, waste or substance, the presence of which is regulated by a federal, state, or local law, ruling, rule or regulation (hereafter collectively referred to as "Hazardous Materials"). Lessee covenants that it shall refrain from unlawfully disposing of or allowing the disposal of any Hazardous Materials upon, within, about or under the Leased Premises and Lessee shall remove all Hazardous Materials from the Leased Premises which were placed or stored there by Lessee, either after their use by Lessee or upon the expiration or earlier termination of this Lease, in compliance with all applicable laws.

15. **Lessor's Right of Entry.** Lessor and its agents, employees, and independent contractors shall have the right to enter the Leased Premises at reasonable hours to inspect and examine same, and to make repairs, additions, alterations, and improvements; provided, however, that Lessor shall, except in case of emergency, afford Lessee such prior notification of an entry into the Leased Premises as shall be reasonably practicable under the circumstances, but not less than 24 hours, and, to the extent possible, undertake not to disrupt Lessee's business on the Leased Premises during normal business hours. Notwithstanding anything to the contrary in this Lease, Lessor acknowledges that the information, records and data maintained within the Leased Premises are confidential. Accordingly, to the extent that Lessor or its employees and agents, through entry to the Leased Premises or otherwise, will need to gain access to such information, records or data, Lessor and its employees and agents shall execute a Business Associate Agreement with Lessee in a form meeting the requirements of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and the regulations issued in connection therewith (collectively, "HIPAA") in advance of obtaining such access and shall maintain the confidentiality of same in accordance with applicable law, including the HIPAA. Lessor's obligations under this Section 15 shall survive the expiration or earlier termination of this Lease.

16. **Surrender of Premises.** Upon the expiration or other termination of this Lease, Lessee shall quit and surrender to Lessor the Leased Premises, broom clean in the same condition as at the Effective Date, reasonable wear and tear, damages by casualty, and repairs and maintenance required to be made by Lessor under this Lease only excepted, and Lessee shall remove all of its personalty, equipment, and fixtures from the Leased Premises. Lessee's obligation to observe or perform this covenant shall survive the expiration or other termination of this Lease.

17. **Signs**. Lessor shall provide building directory and suite plaque signage to Tenant. All signage shall comply with all applicable local codes and ordinances.

18. **Notices.** Any notice required under this Agreement shall be in writing, and delivered by registered or certified mail to the other party at the business address listed below unless such party gives notice in writing to the other party of another address to which such notice shall be sent. Hand delivery to such address shall also suffice if signed for by a representative of the party receiving the notice.

If to Lessor to:

J2 Investments
_____
_____
Attn: _____
Phone: 253-238-0044
Email: hlaird@lee-associates.com

If to Lessee to:

Curo Health Services, LLC
c/o Gentiva
Real Estate Dept.
3350 Riverwood Pkwy., Suite 1400
Atlanta, GA 30339
678-449-0446
RealEstate@GentivaHS.com

19. **Assignment; Subletting.** Lessee shall not, without the prior consent of Lessor, which consent may be withheld in Lessor's sole discretion, assign this Lease or any interest herein in whole or in part, or sublet all or any portion of the Leased Premises, or mortgage, pledge, encumber, hypothecate, or otherwise transfer the Leased Premises or any part thereof, or permit the use of the Leased Premises by any party other than Lessee, its employees, and independent contractors engaged in the operation of the Office, provided, however, that Lessee may assign this Lease or sublet the Premises or a portion thereof to an affiliate of Lessee without Lessor's consent.

20. **Miscellaneous.** This Lease contains the entire agreement of the parties and no representations, inducements, promises, or agreements, oral or otherwise, between the parties not embodied herein shall be of any force or effect.

21. **Governing Law.** This Lease shall be governed by the laws of Washington.

22. **Relationship.** This Lease does not constitute an agreement of partnership or joint venture, and does not create a relationship of principal and agent. Neither party shall have the authority to act as agent of the other for any purpose. The parties are, and shall remain, independent actors responsible for all their respective obligations and responsibilities.

23. **Waiver.** No waiver of any of the provisions of this Lease or of any breach or violation of any provision of this Lease shall be valid unless in writing and signed by the party against whom such waiver is asserted. The waiver by any party of a breach or violation of any provision of this Lease shall not operate or be construed to be a waiver of any subsequent breach hereof.

24. **Parking**. Lessor represents, warrants, and covenants that at all times during the Term, it will provide parking to Lessee adequate (at least 4 parking permits per 1,000 per rentable square feet and parking options for) to comply with all applicable zoning requirements, located either directly adjacent to Property or otherwise in reasonable proximity thereto, for Lessee and Lessee's agents and employees. Parking charges are $135.00 per permit per month.

25. **Holding Over**. If Lessee should remain in possession of the Leased Premises after the expiration of the Term, without the execution by Lessor and Lessee of a new lease or an extension of this Lease, then Lessee shall be deemed to be holding over the Premises on a month-to-month basis and shall remain subject to all of the covenants and obligations of the Lease, and Lessee shall to pay 150% the then-current monthly rate. To the extent that Lessee holds over for a period of time that is shorter than one month, the rent shall be prorated according to the number of days held over.

26. **Renewal**. Lessee shall have the option to renew this Lease for two (2) renewal terms of three (3) years each (each a "Renewal Term"). Lessee shall provide Lessor with written notice of its intent to renew this Lease at least ninety (90) days prior to the expiration of the Initial Term or the applicable Renewal Term then in effect. Otherwise, Lessee shall forfeit its right to renew this Lease and this Lease shall terminate at the conclusion of the Initial Term or the applicable Renewal Term then in effect, unless otherwise agreed to by Lessor in writing. Any renewal of this Lease shall be upon the same terms and conditions as are set forth herein. The Initial Term, together with any Renewal Terms shall be referred to herein as the "Term". Base Rent during the first year of any Renewal Term shall be the then fair market value rate as agreed to by both parties hereto with three percent (3%) annual escalations thereafter. The Base Year during any Renewal Term shall be the first full calendar year of said Renewal Term.

27. **Brokers**. Lessor and Lessee represent and warrant to the other that they have dealt only with Wright Realty and Swearingen Realty Group, LLC and its affiliates ("Broker") in connection with this Lease and that, insofar as they know, no other broker negotiated or is entitled to any commission in connection with this Lease. Lessor will indemnify and defend Lessee from and against all claims (and costs of defending against and investigating such claims) of any broker or similar parties, including Broker, claiming under Lessor in connection with this Lease.

28. **Property Tax**. Lessor shall pay, prior to delinquency, all general real estate taxes and installments of special assessments coming due during the Term on the Property of which the Leased Premises are a part, and all personal property taxes with respect to Lessor's personal property, if any, on the Leased Premises. Lessee shall be responsible for taxes or assessments with regard to Lessee's personal property, if any, on the Leased Premises.

29. **Indemnification**. Lessee shall indemnify Lessor against any expenses, loss, cost, damage, claim, action or liability paid, suffered or incurred as a result of any breach by Lessee, Lessee's agents, servants, employees, visitors or licensees of any covenant or condition of this Lease, or as a result of activities occurring within the Leased Premises, unless caused by the gross negligence or willful misconduct of Lessor, its agents, servants, employees, customers, visitors or licensees.

Lessor shall indemnify Lessee against any expenses, loss, cost, damage, claim, action, or liability paid, suffered or incurred as a result of any breach by Lessor, Lessor's agents, servants, employees, customers, visitors or licensees of any representation, warranty, covenant or condition of this Lease or as a result of activities occurring in the Property or the common areas, unless caused by the gross negligence or willful misconduct of Lessee, its agents, servants, employees, customers, visitors or licensees.

30. **Common Area Maintenance**. Lessor shall be responsible for expenses incurred in connection with maintenance of the common areas of the Property. Such expenses shall include water

supplied to the Property, cleaning services, waste collection services, sewer, burglar alarm and monitoring services, lawn services, elevator services and other supplies or services which Lessee receives the benefit of.

31. **Waiver of Lessor's Lien**. Notwithstanding anything to the contrary contained in this Lease, Lessor shall have no lien (whether contractual, statutory, or otherwise) on, or security interest in, any of Lessee's personal property (including furniture, trade fixtures, and equipment) located in, on or about the Leased Premises or the Property, and Lessor hereby expressly waives and releases any such lien or security interest it may have in any of Lessee's property.

32. **Exclusive Use Covenant**. During the Term of this Lease, Lessor covenants and agrees not to directly or indirectly lease, rent, occupy, or allow to be occupied, any part of the Building other than the Premises for the purpose of conducting either: i) a hospice home care business, or ii) a personal home care business, substantially the same as or that competes with the services provided by the Lessee, without the written consent of Lessee, nor will Lessor permit any tenant or occupant of the Building to sublet in any manner, directly or indirectly, any part thereof to anyone engaged in any such business, without prior written consent of Lessee.

If Lessor breaches the foregoing covenant, Lessee shall notify Lessor in writing of such breach and after giving Lessor a thirty (30) day notice and cure right, Lessee may (1) terminate this Lease without penalty, and upon such termination, Lessor shall immediately repay to Lessee the unamortized portion of the actual hard and soft costs incurred by Lessee in connection with the completion of its leasehold improvement work within the Premises, (2) abate Base Rent by fifty percent (50%) during the period of time Lessor fails to take reasonable action to enforce the provisions of this section, or (3) seek injunctive relief to enforce this covenant.

33. **Confidentiality of Medical Records**. Inasmuch as the nature and practice of Lessee's business involves the use and maintenance of private and confidential medical records and other individually-identifiable health information, Lessor hereby covenants, warrants, and agrees that neither Lessor, its employees, agents, contractors, invited guests, or assigns shall view, inspect, observe, read, examine, document, copy, disseminate, distribute, or otherwise disclose confidential medical records and/or other individually-identifiable health care information that may be located, stored, or otherwise maintained at or on the Premises, regardless of the nature, source, or storage medium of said confidential information. Lessor shall notify Lessee of any entry into the Premises made by Lessor and/or its employees, agents, contractors, invited guests, or assigns. In the event that Lessor and/or its employees, agents, contractors, invited guests, or assigns enters the Premises, Lessor covenants, warrants, and agrees that said party shall at all times maintain the confidentiality of any and all medical records and/or other individually-identifiable health care information to which said party may have access, and Lessor shall ensure that any and all persons entering the Premises at its request or acquiescence, by its authority, or on its behalf shall strictly abide by the terms of this section. Lessor further agrees to immediately notify Lessee of any violation of this section or other compromise of private and confidential medical records and/or other individually-identifiable health information belonging to Lessee of which Lessor becomes aware. Lessor also agrees to execute any additional confidentiality agreement(s) subsequently requested by Lessee as required by the federal government under the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).

34. **Books and Records**. The parties intend this Lease to comply with Section 1861(v)(1)(I) of the Social Security Act (Section 952 of the Omnibus Reconciliation Act of 1980) and the regulations promulgated at 42 C.F.R. Part 420 in implementation thereof, and to the extent necessary, the parties agree to make available to the Comptroller General of the United States ("Comptroller General"), the Secretary of the Department of Health and Human Services ("Secretary") and their duly authorized representatives, for four (4) years after the latest furnishing of services pursuant to this Lease, access to the books, documents and

records and such other information as may be required by the Comptroller General or Secretary to verify the nature and extent of the costs of services provided by each party, respectively. If either party, upon the approval of the other party, carries out the duties of this Lease through a subcontract worth $10,000.00 or more over a twelve (12) month period with a related organization, then the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General and their representatives to the related organization's books and records. For the avoidance of doubt, "related organization" means an organization related to the party entering into the subcontract in question by control or common ownership, as defined in the regulations referenced above.

35. **Lessor Ownership**. Lessor represents and warrants that there is (a) no physician ownership or any "immediate family member" (as defined by Stark) of a physician in the Lessor entity, (b) no ownership in the Lessor entity by any person or entity that makes referrals to Lesseee or any affiliate thereof which may be reimbursable under any federal health care program, and (c) no referrals or other business are being generated between the parties which may be reimbursable under any federal health care program. If any of the representations and warranties in the foregoing sentence cease to be true, Lessor agrees to: (1) immediately notify Lesseee of such change or condition; (2) renegotiate, in good faith, such sections of this Lease as minimally necessary to comply with federal legal and regulatory standards; and (3) indemnify, defend, and hold harmless Lesseee from and against any loss, cost, or damage (including attorney's fees) incurred on account of the foregoing representations and warranties not being true and accurate.

36. **Healthcare Compliance**.

(a) Nothing in this agreement, whether written or oral, nor any consideration in connection herewith, shall require either party to refer any patients to the other, or to any affiliate or subsidiary of the other. This agreement is not intended to influence the judgment of any person in choosing the provider appropriate for the proper treatment and care of the patient. No party to this agreement shall receive any compensation or remuneration for arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicare or Medicaid, or which otherwise may be deemed to violate any federal or state law.

(b) The parties agree that this Lease is intended to comply with all state and federal laws, regulations, and policies including, but not limited to the Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) and the regulations promulgated thereunder, and the Ethics in Patient Referrals Act (42 U.S.C. Section 1395nn) (also known as "Stark") and the regulations promulgated thereunder (collectively, the "Health Care Laws"). If any provision of this Lease is believed by either party in good faith to be materially in violation of the Health Care Laws, the parties shall attempt in good faith to amend this Lease, if possible, to conform to the Health Care Laws. If the parties are unable to agree on any such amendment, or if it is not possible to amend the Lease to comply with the Health Care Laws, then either party may terminate this Lease upon thirty (30) days prior written notice. Further, the parties agree that rent set forth in the Lease reflects the fair market value for the space and furnishings provided. No charges or payments made or given hereunder shall reflect any fluctuation in Premises utilization, nor the volume or value of referrals (if any) to any physicians accessing the Premises hereunder.

37. **Exclusion From Federal Health Care Programs**. Each party represents and warrants that it, and any individual or entity with a direct or indirect ownership interest in such party (such as, without limitation, stock membership interest, partnership interests, limited partnership interests, or voting rights) ("Ownership Group"), neither has been nor is about to be excluded, to the best of its knowledge, from participation in any Federal Healthcare Program (defined below). Each party agrees to notify the other party within one (1) business day of its receipt of a notice of intent to exclude or actual notice of exclusion of the party or its Ownership Group from any such program. Each party further agrees to disclose immediately any

proposed or actual debarment, exclusion or other event that makes the party or its Ownership Group ineligible to participate in Federal Healthcare Programs or Federal procurement or non-procurement programs. In the event that any party or its Ownership Group is excluded from any Federal Healthcare Program, either party may elect to terminate this Lease at any time thereafter upon the delivery of notice to the other party and this lease shall immediately terminate. For the purposes of this section, the term "Federal Healthcare Program" means the Medicare program, the Medicaid program, the Maternal and Child Health Services Block Grant program, the Block Grants for State for Social Services program, any State Children's Health Insurance program, or any similar program.

38. **Security Deposit**. Security Deposit. Within Ten (10) days of receipt of the fully executed Lease and Lessor's W-9, Lessee shall provide a "Security Deposit" in the amount of $9,478.00 to Lessor conditioned on the Lessee's performance of the terms and conditions of this Lease. The Security Deposit shall be returned to Lessee at the termination or upon expiration of this Lease, provided the Premises is left in good order and condition, ordinary wear and tear, damages by casualty, and Lessor's obligations hereunder excepted.

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IN WITNESS WHEREOF, the parties have executed and delivered this Lease as of the day and year first above written.

LESSOR:

J2 INVESTMENTS

By:_____

Name:_____

Title:_____

LESSEE:

ODYSSEY HEALTHCARE OPERATING B, LP

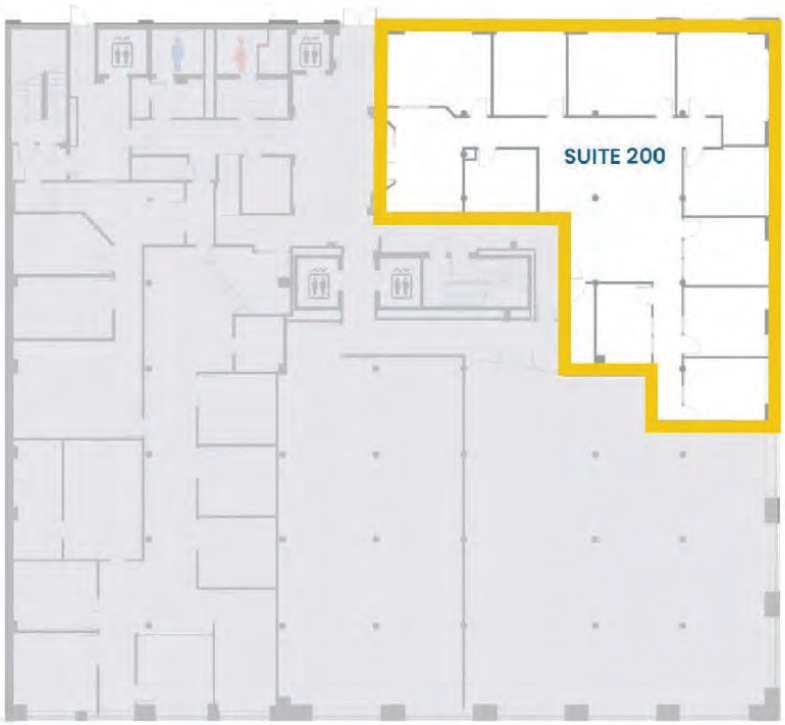
By:_____

Name:_____

Title:_____

EXHIBIT A

FLOOR PLAN



SWEARINGEN REALTY GROUP | EST 1972

5950 Berkshire Lane, Suite 500
Dallas, TX 75225
Tel 214.365.2700
Fax 214.365.2799

January 24, 2025

Harrison Larid
Lee & Associates
Via Email: hlaird@lee-associates.com

RE: Letter of Intent ("LOI")
Gentiva
Tacoma, WA – 1102 Broadway, Suite 200, Tacoma, WA 98402

Dear Harrison:

Pursuant to our recent discussions, Odyssey HealthCare Operating B, LP (Tenant) is prepared to enter into further lease negotiations with J2 Investments (Landlord) for office space, subject to Landlord's acceptance of the major building terms set forth herein. The terms and conditions are subject to Tenant's senior management approval and a mutually acceptable lease agreement.

IF LANDLORD IS, OR COULD BE, A POTENTIAL REFERRAL SOURCE AS DEFINED BELOW, PLEASE STOP AND CALL TENANT'S AGENT IMMEDIATELY.
Landlord hereby covenants, warrants, and agrees that neither Landlord (if he/she is an individual or group of individuals) nor any person with an ownership interest in Landlord is a Physician (defined below), a member of a Physician's office staff, or an Immediate Family Member (defined below) of a Physician. "Physician" means (1) any person licensed to practice medicine (2) an Osteopathic physician; (3) a Chiropractic physician; and (4) a Podiatric physician. "Immediate Family Member" means a husband or wife; a birth or adoptive parent, child or sibling; a stepparent, stepchild, stepbrother, or stepsister; a father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; a grandparent or grandchild; or a spouse of a grandparent or grandchild.

Building Information:	Please provide the following information about your building: a. Building Name and Address: Columbia Bank Building 1102 Broadway Tacoma, WA 98402 b. Owner/Landlord Name and Contact Information: (Please include type of entity) J2 Investments (Contact Name: Harrison Laird) Phone: 253-238-0044 Email: hlaird@lee-associates.com

	c. Leasing Agent Name and Contact Information Harrison Laird Email: hlaird@lee-associates.com Phone: 206-947-1594 The building consists of approximately 90,000 RSF on five (5) floors.
Tenant:	*Odyssey Healthcare Operating B, LP ("GENTIVA" or "Tenant")*
Premises:	Approximately 4,062 SF in Suite 200.
Permitted Use:	General office use.
Lease Agreement:	The lease shall be documented on a GENTIVA form of lease agreement. GENTIVA's Legal Department will draft a customized document based on the business points agreed to in this LOI.
Questionnaire:	Landlord confirms ownership has completed and signed the Questionnaire attached in Exhibit B.
Commencement Date:	April 1, 2025 - Subject to delivery and possession of a Certificate of Occupancy and substantial completion of construction. *Existing tenant is willing to relocate but has a lease in place which expires 7/31/25. A lease commencement date of 4/1/25 is acceptable to Landlord but subject to the existing tenant and Landlord entering into a mutually acceptable early lease termination.*
Lease Term:	Sixty-One (61) months
Rental Abatement:	One (1) month
Base Rent:	Months 00 – 01: Abated. Months 02 – 13: $28.00 PSF or $9,478.00 per month Months 14 – 25: $28.84 PSF or $9,762.34 per month Months 26 – 37: $29.71 PSF or $10,055.21 per month Months 38 – 49: $30.60 PSF or $10,356.87 per month Months 50 – 61: $31.51 PSF or $10,667.57 per month
Operating Expenses:	Base Year 2025 for actual operating expenses, adjusted for a 100% occupied building and fully assessed for tax purposes.

Maintenance:	Landlord shall be responsible for maintaining the structure of the building, HVAC systems, electrical and plumbing systems, parking lots and landscaping.
Early Access:	Tenant shall be able to access the Premises fifteen (15) days prior to the Commencement Date for the purposes of installing furniture, fixtures, and equipment.
Renewals:	GENTIVA will require two 3-year renewal options at FMV. Base Rent to increase by 3% annually.
Sublease / Assignment:	Tenant reserves the right to sublet or assign the Premises, in whole or in part, without the Landlord's consent for affiliates, subsidiaries or any entity owned and controlled by the parent corporation. Also, Tenant shall have the right to sublet or assign its lease to others with the Landlord's consent to not be unreasonably withheld or delayed.
Security Deposit:	One (1) month deposit.
Parking:	Landlord will provide up to 4 parking permits per 1,000 RSF at market rates, which are currently $135/permit/month. Flexible options are available for weekly meetings.
Tenant Improvements:	As-Is.
Space Plans:	A drawing of the final space plan shall be attached to and become an exhibit to the final lease document.
Building Signage:	Landlord to provide building directory and suite plaque signage
Holdover:	With Landlord's prior written consent, Tenant shall have the right to extend the lease after lease expiration on a month-to-month basis at 150% of the rent paid during the last month of the lease term.
Other Utilities and Janitorial Services	Utilities and Janitorial are included in Base Rent.
Code and ADA Compliance:	Landlord shall comply with all necessary building codes, including those pertaining to ADA handicapped-accessibility laws and that the Premises comply with all such codes and all other applicable laws prior to Tenant's occupancy.
Indemnity by Landlord:	Landlord agrees to indemnify and defend Tenant from and against any and all claims, actions, damages, liability, and expense (including, but not limited to, court costs, costs of investigation, and reasonable attorneys' fees) in connection

	with loss of life, bodily injury, and/or damage to property of Tenant or any other person arising from or out of Landlord's use or occupancy of the Premises or any other part of the Project, occasioned wholly or partially by act or omission of Landlord, its officers, partners, agent, employees, contractors, or invitees, including, but not limited to, any failure by Landlord to perform any of its obligations under this Lease or the existence of any Hazardous Substances on the Project as of the Commencement Date.
Brokerage Agreement:	None.
Confidentiality	The information in this LOI is intended only for the use of the individual or entity to which it is addressed and contains information that is privileged, confidential and/or exempt from disclosure under applicable law.

SIGNATURE PAGE FOLLOWS

This letter does not constitute an agreement between the parties, but merely sets forth the general terms under which Tenant agrees to enter further negotiations and is contingent upon Tenant's review of a draft lease agreement and a definitive written agreement signed by the parties.

If the terms and conditions are acceptable, please indicate by signing below and returning this letter to me via email dbrown@swearingen.com.

Sincerely,

Dan Brown
Vice President
Swearingen Realty Group, L.L.C.
5950 Berkshire Lane, Suite 500
Dallas, TX 75225
Phone: 214-433-7025
www.swearingen.com

SWEARINGEN 50
REALTY GROUP | EST 1972

Accepted by Landlord

1/23/25

Signature Date

Accepted by Tenant

Steve Collins 1/24/25

Signature Date

EXHIBIT A – FLOOR PLAN

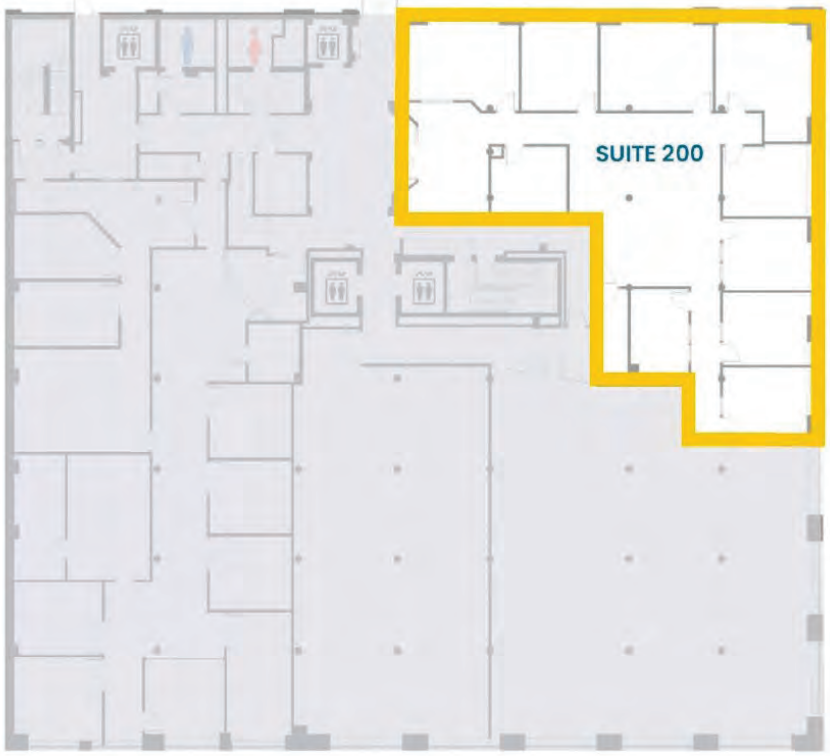


EXHIBIT B - Compliance Questionnaire

LEASE COMPLIANCE QUESTIONNAIRE

Any proposed leasing arrangement between Gentiva Health Services, Inc., including any of its affiliates ("Gentiva"), and any referral source or potential referral source must comply with the Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) and the Ethics in Patient Referrals Act (42 U.S.C. Section 1395nn) (also known as the "Stark" law), as well as the regulations promulgated under each statute. **To ensure that Gentiva is taking the appropriate steps to identify leasing arrangements with referral sources or potential referral sources, all landlords doing business with Gentiva must answer all of the questions below and submit the completed form to Gentiva.**

QUESTION	YES	NO	COMMENTS (if any)
Is Landlord a Physician?			Physician includes any of the following: 1. Person licensed to practice medicine; 2. Osteopathic physician; 3. Chiropractic physician; and/or 4. Podiatric physician
Is Landlord an Immediate Family Member of a Physician?			Immediate Family Member includes any of the following: 1. Husband or wife; 2. Birth or adoptive parent, child or sibling; 3. Stepparent, stepchild, stepbrother, or stepsister; 4. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; 5. Grandparent or grandchild; or 6. Spouse of a grandparent or grandchild
If Landlord is an Entity, does a Physician have an ownership interest in Landlord?			Entity includes any of the following: 1. Association 2. Sole proprietorship; 3. Corporation; 4. Limited liability company; 5. Partnership; 6. Joint venture; 7. Trust; or 8. Unincorporated organization
If Landlord is an Entity, does any Immediate Family Member of a Physician have an ownership interest in Landlord?			
Is Landlord in a position to make or receive referrals for health care services that are reimbursed by a Federal Health Care Program?			Federal Health Care Programs include any program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including Medicare, Medicaid and Tricare.
If Landlord is an Entity, is any Owner of the Entity in a position to make or receive referrals for health care services that are reimbursed by a Federal Health Care Program?			Owner includes any of the following: 1. Proprietor; 2. Member; 3. Shareholder; 4. Partner; or 5. Trustee

The undersigned hereby represents and warrants that the information above is true and accurate to the best of his or her knowledge.

[_____]
Enter the legal name of the landlord entity

By: _____

Printed: _____

Title: _____

gentiva

Exhibit 13a – P&L
Pierce County

	Tacoma (Pierce)				
		Projected			
		2025	2026	2027	2028
	Revenue				
	Medicare (Including Managed Care)	-	441,620	3,107,173	4,270,193
	Medicaid (Including Managed Care)	-	250	1,763	2,378
	Private pay	-	-	-	-
	Other (tri-Care, VA, LNI)	-	(2,625)	(18,544)	(25,003)
	Provide Detail	-	-	-	-
	Non-operating Revenue	-	-	-	-
	Deductions from revenue:	-	-	-	-
	Charity	-	-	-	-
	Provision for Bad Debt	-	-	-	-
	Contractural Allowances	-	(4,832)	(33,994)	(46,723)
				-	-
	Total Income	**-**	**434,413**	**3,056,399**	**4,200,845**
	Expenses				
	Advertising	1,700	21,579	22,608	23,170
	Allocated Costs	-	-	-	-
	B&O Taxes	-	-	-	-
	Depreciation and Amortization	1,200	14,400	14,400	14,400
	Dues and Subscriptions	-	-	-	-
	Education and Training	-	-	-	-
	Equipemnt Rental	-	-	-	-
	Information and Technology/Computers	1,500	18,090	18,633	19,096
	Insurance	1,336	36,287	63,096	76,161
	Interest	-	-	-	-
	Legal and Professional	-	-	-	-
	Licenses and Fees	-	-	-	-
	Medical Supplies	-	22,734	163,934	226,141
	Payroll Taxes	2,233	53,841	89,634	107,137
	Postage	-	-	-	-
	Purchased Services (Utilities/other)	215	2,593	2,671	2,737
	Rental/Lease	9,478	114,020	117,730	120,660
	Repairs and Maintenance	150	1,809	1,863	1,910
	Salaries and Wages	25,185	601,691	998,018	1,191,886
	Supplies	100	1,200	1,200	1,200
	Telephone	75	1,725	1,807	1,833
	Travel	-	6,849	31,951	42,075
	Other (detail what is included)	622	29,900	141,284	187,007
	Total Expenses	43,795	926,718	1,668,779	2,015,415
	Net Income	(43,795)	(492,305)	1,387,620	2,185,430

Additional Notes, Assumptions:

Line 31 DME $5.56 per patient day "PPD"; Medical Supplies $2.48 PPD; Pharmacy $4.35 PPD
Line 41 Other (detail) Contracted Services, Employee Benefits, Marketing Materials, COVID Expenses and Restructuring - Goodwill impairment. Note: Fiscal year is November 1 to October 31, therefore rental expense of $9,478 is for October 2025.

Exhibit 13b – P&L

P&L Gentiva King + Pierce

	KSE + Pierce							
		Historical			Projected			
		2022	2023	2024	2025	2026	2027	2028
	Revenue							
	Medicare (including Managed Care)	1,248,872	1,584,910	2,191,329	2,683,123	3,359,996	6,275,076	7,698,276
	Medicaid (including Managed Care)	-	18,959	19,561	1,948	2,320	3,956	4,693
	Private pay	10,140	5,534	910	-	-	-	-
	Other (tri-Care, VA, LNI)	10	-	(5,329)	(15,971)	(19,898)	(36,518)	(43,979)
	Provide Detail	-	-	-	-	-	-	-
	Non-operating Revenue	-	-	-	-	-	-	-
	Deductions from revenue:	-	-	-	-	-	-	-
	Charity	-	-	-	-	-	-	-
	Provision for Bad Debt	-	-	-	-	-	-	-
	Contractural Allowances	(10,454)	(65,044)	(29,379)	(19,711)	(26,137)	(56,558)	(70,545)
							-	-
	Total Income	**1,248,568**	**1,554,358**	**2,177,092**	**2,649,389**	**3,316,586**	**6,185,956**	**7,588,444**
	Expenses							
	Advertising	88	10,662	-	1,700	21,579	22,608	23,170
	Allocated Costs	-	-	-	-	-	-	-
	B&O Taxes	-	-	-	-	-	-	-
	Depreciation and Amortization	7,907	7,237	7,217	7,769	17,989	17,989	17,989
	Dues and Subscriptions	3,970	4,858	5,719	6,374	6,582	6,847	7,264
	Education and Training	6,230	5,098	6,626	7,907	8,155	8,494	9,011
	Equipment Rental	-	-	-	-	-	-	-
	Information and Technology/Computers	13,020	15,706	14,305	15,385	32,392	33,364	34,269
	Insurance	81,413	71,974	85,637	111,106	129,915	160,285	178,562
	Interest	13,455	17,136	26,129	30,556	30,556	30,556	30,556
	Legal and Professional	-	-	-	-	-	-	-
	Licenses and Fees	97,745	46,866	14,354	4,032	364	379	402
	Medical Supplies	87,970	92,779	124,947	138,443	167,169	316,896	387,629
	Payroll Taxes	102,847	101,574	115,943	145,896	196,174	237,225	262,765
	Postage	4,432	367	2,203	2,037	2,160	2,247	2,384
	Purchased Services (Utilities/other)	6,567	8,116	3,441	7,353	9,969	10,344	10,878
	Rental/Lease	89,002	108,070	107,070	118,331	227,165	230,875	233,805
	Repairs and Maintenance	8,254	4,723	2,515	5,452	7,335	7,555	7,772
	Salaries and Wages	1,102,563	1,120,275	1,342,667	1,658,496	2,243,261	2,699,450	2,986,575
	Supplies	5,648	7,564	5,893	10,050	12,248	12,693	13,393
	Telephone	11,686	13,391	12,008	12,895	14,930	15,408	15,842
	Travel	67,682	94,724	85,528	106,628	113,548	142,678	156,901
	Other (detail what is included)	2,094,259	201,923	114,542	103,405	165,041	282,940	339,274
	Total Expenses	3,804,439	1,933,042	2,076,745	2,495,816	3,406,542	4,238,834	4,718,443
	Net Income	(2,555,871)	(378,683)	100,347	153,574	(89,962)	1,947,122	2,870,001

Additional Notes, Assumptions:

Line 31 Medical Supplies, DME $5.56 PPD; Medical Supplies $2.48 PPD; Pharmacy $4.35 PPD

Line 41 Other (detail) Contracted Services, Employee Benefits, Marketing Materials, COVID Expenses and Restructuring - Goodwill impairment

Exhibit 13c – P&L

P&L Gentiva King + Pierce + Clallam

(Note: This P&L is provided per the instructions for the filing of an application for an additional county, Clallam County, which has shown a need based upon the DOH Needs Assessment.)

KSE + Pierce + Clallam	Historical			Projected			
	2022	2023	2024	2025	2026	2027	2028
Revenue							
Medicare (Including Managed Care)	1,248,872	1,584,910	2,191,329	2,683,123	3,679,753	8,301,999	10,154,547
Medicaid (Including Managed Care)	-	18,959	18,561	1,948	2,540	5,357	6,357
Private pay	10,140	5,534	910	-	-	-	-
Other (tri-Care, VA, LNI)	10	-	(5,329)	(15,971)	(21,911)	(51,249)	(61,481)
Provide Detail	-	-	-	-	-	-	-
Non-operating Revenue	-	-	-	-	-	-	-
Deductions from revenue:	-	-	-	-	-	-	-
Charity	-	-	-	-	-	-	-
Provision for Bad Debt	-	-	-	-	-	-	-
Contractural Allowances	(10,454)	(55,044)	(29,379)	(19,711)	(29,632)	(78,707)	(97,389)
						-	-
Total Income	**1,248,568**	**1,554,358**	**2,177,092**	**2,649,389**	**3,630,751**	**8,177,399**	**10,002,033**
Expenses							
Advertising	88	10,662	-	3,400	43,158	45,215	46,340
Allocated Costs	-	-	-	-	-	-	-
B&O Taxes	-	-	-	-	-	-	-
Depreciation and Amortization	7,607	7,237	7,217	8,969	32,389	32,389	32,389
Dues and Subscriptions	3,970	4,858	5,719	6,374	6,582	6,847	7,264
Education and Training	6,230	5,098	6,626	7,907	8,165	8,494	9,011
Equipemnt Rental	-	-	-	-	-	-	-
Information and Technology/Computers	13,020	15,706	14,305	16,885	50,482	51,996	53,365
Insurance	81,413	71,974	85,837	112,442	185,885	216,663	240,910
Interest	13,455	17,136	26,129	30,556	30,556	30,556	30,556
Legal and Professional	-	-	-	-	-	-	-
Licenses and Fees	97,745	46,866	14,354	4,032	364	379	402
Medical Supplies	87,970	92,779	124,947	138,443	187,190	447,018	545,928
Payroll Taxes	102,847	101,574	115,943	148,129	249,592	317,919	351,517
Postage	4,432	367	2,203	2,037	2,160	2,247	2,384
Purchased Services (Utilities/other)	6,567	8,116	3,441	7,568	12,562	13,015	13,615
Rental/Lease	89,002	108,070	107,070	122,359	251,454	255,892	259,445
Repairs and Maintenance	8,254	4,723	2,515	5,602	9,144	9,418	9,682
Salaries and Wages	1,102,563	1,120,275	1,342,667	1,683,681	2,840,299	3,598,501	3,974,941
Supplies	5,648	7,564	5,893	10,150	13,448	13,893	14,593
Telephone	11,685	13,391	12,008	12,970	16,655	17,208	17,642
Travel	67,682	94,724	85,528	108,628	119,911	168,698	187,308
Other (detail what is included)	2,094,259	201,923	114,542	104,027	192,810	397,448	473,553
Total Expenses	3,804,439	1,933,042	2,076,745	2,534,160	4,232,775	5,633,798	6,270,846
Net Income	(2,555,871)	(378,683)	100,347	115,229	(602,024)	2,543,602	3,731,187

Additional Notes, Assumptions:

Line 31 Medical Supplies, DME $5.56 PPD; Medical Supplies $2.48 PPD; Pharmacy $4.35 PPD

Line 41 Other (detail) Contracted Services, Employee Benefits, Marketing Materials, COVID Expenses and Restructuring - Goodwill impairment

Exhibit 14 – FTE's Historical and Projected

Historical and Projected/Gentiva King + Pierce							
	2022	2023	2024	2025	2026	2027	2028
ADC	21	21	28	32	40	67	88
Executive Director	1	1	1	2	2	2	2
Patient Care Manager	1	1	1	1	2	2	2
Registered Nurses	3	3	6	6	8	8	10
Social Workers	1	1	1	1	2	2	2
Aides	1	1	2	3	4	5	7
Chaplain	1	1	1	1	2	2	2
Volunteer Coord/Bereavement	0.5	0.5	1	1	2	2	2
Medical Records Clerk	1	1	2	2	3	4	5
Medical Director	1	1	1	1	2	2	2
Hospice Care Consultant	2	2	2	3	4	4	5
Totals	12.5	12.5	18	21	31	33	39

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Exhibit 15 - Balance Sheet

Note: Since Pierce will be operating as an alternate delivery site of Gentiva, King County, this is a combined Balance Sheet for both operations.

	Balance Sheet							
		Historical			Projected			
		2022	2023	2024	2025	2026	2027	2028
	ACCOUNTS RECEIVABLE	165,409	186,575	221,160	269,139	336,916	628,402	770,874
	PP&E, NET	29,145	21,908	13,762	71,439	53,450	35,461	17,472
	OTHER INTANGIBLE ASSETS, NET	139,290	139,290	139,290	139,290	139,290	139,290	139,290
	RIGHT-OF-USE ASSETS, OPERATING LEASES	270,719	182,297	86,849	688,064	473,327	246,438	718,033
	OTHER ASSETS	9,088	9,088	9,088	9,088	9,088	9,088	9,088
	TOTAL ASSETS	**613,650**	**539,158**	**470,149**	**1,177,020**	**1,012,070**	**1,058,679**	**1,654,757**
	INTERCOMPANY	2,906,352	1,020,780	950,253	903,052	1,051,871	(621,445)	(3,366,719)
	OPERATING LEASE LIABILITIES	263,169	176,533	77,705	678,203	454,396	227,198	698,549
	TOTAL LIABILITIES	**3,169,521**	**1,197,313**	**1,027,957**	**1,581,255**	**1,506,267**	**(394,247)**	**(2,668,170)**
	RETAINED EARNINGS	(0)	(279,472)	(658,155)	(557,808)	(404,235)	(494,197)	1,452,926
	NET INCOME (LOSS)	(2,555,871)	(378,683)	100,347	153,574	(89,962)	1,947,122	2,870,001
	TOTAL STOCKHOLDERS' EQUITY	**(2,555,871)**	**(658,155)**	**(557,808)**	**(404,235)**	**(494,197)**	**1,452,926**	**4,322,927**
	TOTAL LIABILITIES & STOCKHOLDERS' EQUITY	**613,650**	**539,158**	**470,149**	**1,177,020**	**1,012,070**	**1,058,679**	**1,654,757**

Note: The following Balance Sheet is representative of the Gentiva, King County, plus Pierce County alternate delivery site and Clallam County alternate delivery site, should Gentiva be granted a CON for both Pierce and Clallam.

	Balance Sheet							
		Historical			Projected			
		2022	2023	2024	2025	2026	2027	2028
	ACCOUNTS RECEIVABLE	165,409	186,575	221,160	269,139	368,831	830,703	1,016,059
	PP&E, NET	29,145	21,908	13,762	125,922	93,533	61,144	28,755
	OTHER INTANGIBLE ASSETS, NET	139,290	139,290	139,290	139,290	139,290	139,290	139,290
	RIGHT-OF-USE ASSETS, OPERATING LEASES	270,719	182,297	86,849	1,029,608	703,960	362,827	1,071,614
	OTHER ASSETS	9,088	9,088	9,088	9,088	9,088	9,088	9,088
	TOTAL ASSETS	**613,650**	**539,158**	**470,149**	**1,573,047**	**1,314,702**	**1,403,052**	**2,264,806**
	INTERCOMPANY	2,906,352	1,020,780	950,253	996,215	1,676,300	(437,448)	(4,015,372)
	OPERATING LEASE LIABILITIES	263,169	176,533	77,705	1,019,411	683,006	341,503	1,049,994
	TOTAL LIABILITIES	**3,169,521**	**1,197,313**	**1,027,957**	**2,015,626**	**2,359,306**	**(95,946)**	**(2,965,379)**
	RETAINED EARNINGS	(0)	(279,472)	(658,155)	(557,808)	(442,580)	(1,044,604)	1,498,998
	NET INCOME (LOSS)	(2,555,871)	(378,683)	100,347	115,229	(602,024)	2,543,602	3,731,187
	TOTAL STOCKHOLDERS' EQUITY	**(2,555,871)**	**(658,155)**	**(557,808)**	**(442,580)**	**(1,044,604)**	**1,498,998**	**5,230,185**
	TOTAL LIABILITIES & STOCKHOLDERS' EQUITY	**613,650**	**539,158**	**470,149**	**1,573,047**	**1,314,702**	**1,403,052**	**2,264,806**

Exhibit 16 - Employee Detail (Field/Clinical Model)

		12:1			0-39(0) * 40+ (2) * 50:1	12:1	45 : 1	60 : 1	80 : 1
	ADC	RN/RNA	LPN	SN TOTAL	RN On-Call (post pilot)	Aide	SW	Chaplain	BC/VC
0		1.0		1.0	0	1.0	1.0	1.0	0.0
1		1.0		1.0	0	1.0	1.0	1.0	0.0
2		1.0		1.0	0	1.0	1.0	1.0	0.0
3		1.0		1.0	0	1.0	1.0	1.0	0.0
4		1.0		1.0	0	1.0	1.0	1.0	0.1
5		1.0		1.0	0	1.0	1.0	1.0	0.1
6		1.0		1.0	0	1.0	1.0	1.0	0.1
7		1.0		1.0	0	1.0	1.0	1.0	0.1
8		1.0		1.0	0	1.0	1.0	1.0	0.1
9		1.0		1.0	0	1.0	1.0	1.0	0.1
10		1.0		1.0	0	1.0	1.0	1.0	0.1
11		1.0		1.0	0	1.0	1.0	1.0	0.1
12		1.0		1.0	0	1.0	1.0	1.0	0.2
13		1.1		1.1	0	1.1	1.0	1.0	0.2
14		1.2		1.2	0	1.2	1.0	1.0	0.2
15		1.3		1.3	0	1.3	1.0	1.0	0.2
16		1.3		1.3	0	1.3	1.0	1.0	0.2
17		1.4		1.4	0	1.4	1.0	1.0	0.2
18		1.5		1.5	0	1.5	1.0	1.0	0.2
19		1.6		1.6	0	1.6	1.0	1.0	0.2
20		1.7		1.7	0	1.7	1.0	1.0	0.3
21		1.8		1.8	0	1.8	1.0	1.0	0.3
22		1.8		1.8	0	1.8	1.0	1.0	0.3
23		1.9		1.9	0	1.9	1.0	1.0	0.3
24		2.0		2.0	0	2.0	1.0	1.0	0.3
25		2.1		2.1	0	2.1	1.0	1.0	0.3
26		2.2		2.2	0	2.2	1.0	1.0	0.3
27		2.3		2.3	0	2.3	1.0	1.0	0.3
28		2.3		2.3	0	2.3	1.0	1.0	0.4
29		2.4		2.4	0	2.4	1.0	1.0	0.4
30		2.5		2.5	0	2.5	1.0	1.0	0.4
31		2.6		2.6	0	2.6	1.0	1.0	0.4
32		2.7		2.7	0	2.7	1.0	1.0	0.4
33		2.8		2.8	0	2.8	1.0	1.0	0.4
34		2.8		2.8	0	2.8	1.0	1.0	0.4
35		2.9		2.9	0	2.9	1.0	1.0	0.4
36		3.0		3.0	0	3.0	1.0	1.0	0.5
37		3.1		3.1	0	3.1	1.0	1.0	0.5
38		3.2		3.2	0	3.2	1.0	1.0	0.5
39		3.3		3.3	0	3.3	1.0	1.0	0.5
40		3.3		3.3	2	3.3	1.0	1.0	0.5
41		3.4		3.4	2	3.4	1.0	1.0	0.5
42		3.5		3.5	2	3.5	1.0	1.0	0.5
43		3.6		3.6	2	3.6	1.0	1.0	0.5
44		3.7		3.7	2	3.7	1.0	1.0	0.6

RN: Registered Nurse, SN: Skilled Nurse, SW: Social Worker, BC: Bereavement Coordinator, VC: Volunteer Coordinator

Exhibit 17 - Employee Detail (Administrative Model)

Admin Staffing Model

Census Band	Census Start	Census End	Office Staff (Not including AC)	ED	DCS	PCC/PCM	OC (MRC)	25+ Admit Avg - Prev 3 Mo. (Heartland is Centralized) AC
1	0	12	2	1		1		TBD
2	13	24	2	1		1		TBD
3	25	36	2	1		1		TBD
4	37	48	2	1		1		TBD
5	49	60	2	1		1		TBD
6	61	72	3	1		1	1	TBD
7	73	84	3	1		1	1	TBD
8	85	96	4	1		2	1	TBD
9	97	108	4	1		2	1	TBD
10	109	120	4	1		2	1	TBD
11	121	132	5	1		3	1	TBD
12	133	144	5	1		3	1	TBD
13	145	156	6	1		3	2	TBD
14	157	168	6	1		3	2	TBD
15	169	180	7	1	1	3	2	TBD
16	181	192	7	1	1	3	2	TBD
17	193	204	7	1	1	3	2	TBD
18	205	216	7	1	1	3	2	TBD
19	217	228	7	1	1	3	2	TBD
20	229	240	7	1	1	3	2	TBD
21	241	252	7	1	1	3	2	TBD
22	253	264	7	1	1	3	2	TBD
23	265	276	7	1	1	3	2	TBD
24	277	288	8	1	1	4	2	TBD
25	289	300	8	1	1	4	2	TBD
26	301	312	8	1	1	4	2	TBD
27	313	324	8	1	1	4	2	TBD
28	325	336	9	1	1	5	2	TBD
29	337	348	9	1	1	5	2	TBD
30	349	360	9	1	1	5	2	TBD
31	361	372	9	1	1	5	2	TBD
32	373	384	9	1	1	5	2	TBD
33	385	396	9	1	1	5	2	TBD
34	397	408	9	1	1	5	2	TBD
35	409	420	9	1	1	5	2	TBD
36	421	432	12	1	1	7	3	TBD
37	433	444	12	1	1	7	3	TBD
38	445	456	12	1	1	7	3	TBD
39	457	468	12	1	1	7	3	TBD
40	469	480	12	1	1	7	3	TBD
41	481	492	12	1	1	7	3	TBD
42	493	504	12	1	1	7	3	TBD
43	505	516	15	1	1	9	4	TBD
44	517	528	15	1	1	9	4	TBD
45	529	540	15	1	1	9	4	TBD
46	541	552	15	1	1	9	4	TBD
47	553	564	15	1	1	9	4	TBD

ED: Executive Director/Administrator, DCS: Director Clinical Services, PCC/PCM: Patient Care Coordinator/Patient Care Manager, OC/MRC Medical Records Clerk

Exhibit 18 – Medical Director Agreement

HOSPICE MEDICAL DIRECTOR
INDEPENDENT CONTRACTOR AGREEMENT

THIS AGREEMENT, made and entered into on this 10th day of February, 2023, between **Odyssey HealthCare Operating B, LP** ("Hospice") and **Eric A. Sohn, M.D.** ("Contractor").

W I T N E S S E T H:

WHEREAS, Hospice is licensed and certified to operate a hospice program that provides hospice services to the citizens and residents of the State of **Washington** (the "State"); and

WHEREAS, Contractor is a physician with expertise in psychosocial and medical matters related to the work of Hospice and desires to assume responsibility for the medical component of Hospice's patient care program and to supervise other physicians assisting in such medical component (the "Hospice Physicians"); and

WHEREAS, Hospice and Contractor desire to enter into an agreement on the terms and conditions set forth herein, for Contractor to render services as Medical Director of Hospice for **Odyssey HealthCare Operating B, LP d/b/a Kindred Hospice**, located in **Seattle, Washington** and, should the need arise and only upon the express request of Hospice, its affiliated **Washington** locations; and

WHEREAS, the parties wish to set forth their relationship as independent contractors for purposes of State and federal law.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein contained, Hospice and Contractor agree as follows:

1. Independent Contractor Status. Contractor agrees to provide services hereunder to the Hospice as an independent contractor and not as an employee, as that term is understood for Federal and State law purposes ("Independent Contractor").

2. Term. The initial term of this Agreement shall be for one year, beginning the 10th day of February, 2023 and ending the 10th day of February, 2024, and shall automatically renew for successive one (1) year periods for up to two (2) renewal periods, unless otherwise terminated as provided for hereunder (collectively, the "Term"). The parties agree that, upon termination of this Agreement during its first year for any reason, the parties will not enter into another agreement for the same or substantially the same services provided hereunder until the expiration of the first year of this Agreement.

3. Payment for and Evaluation of Administrative Services.

(a) Hospice shall pay the Contractor for administrative services to be performed by Contractor and in accordance with the schedule as set forth in **Attachment A**. As a condition to receiving payment, Contractor shall invoice Hospice on or before the tenth day of each month for administrative services performed in the prior month. Once the invoice is received payment will be made within thirty (30) days. The invoice shall be substantially in the form of **Attachment B**. Failure to timely submit and adequately describe invoices will result in non-payment by Hospice. The parties acknowledge and agree that (i) the compensation and other consideration set forth in this Agreement represent a fair market value exchange, negotiated in an arm's length transaction, and not determined in a manner which takes into account the value or the volume of referrals or other business generated between the parties and (ii) the aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purposes of the services and Hospice. **WITHOUT LIMITING THE**

GENERALITY OF THE FOREGOING AND NOTWITHSTANDING ANY OTHER PROVISION OF THIS AGREEMENT, IN THE EVENT HOSPICE RECEIVES THE REQUIRED INVOICE AND TIME RECORDS MORE THAN SIXTY (60) DAYS FOLLOWING THE END OF THE MONTH COVERED BY SUCH TIME RECORDS, THEN NO COMPENSATION SHALL BE DUE FROM HOSPICE TO CONTRACTOR WITH RESPECT TO SERVICES PERFORMED DURING SUCH MONTH. Hospice shall have the authority to request additional or supplementary documents to establish the extent of services provided hereunder. In the event Hospice determines that such reports and records do not accurately reflect or document services hereunder for which payment has been made to Contractor, then upon written notice to Contractor, Contractor shall promptly refund to Hospice the amount of overpayment as determined by Hospice. In the event this Agreement is terminated for any reason by either party, compensation shall be due only for services actually rendered through the effective date of such termination, subject to the requirements for verification and other provisions of this Agreement.

(b) Hospice shall review and evaluate Contractor's services in order to assure quality control of services provided to Hospice.

4. Professional Fees.

(a) Contractor acknowledges and agrees that, as a physician under contract with Hospice, he or she shall not bill Medicare Part B for professional fees incurred in connection with his or her personal performance of professional medical services (the "Professional Fees") rendered to Hospice Medicare patients. Instead, in accordance with Section 40.1 of the Medicare Claims Processing Manual, Chapter 11, Contractor shall look solely to Hospice for compensation for such services. To that end, in addition to payment for services rendered under this Agreement in accordance with paragraph 3, Hospice shall pay Contractor 90 percent of the Medicare-allowed amount (less any sequestration withheld, if any) for these professional services, as set by the Medicare Physician Fee Schedule, provided that timely, complete and accurate documentation is submitted as described herein. Contractor shall submit to Hospice the documentation necessary and sufficient for Hospice to bill for his or her professional services for Medicare Hospice patients. Such documentation shall be substantially in the form of a Form CMS-1500 and shall be submitted at intervals as required by Hospice for proper billing, but in no event less frequently than monthly. All forms for payment submitted shall be signed by Contractor. Additionally, Contractor shall timely comply with any other requirements related to reporting of hospice professional services.

(b) Contractor may as applicable directly charge and bill non-Medicare patients or responsible third-party payers (non-Medicare) for Professional Fees. Contractor shall be responsible for his or her own billing and collection of such Professional Fees and shall bear the expense of such billing and collection. Contractor shall bill for Professional Fees in accordance with all applicable laws and all applicable procedures established by the applicable payer.

(c) Contractor shall also serve as a substitute for a Hospice patient's designated Attending Physician who is not employed by or under contract with Hospice. In such instances, the designated Attending Physician, not Hospice, shall bill for Physician's professional services in accordance with applicable federal and state rules and regulations.

5. Contractor's Obligations.

(a) Contractor shall perform such work as is necessary to fulfill his or her duties as Medical Director, as described in **Attachment C**. Medical Director acknowledges and agrees that he/she has ultimate authority for the medical component of patient care and supervisory responsibility for Hospice

Physicians.

(b) Contractor shall conduct his or her duties in accordance with the requirements of applicable accrediting bodies, regulatory agencies, State and Federal laws, the policies and procedures of the Hospice, and current standards of medical practice as they pertain to performance by Contractor of his or her duties under this Agreement.

(c) Contractor shall assist Hospice in obtaining and maintaining all proper licenses for Hospice.

(d) Contractor represents that he or she: (i) is a duly licensed doctor of medicine or osteopathy and otherwise qualified in the State to practice medicine; (ii) is board certified or board eligible in the medical specialty of physical medicine and rehab, pain medicine, or hospice and palliative medicine; (iii) has current and active federal DEA and state controlled substances registrations; and (iv) is qualified as a participating physician in both Medicare and Medicaid. Contractor shall provide a copy of Contractor's professional license, which shall be attached hereto as **Attachment D**.

(e) As specified in 42 U.S.C. § 1396a(a)(68), Contractor, as it relates to the provision of services to Hospice as set forth herein, acknowledges having received and will abide by Hospice's written policies regarding compliance with the federal False Claims Act (31 U.S.C. §§ 3729-3733), administrative remedies for false claims and statements (31 U.S.C. Chapter 38), state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such federal and state false claims laws, as well as detailed information regarding Hospice's policies and procedures for detecting and preventing fraud, waste, and abuse.

(f) Contractor acknowledges that Hospice has provided Contractor with information regarding Hospice's corporate compliance program, including Hospice's Code of Conduct, and that Contractor has read, understood, and shall abide by Hospice's compliance program, including its Code of Conduct.

(g) Contractor further acknowledges and agrees that patients shall be accepted for care only by Hospice.

(h) In order to permit Hospice to properly bill Medicare and other third party payers for any professional services Contractor renders as Attending Physician to Hospice patients, Contractor shall record, maintain, complete, and provide to Hospice upon such forms as Hospice may prescribe, records required by Medicare and other payers of all services provided under this Agreement. Contractor shall comply with federal, state and commercial insurance billing requirements and documentation guidelines when requesting payment or supplying documentation for any such professional services. Contractor further agrees that Contractor shall be solely responsible for the payment of assessments, interest, and penalties of whatever kind assessed by any government agency or other entity which pertain to the services rendered by Contractor, including but not limited to any recoupment by Medicare, Medicaid, or any other third party payer related to the provision of services or the documentation supporting the reimbursement for the services, and shall defend, indemnify, and hold Hospice harmless therefor.

6. Insurance.

(a) Insurance coverage provided by Hospice, including coverage for Contractor's services as specified on Section 4 above and in Attachment C, is set forth in the Certificate of Insurance attached hereto as **Attachment F**. Hospice shall not be responsible for providing any coverage for, nor shall Hospice be liable for, any cause of action or claim relating to Contractor's acts or omissions, including

without limitation, negligence or other misconduct which relate to services performed outside the scope of Contractor's medical director duties.

(b) Contractor shall maintain professional liability insurance to protect against any liability incident to the performance of any services provided by Contractor outside the scope of Contractor's Medical Director Services as set forth herein, at least in the amounts of $1 million per claim and $3 million in the aggregate. Said insurance shall provide that Hospice shall receive not less than twenty (20) days prior written notice of cancellation. Contractor shall provide Hospice with certification of said insurance, limits, and cancellation notice provision. A copy of Contractor's Certificate of Insurance is attached hereto as **Attachment F**.

(c) In the event Contractor fails to obtain or maintain insurance required hereunder, Hospice at its option may procure and/or renew such insurance on the account of Contractor, or in the alternative may terminate this Agreement. If Hospice does so procure and/or renew such insurance, Contractor will promptly reimburse Hospice.

7. Contractor Covenants.

(a) Contractor covenants that he or she shall at all times be licensed to practice medicine or osteopathy in the State and shall comply with all of the policies and procedures of Hospice and all applicable state and federal laws and regulations governing the rendering of services hereunder.

(b) Contractor further covenants that he or she has not:

(i) been charged by the medical staff of any hospital or other healthcare provider due to gross misconduct of either a professional or personal nature;

(ii) been convicted of a crime involving moral turpitude;

(iii) had a guardian of the person or estate appointed for him or her by a court of competent jurisdiction;

(iv) had medical staff privileges or membership at any hospital or other healthcare provider either suspended or revoked for any reason other than failure to timely complete medical records;

(v) had his or her right to practice medicine in the State or any other state either suspended or revoked for any reason;

(vi) been refused the right to dispense narcotics, or had his or her right to dispense narcotics revoked; or

(vii) had his or her participation in Medicare, Medicaid or any other federal healthcare program restricted, suspended or revoked, nor has been excluded from Medicare or Medicaid or any other federal healthcare program, nor has any action ever been commenced or is now pending, to restrict, suspend, revoke or exclude Contractor from Medicare, Medicaid or any other federal healthcare program.

(c) Contractor covenants that if, in the future, any of the acts or things described in 7(b) occur, that such occurrence will be a breach of this Agreement.

(d) Contractor covenants that Contractor shall notify Hospice within two (2) days if any action is commenced against Contractor, or if notification of any potential action is given to Contractor, to restrict, suspend, revoke or exclude Contractor from participation in Medicare, Medicaid or any other federal healthcare program.

(e) Contractor covenants to disclose to Hospice (i) all of Contractor's engagements as a Medical Director or other consultant of healthcare providers other than Hospice and (ii) any financial (ownership or compensation) interest of Contractor in or with a competitor or potential competitor of Hospice, and Contractor hereby represents and warrants that such disclosures as of the date hereof are set forth on **Exhibit A** to this Agreement.

(f) Contractor covenants that he or she will comply with all other terms and conditions of this Agreement.

(g) Contractor covenants that Contractor will not incur any financial obligation on behalf of Hospice without the prior written approval of Hospice.

8. Legislative Limitations. If it is the reasonable opinion of Hospice legal counsel that Medicare, Medicaid, or any third party payor, or any other federal, state, or local laws, rules, regulations, or official interpretations ("Applicable Law") at any time during the Term prohibit, restrict, or in any way substantially change the arrangement for services under this Agreement, then Hospice and Contractor shall negotiate in good faith to attempt to alter their relationship to comply with Applicable Law while preserving the material terms of their relationship. In the event such compliance cannot be accomplished or achieved, this Agreement shall be terminated upon the expiration of thirty (30) days from the receipt by the parties of the opinion of Hospice legal counsel without liability of either party, except for obligations of the parties accruing prior to termination that are not prohibited by Applicable Law, or any obligations which expressly survive termination of this Agreement.

9. Assignment. Contractor may not assign his or her duties under this Agreement to any other person, including any other qualified physician or nurse practitioner, unless previously approved by Hospice as reflected in a written agreement among the parties.

10. Confidential Information. Contractor agrees not to disclose or in any way use, or allow any other person to disclose or use, confidential information of or concerning Hospice without Hospice's prior express written consent, either during or after the Term. Confidential information includes, but is not limited to, financial data, methods of operation and policies and procedures. Contractor shall not disclose, or allow others to disclose the terms of this Agreement except as it is necessary to perform this Agreement or to obtain accounting, legal or tax advice from Contractor's professional advisors. Furthermore, Contractor shall comply in all material respects with the standards for privacy and security of individually identifiable health information of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996, Subtitle D of Title XIII of the Health Information Technology for Economic and Clinical Health Act (codified at 42 U.S.C. §§ 17921-17954), and all rules and regulations promulgated thereunder, all as the same may be amended from time to time (collectively, "HIPAA"). Contractor acknowledges his or her status as a "business associate" under HIPAA and agrees to carry out his or her responsibilities under this Agreement in accordance with such status and further agrees to fulfill the obligations set forth in the Business Associate Agreement attached hereto as **Attachment E**, incorporated herein by reference.

11. Relinquishment of Records. Upon termination of this Agreement, Contractor shall promptly return to Hospice all files, data or materials belonging to or relating to the operations and business of Hospice.

12. Restrictive Covenants.

(a) Contractor covenants not to solicit Hospice's employees for employment during the Term and for twelve (12) months after the termination of this Agreement for any reason.

(b) Given the position of trust and influence held by Contractor under this Agreement, Contractor covenants that Contractor shall not, during the Term, enter into another agreement for Medical Director or medical advisory positions, or render such advisory services under any existing or proposed relationship, for, to or on behalf of another hospice. Nothing herein shall prohibit Contractor from engaging in the regular practice of medicine, inclusive of care plan oversight, and/or Contractor's participation in clinical consultation services for non-competing businesses or industries.

(c) This Paragraph 12 shall survive termination of this Agreement.

13. Invalidity of Portion of Agreement. If any portion, part or provision of this Agreement shall be held invalid or unenforceable, it shall in no way affect or impair the validity and enforceability of the remainder of this Agreement unless such provision is a material term of the Agreement. Further, a determination by any governmental agency or tribunal (and the acquiescence or non-acquiescence by the parties in such determination) that Contractor's status is anything other than an independent contractor for the services provided pursuant to this Agreement shall be limited to the purpose for which it was made and shall have no effect on the parties' relationship for any other purpose.

14. Waiver of Breach. The waiver of a breach of this Agreement by either party hereto shall not constitute the waiver of any subsequent breach of this Agreement.

15. Miscellaneous.

(a) Any notice required or permitted by this Agreement shall be in writing and shall be deemed given at the time it is deposited in the United States Mail, postage pre-paid, certified or registered mail, return receipt requested or Federal Express addressed to the party to whom it is to be given as follows:

Hospice: **c/o Gentiva**
3350 Riverwood Parkway SE #1400
Atlanta, GA 30339
Attn: Legal Department

Contractor: **Eric A. Sohn, M.D.**
7115 N. Division St Suite B349
Spokane, WA 99208

Either party may change its address to which notices shall be sent by a notice similarly sent.

(b) Pursuant to Section 952 of Public Law 96-499, as a condition for reimbursement for costs incurred under this Agreement, Hospice is required to obtain Contractor's agreement and Contractor hereby agrees that Contractor will retain and make available upon request of the Secretary of the Department of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, this Agreement and all books, documents and records necessary to verify the nature and extent of the costs of the services provided under this Agreement, and that such records

will be retained and held available by Contractor for such inspection until the expiration of four years after the services are furnished under this Agreement.

If pursuant to this Agreement and permitted and approved by Hospice under paragraph 9, any of the Contractor's duties and obligations are to be carried out by an individual or entity subcontracting with Contractor and that subcontractor is to a significant extent, associated or affiliated with, owns, or is owned by or has control of or is controlled by Contractor, each such subcontractor shall itself be subject to the foregoing access requirement, and Contractor hereby agrees to require such subcontractors to meet the access requirement.

Contractor understands that request for access must be in writing and contain reasonable identification of the documents, along with a statement as to the reason that the appropriateness of the costs or value of the services in question cannot be adequately or efficiently determined without access to Contractor's books and records. Contractor agrees that it will notify Hospice in writing within ten (10) days, upon receipt of a request for access.

16. Termination and Remedies for Breach. If Contractor or Hospice fails to comply with any material obligation or covenant, or fails to comply with any other material term of this Agreement, such failure to comply, in addition to all other remedies at law and equity for damages or otherwise, shall be grounds for Hospice or Contractor to terminate this Agreement, effective thirty (30) days after giving the other party notice, if said other party fails to correct the same within such thirty (30) day time period. Notwithstanding anything to the contrary in the above, there shall not be any required notice prior to termination as to breach of the covenants set forth in paragraphs 5, 6, 7 and 12 hereinabove; it is the specific intent of this provision that the Agreement may be terminated immediately for a breach of paragraph 5, 6, 7 or 12. In addition to all other grounds for termination, Hospice may terminate this Agreement for cause at any time upon thirty (30) days' prior written notice of termination to Contractor. Either party may terminate this Agreement without cause upon thirty (30) days' prior written notice to the other party.

(a) **Post-Termination Obligations:** Upon termination, and no later than fifteen (15) days of the Termination Date, Contractor shall ensure the timely completion of all required clinical documentation, including the execution of any outstanding physician orders and narratives in accordance with applicable Hospice policies and federal and state laws and regulations for Hospice patient care program. Any final payments by Hospice to Contractor under this Agreement may be withheld if Contractor has not completed all required clinical documentation within the permitted timeframe. Failure to comply with this Section 16 may result in Contractor being held potentially liable for unsigned and incomplete clinical documentation which inhibits Hospice's ability to bill Medicare. Contractor shall continue to work with Hospice in coordinating the continuation of services provided by Contractor under this Agreement and, if requested by Hospice, and agreed upon by Contractor, continue to provide services after this Agreement is terminated. In such case, services shall continue to be provided and compensated in accordance with the terms set forth in this Agreement. Termination of this Agreement shall not relieve any party of obligations incurred prior to the effective date of termination or which survive termination of this Agreement. This Paragraph shall survive termination of this Agreement.

17. No Duty To Refer Patients. The parties do not intend by this Agreement to induce directly or indirectly the referring of any individual to any other person or entity for the furnishing or arranging for the furnishing of any health care services or the provision of any drug or health care device, including but not limited to services, drugs, or devices for which payment may be made in whole or in part under any Federal Health Care Program as defined in 42 U.S.C. § 1320a-7b(f).

18. Entire Agreement. This Agreement represents the entire Agreement of the parties and supersedes

all prior agreements, contracts, and understandings between the parties related to the subject matter hereof. Contractor and Hospice hereby agree that the services to be performed pursuant to this Agreement constitute all services to be furnished to Hospice by Contractor. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

19. Governing Law. This Agreement shall be governed by and construed under the laws of the State.

20. Paragraph Headings; Gender. The paragraph headings contained in this Agreement are for convenience only and shall in no manner be construed as part of this Agreement. Whenever any gender is used in this Agreement, it shall be applicable to the other gender as the context may require, and the plural shall include the singular and the singular the plural, as the context may require.

21. Successors and Assigns. All of the terms and conditions set forth in this Agreement shall be binding upon, and inure to the benefit of, all heirs, successors and assigns of the respective parties.

IN WITNESS WHEREOF, Hospice and Contractor have caused this Agreement to be executed by their duly authorized officers in duplicate originals, one duplicate original to be retained by each of the parties on the day and year first above written.

HOSPICE:
Odyssey HealthCare Operating B, LP:

By: Ann Berryman

Print Name: Ann Berryman

Date: 1/26/23

CONTRACTOR:
Eric A. Sohn, M.D.:

By:

Print Name: Eric A Sohn, MD HMDC

NPI#: 1144220609

Date: 1/25/23

ATTACHMENT A

COMPENSATION

Hospice shall pay Contractor **Two Hundred Ten Dollars ($210.00)** per hour up to a maximum of **$16,800.00** per month, provided that Contractor complies with the documentation requirements of **Attachment B.** The parties anticipate that Contractor will spend approximately **Eighty Hours (80)** hours per month in the provision of the services set forth herein.

In addition, Hospice shall pay Contractor **$210.00 per visit**, such as face to face, to a Hospice patient's home as pre-authorized by Hospice plus Contractor's documented mileage for such visits in accordance with Hospice's mileage reimbursement policies as may be in place from time to time.

ATTACHMENT B

HOSPICE MEDICAL DIRECTOR CONTRACT

Instructions for Record of Services Rendered

Time records must be completed on a monthly basis and submitted to the Hospice administrator.

Each line should record time for a separate date of service. For example, line 5 would be for services performed on the 5th day of the month. Blank lines indicate that no services were performed for that day. The total of all hours recorded for the month should be entered on the line "MONTHLY TOTAL".

The description of services should be reasonably detailed. For example, it should, where possible, identify specific tasks performed and whether anyone else was present.

The actual number of hours worked should be recorded in quarter hour increments. For example, 3.25 hours, 2.75 hours, et cetera.

The physician should sign and date the form, which will constitute his or her certification that the services were performed as stated.

The Record of Services Rendered (**Attachment B**) should be submitted on or before the 10th day of each month for services performed the prior month, after which time it will be reviewed and forwarded for payment. **NOTWITHSTANDING ANY OTHER PROVISION OF THIS AGREEMENT, IN THE EVENT HOSPICE RECEIVES THE REQUIRED INVOICE AND TIME RECORDS MORE THAN SIXTY (60) DAYS FOLLOWING THE END OF THE MONTH COVERED BY SUCH TIME RECORDS, THEN NO COMPENSATION SHALL BE DUE FROM HOSPICE TO CONTRACTOR WITH RESPECT TO SERVICES PERFORMED DURING SUCH MONTH.**

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ATTACHMENT B
HOSPICE PHYSICIAN CONTRACT – RECORD OF SERVICES RENDERED

Record of Hours Worked Timesheet Month & Year:_____ Location:_____

Note: Time to be entered in quarter hour increments: 15 min = 0.25 / 30 min = 0.50 / 45 min =0.75 / 1 hour = 1.00

DATE OF SERVICE	ADMIN HOURS (IDG/On-Call/GIP)	# FACE TO FACE VISITS	MILEAGE	DESCRIPTION OF SERVICES
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
PAGE 1 SUBTOTAL				

Page 1

92017

gentiva

HOSPICE PHYSICIAN CONTRACT – RECORD OF SERVICES RENDERED

DATE OF SERVICE	ADMIN HOURS (IDG/On-Call/GIP)	# FACE TO FACE VISITS	MILEAGE	DESCRIPTION OF SERVICES
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
PAGE 2 SUBTOTAL				**ATTESTATION** By signing the Hospice Physician Timesheet, I am attesting that the information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to payment delay, adjustment, disciplinary action, or termination by Hospice as well as administrative, civil and/or criminal liability under applicable Federal and state laws and regulations.
PAGE 1 SUBTOTAL				
MONTHLY TOTAL				

Contracted Reimbursement

Hospice shall pay Contractor the following values per month provided that Contractor complies with the documentation requirements of Attachment B.

ADMIN HOURS:	$210.00	Per hour up to a maximum of:	$16,800.00	per month or the equivalent of:	80 hours
FACE TO FACE:	$210.00	Per visit			

I certify that the above information is true and complete and that payment is in accordance with the terms outlined within a current fully executed contract.

MD Signature (First & Last) Printed Name Date

Signature of Authorized Hospice Signatory (DOO, IDOO, AVP, VP) Printed Name Date

ATTACHMENT C

MEDICAL DIRECTOR SERVICES DESCRIPTION

- **General supervisory services**
- **Assisting in establishing/reviewing plans of care**
- **Serving on the Interdisciplinary Group ("IDG")**
- **Attend and conduct training sessions**
- **Assess patient hospice eligibility and, if medically appropriate, complete terminal illness certification/recertification, in consultation with patient's Attending Physician, if any, and based upon current clinically relevant information**
- **Assist in the completion of any necessary forms**
- **Supervision of and regular communication with all hospice employed and contracted physicians**
- **State licensure compliance requirements for medical director duties**
- **Acting as a medical resource for the IDG**
- **Coordinate services with each attending physician to ensure continuity in the services provided in the event the attending physician is unable to retain responsibility for patient care**
- **Act as liaison with physicians in the community to educate them regarding Hospice's services and its medical policies and procedures**
- **Facilitate meetings with patient family members**
- **Keep Hospice personnel informed about the patient's needs or condition**
- **Act as part of the local Hospice Quality Assurance Team**
- **Provide 24 hour on-call services to hospice clinicians if requested by Hospice**
- **Unless provided by another Hospice physician or nurse practitioner, provide face to face visits for recertification purposes for any benefit period requiring a face to face**
- **Provide written physician's discharge orders for discharged Hospice patients in consultation with the patients' Attending Physician, if any**
- **Meeting the medical needs of Hospice patients when such patients' Attending Physicians are unavailable, unless those needs are met by another Hospice physician**
- **Review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:**
    - **(i) Effectiveness of drug therapy**
    - **(ii) Drug side effects**
    - **(iii) Actual or potential drug interactions**
    - **(iv) Duplicate drug therapy**
    - **(v) Drug therapy currently associated with laboratory monitoring.**
    - **(vi) Whether a medication is related to the terminal condition.**

Medical Director Signature

ATTACHMENT D

PROFESSIONAL LICENSE
DEA CERTIFICATE
CONTROLLED SUBSTANCE CERTIFICATE

ATTACHMENT E

HIPAA BUSINESS ASSOCIATE AGREEMENT

This **Business Associate Agreement** (this "Agreement") is made and entered into this 10th day of February, 2023 (the "Effective Date"), by and between **Odyssey HealthCare Operating B, LP** ("Covered Entity") and **Eric A. Sohn, M.D.** ("Business Associate").

Covered Entity and Business Associate are parties to that certain **HOSPICE MEDICAL DIRECTOR INDEPENDENT CONTRACTOR AGREEMENT** ("Services Agreement") whereby Business Associate performs functions and/or provides services to or on behalf of Covered Entity. In connection with the Services Agreement, Covered Entity may disclose to Business Associate certain information subject to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and its implementing regulations at 45 C.F.R. Parts 160, 162, and 164, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH") of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 (collectively, "HIPAA"). Covered Entity and Business Associate hereby agree to the terms and conditions of this Agreement in compliance with HIPAA. To the extent applicable, this Agreement replaces any prior Business Associate Agreement between the parties.

Business Associate acknowledges its responsibility to comply with the requirements of HIPAA which are applicable to business associates and all applicable regulations issued by the U.S. Department of Health and Human Services ("HHS") to implement the HIPAA requirements.

In consideration of the foregoing, and the mutual promises contained herein and other valuable consideration, the legal sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

1. Definitions

1.1. Unless otherwise specified, all terms used but not otherwise defined in this Agreement shall have the same meaning for those terms as set forth under HIPAA.

2. Business Associate Obligations

2.1. **Permitted Uses and Disclosures**. Business Associate shall not, and shall ensure that its directors, officers, employees, contractors and agents do not, use or disclose Protected Health Information ("PHI") created, received, maintained or transmitted for the Covered Entity in any manner that would violate HIPAA. Business Associate agrees that it will not use or disclose PHI other than as permitted or required by this Agreement or as required by law. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Services Agreement, provided that such use or disclosure would not violate the HIPAA Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

2.2. **Use/Disclosure for Administrative Activities.** Notwithstanding Section 2.1, Business Associate may use and/or disclose PHI for management and administrative activities of Business Associate or to comply with the legal responsibilities of Business Associate; provided, however, that with respect to any such disclosure: (i) the disclosure is required by law; or (ii) Business Associate obtains reasonable assurances from the third party that receives the PHI that the third party will treat the PHI confidentially and will only use or further disclose the PHI in a manner consistent with the purposes that the PHI was provided by Business Associate, and promptly report any breach of the confidentiality of the PHI to Business Associate. Business Associate may also use

and/or disclose PHI for data aggregation services, if data aggregation services are to be provided by Business Associate pursuant to the Services Agreement.

2.3. **Disclosure Required by Law.** If Business Associate believes it has a legal obligation to disclose any PHI, it will notify Covered Entity as soon as reasonably practical after it learns of such obligation, and in any event at least ten (10) business days prior to the proposed release, as to the legal requirement pursuant to which Business Associate believes the PHI must be released. If Covered Entity objects to the release of such PHI, Business Associate will allow Covered Entity to exercise any legal rights or remedies Covered Entity might have to object to the release of the PHI. Business Associate agrees to provide such assistance to Covered Entity, at Covered Entity's expense, as Covered Entity may reasonably request.

2.4. **Subcontractors of Business Associate.** Business Associate agrees to enter into written contracts with any agent or independent contractor that creates, receives, maintains or transmits PHI on behalf of the Business Associate (collectively, "Subcontractors"). Such contracts shall obligate Subcontractor to abide by the same conditions and terms as are required of Business Associate under this Agreement, and shall require Subcontractor to notify Covered Entity of Incident(s) as required by Section 3 of this Agreement. Upon request, Business Associate shall provide the Covered Entity with a copy of any written agreement(s) entered into by Business Associate and its Subcontractor(s) to meet the obligations of this Section.

2.5. **Restriction.** Business Associate agrees to comply with any requests for restrictions on certain disclosures of PHI to which Covered Entity has agreed in accordance with 45 C.F.R. § 164.522 and of which Business Associate has been notified by Covered Entity, including but not limited disclosures to a health plan if the PHI pertains solely to a health care item or service for which the individual or person other than the health plan on behalf of the individual, has paid the Covered Entity in full.

2.6. **Performance of Covered Entity's Obligations.** To the extent Business Associate has agreed to carry out one or more of Covered Entity's obligations under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligations.

2.7. **Minimum Necessary**. Business Associate shall comply with the minimum necessary requirements for use and disclosure of PHI set forth at 45 C.F.R. § 164.502(b).

2.8. **Access and Amendment.** Business Associate shall notify the Covered Entity within five (5) days of receipt of a request received by Business Associate for access to, or amendment of, PHI. The Covered Entity shall be responsible for responding, or objecting, to such requests.

2.8.1. **Access.** Upon request, Business Associate agrees to furnish Covered Entity with copies of the PHI maintained by Business Associate in a Designated Record Set in the time and manner designated by Covered Entity to enable Covered Entity to respond to an individual request for access to PHI under 45 C.F.R. § 164.524. If the PHI that is the subject of a request for access is maintained electronically and if the Individual requests an electronic copy of such information, Business Associate shall provide Covered Entity with access to the PHI in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by Covered Entity and the Individual.

2.8.2. **Amendment**. Upon request and instruction from Covered Entity, Business Associate shall amend PHI in a Designated Record Set that is maintained by, or otherwise within the possession of, Business Associate in accordance with 45 C.F.R. § 164.526. Any request by Covered Entity to amend such information shall be completed by Business Associate within fifteen (15) business days of Covered Entity's request.

2.9. **Accounting**. Business Associate agrees to document disclosures of PHI as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance; and provide to Covered Entity or an Individual upon Covered Entity's request, information collected in accordance with this Section, within ten (10) days of receipt of written request by Covered Entity. In the event an individual delivers the initial request for an accounting directly to Business Associate, Business Associate shall within ten (10) days forward such request to Covered Entity. The Parties agree and acknowledge that it is Covered Entity's responsibility to respond to all accounting requests.

2.10. **Remuneration and Marketing.** No communication shall be made for purposes of fundraising, sale and/or marketing, as defined by HIPAA, with PHI created, received, maintained or transmitted for the Covered Entity without prior written authorization by Covered Entity.

2.11. **Security Obligations and Safeguards.**

2.11.1. **Security Rule Obligations.** Business Associate shall utilize appropriate physical, administrative and technical safeguards and comply with 45 C.F.R. Part 164, Subpart C with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by this Agreement.

2.11.2. **Encryption for Portable Devices.** PHI transmitted via email or stored, maintained, transmitted or retained on portable devices for or on behalf of Covered Entity shall be rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services ("HHS") pursuant to 45 C.F.R. Section 164.402. The term "portable device" shall include transportable devices that perform or facilitate computing, storage or transmission, including but not limited to CDs, DVDs, USB flash drives, laptops, PDAs, and portable audio/video devices. All portable devices where PHI is stored shall be equipped with remote wiping or remote disabling functionality.

2.12. **Access by Secretary of Health & Human Services.** Business Associate agrees to allow the Secretary of HHS access to its books, records and internal practices with respect to the disclosure of PHI for the purposes of determining the Covered Entity or Business Associate's compliance with HIPAA.

3. **Reporting and Breach Notice Obligations**

3.1. Business Associate agrees to notify Covered Entity, by facsimile or telephone, of any (i) Security Incident or (ii) use, access or disclosure of PHI which is inconsistent with the terms of this Agreement, within ten (10) days of discovery.

3.1.1. The Parties agree that this Section 3 satisfies any notice requirements by Business Associate of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Covered Entity shall be

required. For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

3.2. Business Associate agrees to notify Covered Entity of any breach of unsecured PHI in accordance with the requirements of 45 C.F.R. Part 164 Subpart D; and to submit updated information immediately at the time such information becomes available to Business Associate.

3.3. In the event of any Incident reportable to Covered Entity pursuant to this Section ("Incident"), Business Associate shall provide to Covered Entity in writing such details concerning the Incident as Covered Entity may request and as required by law, and shall cooperate with Covered Entity, its regulators and law enforcement to assist in regaining possession of such unsecured PHI and prevent its further unauthorized use or disclosure, and take reasonable remedial actions as may be required by Covered Entity to prevent further Incidents.

3.4. Business Associate shall bear all reasonable direct and indirect costs associated with Covered Entity's response to Incidents that are attributable to Business Associate or Subcontractor, including, without limitation, the costs associated with providing notification, providing fraud monitoring or other services to affected Individuals and any forensic analysis required to determine the scope of the Incident.

3.5. Business Associate shall establish policies and procedures for mitigating and to mitigate, to the greatest extent practicable, any harmful effect that is known to Business Associate from any Incident or violation of this Agreement, HIPAA or other applicable laws or regulations.

3.6. Breach notifications from the Business Associate shall include: (i) the number of individuals affected; (ii) the nature of the data breached as it may be a subset of data not related to HIPAA; (iii) the specific data elements breached (e.g., name, address, social security number, etc.); (iv) the confirmed date that the breach was discovered; (v) the detailed system(s) breached; (vi) the details on how the breach occurred; (vii) the details on how the breach was discovered; (viii) the details on any business associate communications with outside parties that relate to the breach; and (ix) details regarding what the business associate is doing to further investigate and mediate the breach.

4. **Term and Termination**

4.1. **Term**. This Agreement shall be effective as of the Effective Date and shall terminate upon termination of the Services Agreement or this Agreement, whichever is sooner.

4.2. **Termination Upon Material Breach**. Covered Entity may, in its sole discretion, terminate the Services Agreement and this Agreement, upon determining that Business Associate violated a material term of this Agreement. If the Covered Entity makes such a determination, it shall inform Business Associate in writing that the Covered Entity is exercising its right to terminate under this Section and such termination shall take effect immediately.

4.3. **Reasonable Steps to Cure Material Breach**. At the Covered Entity's sole option, the Covered Entity may, upon written notice to Business Associate, allow Business Associate an opportunity to take prompt and reasonable steps to cure a violation of any material term of this Agreement to the complete satisfaction of the Covered Entity within ten (10) days of the date of

written notice to Business Associate. Business Associate shall submit written documentation acceptable to the Covered Entity of the steps taken by Business Associate to cure any material violation. If Business Associate fails to cure a material breach within the specified time period, then the Covered Entity shall be entitled to terminate this Agreement.

4.4. **Return or Destruction of PHI Upon Termination**. Within thirty (30) days of termination of this Agreement, Business Associate will return to Covered Entity all PHI created, received, maintained or transmitted by Business Associate from or on behalf of the Covered Entity; and ensure that all Subcontractors return PHI created, received, maintained or transmitted by Subcontractor from or on behalf of Business Associate for purposes related to the Services Agreement. If Business Associate cannot obtain the PHI from any Subcontractor, Business Associate will so notify Covered Entity and will require that such Subcontractor directly return PHI to Covered Entity. Alternatively, Covered Entity may request that Business Associate destroy all such PHI, and ensure that Subcontractors take similar action. Business Associate shall provide written documentation of such destruction. Business Associate will be responsible for ensuring Subcontractor returns or destroys such PHI in accordance with this Section.

4.5. **Alternative Measures**. If Business Associate believes that returning or destroying PHI in accordance with Section 4.4 is infeasible, Business Associate will provide written notice to Covered Entity within five (5) business days of the effective date of termination of this Agreement. Such notice will set forth the circumstances that Business Associate believes make the return or destruction of PHI infeasible and the alternative measures that Business Associate recommends for assuring the continued confidentiality and security of the PHI. Covered Entity will notify Business Associate of whether it agrees that the return or destruction of PHI is infeasible. If Covered Entity does not agree that the return or destruction of PHI is infeasible, Covered Entity will provide written notice of its decision, and Business Associate will proceed with the return or destruction of the PHI pursuant to the terms of this Section within fifteen (15) days of the date of Covered Entity's notice. Business Associate shall ensure that all Subcontractors follow a similar process with regard to alternate measures to return or destruction.

4.6. **Retention of PHI After Termination.** To the extent any PHI is retained after termination of this Agreement, regardless of reason, Business Associate agrees, and shall ensure that any Subcontractor agrees, to:

4.6.1. Limit the use or disclosure of the retained PHI to the purposes for which such PHI was retained;

4.6.2. Return or destroy the retained PHI when it is no longer needed for the purpose(s) for which such PHI was retained; and

4.6.3. Extend all protections, limitations, obligations and restrictions of this Agreement (or, in the case of a Subcontractor, of the written Agreement pursuant to Section 2.4) to PHI retained after termination of this Agreement, including without limitation the provisions of Sections 2.11, 3, and 7 (and their corresponding provisions in Subcontractor's agreement). All such protections, limitations, obligations and restrictions shall survive termination of this Agreement and the Services Agreement.

5. **Modification and Amendment**. This Agreement contains the entire understanding of the parties regarding the obligations of Business Associate under HIPAA and will be modified only by a written document signed by each party except as otherwise provided in this Section. The parties

acknowledge and agree that HIPAA may be amended and additional guidance and/or regulations may be issued after the date of the execution of this Agreement and may affect the parties' obligations under this Agreement ("Future Directives"). The parties agree to abide by such Future Directives as these Future Directives may affect the obligations of the parties. If Future Directives affect the obligations of the parties, then Covered Entity shall notify Business Associate of Future Directives in writing within thirty (30) days before Future Directives are effective. The notification of Business Associate by Covered Entity of Future Directives shall be considered amendments to this Agreement binding on both parties.

6. **Relationship of the Parties.** The Parties hereto acknowledge that Business Associate shall be and have the status of independent contractor in the performance of its obligations under the terms of this Agreement as to Covered Entity. Nothing in this Agreement shall be deemed or construed to create a joint venture or partnership between Covered Entity and Business Associate.

7. **Indemnification and Insurance.**

7.1. Business Associate agrees to defend, indemnify and hold Covered Entity and its affiliates and each of their partners, officers, managers, representatives, employees and agents (each an "Indemnitee") harmless from and against any and all claims, losses, damages, judgments, liabilities, costs, fees and expenses (including reasonable attorney's fees and expenses) of any kind or nature that any Indemnitee incurs or that are asserted against any Indemnitee arising in any way directly or indirectly from (i) Business Associate's negligence or breach of its obligations under this Agreement or HIPAA, (ii) a Subcontractor's breach of its obligations under HIPAA; or (iii) Business Associate's or Subcontractor's provision of services under this Agreement, including but not limited to any violations of any federal, state and/or local laws or regulations arising from or related to Business Associate's or Subcontractor's services, acts or omissions related to this Agreement.

7.2. Unless greater coverage is required under any other agreement between Covered Entity and Business Associate for the provision of services related to this Agreement, Business Associate shall maintain the following insurance covering itself and each Subcontractor, if any, through whom Business Associate provides services: (i) a policy of commercial general liability and property damage insurance, and electronic data processing insurance, with limits of liability not less than two million dollars ($2,000,000) per occurrence and two million dollars ($2,000,000) annual aggregate; and (ii) such other insurance or self insurance as shall be necessary to insure it against any claim or claims for damages arising under this Agreement or from violating Business Associate's own obligations under HIPAA, including but not limited to, claims or the imposition of administrative penalties and fines on Business Associate or its subcontractors or agents, if any, arising from the loss, theft, or unauthorized use or disclosure of PHI. Such insurance coverage shall apply to all site(s) of Business Associate and to all services provided by Business Associate or any subcontractors or agents under this Agreement.

8. **Exception to Limitations and Exclusions.** Business Associate's obligations under this Agreement and any breach by Business Associate or a Subcontractor of the obligations in this Agreement shall not be subject to any limitations on damages that may be specified in any agreement, invoice, statement of work or similar document setting forth the services Business Associate is providing to Covered Entity.

9. **Injunctive Relief.** Business Associate expressly acknowledges and agrees that the breach, or threatened breach, by it of any provision of this Agreement may cause Covered Entity to be irreparably harmed and that Covered Entity may not have an adequate remedy at law. Therefore,

Business Associate agrees that upon such breach, or threatened breach, Covered Entity will be entitled to injunctive relief to prevent Business Associate from commencing or continuing any action constituting such breach without having to post a bond or other security and without having to prove the inadequacy of any other available remedies. Nothing in this paragraph will be deemed to limit or abridge any other remedy available to Covered Entity at law or in equity.

10. **Assistance in Litigation or Administrative Proceedings.** Business Associate shall make itself and any Subcontractors and employees assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity to testify as witnesses, or otherwise, in the event of litigation, administrative proceedings or investigations being commenced against Covered Entity, its directors, officers, or employees based upon a claimed violation of this Agreement, HIPAA, or other laws relating to security and privacy.

11. **Right of Inspection**. Within ten (10) business days of a written request by Covered Entity, Business Associate and its Subcontractors, if any, shall allow Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI pursuant to this Agreement for the purpose of determining whether Business Associate has complied with this Agreement; provided, however, that (i) Business Associate and Covered Entity mutually agree in advance upon the scope, location and timing of such an inspection; and (ii) Covered Entity shall protect the confidentiality of all confidential and proprietary information of Business Associate to which Covered Entity has access during the course of such inspection.

12. **Miscellaneous**

12.1. **Ownership Rights.** Business Associate agrees and acknowledges that Business Associate has no ownership rights related to the PHI subject to this Agreement.

12.2. **Conflicts.** The terms and conditions of this Agreement will override and control over any conflicting term or condition of other agreements between the parties; provided, in the event that the Services Agreement contains provisions relating to the use or disclosure of PHI which are more restrictive than the provisions of this Agreement, the more restrictive provisions will control. All non-conflicting terms and conditions of such agreements shall remain in full force and effect.

12.3. **Severability and Compliance**. The parties hereto shall comply with applicable laws and regulations governing their relationship, including, without limitation, HIPAA, and any other federal or state laws or regulations governing the privacy, confidentiality or security of patient health information. If a provision of this Agreement is held invalid under any applicable law, such invalidity will not affect any other provision of this Agreement that can be given effect without the invalid provision. Further, all terms and conditions of this Agreement will be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect. Business Associate shall comply with applicable state and federal statutes and regulations governing the privacy, confidentiality and security of patient health information; and shall maintain appropriate policies and procedures to address such requirements and obligations. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA and other federal or state laws or regulations governing the privacy, confidentiality or security of patient health information.

12.4. **Waiver.** The waiver by Business Associate or Covered Entity of a breach of this Agreement will not operate as a waiver of any subsequent breach. No delay in acting with regard to any breach of this Agreement will be construed to be a waiver of the breach.

12.5. **Assignment.** This Agreement will not be assigned by either party without prior written consent of the other party. This Agreement will be for the benefit of, and binding upon, the parties hereto and their respective successors and permitted assigns.

12.6. **Governing Law,** The interpretation and enforcement of this Agreement will be governed by the laws of the State of the location of the Covered Entity.

12.7. **No Third Party Beneficiary Rights.** Nothing express or implied in this Agreement is intended or shall be interpreted to create or confer any rights, remedies, obligations or liabilities whatsoever in any third party.

12.8. **Headings.** The section headings contained in this Agreement are for reference purposes only and will not affect the meaning of this Agreement.

12.9. **Counterparts.** This Agreement may be executed in counterparts, each of which will be deemed to be an original, but all of which together will constitute one and the same instrument. Transmission of images of signed signature pages by electronic means (including PDF or facsimile) shall have the same effect as the delivery of manually signed documents.

12.10. **Notice.** Except as otherwise provided in this Agreement, any notice permitted or required by this Agreement will be considered made on the date personally delivered in writing or mailed by certified mail, postage prepaid, to the other party at the address set forth on the signature page or as either party may designate in writing.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement which is effective as of the date first above written.

COVERED ENTITY:
Odyssey HealthCare Operating B, LP

By: Ann Berryman
Name: Ann Berryman
Title: AVP O
Date: 1/26/23

BUSINESS ASSOCIATE:
Eric A. Sohn, M.D.

By: [signature]
Name: Eric A Sohn, MD HMDC
Title: Medical Director
Date: 1/25/23

Notice Address:

c/o Gentiva
3350 Riverwood Parkway SE, Suite 1400
Atlanta, GA 30339
ATTN: Selece Beasley
TEL: (770) 951-6285
FAX: (913) 814-5866

Notice Address:

_____
_____
_____
ATTN: _____
TEL: _____
FAX: _____

January 15, 2024

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

RE: CON Application – Odyssey HealthCare Operating B, LP (dba Gentiva)
Projected Need Pierce County
Letter of Financial Commitment

Dear Mr. Hernandez,

As CFO for Odyssey HealthCare Operating B, LP (dba Gentiva), we respectfully submit this Letter of Financial Commitment. Gentiva has adequate financial resources to fund this operation in Pierce County from start-up though profitability with cash reserves on hand.

Thank you for your support. We look forward to serving hospice patients in Pierce County.

Let us know if you have any additional questions.

Sincerely,

Thomas Dolan
Chief Financial Officer
thomas.dolan@gentivahs.com

Exhibit 20 – Unaudited Financial Statements

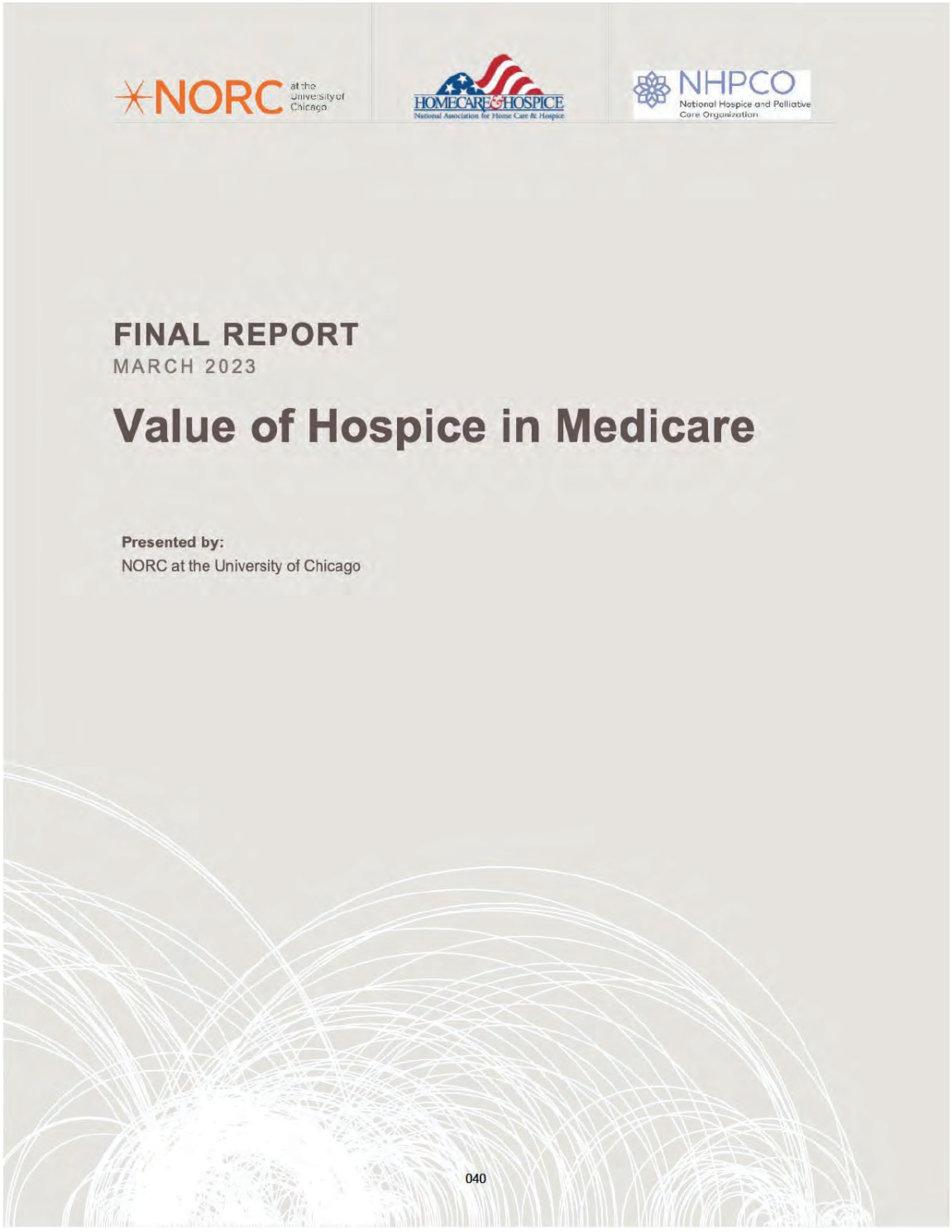
Note: There are no audited financials for Odyssey HealthCare Operating B, LP

ODYSSEY HEALTHCARE OPERATING B, LP
STATEMENT OF OPERATIONS (UNAUDITED)
For the period ended December 31, 2023
(In thousands)

	December 31, 2023
Net revenues	$ 438,407
Cost of services sold	(227,404)
Gross profit	211,003
Selling, general and administrative expenses	(180,530)
Depreciation and amortization expense	(695)
Intangibles and other long-lived asset impairment	(136)
Interest expense	(20,734)
Net income	$ 8,908

ODYSSEY HEALTHCARE OPERATING B, LP
BALANCE SHEETS (UNAUDITED)
As of December 31, 2023
(In thousands)

	December 31, 2023
ASSETS	
Current assets:	
Cash and cash equivalents	$ 1,064
Accounts receivable	54,582
Prepaid expenses and other current assets	3
Total current assets	55,649
Fixed assets, net	3,035
Certificates of need	181,278
Other intangible assets, net	88,415
Goodwill	222,139
Right-of-use assets, operating leases	23,401
Other assets	248
Total assets	574,165
LIABILITIES AND EQUITY	
Current liabilities:	
Current portion of operating lease liabilities	6,440
Payroll and related taxes	130
Obligations under insurance programs	1,542
Accrued nursing home costs	79
Medicare liabilities	28,332
Other accrued expenses	630
Loss contingency accrual	4,000
Total current liabilities	41,153
Long-term portion of operating lease liabilities	16,639
Equity	
Parent investment	516,373
Total liabilities and equity	574,165


NORC at the University of Chicago
HOMECARE & HOSPICE
National Association for Home Care & Hospice
NHPCO
National Hospice and Palliative Care Organization
FINAL REPORT
MARCH 2023
Value of Hospice in Medicare
Presented by:
NORC at the University of Chicago
040

Executive Summary

The National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO) commissioned NORC at the University of Chicago (NORC) to assess the value of hospice to the Medicare program and to beneficiaries, their families, and caregivers.

Background and project goals: Increases in Medicare's hospice benefit enrollment (16.5 percent) and spending (31 percent) from 2015 to 2019 have garnered policymaker attention to hospice and led the Medicare Payment Advisory Commission (MedPAC) to recommend that FY 2023 Medicare base payment rates for hospice remain at 2022 levels, and that the hospice aggregate cap should be wage-adjusted and reduced by 20%. These recommendations amount to a decrease in hospice spending by $250 million–$750 million over one year (approximately 1-3 percent of Medicare hospice outlays) and $5 billion–$10 billion over five years.

This study seeks to estimate the value of the Medicare hospice benefit for patients with terminal conditions, their families, and caregivers, as well as its impact on Medicare spending. Moreover, the analysis explores opportunities for policy makers and hospice organizations to further refine the hospice benefit to ensure it continues to support patients nearing end of life, as well as their families and caregivers.

Approach: NORC assessed the value of Medicare's hospice benefit by primarily using administrative claims data to estimate beneficiary utilization and the impact of hospice use on Medicare spending. NORC compared the outcomes of Medicare beneficiaries who had a hospice stay immediately prior to death to Medicare decedents who did not have a hospice stay but otherwise had a similar risk profile. Differences in chronic health status, end-of-life (EOL) diagnoses, and demographics between the two populations were addressed with a propensity weight model.

Key findings:

- **In the last year of life, the total costs of care for Medicare beneficiaries who used hospice was 3.1 percent lower than the adjusted spending of beneficiaries who did not use hospice.** This relatively modest reduction in adjusted Medicare spending translates to an estimated $3.7 billion less in Medicare outlays for beneficiaries in their last year of life.
- Examination of Medicare spending in policy-relevant length of stay groupings (0-14 days, 15-30, 31-60, etc.) found that total **Medicare spending in the 12 months preceding death is consistently lower for beneficiaries with LOS of 15 days or more,** compared to beneficiaries who did not use hospice, regardless of disease group.
- Furthermore, analyses to find the specific day when Medicare spending for non-hospice users equals spending for hospice users—revealed the "break-even" point at day 10. **Starting on day 11 (prior to death), hospice users' Medicare spending is lower compared to spending for non-**

hospice users. In other words, earlier enrollment in hospice—and longer lengths of stay—may reduce Medicare spending.

- **Hospice stays of six months or more add value to Medicare.** For those who spent at least 6 months in hospice in the last year of their lives, spending was 11 percent lower than the adjusted spending of beneficiaries who did not use hospice. When sorted by disease group, spending ranged from being 4 percent lower for neurodegenerative disease to 25 percent lower for chronic kidney disease/end stage renal disease (CKD/ESRD).
- **Hospice care benefits patients, family members, and caregivers.** From increased satisfaction and quality of life, to improved pain control, to reduced physical and emotional distress, and reduced prolonged grief and other emotional distress, hospice offers multiple benefits to patient, families, and caregivers.

Exhibit 22 – JAMA Health Forum

Association Between Hospice Enrollment and Total Healthcare Costs for Insurers and Families, 2002-2018

JAMA Health Forum

Original Investigation

Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018

Melissa D. Aldridge, PhD; Jaison Moreno, MA; Karen McKendrick, MS; Lihua Li, PhD; Ab Brody, PhD; Peter May, PhD

Abstract

IMPORTANCE Use of hospice has been demonstrated to be cost saving to the Medicare program and yet the extent to which hospice saves money across all payers, including whether it shifts costs to families, is unknown.

OBJECTIVE To estimate the association between hospice use and total health care costs including family out-of-pocket health care spending.

DESIGN, SETTING, AND PARTICIPANTS This retrospective cohort study of health care spending in the last 6 months of life used data from the nationally representative Medicare Current Beneficiary Survey (MCBS) between the years 2002 and 2018. Participants were MCBS participants who resided in the community and died between 2002 and 2018.

EXPOSURES Covariate balancing propensity scores were used to compare participants who used hospice (n = 2113) and those who did not (n = 3351), stratified by duration of hospice use.

MAIN OUTCOMES AND MEASURES Total health care expenditures were measured across payers (family out-of-pocket, Medicare, Medicare Advantage, Medicaid, private insurance, private health maintenance organizations, Veteran's Administration, and other) and by expenditure type (inpatient care, outpatient care, medical visits, skilled nursing, home health, hospice, durable medical equipment, and prescription drugs).

RESULTS The study population included 5464 decedents (mean age 78.7 years; 48% female) and 38% enrolled with hospice. Total health care expenditures were lower for those who used hospice compared with propensity score weighted non-hospice control participants for the last 3 days of life ($2813 lower; 95% CI, $2396-$3230); last week of life ($6806 lower; 95% CI, $6261-$7350); last 2 weeks of life ($8785 lower; 95% CI, $7971-$9600); last month of life ($11 747 lower; 95% CI, $10 072-$13 422); and last 3 months of life ($10 908 lower; 95% CI, $7283-$14 533). Family out-of-pocket expenditures were lower for hospice enrollees in the last 3 days of life ($71; 95% CI, $43-$100); last week of life ($216; 95% CI, $175-$256); last 2 weeks of life ($265; 95% CI, $149-$382); and last month of life ($670; 95% CI, $530-$811) compared with those who did not use hospice. Health care savings were associated with reductions in inpatient care.

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

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Key Points

Question Does hospice enrollment save money across all payers including families and does hospice shift costs from Medicare to families?

Findings In this cohort study, hospice use by community-dwelling Medicare beneficiaries was associated with significantly lower total health care costs across all payers in the last 3 days to last 3 months of life. We found no evidence of cost shifting from Medicare to families and families had significantly lower out-of-pocket health care costs in the last 3 days to last month of life when patients enrolled with hospice.

Meaning The findings of this study suggest that hospice care is associated with financial benefits to the health care system and families through lower health care costs at the end of life.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Introduction

Hospice has expanded to become the dominant model of home care for those with terminal illness and their families. Use of hospice has risen in the past 2 decades from 10% to 50%[1] of Medicare decedents concurrent with the rise of in-home death and is considered to be an indicator of high-quality end-of-life care.[2,3] Hospice is a comprehensive model of care that focuses on quality of life and provides an alternative to burdensome interventions.

Evidence from the early 2000s demonstrated that hospice was cost saving to the Medicare program.[4-7] From 2002 to 2008, hospice use was found to save Medicare money across a range of hospice enrollment durations primarily owing to lower rates of hospital admission and in-hospital death for hospice users. Given that intensity of care at the end of life (outside of hospice) continues to rise,[2,3,8,9] the cost savings to Medicare from hospice enrollment are likely even higher today.

A critical gap in this evidence, however, is how hospice use affects total health care costs, across all payers, including spending by patients and families. Use of hospice may shift economic burden onto families through higher out-of-pocket spending that may be required to care for patients at home. To the extent that hospice is not meeting patient needs adequately, families may face increased pressure to pay for supplemental care, services, medication, or other health care expenditures as has been found outside the hospice setting.[2,10-13] The financial burden of family caregiving for hospice enrollees may be particularly high for patients with prolonged and substantial personal care needs (ie, those with advanced heart or lung disease or with dementia) and out-of-pocket expenditures for these populations can be substantial.[14-18] Nevertheless, we know little about the drivers of costs to families of those at the end of life and whether hospice use provides health care savings in total, or merely shifts the financial burden from Medicare to families.

To address these questions, we used the Medicare Current Beneficiary Survey (MCBS), a nationally representative survey of Medicare beneficiaries, linked to Medicare administrative and claims data. We estimated total health care spending by payer (including family out-of-pocket, Medicare, Medicare Advantage, Medicaid, private insurance, private health maintenance organizations (HMOs), Veteran's Administration, and other) at the end of life for hospice decedents compared with matched decedents who did not receive hospice. We estimated family health care spending using validated self-report of out-of-pocket spending. As hospice use increases and health care continues to shift from the hospital to community settings, the effect on family finances needs to be understood.

Methods

Study Population

We conducted a retrospective cohort study using data from the MCBS from 2002 through 2018. These data exclude survey results from 2014, which were not released by Centers for Medicare & Medicaid Services. The MCBS sample is representative of the Medicare population by age group with oversampling for the oldest old (85 and over), and includes Medicare Advantage enrollees. Of 9118 decedents, 8813 had spending data. We excluded individuals in nursing homes (n = 3059), as our focus is on community-based hospice use. We also excluded those who disenrolled from hospice prior to death (n = 290) because our outcomes are cumulative spending retrospectively from death and assignment to hospice vs no hospice for such individuals is not clear. Our final sample consisted of 5464 MCBS participants living in the community who died between 2002 and 2018 (eTable 1 in the Supplement). The Mount Sinai Institutional Review Board determined that this study was exempt secondary research for which patient informed consent was not required.

Measures

Medicare Current Beneficiary Survey surveys are conducted in person, 3 times per year. All measures are self- or proxy-reported. The response rate for the MCBS in 2018 was 65.4%.[19] All measured

variables are as of an individual's last MCBS interview date prior to death or the after-death proxy interview, which occurred an average of 69.6 days following death. We measured age at death, sex, education (college degree or less than college degree), marital status (married, not married), Medicaid coverage (yes/no), metropolitan area, and census region. Race was self-reported and categorized in MCBS as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, and White. Ethnicity was self-reported and categorized as Hispanic (yes/no). We categorized race and ethnicity as Hispanic, Non-Hispanic Black, Non-Hispanic White, and Other/multiracial. We identified medical conditions using self-report of having ever had the illness and claims data diagnostic codes for heart disease, stroke, lung disease, cancer, and diabetes. For dementia, we used an inclusive case definition developed for use with MCBS data.[20] We measured functional status based on self- or proxy-reported difficulty with 3 or more basic activities of daily living (ADLs): walking, feeding, dressing, toileting, bathing, and transferring.

We categorized hospice decedents by mutually exclusive periods of hospice enrollment based on the number of days prior to death that enrollment occurred, as follows: 0 to 7 days, 8 to 14 days, 15 to 28 days, 29 to 91 days, 92 to 182 days, and more than 182 days.

We measured total health care spending as the sum of family out-of-pocket, Medicare, Medicare Advantage, Medicaid, private insurance, private HMOs, Veteran's Administration, and other. The MCBS team employs numerous strategies to improve the accuracy of self-reported spending data. Respondents are requested to record medical events on calendars provided by the interviewer and to save Explanation of Benefit forms from Medicare and receipts and statements from Medicaid and other public or private health insurers. To assist in reporting data on prescription medications, respondents are asked to bring to the interview bottles, tubes, and prescription bags provided by the pharmacy. All health care services paid for by Medicare are verified through linkage with Medicare claims.[21] Family health care spending includes insurance deductibles, copays, prescription drugs, over-the-counter medications, medical devices and equipment, private duty nurses, social workers, and therapists. Expenditures were measured for the last 3 days, 1 week, 2 weeks, 1 month, 3 months, and 6 months of life. All costs were adjusted for inflation using the medical care component of the Consumer Price Index to 2018 dollars.

Statistical Analysis

For each hospice enrollment period, we estimated covariate balancing propensity scores (CBPS)[22] to estimate each decedent's likelihood of hospice enrollment during the specified period (last 7, 8-14, 15-28, 29-91, 92-182, and >182 days of life). Variables in the CBPS were age, dementia, cancer, help with 3 or more ADLs, and region. Standardized differences are shown in eTable 2 in the Supplement. We used the CBPS-type weight in conjunction with the MCBS survey weights in all analytic comparisons.[22] We used generalized linear models (GLMs) with a gamma distribution and log link function to analyze health care expenditures, adjusting for age, sex, race and ethnicity, education, marital status, survey year, Medicaid status, census region, metropolitan area, serious illness, and help with 3 or more ADLs. Decedents missing 1 or more covariates (n = 644) and were excluded from the analytic sample. We report the adjusted mean health care spending between groups of hospice enrollees and non-hospice control participants. We conducted sensitivity analyses stratifying by year of death (2002-2009 and 2010-2018) and including individuals who disenrolled from hospice in the hospice group.

Results

The study population included 5464 community-dwelling decedents with mean age of 78.7 years at death representing 20 961 442 million Medicare beneficiary decedents. A total of 48% were female, 77.8% were non-Hispanic White, and 53.6% received help with 3 or more ADLs (Table 1). A total of 2113 (37.9%) decedents enrolled with hospice (median 12 days, mean 36 [SD 119] days). Hospice use by year is in eTable 3 in the Supplement.

Total Health Care Cost Savings Associated With Hospice Use

Mean total (SD) health care costs in the last 3 days of life, week of life, 2 weeks of life, month of life, 3 months of life, and 6 months of life were $3879 ($6722), $7073 ($10 682), $10 874 ($15 331), $17 929 ($24 132), $29 048 ($36 916), and $40 843 ($46 747), respectively. Individuals who used hospice incurred significantly lower health care costs for the last 3 days of life ($2813 lower; 95% CI, $2396-$3230); last week of life ($6806 lower; 95% CI, $6261-$7350); last 2 weeks of life ($8785 lower; 95% CI, $7971-$9600); last month of life ($11 747 lower; 95% CI, $10 072-$13 422); and last 3 months of life ($10 908 lower; 95% CI, $7283-$14 533) compared with those who did not use hospice (**Table 2**). There was no significant difference in health care costs in the last 6 months of life between those who used hospice and those who did not. Health care cost savings for those who used hospice were driven by statistically significant reductions in expenditures for inpatient care ($3476 lower in the last 3 days of life; $7404 lower in the last week of life; $10 365 lower in the last 2 weeks of life; $14 175 lower in the last month of life; $21 047 lower in the last 3 months of life; and $24 953 lower in the last 6 months of life) (**Figure 1**). For each comparison group, differences in inpatient care were most apparent in the last week of life. Sensitivity analyses including individuals who disenrolled from hospice prior to death in the hospice group (eTable 4 in the Supplement) and stratifying by year of death (2002-2009 and 2010-2018) yielded similar results (eTable 5 in the Supplement).

Family Out-of-Pocket Health Care Cost Savings Associated With Hospice Use

Family out-of-pocket mean (SD) health care costs in the last 3 days of life, week of life, 2 weeks of life, month of life, 3 months of life, and 6 months of life were $106 ($521), $222 ($946), $388 ($1233), $883 ($2273), $1893 ($4185), and $3276 ($7097), respectively. Out-of-pocket spending in the last 3 days of life, last week of life, last 2 weeks of life, and last month of life were highest for inpatient care

Table 1. Characteristics of Medicare Decedents, 2002-2018[a]

Characteristic	% Total (N = 5464)	Decedents who used hospice (n = 2113)	Decedents who did not use hospice (n = 3351)	*P* value
Age, mean (SD), y	78.7 (10.9)	81.2 (10.5)	77.1 (11.2)	<.001
Race/ethnicity				.001
Hispanic	6.5	6.3	6.5	
Non-Hispanic				
Black	10.2	7.6	11.8	
White	77.8	81.3	75.7	
Other/multiracial[b]	5.5	4.8	6.0	
Female sex	48.4	51.0	46.8	.01
Married	44.3	43.8	44.6	.59
Education: college degree	13.9	13.8	14.0	.89
Medicaid coverage	23.2	18.7	26.0	<.001
Serious illness				
Cancer	43.0	53.2	36.8	<.001
Dementia	30.4	38.4	25.5	<.001
Diabetes	35.9	32.9	37.7	.002
Heart disease	42.3	41.8	42.5	.66
Lung disease	33.1	32.2	33.7	.29
Stroke	22.7	22.4	22.8	.80
Receive help with ≥3 ADLs	53.6	62.6	48.2	<.001
Metropolitan area	76.0	80.1	73.5	.002
Region				.01
Northeast	18.4	14.6	20.7	
Midwest	23.2	25.0	22.1	
South	39.3	42.2	37.6	
West	19.1	18.2	19.6	

Abbreviation: ADLs, activities of daily living.

[a] Table depicts characteristics of the study sample prior to propensity score weighting. All percentages incorporate Medicare Current Beneficiary Survey weights and weighted values exceed 1 million.

[b] Other/Multiracial includes American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and anyone who self-reported more than 1 race.

and in the last 3 and 6 months of life were highest for care in non-nursing home facilities (eg, in assisted living facilities) followed by costs for prescription drugs, durable medical equipment, and inpatient care (**Figure 2**).

Decedents who used hospice incurred significantly lower out-of-pocket costs for the last 3 days ($71 lower; 95% CI, $43-$100), 1 week ($216 lower; 95% CI, $175-$256), 2 weeks ($265 lower; 95% CI, $149-$382), and 1 month ($670 lower; 95% CI, $530-$811) of life (Table 2). There was no significant difference in out-of-pocket health care costs in the last 3 or 6 months of life between those who used hospice and those who did not.

Medicare Cost Savings Associated With Hospice Use

Medicare costs in the last 3 days of life, week of life, 2 weeks of life, month of life, 3 months of life, and 6 months of life were $3187 (SD, $5902), $5785 (SD, $9169), $8910 (SD, $13 613), $14 520 (SD, $22 085), $22 798 (SD, $34 054), and $30 872 (SD, $42 742), respectively. Individuals who used

Table 2. Adjusted Health Care Expenditures at the End of Life for Individuals Enrolled With Hospice and Non-Hospice Control Individuals, 2002-2018

Characteristic	Adjusted mean, $		Difference	*P* value
	Hospice group	Propensity score weighted controls		
Total expenditures				
Last 3 d[a]	2473	5285	−2831	<.001
Last wk[b]	2106	8911	−6806	<.001
Last 2 wks[c]	4083	12 869	−8785	<.001
Last mo[d]	8558	20 305	−11 747	<.001
Last 3 mos[e]	20 908	31 816	−10 908	<.001
Last 6 mos[f]	43 679	43 357	322	.93
Family out of pocket				
Last 3 d[a]	67	139	−71	<.001
Last wk[b]	46	262	−216	<.001
Last 2 wks[c]	159	424	−265	<.001
Last mo[d]	241	912	−670	<.001
Last 3 mos[e]	2412	1763	649	.41
Last 6 mos[f]	4096	2988	1109	.55
Medicare				
Last 3 d[a]	2121	4389	−2267	<.001
Last wk[b]	2029	7337	−5308	<.001
Last 2 wks[c]	3824	10 576	−6752	<.001
Last mo[d]	7835	16 559	−8724	<.001
Last 3 mos[e]	17 523	25 250	−7727	<.001
Last 6 mos[f]	36 208	33 036	3171	.26
Private insurance				
Last 3 d[a]	90	207	−117	<.001
Last wk[b]	3	347	−345	<.001
Last 2 wks[c]	11	567	−556	<.001
Last mo[d]	52	918	−866	<.001
Last 3 mos[e]	165	1499	−1334	<.001
Last 6 mos[f]	105	2252	−2147	<.001
All other payers				
Last 3 d[a]	231	568	−337	<.001
Last wk[b]	80	992	−912	<.001
Last 2 wks[c]	64	1408	−1344	<.001
Last mo[d]	213	2175	−1962	<.001
Last 3 mos[e]	500	3518	−3018	<.001
Last 6 mos[f]	1152	5422	−4270	<.001

Abbreviation: GLM, generalized linear models.

[a] Sample sizes vary due to hospice enrolment period: hospice enrollment in the last week of life and comparison group (n = 3781).

[b] Sample sizes vary due to hospice enrolment period: hospice enrollment 8-14 days before death and comparison group (n = 3242).

[c] Sample sizes vary due to hospice enrolment period: hospice enrollment 15-28 days before death and comparison group (n = 3223).

[d] Sample sizes vary due to hospice enrolment period: hospice enrollment 29-91 days before death and comparison group (n = 3202).

[e] Sample sizes vary due to hospice enrolment period: hospice enrollment 92-182 days before death and comparison group (n = 2832).

[f] Sample sizes vary due to hospice enrolment period: hospice enrollment >182 days before death and comparison group (n = 2551).

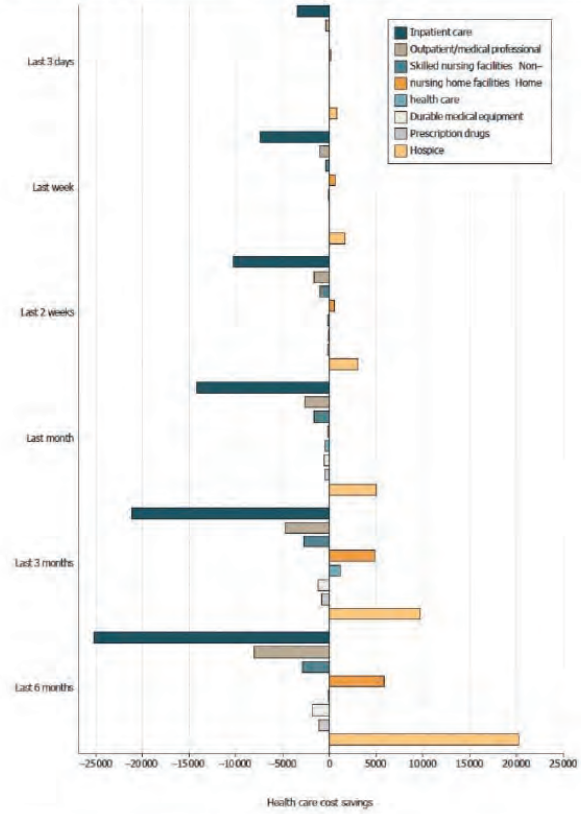
Variables included in the covariate balancing propensity score: age, dementia, cancer, help with 3+ activities of daily living, region. Variables included in the GLM model: age, sex, race/ethnicity, education, marital status, survey year, Medicaid status, census region, census metropolitan area, serious illness (dementia, heart disease, stroke, lung disease, cancer, and diabetes), and if the respondent needed help with 3 or more activities of daily living. All other payers includes Medicare Advantage, Medicaid, private health maintenance organizations, Veteran's Administration, and other.

hospice incurred significantly lower Medicare costs for the last 3 days ($2267 lower; 95% CI, $1864-$2671), last week ($5308 lower; 95% CI, $4771-$5845), last 2 weeks ($6752 lower; 95% CI, $5989-$7515), 1 month ($8724 lower; 95% CI, $7135-$10 313), and 3 months ($7727 lower; 95% CI, $4721-$10 733) of life (Table 2). There was no significant difference in Medicare costs associated with hospice enrollment for the last 6 months of life.

Costs Savings Associated With Hospice Use for Private Insurance and All Other Payers

Private insurance expenditures were lower for those who enrolled with hospice compared with those who did not enroll with hospice for all periods examined (Table 2). Unlike Medicare and families, private insurance and all other payers combined (Medicare Advantage, Medicaid, private HMOs, Veteran's Administration, and other) had evidence of cost savings associated with hospice in the last

Figure 1. Adjusted Health Care Cost Savings for Individuals Enrolled With Hospice Compared With Non-Hospice Control Participants by Health Care Event, 2002-2018



6 months of life ($2147 lower for private insurance; 95% CI, $1905-$2388; and $4270 lower for all other payers; 95% CI, $3296-$5245).

Discussion

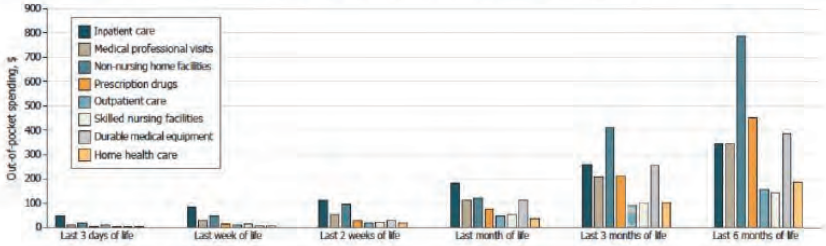
To our knowledge, this is the first examination of the association between hospice use and total health care costs across all payers. We found that hospice use was associated with lower total health care costs in the last 3 days to last 3 months of life. Given that more than 80% of community-dwelling hospice enrollees in our sample received care for 3 months or less, cost savings are attributable to the vast majority of the community-dwelling hospice population. We found no difference in total health care expenditures in the last 6 months of life associated with hospice use.

Importantly, we found that use of hospice did not shift costs from Medicare to families through higher family out-of-pocket spending. Health care costs were lower for patients and families receiving hospice for each time period examined up to 1 month prior to death compared with health care costs of patients and families who did not receive hospice. The magnitude of out-of-pocket savings owing to hospice are meaningful to many Americans, particularly those with lower socioeconomic status, including the 23% in the present study sample who were Medicaid eligible. The estimated 1-month out-of-pocket savings associated with hospice is $670, which represents roughly 20% of the monthly income of the lowest third of older adults in the US.[23] Further, the $670 estimated savings represents an almost 75% reduction in out-of-pocket costs compared with older adults who did not receive hospice care.

The present study provides new details regarding family out-of-pocket spending at the end of life. In the last month of life, families paid the highest amount in out-of-pocket health care expenses for inpatient care compared with what they spent for outpatient care, medical provider visits, prescription drugs, and other health care needs. In the last 3 months and 6 months of life, family health care spending was driven by care received in non-nursing home facilities such as assisted living facilities. Family spending for health care in these facilities averages $413 in the last 3 months of life and $789 in the last 6 months of life. These types of community-based residential settings comprise a wide range of environments with differing amounts of built-in services and high rates of hospice use.[24] The type of health care received in these settings and the financial burden for those residing there is an important emerging area of research.

Hospice was associated with lower total health care expenditures across all payers and families primarily owing to lower spending for inpatient care, consistent with prior work.[1] A primary goal of hospice is to manage pain and other symptoms in the home setting and avoid hospitalization. Exacerbations in clinical conditions can be addressed through higher levels of hospice care including continuous home care, which provides a minimum of 8 hours of licensed nursing care per day in the

Figure 2. Family Out-of-Pocket Health Care Expenditures of the Entire Study Population at the End of Life (N = 5464), 2002-2018



home. Although use of continuous home care by hospices is more expensive to Medicare, its association with reductions in hospitalizations may be contributing to our finding of health care savings.[25]

Medicare incurred lower health care costs for all measured time periods up to 3 months prior to death for community-dwelling individuals who enrolled with hospice. Cost savings were evident even for those who only enrolled with hospice in their last week of life, which is the case for approximately 25% of all hospice users in the US.[1] Although even a single day of hospice care may be beneficial to patients and families, many advocate for patients to receive at least 2 weeks of hospice care to experience the benefits. Greater cost savings from longer enrollment align with this quality metric. For those who enroll with hospice for 6 months of more prior to death, the cost of hospice care itself offsets the reductions in inpatient spending, mostly owing to high inpatient costs that occur near the end of life.

It will be important to evaluate the effect of the 2016 hospice payment reform on Medicare hospice spending. The 2-tiered per diem payment methodology implemented in 2016 pays higher per diem amounts for the first 60 days of hospice care and lower per diem amounts for each day beyond 60 days, as well as a service intensity add-on payment for visits in the last week of life. Although this change does not effect family out-of-pocket spending or spending by insurers other than Medicare, its effect on Medicare spending, differentially across length of hospice enrollment category, is a key area for future research.

Limitations

The present study limitations include the inability to adjust for unmeasured characteristics of those who do and do not use hospice. In particular, preferences among people with serious illness, their family members, and their health care professionals are likely associated with both the exposure and outcome of interest. Given that preferences are not measured in MCBS or any of our linked data, we were unable to control for them. Although tools such as instrumental variables could help address unmeasured confounders such as preferences for care,[26] we did not identify a valid instrument in the data set. While imperfect, propensity score weighting is among the most rigorous tools available to compare groups outside of a randomized trial and it has been used in a wide range of studies to inform policy-relevant questions with observational data. Our analyses yield important, new information regarding spending at end of life across all payers, including families, in a large, population-based sample that could not otherwise be achieved for ethical and practical reasons with a randomized trial design. Second, we include only monetary costs and do not include unpaid caregiving by family members, which may be higher for those who are not receiving the interdisciplinary care of hospice teams. In addition, owing to sample size limitations, our examination of expenditures in the last 3 days of life is for hospice users who enrolled with hospice 0 to 7 days prior to death and therefore inflates the expenditures associated with hospice for those who enrolled with hospice 0 to 2 days prior to death. Despite this conservative approach, hospice use was associated with cost savings for all payers in the last 3 days of life. Finally, we are unable to account for payments that Medicare receives from hospices owing to the Hospice Aggregate Cap, which 10% to 15% of hospices incur each year.[27,28] Its inclusion would decrease estimates of Medicare spending for hospice enrollees and increase cost savings owing to hospice enrollment.

Conclusions

The findings of this cohort study suggest that hospice use is an example of a health care model that demonstrates both components of the value proposition: it improves the quality of end-of-life care and is associated with lower health care costs. Moreover, unlike many other aspects of our health care system, cost reductions to insurers in the present study did not translate into higher costs for patients and their families.

ARTICLE INFORMATION

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Author Contributions: Dr Aldridge had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Aldridge, Moreno, McKendrick, Brody, May.

Acquisition, analysis, or interpretation of data: All authors.

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SUPPLEMENT.

eTable 1. Sample Derivation, Medicare Current Beneficiary Survey, 2002-2018

Exhibit 23 – Truist Bank Letter and Account Balance

TRUIST

Truist Bank
5130 Parkway Plaza Blvd
Charlotte, NC 28217

Lachelle Kornegay
WP-Dedicated Support Specialist II
Office: 800-774-8179
Lachelle.Kornegay@truist.com

Date: 10/31/2024

To whom it may concern:

ATTN: Controller or Treasury Manager
RE: Account / Routing Number Confirmation

Please accept this letter as confirmation that according to our records, the account referenced below is maintained at Truist Bank with the following information.

Account Name:	CURO HEALTH SERVICES LLC
Account Address:	3350 RIVERWOOD PKWY SE STE 1400 ATLANTA GA 30339
Account number:	[redacted]
Routing number ACH/EFT:	[redacted]
Routing number WIRES:	[redacted]
SWIFT Code INTL WIRES:	[redacted]
Bank Name:	TRUIST BANK
Bank Address:	214 N. Tryon St., Charlotte, NC 28202 United States

Best Regards,

Lachelle Kornegay

Lachelle Kornegay
WP-Dedicated Support Specialist II
Treasury Operations

025

10-04-2024

5121974 AA
CURO HEALTH SERVICES LLC
MASTER ACCT
3350 RIVERWOOD PKWY SE STE 1400
ATLANTA GA 30339-3314

FROM 09-01-2024
TO 09-30-2024

* * * * * * HOLD STATEMENT * * * * * *

ACCOUNT OFFICER JORDAN R WILDER 55499

GROUP NO.
ACCOUNT NO. [redacted]

COMBINED ANALYSIS
ANALYZED INTEREST CHECKING

AVERAGE BALANCE				21,964,097.74
LESS: AVERAGE FLOAT				178,766.64
AVERAGE COLLECTED BALANCE				21,785,331.10
AVG POSITIVE COLLECTED BAL				21,785,331.10
LESS: REQUIRED RESERVES				.00
AVG POSITIVE AVAILABLE BAL				21,785,331.10
LESS: BALANCE REQUIRED				2,604,518.85-
NET AVAILABLE BALANCE				19,180,812.25
APPLICABLE RATES:				
EARNINGS CREDIT	3.100	INTEREST	3.350	
***INTEREST AMOUNT				52,688.62

The applicants bank account is a consolidated account held by its indirect parent company, Curo Health Services, LLC.

Exhibit 24 – Copy of Application Fee & FedEx Tracking Number

Gentiva

Vendor
WA DEPARTMENT OF HEALTH

Vendor ID

Date

Check Number

PAYMENT INFORMATION

Invoice Number	Invoice Date	Description	Patient Liability	Invoice Amount	Denied Amount	Paid Amount
CDWAW 012125		ODYSSEY HEALTHCARE OPERATING B				

TOTALS

Gentiva
PO Box 4850
Mooresville, NC 28117

TRUIST
ATLANTA, GA 30303

Pay Twenty One Thousand Nine Hundred Sixty Eight Dollars And 00 Cents

Pay to the Order of:
WA DEPARTMENT OF HEALTH
CERTIFICATE OF NEED PROGRAM
111 ISRAEL RD SE
TUMWATER, WA 98501

VOID AFTER 180 DAYS

after printing this label:
CONSIGNEE COPY - PLEASE PLACE IN FRONT OF POUCH
1. Fold the printed page along the horizontal line.
2. Place label in shipping pouch and affix it to your shipment

Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com. FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery, misdelivery, or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim. Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental, consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss. Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our Service Guide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

gentiva

Exhibit 25 – Letters of Support

Letters of Support	
Name	**Organization**
Sherri M. Hall	Daughter of Previous Patient
Christina Foutch, OTR, Owner	Home Matters Caregiving
Anna Page	Surviving Spouse
Cyndi Fuchek, RN	Community Nurse
Cindi Bohall	NW Senior Advisors

January 3, 2025

To whom It May Concern:

My name is Sherri Hall. I am a current resident of Pierce County, WA. My family used Gentiva for my mother and mother n law. I was their primary caregiver. Gentiva has been in King County for many years. They have an excellent reputation, and they did not disappoint us when caring for our family. The nurses and caregivers were professionally trained and have compassionate bedside care. The caregivers that came to our home in Auburn, Washington always spoke highly of their experience working for Gentiva. Our bath aid had worked for them for more than 15 years. She came every week and was kind and gentle. If they were going to be late, they always called and made sure we knew when they were coming.

When I had to call with questions or concerns, I could reach them any time of the day. Even when our regular nurse was not available we would have excellent care from nurses covering for her. Gentiva was at the top of our list for our father when he needed hospice care for him, but when we called, they could not serve him because they were not licensed in Pierce County.

As a family member and previous healthcare worker myself, I highly recommend Gentiva to be chosen as a provider in Pierce County.

With gratitude to Gentiva for their tender care of my family,

Sherri M. Hall

Daughter of previous patient

HOME MATTERS
CAREGIVING

4875 SW Franklin Ave
Beaverton, OR 97005
503-352-5634
www.homematterscaregiving.com

December 6, 2024

To Whom It May Concern,

I am the owner of Home Matters Caregiving. As the owner and Clinical Director, it's been my privilege to work with Karly and the staff at Gentiva Hospice. They not only provide compassionate end of life care to their clients, but they also ensure the caregivers in the Portland metro area are trained to do so. I strongly support Gentiva and those they serve in our surrounding counties.

I have first had experience working with the nurses and staff at Gentiva. Not only working with clients together, but they were the first to call for a family member. I will forever be grateful for their time, compassion and patience they showed not only the client but the family members. I highly recommend Gentiva and have not doubt they will bring the highest level of care to those in need in the Pierce and Clallum County.

Sincerely,

Christina Foutch, OTR
Owner
Home Matters Caregiving

January 7, 2025

To Whom It May Concern,

I am writing to express my heartfelt gratitude and unwavering support for Gentiva Hospice and the extraordinary care they provided to my husband, as well as our family, during the final chapter of his life. My family and I are forever indebted to the compassionate staff at Gentiva Hospice in Spokane, Washington. They helped us navigate one of the most challenging times of our lives with dignity, grace, and compassion.

It is my understanding that Gentiva Hospice is applying for a certificate of need in Pierce County, WA. I would like to wholeheartedly recommend Gentiva Hospice to be able to serve the residents of Pierce County as that community deserves to have the opportunity to experience the same unwavering care that we received here in Spokane.

I am a retired medical provider, and efficiency, compliance and quality of care is extremely important to me. Given that Gentiva is a national company with protocols in place to maintain those measures, gave me peace of mind in my selection of Gentiva Hospice to care for my husband. He was very difficult for me to care for, but Gentiva came in and changed our entire experience. Ensuring he was cared for and comfortable, I was able to return to being his loving wife instead of an exhausted caregiver. Our nurse and Truly the CNA, "truly" changed our entire experience for the better and gave my husband the exceptional care that he deserved but I was not equipped to provide.

Again, I recommend that you consider Gentiva Hospice to be a provider in Pierce County.

Anna Page

Anna Page

Surviving spouse

Cyndi Fuchek, RN
Lake Tapps, WA 98391
206-227-0558

November 24, 2024

State of Washington CON Committee
PO Box 47852
Olympia, WA 98504

To whom it my concern,

I am writing in support of Gentiva Hospice in submitting for certificate of need in Pierce County for hospice services. I worked with Gentiva from 2009 to 2013 and during this tenure, I was part of the partnership Gentiva had with the community. Gentiva is highly regarded as a trusted partner with healthcare facilities, from hospitals, skilled nursing, long term care, and senior housing.

Gentiva was actively involved in senior health fairs, participant in pierce coalition for continuity of care with other healthcare facilities for best patient outcomes, as well as advocating for patient choice and being transparent in care provided.

I am happy to speak to any additional information on Gentiva for certificate of need for hospice and the value they will bring to Pierce County and residents having them as choice.

Sincerely,

Cyndi Fuchek, RN

NW SENIOR ADVISORS
Personally guiding you to housing and care.

253-576-7293
CindieB@NWSeniorAdvisors.com
www.nwseniorsadvisors.com
PO Box 7083
Bonney Lake, WA 98391

January 16th, 2025

To Whom It May Concern,

It is my absolute privilege to write this letter of recommendation for Gentiva Hospice. Over the past 20 years, I have had the distinct pleasure of working closely with Gentiva in various capacities. Their reputation for excellence and professionalism is unparalleled in the hospice care industry, and their presence in Pierce County is essential for the well-being of families in our community.

Gentiva Hospice's longstanding reputation as a leader in compassionate end-of-life care is widely recognized, not only in Pierce County but also in King County, where their name has become synonymous with quality and dignity. They have consistently demonstrated a level of service and professionalism that far exceeds expectations. Families who rely on Gentiva are met with warmth, understanding, and a deep commitment to ensuring comfort during some of life's most challenging moments.

As a business owner and senior advisor in Pierce County, I cannot overstate the importance of having resources like Gentiva available to our community. Their team's dedication to providing outstanding hospice care is vital to the families who entrust them with their loved ones. Gentiva's ability to balance professionalism with genuine empathy is a hallmark of their service, and it sets them apart from others in the field.

In my two decades of experience with Gentiva, I have witnessed firsthand the positive impact they have made in countless lives. Their steadfast commitment to excellence and their reputation for delivering high-quality care have cemented their role as an indispensable asset to our community. Their presence in Pierce County is not just beneficial—it is essential.

I wholeheartedly recommend Gentiva Hospice and commend their unwavering dedication to serving families with compassion and professionalism. They are a cornerstone of support in our region, and their continued success is vital to ensuring the highest standard of care for those in need.

Sincerely,
Cindie Bohall

Cindie Bohall

Exhibit 26 - NHPCO Hospice Staffing Framework

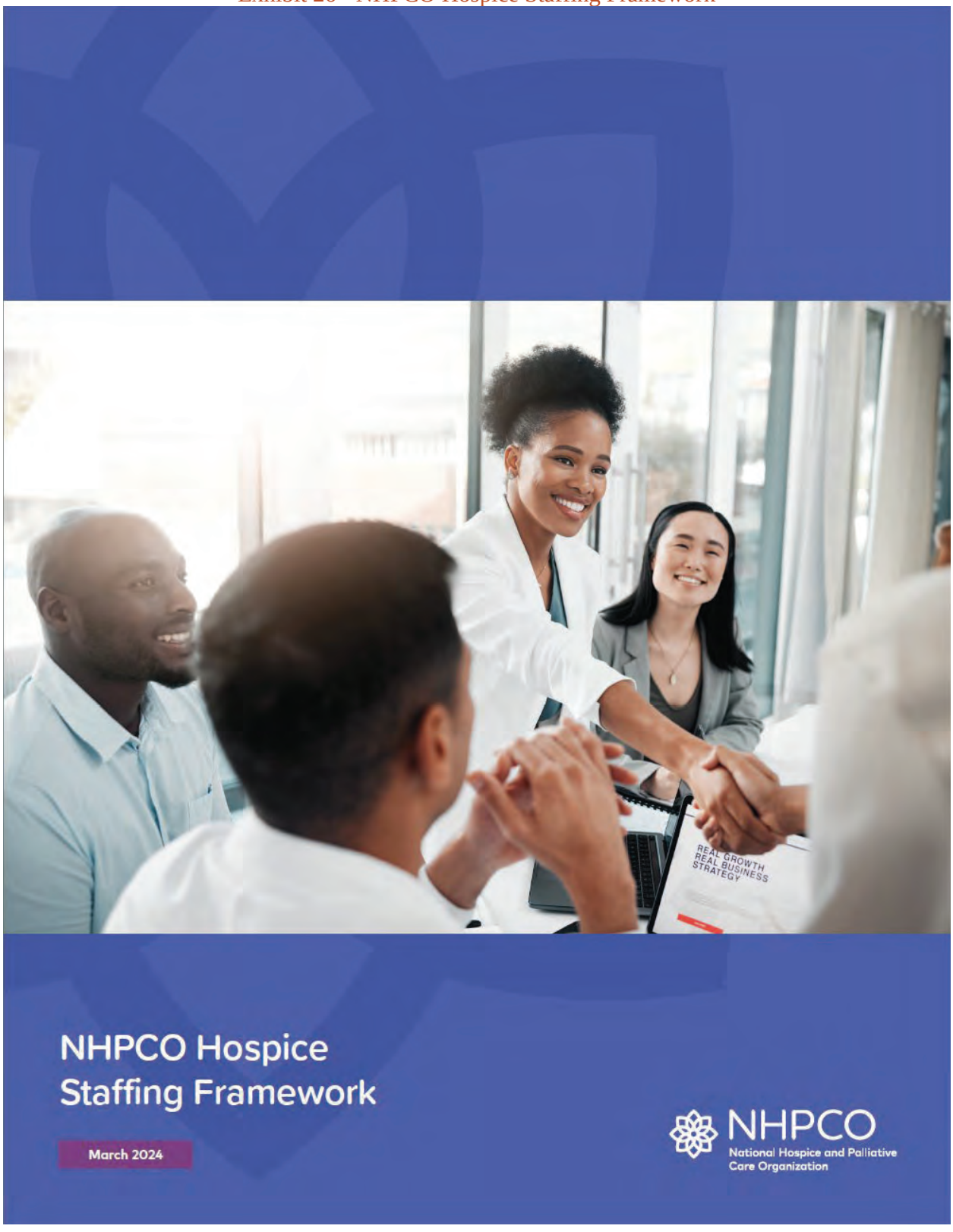

Table of Contents

NHPCO Hospice Staffing Framework

Background

Guidelines for staffing ratios were introduced by NHPCO as part of the Hospice Service Guidelines published in 1994. The Hospice Service Guidelines document was produced by the NHPCO Standards and Accreditation Committee as an effort to reflect industry practice and provide specific operational guidelines and benchmarks that were not incorporated into the Standards of Practice for Hospice Programs. In addition to staffing ratios, the guidelines included sections on admission and discharge policies and practices, levels of care, scope of services, and facility-based services. The staffing ratios section provided ranges for recommended caseload numbers for clinical staff and proved to be a useful and popular tool for hospice administrators and interdisciplinary team members.

The recommended numbers for staffing ratios in the Hospice Service Guidelines were developed when hospice was still in its formative years and data on hospice operations were sparse. At that time hospice service models were more basic and uniform, and the patient population served was quite different from the population served today by hospice programs. As hospice practice evolved and became more complex, the need for an up-to-date process to determine optimal staffing became evident. To meet that need, NHPCO and the Quality and Standards and Regulatory Committees undertook the development of NHPCO Hospice Staffing Framework to provide hospices with a method for assessing their organizational staffing needs that aligns with the current realities of providing hospice care.

No one "best standard" in the literature regarding hospice staffing caseloads currently exists. Around the nation, hospices have evolved in various directions, creating diverse models of care to serve hospice patients and families. The NHPCO Hospice Staffing Framework is based on the recognition of the current diverse nature of hospice care and allows for individualization of staffing caseloads according to the organizational and environmental characteristics specific to each hospice, in much the same way hospices individualize patient care.

The NHPCO Hospice Staffing Framework utilizes an assessment process to help determine optimal staffing levels for hospice programs that includes an analysis of the model of care delivery, characteristics of the patient population served, environmental considerations, and quality outcomes. However, it is important to keep in mind that the primary consideration that should be used by a hospice to determine optimal staffing levels is the hospice's ability to meet the needs of patients and families through appropriate use of resources and achieving the quality and financial goals set by the hospice program.

Introduction to the NHPCO Hospice Staffing Framework

The purpose of this framework is to help each hospice provider assess a number of factors with the potential to impact staffing in order to better determine whether their current staffing framework is appropriate to their organizational needs. The diverse models of hospice care which are driven by variation in patient populations, population density, travel time, and other factors inherent to the uniqueness of each hospice program require an innovative process to determine appropriate staffing. The NHPCO Hospice Staffing Framework presents a process to analyze these factors so that hospice programs can evaluate their current staffing through the lens of a number of relevant variables and outcomes and determine where there may be a need to adjust staffing resources. Through the application of a systematic process grounded in critical thinking, the framework also offers hospices with a library of current staffing models that may be applicable to their organizational environment.

This framework differs from the previously published staffing ratios and guidelines in that recommended ranges for caseloads are not provided. Instead, using the analysis process delineated in the framework, each hospice may assess a number of variables and outcomes measures to identify whether there are opportunities to better tailor staffing to meet the needs of their organization.

The NHPCO Hospice Staffing Framework is divided into the following four sections:

Section 1. Using the NHPCO Hospice Staffing Framework

This section describes the steps that an organization should take in order to effectively utilize the NHPCO Staffing Framework for Hospice. There are five steps outlined in this section:

- **Review descriptions** of variables and outcome measures
- **Review additional factors** that may impact staffing decisions
- **Input organizational metrics** into Staffing Framework Tool and compare to benchmarks
- **Determine need** for potential staffing adjustments
- **Review Staffing Models Reference Library** for creative staffing model options

Section 2. Variables, Outcomes, and Benchmarks

This section includes a description of each variable and outcome measure included in the Staffing Framework Tool, as well as an explanation of how to assess organizational metrics as compared to the available benchmarks. For example, for certain indicators an organizational metric below benchmark reference may indicate a need for increased staffing resources, while for other indicators an organizational metric above benchmark reference may indicate a need for increased staffing resources.

Section 3. NHPCO Hospice Staffing Framework Tool

This section includes the NHPCO Hospice Staffing Framework Tool, a fillable document that organizations may complete in order to assess the impact of selected variables and outcomes on their staffing configuration.

Section 4. Staffing Models Reference Library

This section includes a list of staffing models for organizations to explore, including circumstances in which each model may be appropriate to consider.

Section 1: Using the NHPCO Hospice Staffing Framework

This section describes the steps that an organization should take in order to effectively utilize the NHPCO Staffing Framework for Hospice.
There are five steps outlined in this section:

Step 1 – Review Descriptions of Variables and Outcome Measures

The NHPCO Staffing Framework for Hospice includes several organizational variables and outcome measures for organizations to consider when determining whether staffing adjustments need to be made. While there is no existing validated instrument capable of capturing the complexity of hospice care and determining staffing minimums by discipline, this tool is intended to highlight the multiple factors that organizations should assess when considering their staffing models, such as:

- Higher percentage of short length of stay (LOS) patients: A hospice that has a higher percentage of short length of service (LOS) patients, compared to the national average, could be considered to have a patient caseload that has higher than average acuity. Evidence exists indicating that the intensity of services provided in the first and last week or two of service may be higher than in the interim period, and patients who die within one week are generally more resource intensive, with higher acuity than patients who live for longer periods of time.
- Lower percentage of Routine Home Care and higher percentage of GIP/CHC: A hospice that has a lower percentage of routine level of care patients than the national average (and thus a higher percent of patients at a general inpatient (GIP) level of care or receiving continuous care (CHC) at a higher rate) could be considered to have a patient population with a higher-than-average acuity level.
- Higher percentage of Open Access patients (patients receiving disease-modifying therapies): A hospice that admits patients who are receiving disease-modifying therapies may have a patient population in need of higher intensity of services. For example, if patients remain on disease modifying therapy, they may require close monitoring and intensive treatment for side effects of therapy (e.g., cancer patients on chemotherapy), or have interventions requiring frequent monitoring and increased levels of expertise with invasive technology (e.g., patients on ventilators).

Please review the full NHPCO Hospice Staffing Framework Tool for complete variables and outcome measures.

Step 2 – Review Additional Factors that May Impact Staffing Decisions

Other factors that are more difficult to quantify may also impact the staffing caseload for one or more disciplines and should be carefully considered when making adjustments to caseloads. Below is a list of common major factors that may influence caseload estimation. The list is not intended to be all inclusive; individual hospices may encounter other influential factors specific to their situation. If an organization determines that one or more of these factors impacts their operations, they are encouraged to incorporate the following considerations into their staffing decisions.

- ☐ **Psychosocially complex patients:** Hospices that care for a high number of patients with psychosocial issues of high complexity (e.g., a hospice specializing in serving patients with AIDS; a hospice with a high proportion of pediatric and/or young adult patients) may require additional staffing and lower caseloads. For example, hospices specializing in serving:
  - » Patients with AIDS
  - » Pediatric and/or young adult patients
  - » Patients with mental health comorbidities
  - » Complex family dynamics
  - » Frequent need for translators
  - » Diverse spiritual/cultural populations
  - » Patients experiencing challenges with social determinants of health

- **Primary team performing CHC:** Hospices that rely on primary team members to implement and perform continuous home care, as opposed to a specialized CHC team, may find that they require additional staffing and lower patient caseloads.
- **Contracted GIP:** Hospices that rely on contract beds for GIP patients may find that a lower caseload for clinical team members is appropriate due to increased intensity and frequency of visits and care coordination.
- **IDT members with multiple roles:** Lower caseloads may be appropriate for those IDT members who have additional roles such as teaching/mentoring other staff or health professionals in training or involvement in research activities. Lower caseloads for IDT members, such as social workers and chaplains, may be appropriate if core IDT members routinely provide services to the community such as crisis outreach and bereavement services to non-hospice individuals. In addition, organizations in which administrative or leadership staff are frequently called upon to serve in clinical roles, or clinical staff with multiple roles, may choose to implement lower caseloads.
- **High percentage of facility-based patients:** Hospices with a concentration of patients in one facility and/or that have dedicated facility-based homecare teams may be able to utilize a higher than median caseload. However, also take into consideration that maintenance of a good relationship with a facility requires constant effort to communicate collaboratively, ongoing education for facility staff (which generally have a high turnover rate), and additional time and effort to communicate with families who may not be present during hospice staff visits to patients.
- **Supplemental/administrative support:** If office-based staff are utilized other than the primary IDT to provide administrative support, such as triaging patient calls, facilitating medication and supply orders, coordinating transportation needs, etc. during routine business hours, all IDT staff may be able to carry higher than median caseloads.
- **Specialty programs:** Hospices that utilize specialty/disease specific programs may be able to support a higher caseload for some staff, if teams providing specialty care relieve other core staff from providing direct care to the specialty patient population. A lower caseload for staff providing care in the specialty/disease specific program may be appropriate if intensity of services or monitoring is increased. Hospices that utilize dedicated staff to manage specific aspects of a patient's illness (for instance, pressure ulcers managed by a clinical nurse specialist in wound care, or intravenous therapy managed by an intravenous therapy nurse specialist) may be able to have homecare nurse case-managers carry a higher caseload. A lower caseload for IDT members dedicated to serving pediatric patients may be appropriate due to longer visit times and complexity of care, along with additional collaboration with community/outside partners in care.
- **Rapid growth:** Lower caseloads for IDT members may be needed to maintain provision of quality care and manage the additional patients and multiple admissions that occur during growth spurts.
- **Community spiritual support:** A higher caseload for hospice chaplains may be appropriate for hospices that routinely utilize community clergy to provide direct services to most patients. However, this may be mitigated by the greater outreach and education efforts hospice chaplains may need to employ in this circumstance. A lower caseload for chaplains may be appropriate for hospices whose chaplains are routinely heavily involved in providing or participating in funeral and memorial services for their patients who have died.
- **Staff safety issues:** Hospices that provide services in high crime areas may need to utilize a lower than median caseload for their IDT members, because IDT members may need to do joint visits for safety reasons which results in less efficient use of staff time.
- **Travel time:** Hospices may need to utilize lower caseloads for the IDT members if an inordinately long time is necessary for between-visit travel. Travel time may be lengthened for a number of reasons such as high absolute square mileage of service area per team, traffic congestion in urban/suburban areas, etc. Travel time is a particularly important factor for determining caseloads for "frontier" hospice providers because hours may be required between visits for travel.
- **Volunteer utilization:** A higher caseload may be appropriate for hospices that effectively use well-trained patient volunteers. However, the time needed for close supervision and support of the volunteers may offset the advantages of volunteer use to some degree.

Step 3 – Input Organizational Metrics into Staffing Framework Tool and Compare to Benchmarks

Review the following fillable NHPCO Staffing Framework tool and gather as many relevant organizational metrics as possible. Enter these values into the tool and compare them to the available benchmark references.

The NHPCO Staffing Framework Tool includes a description of each metric, as well as the potential significance of each in order to assist with interpreting the comparison of organizational metrics to benchmarks.

Step 4 – Determine Need for Potential Staffing Adjustments

Based on the comparison of organizational variables and outcomes to benchmarks, as well as a review of the additional factors listed above, organizations should identify whether the majority of their metrics indicate a need for increased staffing or that sufficient staffing is present. There is no specific number of metrics that should fall above or below benchmarks in order to indicate a need to adjust staffing. Using the analysis process delineated in the framework, each hospice should identify whether there are opportunities to better tailor staffing to meet the needs of their organization.

Organizations should first review the full list of variables, followed by analyzing performance on outcomes measures. If the organization is achieving outcomes at appropriate levels, it may be reasonable to forego staffing adjustments even if selected variables are outside of benchmark values.

Step 5 – Review Staffing Models Reference Library for Creative Staffing Model Options

The Staffing Models Reference Library is provided as a snapshot of frequently used staffing combinations that may help to address staffing challenges in a hospice organization. Based on the patterns identified after analysis of the NHPCO Staffing Framework Tool, hospices are encouraged to review the staffing models provided to identify whether any would meet the needs of their organization.

Section 2: Variables, Outcomes, and Benchmarks

This section includes a description of each variable and outcome measure included in the Staffing Framework Tool, as well as an explanation of how to assess organizational metrics as compared to the available benchmarks. For example, for certain indicators an organizational metric below benchmark reference may indicate a need for increased staffing resources, while for other indicators an organizational metric above benchmark reference may indicate a need for increased staffing resources.

Variable metrics are those data points that include aspects of the hospice organizational environment that are subject to change, such as patient census characteristics, admission patterns, and staffing mix. Outcome metrics include data points that result from hospice operations such as quality measures, staff satisfaction data, and financial data.

Each metric includes a brief description as well as an indicator of the significance of organizational performance against the selected benchmark. For example, for certain indicators an organizational metric *below* benchmark reference may indicate a need for increased staffing resources, while for other indicators an organizational metric *above* benchmark reference may indicate a need for increased staffing resources.

Section 3: NHPCO Hospice Staffing Framework Tool

VARIABLE METRICS

Variable	Description	Significance
Acuity		
Median Length of Stay (LOS)	Shorter median LOS often indicates higher patient acuity	Below benchmark may indicate need for additional staffing
% of patients with LOS <5 days	Higher percentage of patients with short length of stay often indicates higher acuity	Above benchmark may indicate need for additional staffing
Patient Mix		
% Hospital Referrals	Higher percentage of hospital referrals often indicates higher patient acuity	Higher percentages may indicate need for additional staffing
% Cancer patients	Higher percentage of cancer patients often indicates higher patient acuity	Above benchmark may indicate need for additional staffing
% patients residing in Nursing Facilities, Skilled Nursing Facilities, and Long-Term Care Facilities	Higher percentage of facility patients may indicate less travel time between patients, and often facility patients have longer length of stay and lower acuity	Below benchmark may indicate need for additional staffing
% patients receiving Open Access/ Complex palliative treatments and services	Higher percentage of Open Access patients often indicates higher patient acuity	Higher percentages may indicate need for additional staffing
% total days General Inpatient (GIP) level of care	Higher percentage of GIP patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management	Above benchmark may indicate need for additional staffing
% total days Continuous Home Care (CHC) level of care	Higher percentage of CHC patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management	Above benchmark may indicate need for additional staffing
Organizational Characteristics		
ADC	Organizations with a smaller census may have fewer staffing resources and less ability for staff to flex to cover increased patient care needs	Rapid increases or decreases in ADC may indicate need for reevaluation of staffing needs
Turnover % (annual)	Higher turnover rates may indicate increased staffing resources dedicated to orientation and precepting and reduced ability make patient visits	Higher percentages may indicate need for additional staffing
Referral/Admission Conversion Rate	Lower conversion rates may indicate inadequate staffing resources dedicated to admitting and supporting new patients	Below benchmark may indicate need for additional staffing
Staffing Characteristics		
% Full Time Employees	Higher percentage of full-time employees may indicate more stable staffing, better coordination of care, and less stress on staff	Below benchmark may indicate need for additional staffing
% Part Time or PRN Employees	Higher percentage of full-time employees may indicate more flexibility but limited coordination of care and additional stress of staff	Above benchmark may indicate need for additional staffing

NHPCO Hospice Staffing Framework

VARIABLE METRICS

Variable	Description	Significance
% Salaried Employees	Higher percentage of salaried employees may indicate fewer labor costs attributable to overtime	Below benchmark may indicate need for additional staffing
% Hourly Employees	Higher percentage of hourly employees may indicate additional labor costs attributable to overtime	Above benchmark may indicate need for additional staffing
Length of Employment		
Less than 1 year	Higher percentage of new employees may indicate high turnover, staffing resources dedicated to orientation and precepting, and reduced ability to make patient visits	Above benchmark may indicate need for additional staffing
Hospice-certified staff	Higher percentage of certified hospice staff may indicate more experience and improved ability to manage caseloads	Lower percentages may indicate need for additional staffing
Visit Patterns		
Average number of visits per patient per week: **RN and LPN**	Average number of visits per patient/per week, by discipline	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: **Aide**	Average number of visits per patient/per week, by discipline	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: **Social worker**	Average number of visits per patient/per week, by discipline	Below benchmark may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Significance
Quality Metrics		
HCI Indicator 5: Burdensome Transitions Type 1	The percentage of all live discharges from hospice that were followed by hospitalization within two days and followed by hospital readmission within two days of hospital discharge. Higher percentages may indicate poor care coordination.	Above benchmark may indicate need for additional staffing
HCI Indicator 6: Burdensome Transitions Type 2	The percentage of all live discharges from hospice that were followed by hospitalization within two days, and where the patient also died during the inpatient hospitalization stay. Higher percentages may indicate poor care coordination.	Above benchmark may indicate need for additional staffing
HCI Indicator 8: Skilled Nursing Care Minutes per RHC day	Average total skilled nurse minutes provided by hospices on all Routine Home Care (RHC) service days: the total number of skilled nurse minutes provided by the hospice on all RHC service days divided by the total number of RHC days the hospice serviced.	Below benchmark may indicate need for additional staffing
HCI Indicator 9: Skilled Nursing Visits on Weekends	The percentage of skilled nurse visits minutes that occurred on Saturdays or Sundays out of all skilled nurse visits provided by the hospice during RHC service days.	Below benchmark may indicate need for additional staffing
HCI Indicator 10: Visits Near Death	The percentage of beneficiaries receiving at least one visit by a skilled nurse or social worker during the last three days of the patient's life (a visit on the date of death, the date prior to the date of death, or two days prior to the date of death).	Below benchmark may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Significance
HVLDL (Hospice Visits Last Days of Life)	The percentage of patients who received in-person visits from a registered nurse (RN) or medical social worker (MSW) on at least two out of the final three days of the patient's life.	Below benchmark may indicate need for additional staffing
Complaints/Concerns per 1000 patient days	Higher rate of complaints/concerns may indicate that patient and family needs are not being met due to staffing constraints.	Above benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing timely help	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on rating hospice 9 or 10	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing help for pain and symptoms	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.	Below benchmark may indicate need for additional staffing
Survey Deficiencies (Subpart C)	Review survey deficiencies related to missed visits, plan of care, comprehensive assessment, etc. Higher numbers of patient care deficiencies may indicate that patient and family needs are not being met due to staffing constraints.	Higher numbers may indicate need for additional staffing
Financial		
SIA (Service Intensity Add-On): Nurse Visits in Last 7 Days of Life	Percentage of days with at least one in-person registered nurse visit in the last 7 days of life	Below benchmark may indicate need for additional staffing
SIA (Service Intensity Add-On): Social Worker Visits in Last 7 Days of Life	Percentage of days with at least one in-person social work visit in the last 7 days of life	Below benchmark may indicate need for additional staffing
Staffing		
Staff Satisfaction: My workload is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.	Below benchmark may indicate need for additional staffing
Staff Satisfaction: The amount of stress in my job is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.	Below benchmark may indicate need for additional staffing
Staff Satisfaction: I rarely think about looking for a new job with another company (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.	Below benchmark may indicate need for additional staffing

NHPCO Hospice Staffing Framework Tool

VARIABLE METRICS

Variable	Description	Organizational Metric	Benchmark Metric (Where Available)	Significance
Acuity				
Median Length of Stay (LOS)	Shorter median LOS often indicates higher patient acuity		17 days[1]	Below benchmark may indicate need for additional staffing
% of patients with LOS <5 days	Higher percentage of patients with short length of stay often indicates higher acuity		25%[2]	Above benchmark may indicate need for additional staffing
Patient Mix				
% Hospital Referrals	Higher percentage of hospital referrals often indicates higher patient acuity		Not Available*	Higher percentages may indicate need for additional staffing
% Cancer patients	Higher percentage of cancer patients often indicates higher patient acuity		7.5%[2]	Above benchmark may indicate need for additional staffing
% patients residing in Nursing Facilities, Skilled Nursing Facilities, and Long-Term Care Facilities	Higher percentage of facility patients may indicate less travel time between patients, and often facility patients have longer length of stay and lower acuity		17.4%[6]	Below benchmark may indicate need for additional staffing
% patients receiving Open Access/ Complex palliative treatments and services	Higher percentage of Open Access patients often indicates higher patient acuity		N/A	Higher percentages may indicate need for additional staffing.
% total days General Inpatient (GIP) level of care	Higher percentage of GIP patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management		0.9%[3]	Above benchmark may indicate need for additional staffing
% total days Continuous Home Care (CHC) level of care	Higher percentage of CHC patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management		0.1%[3]	Above benchmark may indicate need for additional staffing

NHPCO Hospice Staffing Framework

VARIABLE METRICS

Variable	Description	Organizational Metric	Benchmark Metric (Where Available)	Significance
Organizational Characteristics				
ADC	Organizations with a smaller census may have fewer staffing resources and less ability for staff to flex to cover increased patient care needs		Utilize internal historical and planned ADC	Rapid increases or decreases in ADC may indicate need for reevaluation of staffing needs
Turnover % (annual)	Higher turnover rates may indicate increased staffing resources dedicated to orientation and precepting and reduced ability make patient visits		Utilize internal or vendor benchmarks as available	Higher percentages may indicate need for additional staffing.
Referral/Admission Conversion Rate	Lower conversion rates may indicate inadequate staffing resources dedicated to admitting and supporting new patients		Utilize internal or vendor benchmarks as available	Below benchmark may indicate need for additional staffing
Staffing Characteristics				
% Full Time Employees	Higher percentage of full-time employees may indicate more stable staffing, better coordination of care, and less stress on staff		86.7%[4]	Below benchmark may indicate need for additional staffing
% Part Time or PRN Employees	Higher percentage of full-time employees may indicate more flexibility but limited coordination of care and additional stress of staff		10.65%[4]	Above benchmark may indicate need for additional staffing
% Salaried Employees	Higher percentage of salaried employees may indicate fewer labor costs attributable to overtime		46.14%[4]	Below benchmark may indicate need for additional staffing
% Hourly Employees	Higher percentage of hourly employees may indicate additional labor costs attributable to overtime		53.14%[4]	Above benchmark may indicate need for additional staffing
Length of employment: Less than 1 year	Higher percentage of new employees may indicate high turnover, staffing resources dedicated to orientation and precepting, and reduced ability to make patient visits		20.17%[4]	Above benchmark may indicate need for additional staffing
Hospice-certified staff	Higher percentage of certified hospice staff may indicate more experience and improved ability to manage caseloads		Utilize internal or vendor benchmarks as available	Lower percentages may indicate need for additional staffing

NHPCO Hospice Staffing Framework

VARIABLE METRICS

Variable	Description	Organizational Metric	Benchmark Metric (Where Available)	Significance
Visit Patterns				
Average number of visits per patient per week: RN and LPN	Average number of visits per patient/per week, by discipline		1.7[1]	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: Aide	Average number of visits per patient/per week, by discipline		1.8[1]	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: Social worker	Average number of visits per patient/per week, by discipline		0.3[1]	Below benchmark may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Organiztional Metric	Benchmark Metric (Where Available)	Significance
Quality Metrics				
HCI Indicator 5: Burdensome Transitions Type 1	The percentage of all live discharges from hospice that were followed by hospitalization within two days and followed by hospital readmission within two days of hospital discharge. Higher percentages may indicate poor care coordination.		8.2%[5]	Above benchmark may indicate need for additional staffing
HCI Indicator 6: Burdensome Transitions Type 2	The percentage of all live discharges from hospice that were followed by hospitalization within two days, and where the patient also died during the inpatient hospitalization stay. Higher percentages may indicate poor care coordination.		2.3%[5]	Above benchmark may indicate need for additional staffing
HCI Indicator 8: Skilled Nursing Care Minutes per RHC day	Average total skilled nurse minutes provided by hospices on all Routine Home Care (RHC) service days: the total number of skilled nurse minutes provided by the hospice on all RHC service days divided by the total number of RHC days the hospice serviced.		13.9	Below benchmark may indicate need for additional staffing

NHPCO Hospice Staffing Framework

OUTCOME METRICS

Outcome	Description	Organiztional Metric	Benchmark Metric (Where Applicable)	Significance
HCI Indicator 9: Skilled Nursing Visits on Weekends	The percentage of skilled nurse visits minutes that occurred on Saturdays or Sundays out of all skilled nurse visits provided by the hospice during RHC service days.		9.3%	Below benchmark may indicate need for additional staffing
HCI Indicator 10: Visits Near Death	The percentage of beneficiaries receiving at least one visit by a skilled nurse or social worker during the last three days of the patient's life (a visit on the date of death, the date prior to the date of death, or two days prior to the date of death).		90%	Below benchmark may indicate need for additional staffing
HVLDL (Hospice Visits Last Days of Life)	The percentage of patients who received in-person visits from a registered nurse (RN) or medical social worker (MSW) on at least two out of the final three days of the patient's life.		49.2%	Below benchmark may indicate need for additional staffing
Complaints/Concerns per 1000 patient days	Higher rate of complaints/concerns may indicate that patient and family needs are not being met due to staffing constraints.		Utilize internal or vendor benchmarks as available	Above benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing timely help	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.		78%[1]	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on rating hospice 9 or 10	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.		81%[1]	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing help for pain and symptoms	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.		75%[1]	Below benchmark may indicate need for additional staffing
Survey Deficiencies (Subpart C)	Review survey deficiencies related to missed visits, plan of care, comprehensive assessment, etc. Higher numbers of patient care deficiencies may indicate that patient and family needs are not being met due to staffing constraints.		Utilize internal survey data	Higher numbers may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Organiztional Metric	Benchmark Metric (Where Applicable)	Significance
Financial				
SIA (Service Intensity Add-On): Nurse Visits in Last 7 Days of Life	Percentage of days with at least one in-person registered nurse visit in the last 7 days of life		63%[1]	Below benchmark may indicate need for additional staffing
SIA (Service Intensity Add-On): Social Worker Visits in Last 7 Days of Life	Percentage of days with at least one in-person social work visit in the last 7 days of life		9%[1]	Below benchmark may indicate need for additional staffing
Staff Satisfaction				
Staff Satisfaction: My workload is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.		24.24%[4]	Below benchmark may indicate need for additional staffing
Staff Satisfaction: The amount of stress in my job is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.		20.27%[4]	Below benchmark may indicate need for additional staffing
Staff Satisfaction: I rarely think about looking for a new job with another company (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.		35.95[4]	Below benchmark may indicate need for additional staffing

NHPCO Hospice Staffing Framework Tool References

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3. FY2024 Hospice Wage Index and Quality Reporting Proposed Rule https://www.federalregister.gov/documents/2023/04/04/2023-06769/medicare-program-fy-2024-hospice-wage-index-and-payment-rate-update-hospice-conditions-of#h-58
4. NHPCO National STAR Report 2022 https://www.nhpco.org/wp-content/uploads/2022_STAR_National_Report.pdf
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6. NHPCO Facts and Figures 2020 https://www.nhpco.org/wp-content/uploads/NHPCO-Facts-Figures-2020-edition.pdf

Section 4: Staffing Models Reference Library

This section includes a list of staffing models for organizations to explore, including circumstances in which each model may be appropriate to consider.

The Staffing Models Reference Library was developed by members of the NHPCO Quality and Standards and Regulatory Committees as a partial list of staffing models employed by hospice organizations around the country. The intent of the Reference Library is to show examples of creative solutions to staffing challenges that may be feasible for organizations with varying size, geography, and scope of services.

Organizations are encouraged to use this Reference Library as inspiration to consider possible means of organizing their teams to best meet the needs of patients and families. Example staffing models are organized by the discipline primarily impacted, but organizations should ensure that all disciplines are represented in their staffing plans. In addition, many of these models could be combined to create a unique staffing plan.

Nursing Models

- **Admission Nurse**
  - Designated Admissions RN completes Initial Assessment
  - RN Case Manager assume responsibility for patient going forward
- **RN/LPN Team**
  - RN Case Manager completes comprehensive assessments and manages plan of care
  - LPN makes supplemental visits as needed
- **Visit Nurses**
  - RN Case Manager completes comprehensive assessments and manages plan of care
  - A support team of Visit Nurses make symptom-management, routine reassessment, death verification, and additional visits as needed in between
- **Administrative Support Nursing**
  - Designated nurses provide administrative support in office, such as managing DME, pharmacy, and physician's orders
  - RN Case Managers and additional nursing staff make patient visits
- **On-Call Nursing Team**
  - Dedicated nursing team for on-call/after-hours patient care
- **Hybrid RN**
  - Dedicated RN to facilitate admissions and transfers between community and hospice inpatient unit

NHPCO Hospice Staffing Framework

Physician Models

- **Medical Director**
  - » Patient Visits, including Face-to-Face Encounters
    - Patient visits (can be done by an NP, who may bill for the visit if selected by the patient/representative as the Hospice Attending, or a physician, who may bill for the visit regardless of status as the Hospice Attending)
  - » **Administrative**
    - the Face-to-Face encounter (can be done by a W2 employed NP or a physician)
    - Certification of Terminal Illness completion (can only be done by a physician)
    - presence at Interdisciplinary Group Meetings (can only be done by a physician)
- **NP models:**
  - » Dedicated to all agency face to face encounters
  - » Shared teams with the Medical Director
    - Performing patient visits and face to face encounters
- **Medical Director with team physicians and/or nurse practitioners**
  - » Teams based on geographical locations, care settings, etc.
  - » NPs for Face-to-Face and other patient care needs

Team Design Models

- **Facility Team**
  - » Dedicated teams focused specifically on caring for facility-based patients
  - » May apply to one or all disciplines
- **CHC Team**
  - » Dedicated teams focused specifically on caring for patients using Continuous Home Care
  - » May apply to one or all disciplines
- **Triage Team**
  - » Dedicated triage team to facilitate appropriate IDG support to patients during the day and/or after-hours
  - » Consider outsourced on-call services
- **Geographic Teams**
  - » Dedicated teams focused specifically on certain geographic regions of the service area
- **Administrator On-Call**
  - » Dedicated clinical leader on-call after hours to support after-hours staff in managing complex patient care needs
- **Dedicated Pediatric Team**
  - » Dedicated pediatric nurse
    - Completes admission patient visits
  - » Dedicated medical social worker
    - Provides social work support and bereavement care to surviving family members of pediatric hospice patients
    - Follows pediatric grievers (both internal and external/community bereavement referrals).
  - » Dedicated spiritual counselor
- **Hybrid/Blended Pediatric team**
  - » IDG members care for pediatric and adult patients
  - » Dedicated IDG members dependent on organization's current pediatric caseload
- **Non-Patient Facing Clinical Support**
  - » Utilize administrative or other staff to support clinical needs such as triaging patient calls, facilitating medication and supply orders, coordinating transportation needs

NHPCO Hospice Staffing Framework At-A-Glance

What is the NHPCO Hospice Staffing Framework?

The NHPCO Hospice Staffing Framework is a tool intended to help hospice providers assess a number of factors with the potential to impact staffing in order to better determine whether their current staffing framework is appropriate to their organizational needs. The framework utilizes an assessment process to help determine optimal staffing levels for hospice programs that includes an analysis of the model of care delivery, characteristics of the patient population served, environmental considerations, and quality and financial outcomes.

How is this Framework different from past NHPCO Hospice Staffing Guidelines?

Although NHPCO has provided staffing guidance to member organizations for many years, no one "best standard" in the literature regarding hospice staffing caseloads currently exists. This framework differs from the previously published staffing ratios and guidelines in that recommended ranges for caseloads are not provided. Instead, using the analysis process delineated in the framework, each hospice may assess a number of variables and outcomes measures to identify whether there are opportunities to better tailor staffing to meet the needs of their organization.

Why should my hospice organization utilize this framework?

Around the nation, hospices have evolved in various directions, creating diverse models of care to serve hospice patients and families. The NHPCO Hospice Staffing Framework is based on the recognition of the current diverse nature of hospice care and allows for individualization of staffing caseloads according to the organizational and environmental characteristics specific to each hospice, in much the same way hospices individualize patient care. This resource provides a framework that utilizes outcomes to help determine the organization's needs and improve the hospice model of care, in a transparent manner that allows staff to remain informed and provide valuable input.

How does my organization use the framework?

The NHPCO Staffing Framework for Hospice includes several organizational variables and outcome measures for hospice leaders to consider when determining whether staffing adjustments need to be made. While there is no existing validated instrument capable of capturing the complexity of hospice care and determining staffing minimums by discipline, this tool is intended to highlight the multiple factors that organizations should assess when considering their staffing models.

What data sources does the framework reference?

The NHPCO Hospice Staffing Framework is reviewed annually and references up-to-date clinical and operational data from the following sources to identify comparative benchmarks.

- MedPac Report to Congress
- Hospice Wage Index and Quality Reporting Proposed Rule
- NHPCO Facts and Figures Report
- NHPCO National STAR Report
- CMS Hospice National Data Set
- CMS Hospice Quality Reporting Program User's Manual

For more information, please visit NHPCO Quality Resources or reach out to quality@nhpco.org.

References

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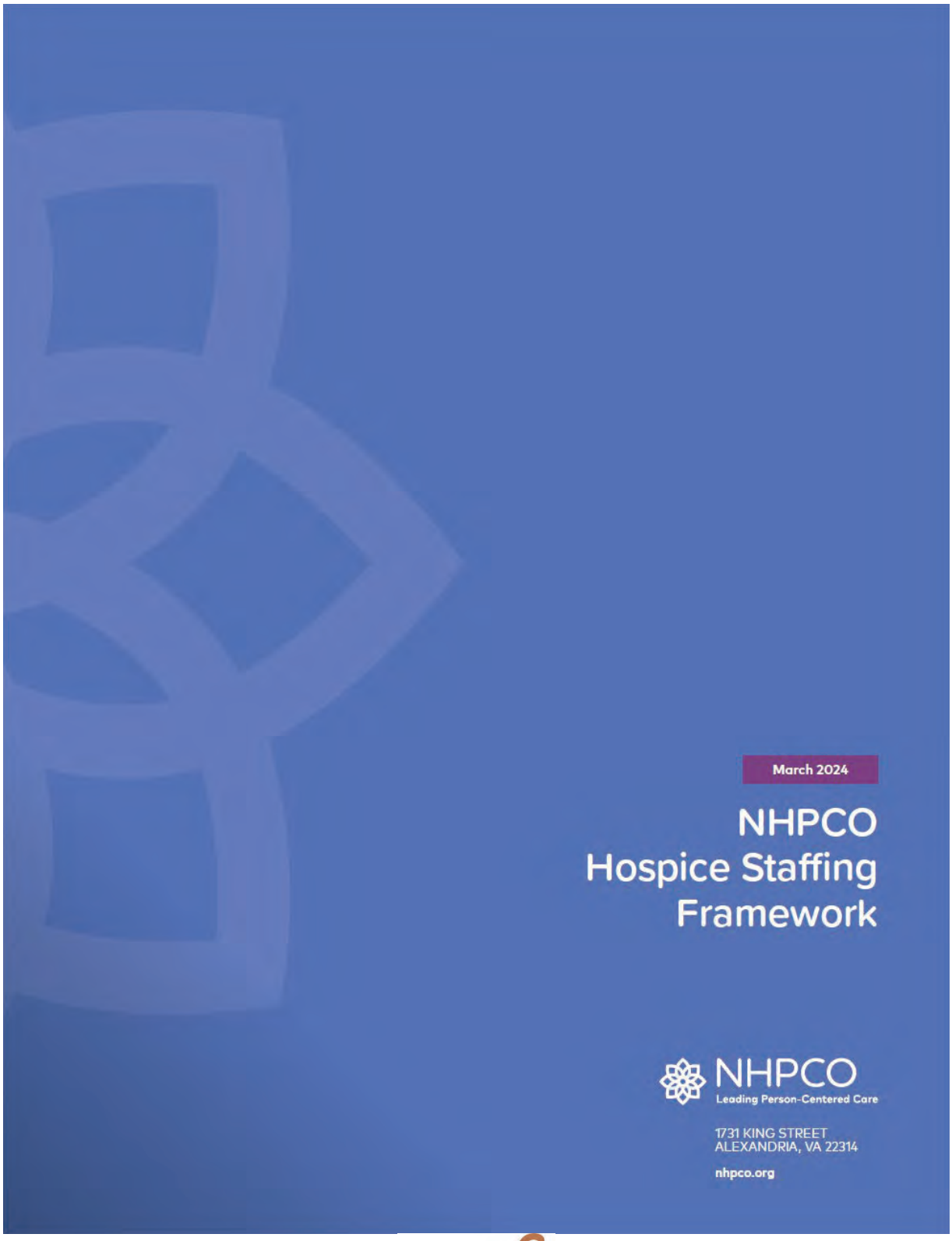
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