Washington State Department of Health

CN 19-52

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

APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS
(Excludes amendments)

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form.
Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310 adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer: **Date:** January 18, 2019	**Person to Whom Questions Regarding this Application Should Be Directed:** Dapo Amosun President, Owner 15220 32nd Ave. South, Ste. B SeaTac, WA 98188 **Telephone Number:** (206) 444-4810
Legal Name of Applicant: Amicable Healthcare, Inc. **Address of Applicant:** 15220 32nd Ave. South, Ste. B SeaTac, WA 98188 **Telephone Number: 1 (877) 446-0550**	**Type of Project (check all that apply):** [ ] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Expanding into Different County [X] Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid Eligible
Project Summary: Seeking to establish a Medicare certified/Medicaid eligible home health agency to serve King County. **Estimated capital expenditure:** $24,000.00	

Amicable Healthcare

Care from the heart

January 4, 2019

Janis Sigman, Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Ms. Sigman:

Enclosed please find a copy of Amicable Healthcare Inc.'s Certificate of Need application proposing to establish a Medicare Certified/Medicaid Eligible home health agency in King County. Also enclosed is the processing fee of $24,666.

If you have any questions, please do not hesitate to contact me at 206-444-4810, or Ferguson Adesoye, CEO, at 206-444-4847.

Sincerely,

Dapo Amosun
President
Amicable Healthcare

Certificate of Need Application Proposing the Establishment of a Medicare Certified/Medicaid Eligible Home Health Agency in King County

January 2019

Section 1
Applicant Description

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

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

The legal name of the applicant is **Amicable Healthcare, Inc (Amicable)**. Individuals with a 10% or greater financial interest in Amicable include:

Dapo Amosun: 50% ownership
Ferguson Adesoye: 50% ownership

B. For each licensed applicant, please provide the professional license number and specialty represented. If the license was not issued by Washington State, please identify the state it was issued.

Amicable has held a Washington State In-Home Services Agency License (IHS.FS.00000215) since 1997. None of the individuals with a 10% or greater financial interest hold professional licenses.

C. <u>For existing facilities</u>, provide the name and address of the facility.
Note: The term "existing facility" for this purpose is defined as a home health agency that is currently providing licensed only home health care services OR a home health agency that is seeking to expand its Medicare certified service area.

Amicable operates at three locations in three different Counties. The address for which this application seeks Certificate of Need (CN) approval (King County) is:

Amicable Healthcare, Inc.
15220 32nd Ave. South, Ste. B
SeaTac, WA 98188

Other addresses in Snohomish and Pierce Counties that Amicable operates are:

Amicable Healthcare, Inc.
755 Tacoma Ave. Ste. 7
Tacoma, WA 98402

Amicable Healthcare, Inc.
2722 Colby Ave. #430
Everett, WA 98201

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

Amicable is a for profit corporation. Amicable's Unique Business Identifier registered with the Washington Secretary of State's Office is: 601 788 680.

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

the owning entity will be the same as the applicant.

F. Provide the name and address of *operating* entity at completion of project (unless same as applicant).

The operating entity will be the same as the applicant.

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

See Exhibit 1 for the organizational chart.

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

No other facilities are owned or operated by Amicable. Question C above, includes the addresses of Amicable's current operations.

I. <u>For existing facilities</u>, please identify the geographic primary service area.

This question is not applicable, as Amicable is not an existing Medicare certified/Medicaid eligible facility.

J. Identify the facility licensure/accreditation status.

As noted above, Amicable (consistent with RCW 70.127) currently operates with a Washington State In-Home Services Agency License (IHS.FS.00000215). The current license is effective through 08/31/2020.

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

Amicable currently receives reimbursement for Medicaid Home Care under Title XIX of the Social Security Act.

L. If applicable, identify the medical director and provide his/her professional license number, and specialty represented.

Amicable is in process of making a final decision on a medical director. A copy of the draft agreement is included in Exhibit 2. We understand that the CN Program has previously issued CNs with the condition that the applicant provide the name and medical license as well as a copy of the signed final agreement (to assure no change in terms or costs). Amicable would be amenable to such a condition.

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

The medical director will be contracted with Amicable. A draft contract can be found in Exhibit 2.

N. <u>For existing facilities</u>, please provide the following information broken down by discipline <u>for each county</u> currently serving:

1. **Total number of home care hours per year for the last three years; and**

2. **Total number of unduplicated home health *patients* served per year for the last three years.**

Amicable does not currently operate a Medicare certified/Medicaid eligible home health agency. Today, Amicable averages more than 450 active home care clients in King County.

Section 2
Project Description

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

The address for the proposed agency is:

Amicable Healthcare, Inc.
15220 32nd Ave. South, Suite. B,
SeaTac, WA 98188

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

Amicable already provides high-quality home care services to the community. Amicable has been providing these services in King County since 1997, and in Pierce and Snohomish Counties since 2017. With this CN Application, Amicable seeks to establish a Medicare certified/Medicaid eligible home health agency in King County.

Amicable partners with various respected community and civic organizations including Aging and Disability Services, City of Seattle's Human Services Department, Seattle Southside Chamber of Commerce, Pierce County Human Services, and Snohomish County Human Services.

Amicable previously applied for CN approval to establish a home health agency in King County in 2016 under the name ADMA Healthcare, Inc. The application was not found to be consistent with several criteria. Since the denial, Amicable has retained experts in home health, home health cost reporting and CN project management to help refine the application. Furthermore, a TA with the CN Program was requested by the applicant, and held with Karen Nidermayer on November 27, 2018. Based on that TA, we are confident that this current application fully responds to the areas of concern raised by the CN Program in 2016.

C. List new services or changes in services represented by this project. In the following table, please indicate (by marking an 'X' in the appropriate column) which would be provided directly by the agency and which services would be contracted.

Services to be provided by Amicable in King County will include:

Table 1
Services to be Provided by Amicable

	Direct	Contracted
Skilled Nursing	X	
Physical Therapy		X
Occupational Therapy		X
Speech Therapy		X
Medical Social Work	X	
Home Health Aide	X	
Medical Director		X
Respite Care	X	
IV Therapy	X	
Other (list):		

Source: Applicant

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

Amicable opened its doors in 1997 because of its owner's respect for the elderly and interest in supporting functional independence. As a company with minority owners, Amicable recognizes the opportunity and privilege to serve those who need help, and while Amicable will serve the entirety of the County, we will have a focus on residents of South King County and South Seattle.

Among Amicable's current active clients, 58% reside in South King and another 31% reside in and around South Seattle (including the communities of Rainier Valley, Columbia City, Beacon Hill, Georgetown, Burien, and White Center). 75.9% of current home care clients are racial minorities, with 56.0% Black, 14.8% Asian, 3.8% Hispanic, 0.4% Filipino, 0.4% Native American, and 0.4% Pacific Islander.

As the population ages and continues to diversify in King County, we expect that demand will continue to grow. Individuals served by this project will be home bound and in need of intermittent care for skilled nursing and/or, physical therapy, occupational therapy, speech therapy, medical social work, home health aide, and respite care.

E. List the equipment proposed for the project:

1. Description of equipment proposed; and

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

A listing of equipment proposed is included in Exhibit 3.

F. Provide drawings of proposed project:

1. Single line drawings, *approximately to scale,* of <u>current</u> locations which identify current department and services; and

Single line drawings of the current agency location in King County are provided in Exhibit 4. Home care spaces are labeled as "home care designated".

2. Single line drawings, *approximately to scale,* of <u>proposed</u> locations which identify proposed services and departments; and

The proposed home health agency will be co-located with Amicable's existing home care agency. The spaces dedicated for Amicable Home Care are marked accordingly in Exhibit 4. Public spaces such as restrooms, break room and reception will be shared.

3. Total net and gross square feet of project.

The entire space, includes the following square footages:

Total net square feet: 1,658
Total gross square feet: 2,800

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

Assuming timely CN approval, Amicable anticipates a commencement date of November 1, 2019 and a completion date of April 1, 2020.

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

The demand for home health services from Amicable's existing patients and from our primary referral sources is high; we receive calls almost daily from providers, patients and their families seeking home health. Consistent with our business planning, becoming Medicare Certified and Medicaid Eligible will enable Amicable to expand to serve more King County residents. Furthermore, Medicare certification is a pre-requisite for many commercial insurance contracts. Therefore, CN approval will allow Amicable to serve others that seek our care, but whose insurance does not currently allow, due to our lack of Medicare certification.

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

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

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

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

Amicable's owners are also the legal owner of the King County office location. The legal entity that owns the property and building is Amicable Holdings, LLC. Amicable Holdings, LLC is owned by the same individuals that own Amicable. Amicable's home care operations have an existing lease with Amicable Holdings, Inc. The King County parcel number is 004300-0003. A copy of parcel information from the King County Assessor's website can be found at Exhibit 5.

In the pro forma financial, for use of the space, Amicable has assumed an allocation of cost on a monthly basis for the space at 0.75% of gross patient services revenue. Amicable is in the process of developing a sublease that will document the costs assigned to the home health operations. This sublease will be provided with the request for supplemental information.

Section 3
Project Rationale: Need

1. **Identify the proposed geographic service area.**

Consistent with the *State Health Plan's* Home Health Service Area definition, the proposed geographic service area is King County.

2. **If the proposed service area is designated as a Medically Underserved Area (MUA) as defined by HCFA or a Health Professional Shortage Area (HPSA), please provide documentation verifying the designation.**

Within the King County Planning Area, Central Seattle, South Seattle and South King County (as defined by census tracts in the MUA definition) have MUA designations as follows:

Central Seattle: MUA Designation
South Seattle: MUA Designation
South King County: Governor's MUA Designation

The following geographies in King County have Primary Care HPSA designations as follows:

Enumclaw: HPSA Designation
Snoqualmie/North Bend: HPSA Designation
Vashon Maury Island: HPSA Designation

The following eleven organizations operating in King County have Primary Care HPSA designations as follows:

Healthpoint: HPSA Designation
Neighborcare Health: HPSA Designation
Sea Mar Community Health Center: HPSA Designation
Seattle King County Department of Public Health: HPSA Designation
Country Doctors Community Clinic: HPSA Designation
International Community Health Services: HPSA Designation
Seattle Indian Health: HPSA Designation
Muckleshoot Tribal Clinic: HPSA Designation
Snoqualmie-North Bend Family Clinic: HPSA Designation
Snoqualmie-Tolt Community Clinic: HPSA Designation
Federal Detention Center-SeaTac: HPSA Designation

The methodology for calculating Primary Care HPSA score criterion includes population to provider ratios, percentage of population below Federal-Poverty Level, travel time to nearest source of care, and infant mortality rate or low birth weight. Amicable serves many of the same populations as these organizations, and we are confident that these scores are indicative of low metrics are indicative of the gaps in care we seek to address.

See Exhibit 6 for documentation of HPSA and MUA designations.

3. Identify and analyze the unmet home health service needs and/or other problems toward which this project is directed.

A. Identify the unmet home health needs of the patient population in the proposed service area(s). *Note that the unmet <u>patient need</u> should not include physical plant deficiencies and/or increase facility operating efficiencies.*

Although no methodology exists in Rule, the CN Program has consistently used the methodology contained within the 1987 Washington State Health Plan to project demand for additional home health providers. The four-step methodology and its results are summarized below and in Exhibit 7. The methodology identifies a need for 35 additional agencies.

<u>Step 1: Population by Age Cohort</u>
King County population for years 2020-2022, broken down by age groups, is in Table 2.

Table 2
Step 1 – King County Population Projections

Age Group	2020	2021	2022
0-64	1,906,749	1,917,491	1,928,708
65-79	254,184	262,860	271,943
80+	70,476	73,679	77,055

Source: Washington State 2017 GMA Projections - Medium Series

Step 2: Projected Patients by Age Cohort

Table 3 depicts the result of multiplying the specific use rate by age group to the County populations identified in Table 2. The resulting number is the total number of the planning area residents projected to need home health services.

Table 3
Step 2 - King County Projected Patients

Age Group	Use Rate	2020	2021	2022
0-64	0.005	9,534	9,587	9,644
65-79	0.044	11,184	11,566	11,965
80+	0.183	12,897	13,483	14,101
Total		**33,615**	**34,637**	**35,710**

Source: Use Rates from State Health Plan

Step 3: Projected Visits by Age Cohort

The projected number of patients from Table 3 above is multiplied by the average projected number of visits by age group. The estimates, by age group, are then summed to determine the total number of visits in the planning area. Table 4 illustrates the number of visits per year by age group and shows the total number of visits for the planning area.

Table 4
King County Projected Visits by Age

Age Group	No. of Visits	2020	2021	2022
0-64	10	95,337	95,875	96,435
65-79	14	156,577	161,922	167,517
80+	21	270,839	283,148	296,121
Total		**522,754**	**540,945**	**560,074**

Source: Applicant

Step 4: Estimated Agencies Needed

The final step divides the total projected number of visits calculated in Step 3 (Table 4) by 10,000 – the minimum required volumes per home health agency. The result of this calculation is shown in Table 5.

Table 5
King County Agency Need

	2020	2021	2022
Total Estimated Patient Visits	522,754	540,945	560,074
Quotient of 10,000	52.28	54.09	56.01

Source: Applicant

In order to determine the 'net need' for a new home health provider, Amicable calculated the available supply of home health agencies (Question 9 provides the methodology Amicable used to determine supply), and subtracted this number from the 2022 estimated home health agency gross need. This results in a net need for 35 additional agencies.

Table 6
Unmet Need for Home Health Agencies in King County

2022 Estimated Home Health Agency Gross Need	Existing Medicare Certified/Medicaid Eligible Agencies Counted in Supply	Licensed Only In Home Care Agencies Counted in Supply	Subtract Agencies Included in Supply	Net Need for Medicare Certified/Medicaid Eligible Agencies
56	17	4	21	35

Source: Applicant

While Amicable will serve all persons in need of home health services, we do propose a specific focus on minority and immigrant populations given the unmet need as demonstrated in our current agency experience, and also in a number of reports. For example, several community health needs assessments (CHNA), and particularly, Valley Medical Center, Renton, (VMC) and the King County Department of Public Health's (undertaken in conjunction with the Washington State Hospital Association (WSHA) and local area hospitals found access to care and other barriers:

- VMC's CHNA identified four focus areas, with the first being access to care[1].

- King County's CHNA stated that it expects an increasing need for culturally competent home health services due to the rapidly growing and rapidly aging and changing population, with need doubling from 2010-2020[2].

- King County's CHNA also pointed out that due to the recent national political climate, immigrants are more hesitant to seek medical care. Amicable's minority owners are committed to making minorities in the community feel safe and cared for with culturally competent home health services. Providing culturally competent care has social, health, and business benefits. According to the Health Research & Educational Trust, culturally competent care increases community participation and involvement in health issues, assists patients and families in their care, promotes patient and family responsibilities for health, improves patient data collection, increases preventive care by patients, reduces care disparities in the patient population, increases cost savings by reducing medical errors, treatments, and legal costs, reduces the number of medical visits, improves efficiency of care services, and increases the market share of the organization[3].

[1] http://www.valleymed.org/uploadedFiles/valleymedorg/About_Us/Valley%20Medical%20Center%202017%20CHNA_FINAL.pdf

[2] https://www.kingcounty.gov/depts/health/data/community-health-indicators/~/media/depts/health/data/documents/2018-2019-Joint-CHNA-Report.ashx

[3] http://www.diversityconnection.org/diversityconnection/membership/Resource%20Center%20Docs/Equity%20of%20Care%20Report%20FINAL.pdf

CMS data for the period of 2007 to 2013 demonstrates that all cause, national inpatient readmission rates are highest among Blacks, Hispanics, American Indian/Alaska Natives, and Asian/Pacific Islanders. High readmission rates are often indicators of a lack of access to transitional services (including home health). In addition, Blacks experience longer lengths of stay for a number of procedures for which home heath is proven helpful, including hip athroplasty[4], Whipple procedure[5], and spine surgery[6].

Amicable is uniquely positioned to serve the needs of minority and underserved populations because of our already respected reputation among immigrant communities, our mission-driven focus, and our desire to provide culturally competent home health services.

B. Identify the negative impact and consequences of unmet home health needs and deficiencies.

Consistent with Medicare's Conditions of Participation, Amicable expects to provide home health services to homebound patients (those unable to leave their place of residence following an illness or injury). Costly hospitalization and emergency department visits can often be prevented by utilizing home health. In fact, longer "Length of Stay", or "Days in Episode" in home health care decreases the odds of hospitalization by 11-13%[7]. Hospitalizations put patients at risk for hospital-acquired infections (HAIs), and are also costly for the patient, payor, and healthcare delivery system. Home health providers have the capacity to monitor and prevent expensive complications in the most clinically complex, and socially vulnerable patients. With increased focus on cost reduction, increasing access to home health services is an effective strategy to reduce fragmentation, reduce costs, and increase quality of care. The various CHNAs we have cited in this CN Application demonstrate the need to improve access and focus on traditionally underserved areas in South King County and South Seattle. Amicable's CN request will significantly benefit the delivery system.

[4] https://journals.lww.com/c-orthopaedicpractice/Abstract/2008/09000/Race,_ethnicity_and_length_of_hospital_stay_after.19.aspx
[5] https://www.sciencedirect.com/science/article/pii/S0039606014001433
[6] https://www.healio.com/spine-surgery/practice-management/news/print/spine-surgery-today/%7B21de607c-339e-48b8-96ed-7957960b3765%7D/race-can-impact-hospital-length-of-stay-after-elective-spine-surgery
[7] O'Connor, Melissa et al. "The Impact of Home Health Length of Stay and Number of Skilled Nursing Visits on Hospitalization among Medicare-Reimbursed Skilled Home Health Beneficiaries." Research in nursing & health38.4 (2015): 257–267. PMC. Web. 15 Aug. 2018.

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

All of King County, but particularly South King County, as well as South Seattle, where approximately 89% of Amicable's in home patients live (South King County: 58% + South Seattle: 31%), has a growing diverse population. Amicable's mission is to provide the highest quality in-home care, delivering care from the heart, for every patient. As such, Amicable has been providing culturally competent home care services since 1997. Amicable will continue to fill a gap in culturally competent care for King County with the hopes of furthering their mission and serving the population at the right time, in the right place, in the right way.

Table 7 shows the distribution and growth of various race and ethnic groups in King County as compared with South King County. As Table 7 demonstrates, King County's population of Whites has grown much more slowly that other cohorts. For example, between 2010-2017, the Hispanic population grew at a rate almost double that of the County in total. Table 7 also demonstrates the diversity of South King County, with Asians, Hispanics, Multi-Racial Persons, Black, and Native Hawaiian/Pacific Islander populations experiencing the highest rates of growth between 2010-2017, and South King County also has a higher distribution of these races. Over 170 languages are spoken, and 13.5% of people over 5 years of age in South King County speak English less than "very well". This language barrier creates another obstacle for residents seeking healthcare in South King County. In fact, Public Health data indicates that people of color, undocumented immigrants, and members of tribal communities have higher rates of difficulty accessing health and human services in King County[8].

[8] https://www.kingcounty.gov/depts/health/data/community-health-indicators/~/media/depts/health/data/documents/2018-2019-Joint-CHNA-Report.ashx

Table 7
Race and Ethnic Distribution and Growth – King County & South King County

	2010 Pop		2017 Pop		2017 % of Tot Pop		% Chg 2010-2017		2022 Projected Pop		2022 Projected % of Tot Pop		% Chg 2017-2022	
	KC	SKC	KC	SKC	KC	SKC	KC	SKC	KC	SKC	KC	SKC	KC	SKC
American Indian/ Alaskan Native Alone	14,784	7,388	15,985	8,036	0.7%	1.0%	8.1%	8.8%	16,763	8,489	0.7%	1.0%	4.9%	5.6%
Asian Alone	258,093	81,040	332,710	104,469	15.3%	13.5%	28.9%	28.9%	392,049	123,628	16.8%	14.8%	17.8%	18.3%
Black/ African American Alone	109,352	52,988	129,998	65,280	6.0%	8.4%	18.9%	23.2%	145,768	75,018	6.2%	9.0%	12.1%	14.9%
Hispanic Alone	172,960	92,706	212,441	117,412	9.8%	15.1%	22.8%	26.6%	243,490	137,011	10.4%	16.5%	14.6%	16.7%
Native Hawaiian/ Pacific Islander Alone	13,240	9,543	16,008	11,729	0.7%	1.5%	20.9%	22.9%	18,114	13,367	0.8%	1.6%	13.2%	14.0%
Some Other Race Alone[9]	69,467	40,186	83,929	49,969	3.9%	6.4%	20.8%	24.3%	95,106	57,475	4.1%	6.9%	13.3%	15.0%
Two or More Races[10]	88,627	34,957	109,731	42,690	5.1%	5.5%	23.8%	22.1%	126,244	48,861	5.4%	5.9%	15.0%	14.5%
White Alone	1,215,311	381,516	1,270,662	376,628	58.5%	48.5%	4.6%	-1.3%	1,296,376	368,765	55.5%	44.3%	2.0%	-2.1%
Total	**1,941,834**	**700,325**	**2,171,465**	**776,212**	**100%**	**100%**	**11.8%**	**10.8%**	**2,333,911**	**832,615**	**100%**	**100%**	**7.5%**	**7.3%**

Source: Claritas. South King County zip codes as defined by the King County 2018-2019 CHNA are 98168, 98188, 98003, 98178, 98198, 98146, 98032, 98030, 98031, 98148, 98058, 98104, 98002, 98023, 98055, 98092, 98057, 98042, 98001, 98166, 98038, 98006, 98012, 98027, 98028, 98033, 98034, 98040, 98199.
Legend: KC = King County
SKC = South King County

[9] Based off self-identification per the U.S. Census Bureau.
[10] Based off self-identification per the U.S. Census Bureau.

The King County Department of Public Health's CHNA clearly demonstrates the socio-economic and health disparities many in South King County face. Over 31% of people live in poverty or near-poverty in South King County, a higher rate than anywhere else in the County. Those in South King County are more likely than the rest of King County to have chronic diseases such as diabetes and asthma, are more likely to be uninsured, have more unmet medical needs, higher rates of disability, and have the highest rate of unintentional injury hospitalizations (the 65+ age group rate of hospitalization for unintentional injuries is 4.2 times the county average) [11].

Communities in South King County, SeaTac, Tukwila, and parts of Renton, Kent and Auburn all have a median household income below that of King County at large. Furthermore, 14% of adults in King County are found to have unmet medical needs due to cost, with rates higher for American Indian/Alaska Natives (15%), Blacks (23%), Hispanics (23%), Multi-Racial persons (24%), and Native Hawaiian/Pacific Islanders (17%). Whites and Asians have unmet medical needs at a rate lower than the King County average, 12% and 8%, respectively[12]. These socio-economic and health disparities further support the need for additional culturally appropriate home health services in South King County.

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

While Amicable is not an existing provider of Medicare certified/Medicaid eligible home health services, Exhibit 8 provides patient origin data for its active in-home clients. As Exhibit 8 indicates, more than half of Amicable's in-home clients reside in South King County (as defined by the King County CHNA) and another one third reside in South Seattle neighborhoods, other predominantly minority communities. Although the majority of Amicable's current patients reside in these communities, Amicable recognizes and plans to serve the entirety of King County as a Medicare certified/Medicaid eligible home health provider.

[11] https://www.kingcounty.gov/depts/health/data/community-health-indicators/~/media/depts/health/data/documents/2018-2019-Joint-CHNA-Report.ashx
[12] https://www.kingcounty.gov/depts/health/data/community-health-indicators/~/media/depts/health/data/documents/2018-2019-Joint-CHNA-Report.ashx

6. **For existing facilities, please identify the number of patients currently receiving skilled services, broken down by type(s) of services (i.e., skilled nursing).**

Amicable is not a current Medicare certified/Medicaid eligible home health agency. This question is not applicable.

7. **Please provide utilization forecasts for the following, broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) <u>for each county</u> proposing to serve:**

   A. **Total number of home health *visits* per year for the first three years; and**

   B. **Total number of unduplicated home health *patients* served per year for the first three years.**

Projected visits for the initial operating year as well as the three full years are included in Table 8.

Table 8
Amicable Home Health
Projected Visits by Discipline and Year, 2020-2023

	2020 (April-Dec)	2021	2022	2023
	Visits	**Visits**	**Visits**	**Visits**
Registered Nurse	1,415	2,877	3,549	4,275
Physical Therapy	1,153	2,329	2,873	3,461
Home Health Aide	206	411	507	611
Occupational Therapy	520	1,028	1,268	1,527
Speech Therapy	56	137	169	204
Medical Social Work	43	69	85	102
Unduplicated Patients	**200**	**403**	**497**	**599**
Total	**3,393**	**6,851**	**8,451**	**10,180**

Source: Applicant

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

Utilization projections are based on the following assumptions:

- Amicable expects to begin providing home health services in March of 2020
- An average of 17 visits per patient
- The following distribution of visits by discipline
  - Skilled Nursing: 42%
  - Physical Therapy: 34%
  - Speech Therapy: 2%
  - Occupational Therapy: 15%
  - Social Work: 1%
  - Home Health Aides: 6%
- The following market share, % of total projected King County visits
  - 2020 (April – December): 0.6%
  - 2021: 1.3%
  - 2022: 1.5%
  - 2023: 1.8%
- No change in use rates were assumed (use rates were described earlier in the application of the home health methodology)

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

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

As stated above, there are 17 Medicare certified/Medicaid eligible home health agencies serving King County. These are the agencies that Amicable considers to be 'similar" in that they are generally available and accessible to the population to be served by Amicable. Table 9 provides information on the 17 agencies.

In addition to the providers in Table 9, it has been the CN Program's practice, since about 2012, to include some or all of the licensed only agency capacity. While Amicable does not concur with this practice, we did review the most recent King County decision (May 2018 for Eden Home Health) to understand which of the licensed only agencies the CN Program counted in supply. In that CN decision, the CN Program counted 14 additional agencies. In its Eden evaluation, the CN Program stated explicitly that discrepancies in counts do occur (the applicant, Eden, and the CN Program had different counts) and explained it as follows:

> *This is not unexpected- licensed-only agencies are not subject to CN review and can be established relatively quickly... Acceptable reasons for exclusion of an agency can include, but not limited to service area limitations, patient type limitations, and service type limitations. Furthermore, it is possible that an agency may claim a county on their license, but the agency website and marketing may indicate a narrower service area.*

Given that the supply of licensed only comparable can change over a short time, in August 2018, Amicable obtained a listing of all of the agencies with a current in home services license (total of 60)[13]. This list of 60 was reviewed against the Department of Health Provider Credential Search to ensure that the licenses were currently "Active". This "Active" list was compared to the listing in the Eden Home Health evaluation and those agencies that the CN Program had concluded were not available or accessible to home health patients were excluded from Amicable's count of 'supply'. Finally, the remaining agencies were evaluated (via website or by phone) to ascertain their availability and accessibility for King County home health patients.

Amicable included only those licensed-only home health agencies that comply with the Medicare home health definition, which requires very specific services to be provided including, at a minimum, skilled nursing and therapeutic services. A list of the licensed only home health agencies compliant with the Medicare home health definition, and for the purposes of this application, counted in supply, are also included in Table 9. Agencies excluded, along with exclusion criteria are provided in Exhibit 10. In summary, while only 17 are Medicare certified, Amicable is 'counting' in supply a total of 21 agencies. This compares to 31 agencies noted in the CN Program's Eden decision from 2018. Regardless, even if the CN Program's count is used, there remains need for the agency proposed in this CN application.

[13] In comparison, in the Eden Home Health evaluation, the CN Program's count was 68.

Table 9
King County Licensed In-Home Services Agencies Counted in Supply

	Agency Name	CN Approved?	Notes/Limitations	Source
1	Assured Home Health	Yes	None	DOH Decision: Eden 2018
2	Brookdale Home Health	Yes	None	DOH Decision: Eden 2018
3	Careage Home Health	Yes	None	DOH Decision: Eden 2018
4	CHI Franciscan at Home	Yes	None	DOH Decision: Eden 2018
5	Eden Home Health	Yes	None	DOH Decision: Eden 2018
6	Envision Home Health	Yes	None	DOH Decision: Eden 2018
7	Evergreen Health	Yes	None	DOH Decision: Eden 2018
8	Harvard Partners LLC	Yes	None	DOH Decision: Eden 2018
9	Home Care by Wesley	Yes	None	DOH CN files
10	Kaiser Permanente Home Health and Hospice	Yes	Only serves HMO population	DOH CN files, DOH Decision: Eden 2018 excluded based on limitations
11	Kindred at Home	Yes	None	DOH Decision: Eden 2018
12	Kline Galland Community Based Services	Yes	None	DOH Decision: Eden 2018
13	MultiCare Home Health Hospice and Palliative Care	Yes	None	DOH Decision: Eden 2018
14	Providence Home Services	Yes	None	DOH Decision: Eden 2018
15	Rainier Home Health	Yes	None	DOH Decision: Eden 2018
16	Sea Mar Community Health Center	Yes	None	DOH Decision: Eden 2018
17	Signature Home Health	Yes	None	DOH Decision: Eden 2018
Licensed only home health agencies, counted in supply, not available and accessible to majority of home health patients				
1	Goldencare Home Health Agency	No	Nursing and therapies	Website
2	Visions Home Health Care	No	Skilled nursing, home health aide, and therapy services	DOH Decision: Eden 2018
3	AdvisaCare	No	Skilled nursing, home health aide, and therapy services	DOH Decision: Eden 2018
4	Millennia Healthcare	No	Skilled nursing, home health aide, and therapy services	DOH Decision: Eden 2018

Source: CN Program Files

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

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

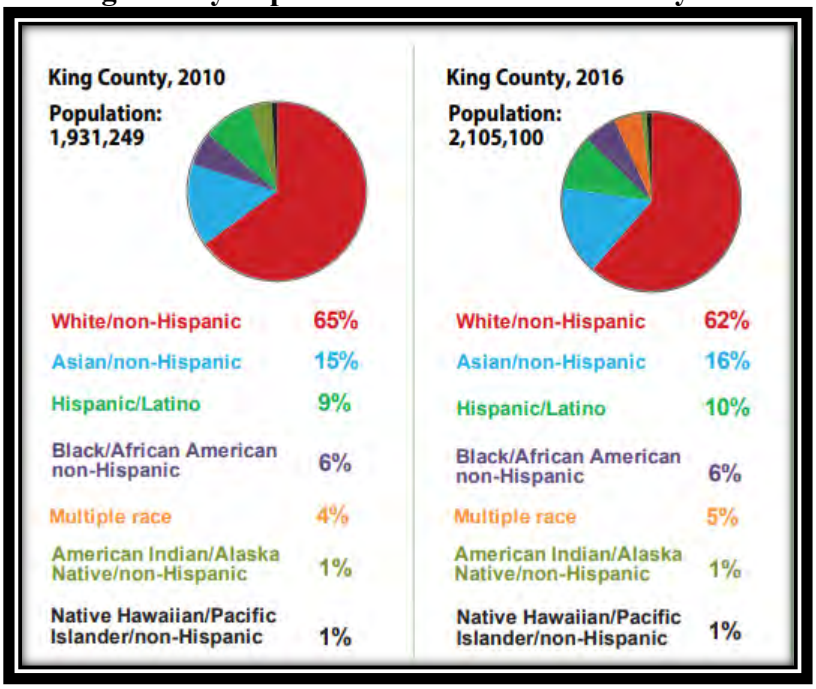
Amicable's project is not an unnecessary duplication of services in that it there is a significant unmet need for additional home health providers in King County. More importantly, patients are often more comfortable seeking care from agencies representing their own cultures and background. Amicable is unique in its ability to support immigrant, refugee, minority, and under-served populations and will improve access and acceptability for select patient groups.

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

Amicable is uniquely positioned and committed to serving low-income, racial and ethnic minorities, and other under-served groups. Furthermore, Amicable is also committed to serving all persons, regardless of gender, age or disability. Amicable was founded on the principle that all life is valuable, and treats all humans with a respect that values their life, perspective, health, and well-being. In addition, as noted in other sections of this application, three quarters of Amicable's current in home patients are racial or ethnic minorities. And, as has been discussed earlier, these populations are among the fastest growing populations in King County.

Figure 2, from the 2018-2019 King County CHNA, demonstrates the shift in population by race in King County.

Figure 2
King County Population Growth 2010-2016 By Race



Source: King County 2018-2019 CHNA

As Figure 2 demonstrates, White/non-Hispanics account for a smaller portion of the population and Hispanics, Asian/non-Hispanic, and Multi-Racial persons are increasingly a larger portion of the King County population. Furthermore, Table 7 shows that the White population is the slowest growing race group, with the Asian and Multi-Racial populations growing the fastest. Of the growth experienced in King County from 2010-2016, over half of the growth was from foreign-born populations[14]. In 2016, 20.3% of King County was comprised of foreign-born individuals, in comparison to 12.9% of the United States.

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

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

Copies of the requested policies are included in Exhibit 11.

[14] https://www.kingcounty.gov/~/media/depts/executive/performance-strategy-budget/documents/pdf/RLSJC/2017/Feb23/KingCountyDemographics022317

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

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

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

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

This question is not applicable.

Section 4
Financial Feasibility

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

Table 10 details the capital expenditures for the project.

Table 10
Capital Expenditures

Equipment	Estimated Price
Partition Panels and installation	$5,500.00
Furnishing	$3,000.00
Office upgrades: carpet, paint and cabling	$4,000.00
Office Equipment	
2 computers	$3,000.00
4-in-one -printer/fax/copier/scanner	$1,500.00
Land lines phone systems	$1,000.00
Software and licenses	$2,000.00
Cell-phones and i-Pads for clinical visiting staff	$4,000.00
Total	**$24,000.00**

Source: Applicant

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

Estimates of equipment and furniture are from Amicable's recent experience with its office expansions into Pierce and Snohomish Counties as well as vendor quotes.

3. **Document the project impact on: (a) Capital costs (b) Operating costs and charges for health services.**

Amicable is an ongoing home-care operation and already has a majority of the infrastructure in place in its King County operation. The small, incremental capital to become Medicare certified/Medicaid eligible will be funded from reserves and will not impact costs or charges for health services. A copy of audited financials demonstrating sufficient reserves can be found in Exhibit 12.

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

See Exhibit 13 for the proforma operating revenue and expenses for the first three years of operation, along with assumptions.

5. **Please note: according to revised HCFA regulations, home health agencies must have enough reserve funds (determined by an authorized fiscal intermediary) to operate for three months after becoming Medicare/Medicaid certified. Please provide the following information in relation to this requirement:**

   A. **Provide the name and address of the fiscal intermediary you will be using to determine capitalization;**

The fiscal intermediary used will be National Government Services. The address is:

P.O. Box 100142
Columbia, South Carolina 29202-3142

   B. **Provide a copy of the forms you are providing to the fiscal intermediary.**

Exhibit 14 contains a copy of the forms Amicable will provide to the fiscal intermediary.

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

Due to minimal capital expenditures for this project, Amicable will use reserves to fund the project. There will be no debt incurred. A copy of audited financials is included in Exhibit 12 to demonstrate sufficient reserves.

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

Amicable's audited financials identify sufficient reserves. A letter from Amicable's President, indicating commitment to fund this project, is included as Exhibit 15. Audited financial statements, including the balance sheet, can be found in Exhibit 12.

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

As stated in Section 4, Question 6, financing will come from Amicable's reserves. Capital expenditures are minor and use of reserves are preferred as they do not carry financing costs.

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

A proforma balance sheet, along with revenues and expense statements are included in Exhibit 13.

10. **Provide a capital expenditure budget through the project completion and for the tree years following completion of the project.**

There are no further capital expenditures beyond those stated in this application anticipated for the first three years.

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

Payer mix for total operations for home health is found below in Table 11.

Table 11
Payer Mix: Home Health

Payer	%
Medicare	73%
Medicaid	5%
Commercial[15]	22%
Total	100%

Source: Applicant

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

This question is not applicable, as Amicable is not currently providing Medicare certified/Medicaid eligible home health care services.

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

This question is not applicable, as Amicable is not currently providing Medicare certified/Medicaid eligible home health care services.

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

This question is not applicable, as Amicable is not currently providing Medicare certified/Medicaid eligible home health care services.

[15] Includes Medicaid Managed Care (10%).

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

This question is not applicable, as Amicable is not currently providing Medicare certified/Medicaid eligible home health care services.

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

Table 12 contains costs and charges per visit by discipline and Table 13 contains costs and charges by payor source for the year 2023.

Table 12
Costs and Charges per Visit by Discipline, 2023

	Costs per Visit	Charges per Visit
Skilled Nursing	$160.43	$201.00
Physical Therapy	$141.57	$177.00
Speech Therapy	$141.57	$177.00
OT	$141.57	$177.00
MSW/Other	$141.37	$177.00
Home Health Aide	$86.27	$108.00

Source: Applicant

Table 13
Costs and Charges by Payor Source, 2023

	Costs	Charges
Medicare	$1,116,000	$1,384,000
Medicaid	$74,000	$92,000
Private Pay/Insurance	$298,000	$416,000
Total	$1,488,000	$1,892,000

Source: Applicant

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

The proposed addition of FTEs, salaries, and their associated visits are included in Table 14.

Table 14
Proposed FTEs and Salaries

	2020 (April-Dec)		2021		2022		2023		
Types of Staff	**FTE**	**Visits**	**FTE**	**Visits**	**FTE**	**Visits**	**FTE**	**Visits**	**Salary/FTE**
RN	1.64	1,415	3.33	2,877	4.11	3,549	4.95	4,275	$70,000
PT	Contracted	1,153	-	2,329	-	2,873	-	3,461	-
HH AIDE	0.15	206	0.31	411	0.38	507	0.46	611	$34,320
OT	Contracted	520	-	1,028	-	1,268	-	1,527	-
Speech Therapist	Contracted	56	-	137	-	169	-	204	-
Med Social Work	0.05	43	0.07	69	0.09	85	0.11	102	$62,000
Clinical Subtotal	1.84	3,393	3.71	6,851	4.58	8,451	5.52	10,180	
Administrator	0.75	-	1	-	1	-	1	-	$80,000
Office Manager	0.75	-	1	-	1	-	1	-	$45,000
Marketing/Business Development	0.38	-	0.5	-	0.5	-	0.5	-	$86,667
Admin Assistant	0.75	-	1	-	1	-	1	-	$32,250
Account Clerk	0.25	-	0.25	-	0.25	-	0.25	-	$35,000
Medical Director	Contracted	-	-	-	-	-	-	-	-
Administrative Subtotal	2.88	0	3.75	0	3.75	0	3.75	0	
Total	**4.72**		**7.46**		**8.33**		**9.27**		

Source: Applicant

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

Amicable currently provides home care services and will use reserve funds to cover costs of home health care operations until Medicare reimbursement is received. Audited financials can be found in Exhibit 12.

Section 5
Project Rationale: Structure and Process (Quality) of Care

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

Amicable is not currently a home health agency. The proposed number of employees was detailed in Table 15.

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

In developing its proposed staff to visit ratio, Amicable reviewed several of the recent CN approved King County home health CN applications, and also consulted with our home health operations consultant. Ultimately, the average of the recent CN approved applications was used as a comparator for our staff to visit ratio. Amicable believes that the chosen staff to visit ratio results in conservative projections and is prudent. Please note that the Director of Nursing (DON) is initially included in the RN staff to visit ratio and FTE.

Amicable's staff to visit ratio is included in Table 15.

Table 15
Staff to Visit Ratio

Types of Staff	Staff/Visit Ratio *1,000 (FTE)
Registered Nurse	1.15
Physical Therapy	Contracted
Home Health Aide	0.73
Occupational Therapy	Contracted
Speech Therapy	Contracted
Medical Social Work	1.16

Source: Applicant

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

Amicable consulted with a home health consulting agency that confirmed that these staffing ratios are comparable to or better than national ratios.

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

Amicable operates a home care agency in King, Pierce, and Snohomish Counties. As such, we are very familiar with the availability of qualified staff in the King County labor market. Furthermore, Amicable has operated a staffing agency in the past, and is knowledgeable about the avenues and resources used to find and attract qualified staff. Many existing Amicable staff (currently providing home care) will be available for home health staffing based on their skills and licensure.

Furthermore, Amicable is aware of current home-care staff such as CNAs and Home Care Aides that wish to further develop their skills as Registered Nurses. Amicable will work with these staff to allow them to pursue their education and create a pipeline of Registered Nurses to deliver home healthcare upon CN approval of this application. To overcome many challenges plaguing agencies today, we have partnered with agencies that offer a suite of recruitment tools to recruit Caregivers, CNAs, Nurses & Home Health Aides such as, myCNAjobs, Care.com, Hand-Shake (Career Site for students), Indeed, Work-Source and International Manpower Connection for foreign workers. Amicable also utilizes social media in our recruitment efforts, such as Facebook and LinkedIn.

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

Find a copy of the in-service training plan for staff in Exhibit 15.

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

As part of its continuous customer and payer experience improvement, Amicable will establish and maintain an ongoing Quality Assessment and Performance Improvement Program (QAPI) comprised of a system of measures that captures significant outcomes that are essential to optimal care and are used in the care planning and coordination of services and events.
The QAPI committee will be appointed by the Administrator and approved by the governing Body. The DON is responsible for the day to day QI activities.

Procedures to measure, monitor, and correct performance are laid out below.

Procedure:

A. Monitoring of the QAPI Program
    1. The QAPI Committee will be responsible for the ongoing monitoring of the QAPI Program. Findings are to be used by the Agency to contact identified problems and revise policies, if necessary.

2. The QAPI Committee will review the plan at least quarterly within a calendar year and revise the plan if needed.

B. QAPI Committee Membership Qualifications and Frequency of Meetings

1. At a minimum, the QAPI Committee must consist of at least (1) the Administrator; (2) the director of nurses; (3) a therapist (one person may represent all therapies, e.g., PT, OT, SLP, SW, provided however, that should be the therapy being delivered); (4) representation from an unskilled discipline.
   NOTE: A nurse cannot represent the therapies and a therapist cannot represent the skilled nurses.
2. The QAPI Committee must meet at least quarterly and more often if needed.

3. Members are trained on PI (process improvement) activities which include but may not be limited to:
   - The purpose of PI activities
   - Persons responsible for coordinating PI activities
   - Individual's role in PI
   - PI outcomes

In addition, Amicable will conduct a formal patient satisfaction survey, measuring the quality of care and service provided. Amicable will survey patients upon discharge to obtain information regarding their satisfaction with the services. The information obtained will be analyzed and any problems identified will be addressed.

Procedure:

1. Upon discharge and/or while the patient is under the Agency's care, mail the patient and/or the family a satisfaction survey and pre-addressed return envelope. Phone surveys may also be conducted.
2. DON or designee reviews all returned surveys. Returned surveys, which have narrative comments, are retained in the Agency's administrative files.
3. DON or designee investigates all negative comments and/or scores, documenting findings and actions taken on the Patient Satisfaction Follow-up Report.
4. DON forwards findings to the Administrator if further review is indicated.
5. Include findings of Patient Satisfaction Surveys in QA activities.

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

Amicable's office hours will be 8:00AM to 5:00 PM, Monday through Friday (excluding major holidays -New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas). Amicable will provide 24/7 access to staff through an on-call service in which an RN will respond within two hours.

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

Whereas Amicable already has an established presence in King County with their active home-care agency, Amicable does not anticipate any issues meeting ancillary and support service demands.

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

Amicable already operates home care agencies in King, Pierce, and Snohomish Counties. With CN approval of this project, Amicable will be able to better coordinate any home health and home care needed for their patients, streamlining the patient experience and breaking down any silos or cultural barriers that may exist between home care and home health, as can occur when they are provided by separate agencies. Established relationships with healthcare providers in King County will allow for open and easy communication in order to prevent fragmented care for patients when transitioning to the post-acute care setting. Moreover, Amicable has a history of collaborating and working with other healthcare organizations in King County as a home care agency and will be able to expand these relationships for its home health patients and services.

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

Amicable has no history with respect to criminal convictions, denial or revocation of a license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program.

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

Dapo Amosun: Not Applicable
Ferguson Adesoye: Not applicable

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

Amicable Healthcare has been providing home care services in the Puget Sound region since 1997, making the organization and owners seasoned in the challenges and opportunities of in-home care. Background information of key personnel is found in Exhibit 16.

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

Amicable Healthcare is not an existing home health agency. Should the CN Program require the surveys for our licensed home care agency, please advise.

Section 6
Cost Containment

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

    - **Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.):***
    - **Advantages and disadvantages, and whether the sum of either the advantages of the disadvantages outweighs each other by application of the decision-making criteria;**
    - **Capital costs;**
    - **Staffing impact.**

Given the need demonstrated by the CN Program's methodology (See Exhibit 7), Amicable Healthcare evaluated only two alternatives prior to submitting this CN.

1. Continue operating as a licensed only home health provider, or,
2. Submit a CN application seeking approval to establish a Medicare certified/Medicaid eligible home health agency.

Given the continued large need for additional home health agencies (as identified in earlier sections of this application, Amicable made the decision to again file an application to become a Medicare certified and Medicaid eligible home health agency. As noted earlier, in 2016, Amicable had previously submitted an application for CN approval. Since the 2016 application was found to be deficient and not meet all CN review criteria, Amicable opted to invest time and resources to develop an application that it is confident meets all CN review criteria. Approval of this application will allow Amicable to meet the large need for home health services for King County residents in general and to be able to provide these services, in particular, to the large and growing racial and ethnic minority populations.

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

This question is not applicable as Home Health Agencies are no longer subject to Medicare cost caps.

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

As an established home care agency, Amicable will be able to build on its existing operations for the provision of home health services. Amicable expects that it will be able to achieve some economies of scale by streamlining and sharing of administrative functions between home care and home health.

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

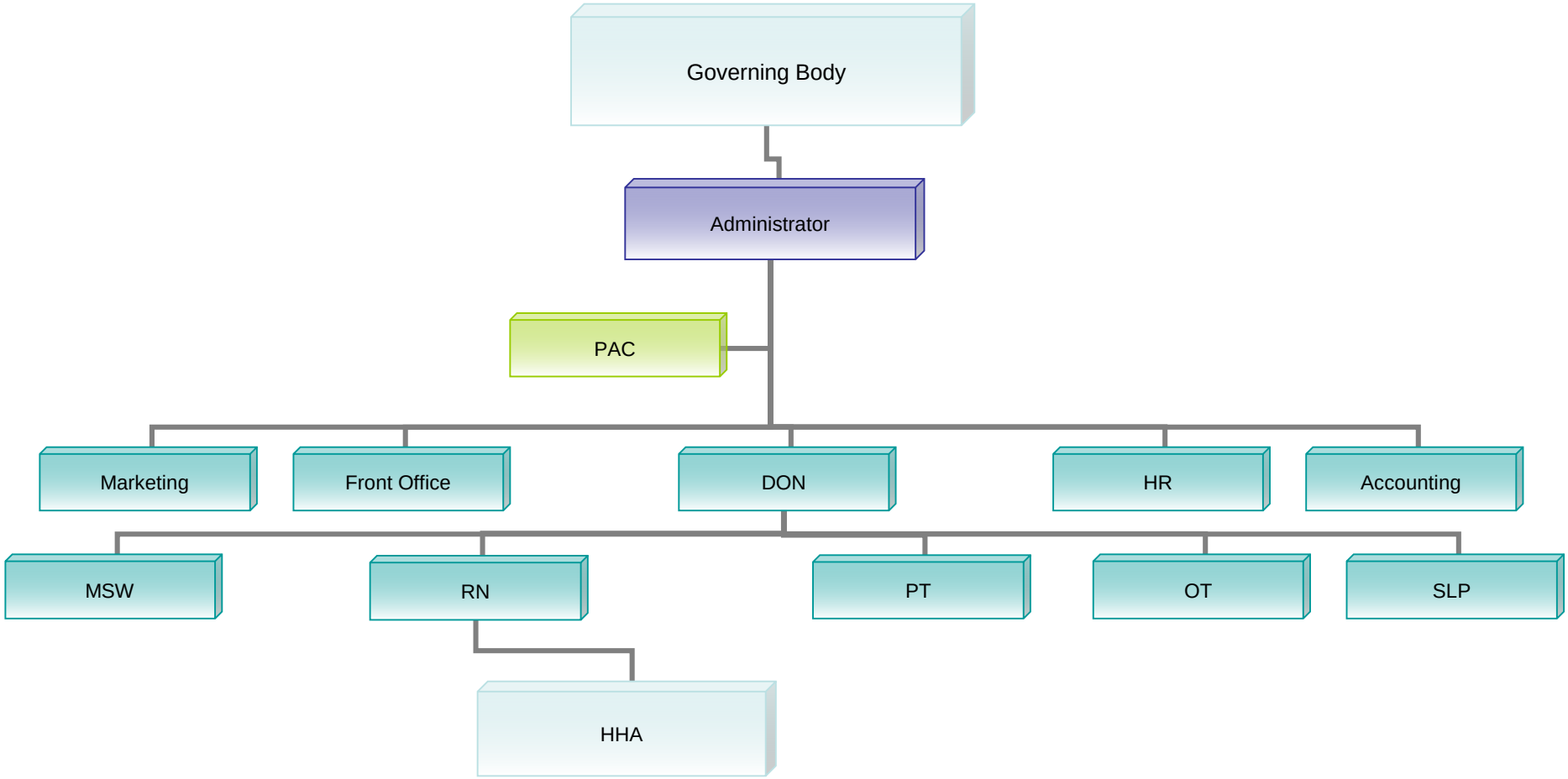
This question is not applicable, as no construction costs are required.

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

This question is not applicable.

Exhibit 1: Organizational Chart

AMICABLE Healthcare, Inc.
Chain Of Command



The patient may communicate with any team member.

Exhibit 2: Medical Director Draft Agreement

Amicable Healthcare

AGREEMENT FOR PROFESSIONAL SERVICES

MEDICAL DIRECTOR

THIS AGREEMENT FOR PROFESSIONAL SERVICES, hereinafter referred to as the Agreement is made and entered into this ___ day of _____2019. by and between Amicable Healthcare, Inc. hereinafter referred to as the AGENCY and_____ _____MD, hereinafter referred to as **MEDICAL DIRECTOR**.

THIS AGREEMENT is based on the following premises:

1. **AGENCY** Is attempting to become a certified Medicare agency in the business of providing home health services to home health patients AND IDENTIFIED THE NEED FOR A Medical Director to serve as an advisor on professional issue, to participate in the evaluation of the agency's healthcare program and to assist the agency in maintaining liaison with other health care providers in the area served by the agency.

   Furthermore, the agency is required to implement an Advisory Committee, which meets at least annually and includes a licensed physician. The physician serves as a consultant and assists in reviewing the agency's policies governing the scope of services offered, admission and discharge policies, medical supervision, plans of treatment, emergency care, clinical records, personnel qualifications and program evaluation.

2. **MEDICAL DIRECTOR** is duly licensed and board certified with, demonstrated knowledge and well-developed skills in medicine, oncology, pharmacology, pain and symptom control1 psychology of loss, experience in patient care and is currently licensed under the laws of the State of Washington

NOW, THEREFORE, in consideration of the covenants set forth herein, it is mutually agreed by and between the parties as follows:

PROFESSIONAL SERVICES: MEDICAL DIRECTOR hereby agrees to provide professional services in connection with AGENCY's business, and AGENCY accepts such professional services from MEDICAL DIRECTOR. upon the terms and conditions herein set forth

RESPONSIBILITIES OF THE MEDICAL DIRECTOR

- Serve as a member of a professional advisory committee, quality improvement committee, and interdisciplinary group.

- Confirm patient eligibility for home health services in accordance with the agency policy
- Consult with physician about potential home health patient as indicated
- Serve as a consultant with patient's primary physician as requested
- Assist in developing plan of care for patient/family as needed
- Consult with attending physician and home health staff as requested
- Coordinate efforts with attending physician to provide medical care if he/she is unable or unavailable
- Consult with team members on an on-call basis for medical issues relating to the patient/family plan of care
- Offer advice and information to staff and referring physicians on medical intervention consistent with home health philosophy and plan of care
- Serve as medical liaison with physicians in community and promote referrals
- Participate in patient conference with emphasis on the medical management of patient's plan of care
- Present or arrange for orientation and education presentations as requested for interdisciplinary team members involved in patient care
- Participate in community programs for the purpose of providing education and information to members of the medical community.

MEDICAL DIRECTOR agrees to faithfully perform the services and duties assigned to him or her by AGENCY as outlined in this contract under Responsibilities of the Medical Director, to the best of his or her abilities, as listed above. Conforming to all laws, rules and regulations, policies, procedures, and professional codes of ethics as are applicable to the AGENCY and to the MEDICAL DIRECTOR, insofar as they relate to the AGENCY's services.

QUALIFICATIONS OF MEDICAL DIRECTOR: MEDICAL DIRECTOR must be Board Certified and Licensed in the State of Washington, Drug Enforcement Registration and Presentation of Certificate of Insurance.

COMPENSATION: MEDICAL DIRECTOR'S fee will be provided on a fee for services basis. The AGENCY agree to pay MEDICAL DIRECTOR the rate of $150 per hour, rounded up to the nearest hour. Medical Director services will not exceed 4 hours per month without the prior authorization of Agency's Executive Director. The AGENCY shall also pay all such bills within their budget, allotted time. and according to the AGENCY's billing procedure.

MEDICAL DIRECTOR is not considered an employee of the agency for any purpose and services will be provided on as needed basis

RESPONSIBILITIES OF THE AGENCY: AGENCY, under this Agreement is responsible to:

- Coordinate the transmittal of information required by the MEDICAL DIRECTOR for the orderly and efficient delivery of services and applicable administrative transaction.
- Provide all records and information to the MEDICAL DIRECTOR relevant to the patients for purposes of services being provided and provide appropriate report. Forms for treatment rendered, and progress reports including goals.
- Determining the appropriateness of treatment for patients in cooperation with referring physician and MEDICAL DIRECTOR
- Reviewing and evaluating MEDICAL DIRECTOR'S services to assure quality control of services provided to the AGENCY.
- Acquiring and maintaining adequate professional liability insurance.

CONFIDENTIALITY: During the term of this agreement and thereafter, both parties shall hold confidential information in the strictest confidence and in accordance with state and federal laws.

DURATION OF AGREEMENT:

The duration of this agreement is indefinite. However, either party may:

- Terminate this agreement by providing the other party with a sixty (60) day written notice of such intent
- Terminate this agreement when either party fails to abide by its contents

INDEPENDENT CONTRACTOR: The intent of this document is to create an independent contractor agreement. It Is expressly understood and agreed to by both parties, that the MEDICAL DIRECTOR shall not be treated as an employee of the AGENCY for Federal or State Tax purposes and that the MEDICAL DIRECTOR is responsible for paying his/her estimated income and self-employment taxes. MEDICAL DIRECTOR agrees to provide the AGENCY with the appropriate Tax Identification Number and address for reporting such independent contract payment made to MEDICAL DIRECTOR as required by law. It is also understood that the MEDICAL DIRECTOR is responsible for acquiring and maintaining adequate personal worker's compensation or waiver to meet the MEICAL DIRECTOR's personal needs for his/her own injury or death arising out of any act or omission by the MEDICAL DIRECTOR in the performance of professional duties. MEDICAL DIRECTOR shall maintain appropriate insurance against liability for personal injury, death and property damage arising out of his/her ownership, maintenance, and or use of his automobile. Evidence of such coverage will be made available to the AGENCY upon request. If MEDICAL DIRECTOR is unable to maintain appropriate liability insurance, the AGENCY will provide such coverage at a charge! to the MEDICAL DIRECTOR.

INDEMINIFICATION: MEDICAL DIRECTOR hereby agrees to indemnify and hold harmless the AGENCY against loss, cost, or damages because of any injury of person(s) or property arising from any act or omission on the part of the MEDICAL DIRECTOR in relation to services provided hereunder. AGENCY hereby agrees to indemnify and hold harmless the MEDICAL DIRECTOR against loss, cost, or damage because of any Injury to person(s) or property arising from any act of omission on the part of the AGENCY in relation to services provided hereunder.

INTEGRATION: This Agreement contains the entire agreement between the parties, and no representations, agreements or understandings, oral or written, shall be effective as between the parties hereto other than these contained herein. No alteration to, amendment of, or changes to this Agreement shall be binding unless in writing and signed by the parties hereto as an addendum to this Agreement

ENTIRE AGREEMENT: This agreement contains the entire understanding of both parties and supersedes all prior agreements, understandings and representations between the parties. No other statements promise, or agreements have been made to either party, which are not reflected within the policy and the agreement.

Signature represents review of the policy and agreement related to Medical Director and understanding of the scope of services requested as the consulting physician.

This agreement is made and entered into on the date noted below between the AGENCY and the physician.

AGENCY

By its Manager, Amicable Healthcare, Inc.

By: _____

Name: _____

Title: _____

Date: _____

PHYSICIAN

By: _____

Name: _____

Title: _____

Date: _____

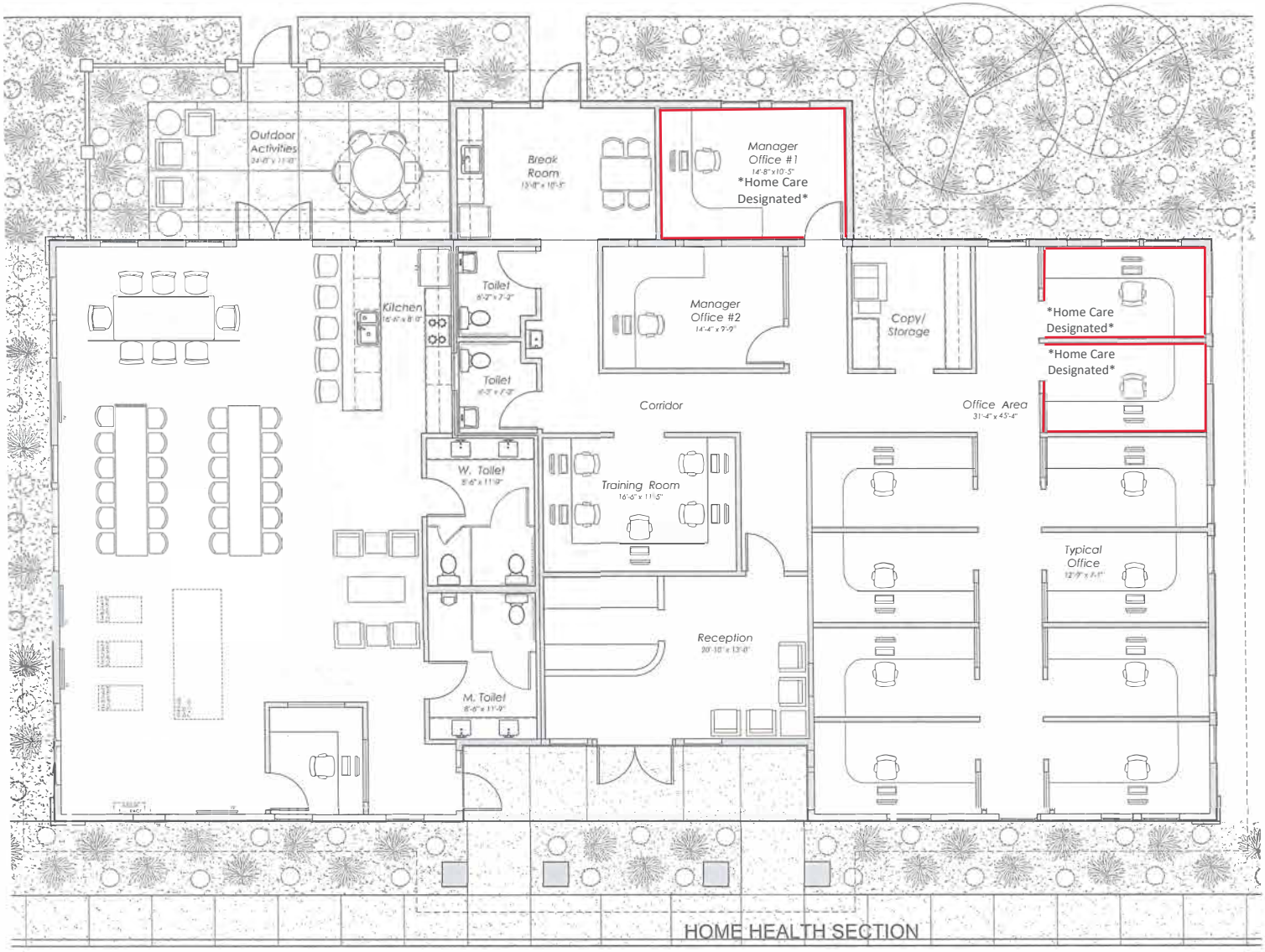
UPIN#: _____

Exhibit 3: Equipment List

Equipment List

Equipment	Estimated Price
Partition Panels and installation	$5,500.00
Furnishing	$3,000.00
Office upgrades: carpet, paint and cabling	$4,000.00
Office Equipment	
2 computers	$3,000.00
4-in-one -printer/fax/copier/scanner	$1,500.00
Land lines phone systems	$1,000.00
Software and licenses	$2,000.00
Cell-phones and i-Pads for clinical visiting staff	$4,000.00
Total	**$24,000.00**

Exhibit 4: Single Line Drawing of Building



980 South Horney Street
Seattle, WA 98108

COHAN ARCHITECTURE

11 JUL 2018
1/8" = 1'-0"
CA1804

CONCEPT FLOOR PLAN
BUILDING A

AMICABLE HEALTCARE, INC
5220 32nd Ave S
Seatac, Washington

A

= Home Care Designated Space

Exhibit 5: King County Assessor's Website Parcel Information

Department of Assessments

500 Fourth Avenue, Suite ADM-AS-0708, Seattle, WA 98104

Office Hours: Mon - Fri 8:30 a.m. to 4:30 p.m.

TEL: 206-296-7300
FAX: 206-296-5107
TTY: 206-296-7888

Send us mail

- New Search
- Property Tax Bill
- Map This Property
- Glossary of Terms
- Area Report
- Property Detail

PARCEL

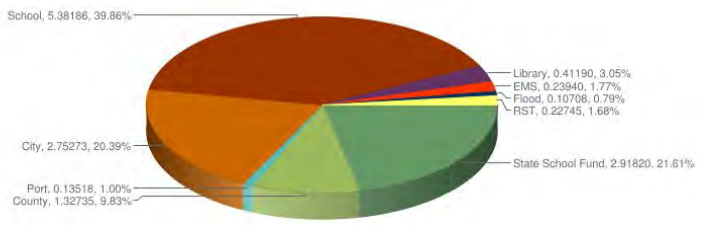
Parcel Number	004300-0003
Name	AMICABLE HOLDINGS LLC
Site Address	15220 32ND AVE S 98188
Legal	ADAMS HOME TRS 3RD ADD N 229.90 FT OF LOT 1 LESS S 29.90 FT OF E 1/2 LESS CO RD

BUILDING 1

Year Built	1977
Building Net Square Footage	4064
Construction Class	WOOD FRAME
Building Quality	LOW COST
Lot Size	26224
Present Use	Office Building
Views	No
Waterfront	

TOTAL LEVY RATE DISTRIBUTION

Tax Year: 2018 **Levy Code:** 2212 **Total Levy Rate:** $13.50115 **Total Senior Rate:** $7.03198



51.70% Voter Approved

Click here to see levy distribution comparison by year.

TAX ROLL HISTORY

Valued Year	Tax Year	Appraised Land Value ($)	Appraised Imps Value ($)	Appraised Total ($)	Taxable Land Value ($)	Taxable Imps Value ($)	Taxable Total ($)
2018	2019	367,100	431,400	798,500	367,100	431,400	798,500
2017	2018	367,100	365,000	732,100	367,100	365,000	732,100
2016	2017	367,100	365,000	732,100	367,100	365,000	732,100
2015	2016	445,800	286,300	732,100	445,800	286,300	732,100
2014	2015	445,800	282,600	728,400	445,800	282,600	728,400
2013	2014	266,500	383,500	650,000	266,500	383,500	650,000
2012	2013	340,900	494,400	835,300	340,900	494,400	835,300
2011	2012	340,900	419,600	760,500	340,900	419,600	760,500
2010	2011	222,900	519,600	742,500	222,900	519,600	742,500
2009	2010	222,900	566,800	789,700	222,900	566,800	789,700
2008	2009	222,900	592,500	815,400	222,900	592,500	815,400
2007	2008	222,900	534,100	757,000	222,900	534,100	757,000
2006	2007	222,900	489,600	712,500	222,900	489,600	712,500
2005	2006	222,900	372,100	595,000	222,900	372,100	595,000
2004	2005	183,500	379,000	562,500	183,500	379,000	562,500
2003	2004	183,500	379,000	562,500	183,500	379,000	562,500
2002	2003	157,300	264,600	421,900	157,300	264,600	421,900
2001	2002	157,300	264,600	421,900	157,300	264,600	421,900
2000	2001	157,300	255,100	412,400	157,300	255,100	412,400
1999	2000	157,300	255,100	412,400	157,300	255,100	412,400

Reference Links:

- King County Taxing Districts Codes and Levies (.PDF)
- King County Tax Links
- Property Tax Advisor
- Washington State Department of Revenue (External link)
- Washington State Board of Tax Appeals (External link)
- Board of Appeals/Equalization
- Districts Report
- iMap
- Recorder's Office
- Scanned images of surveys and other map documents
- Scanned images of plats

Notice mailing date: 07/19/2018

1998	1999	157,300	255,100	412,400	157,300	255,100	412,400
1997	1998	0	0	0	157,300	255,100	412,400
1996	1997	0	0	0	157,300	255,100	412,400
1994	1995	0	0	0	157,300	255,100	412,400
1992	1993	0	0	0	157,300	255,100	412,400
1990	1991	0	0	0	157,300	255,100	412,400
1989	1990	0	0	0	91,800	258,200	350,000
1988	1989	0	0	0	91,800	258,200	350,000
1986	1987	0	0	0	78,700	219,500	298,200
1985	1986	0	0	0	78,700	219,500	298,200
1984	1985	0	0	0	78,700	219,500	298,200
1982	1983	0	0	0	22,800	186,700	209,500

Updated: March 17, 2016

Exhibit 6: HPSA and MUA Designations

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	HPSA FTE	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1538700586	Enumclaw	Geographic HPSA	Washington	6	10	Designated	Non-Rural	09/18/2017	09/18/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King County	312.02	Census Tract	53033031202	Non-Rural
Washington	King County	313.01	Census Tract	53033031301	Non-Rural
Washington	King County	313.02	Census Tract	53033031302	Non-Rural
Washington	King County	314	Census Tract	53033031400	Non-Rural
Washington	King County	315.01	Census Tract	53033031501	Non-Rural
Washington	King County	315.02	Census Tract	53033031502	Non-Rural
Washington	King County	316.03	Census Tract	53033031603	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	HPSA FTE	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1535586501	Snoqualmie/North Bend	Geographic HPSA	Washington	10.72	10	Designated	Partially Rural	10/16/2017	10/16/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King County	320.03	Census Tract	53033032003	Non-Rural
Washington	King County	321.02	Census Tract	53033032102	Non-Rural
Washington	King County	322.10	Census Tract	53033032210	Non-Rural
Washington	King County	325	Census Tract	53033032500	Non-Rural
Washington	King County	326.01	Census Tract	53033032601	Non-Rural
Washington	King County	326.02	Census Tract	53033032602	Non-Rural
Washington	King County	327.02	Census Tract	53033032702	Non-Rural
Washington	King County	327.03	Census Tract	53033032703	Non-Rural
Washington	King County	327.04	Census Tract	53033032704	Non-Rural
Washington	King County	328	Census Tract	53033032800	Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	HPSA FTE	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1531111612	Vashon Maury Island	Geographic HPSA	Washington	0.65	15	Designated	Non-Rural	07/28/2017	07/28/2017

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	HPSA FTE	HPSA Score	Status	Rural Status	Designation Date	Update Date
Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status					
Washington	King County	277.01	Census Tract	53033027701	Non-Rural					
Washington	King County	277.02	Census Tract	53033027702	Non-Rural					
Primary Care	1531178648	Federal Detention Center-Seatac	Correctional Facility	Washington	0	12	Designated	Non-Rural	07/01/2002	12/30/2015
Primary Care	153999532F	Country Doctors Community Clinic	Federally Qualified Health Center	Washington	0	15	Designated	Non-Rural	12/03/2003	08/11/2014
Primary Care	153999531P	Healthpoint	Federally Qualified Health Center	Washington	0	15	Designated	Non-Rural	09/22/2003	12/12/2013
Primary Care	153999532G	International Community Health Services	Federally Qualified Health Center	Washington	0	14	Designated	Non-Rural	12/03/2003	09/26/2013
Primary Care	153999531V	Neighborcare Health (Formerly Puget Sound)	Federally Qualified Health Center	Washington	0	17	Designated	Non-Rural	12/02/2003	12/10/2015
Primary Care	153999531Y	Sea Mar Community Health Center	Federally Qualified Health Center	Washington	0	14	Designated	Non-Rural	12/02/2003	12/30/2013
Primary Care	153999532J	Seattle Indian Health	Federally Qualified Health Center	Washington	0	19	Designated	Non-Rural	12/03/2003	04/12/2012
Primary Care	153999532C	Seattle King County Department of Public Health	Federally Qualified Health Center	Washington	0	5	Designated	Non-Rural	12/03/2003	12/03/2003
Primary Care	15399953H8	Muckleshoot Tribal Clinic	Native American/Tribal Facility/Population	Washington	0	15	Designated	Non-Rural	10/26/2002	10/13/2009
Primary Care	15399953PD	Snoqualmie-North Bend Family Clinic	Native American/Tribal Facility/Population	Washington	0	16	Designated	Non-Rural	10/26/2002	05/13/2014
Primary Care	15399953PE	Snoqualmie-Tolt Community Clinic	Native American/Tribal Facility/Population	Washington	0	16	Designated	Non-Rural	10/26/2002	10/20/2011

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
03692	Governor King Service Area	Medically Underserved Area – Governor's Exception	Washington	0.0	Designated	Non-Rural	1992/07/29	1994/02/03
CT 0252.00								
CT 0253.01								
CT 0253.02								
CT 0254.00								
CT 0262.00								
CT 0291.01								
CT 0291.02								
CT 0292.04								
CT 0292.05								
CT 0292.06								
CT 0295.02								
CT 0295.04								
CT 0296.02								
CT 0297.00								
CT 0298.01								
CT 0305.01								
CT 0305.03								
CT 0306.00								
CT 0307.00								
CT 0308.01								
03695	King Service Area	Medically Underserved Area	Washington	57.7	Designated	Non-Rural	1982/06/08	1994/05/04

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
CT 0100.01								
CT 0100.02								
CT 0101.00								
CT 0103.00								
CT 0104.01								
CT 0104.02								
CT 0107.01								
CT 0107.02								
CT 0108.00								
CT 0109.00								
CT 0110.01								
CT 0110.02								
CT 0111.02								
CT 0112.00								
CT 0113.00								
CT 0114.01								
CT 0114.02								
CT 0115.00								
CT 0116.00								
CT 0264.00								
CT 0265.00								
CT 9901.00								
03696	King Service Area	Medically Underserved Area	Washington	52.46	Designated	Non-Rural	1994/05/11	1994/05/11

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
CT 0071.00								
CT 0072.00								
CT 0073.00								
CT 0080.01								
CT 0080.02								
CT 0081.00								
CT 0082.00								
CT 0083.00								
CT 0084.00								
CT 0085.00								
CT 0091.00								
CT 0092.00								
CT 9901.00								

Exhibit 7: Home Health Agency Need Methodology

1987 State Health Plan Methodology - Home Health

County: King
Years: 2020-2022

2020	Age Cohort	*	County Population	*	SHP Formula	*	Number of Visits	=	Projected Number of Visits
	0-64		1,906,749		0.005		10		95,337
	65-79		254,184		0.044		14		156,577
	80+		70,476		0.183		21		270,839
								TOTAL:	**522,754**
								Number of Expected Visits per Agency	*10,000*
								Projected Number of Needed Agencies	**52.28**

2021	Age Cohort	*	County Population	*	SHP Formula	*	Number of Visits	=	Projected Number of Visits
	0-64		1,917,491		0.005		10		95,875
	65-79		262,860		0.044		14		161,922
	80+		73,679		0.183		21		283,148
								TOTAL:	**540,945**
								Number of Expected Visits per Agency	*10,000*
								Projected Number of Needed Agencies	**54.09**

2022	Age Cohort	*	County Population	*	SHP Formula	*	Number of Visits	=	Projected Number of Visits
	0-64		1,928,708		0.005		10		96,435
	65-79		271,943		0.044		14		167,517
	80+		77,055		0.183		21		296,121
								TOTAL:	**560,074**
								Number of Expected Visits per Agency	*10,000*
								Projected Number of Needed Agencies	**56.01**

Source: OFM 2017 GMA projections, medium series

Exhibit 8: Patient Origin

King County Patient Origin YTD as of November 19, 2018

	Postal Code	Patient Count
Seattle	98118	43
Tukwila	98168	34
Tukwila	98188	29
Seattle	98106	25
Seattle	98108	23
Seattle	98144	22
Federal Way	98003	21
Tukwila	98178	21
Seattle	98126	19
Seattle	98198	19
Seattle	98146	17
Kent	98032	14
Kent	98030	13
Renton	98031	12
Seattle	98148	12
Renton	98058	11
Seattle	98104	11
Auburn	98002	7
Federal Way	98023	7
Renton	98055	7
Seattle	98122	7
Auburn	98092	6
Seattle	98121	6
Renton	98057	5
Seattle	98115	5
Seattle	98125	5
Kent	98042	4
Renton	98059	4
Seattle	98133	4
Auburn	98001	3
Renton	98056	3
Issaquah	98029	2
Seattle	98103	2
Seattle	98105	2

	Postal Code	Patient Count
Seattle	98107	2
Seattle	98112	2
Seattle	98116	2
Seattle	98136	2
Seattle	98166	2
Bellevue	98006	1
Bellevue	98008	1
Bothell	98012	1
Buckley	98321	1
Issaquah	98027	1
Kenmore	98028	1
Kirkland	98033	1
Kirkland	98034	1
Maple Valley	98038	1
Mercer Island	98040	1
Monroe	98272	1
Seattle	98101	1
Seattle	98102	1
Seattle	98109	1
Seattle	98117	1
Seattle	98155	1
Seattle	98199	1
Total		**452**

Exhibit 9: Agencies Excluded from Supply & Exclusion Criteria

King County Licensed In-Home Services Agencies Not Counted in Supply						
	Facility Name	**Site County**	**CN Approved?**	**Included or Excluded?**	**Exclusion Criteria**	**Source**
1	A and K Health Care Services LLC	King	No	Excluded	No information available	No website. Phone number listed, but unreachable.
2	Accredo Health Group	King	No	Excluded	Specialty pharmacy provider	Website
3	Alliance Nursing	King	No	Excluded	Provides medically intensive home health only	DOH Decision: Eden 2018
4	American Healthcare Services	King	No	Excluded	Nursing only, no therapies.	Website
5	Ashley House	King	No	Excluded	Medically fragile and complex children only	Website
6	Beam for Seniors - Bridge Park, Seattle, WA	King	No	Excluded	According to website, does not provide care outside of independent living community	DOH Decision: Eden 2018
7	BrightStar Care N Seattle	King	No	Excluded	Closed	DOH Facility Search
8	Care Force	King	No	Excluded	Nursing only, no therapies.	Website
9	Chesterfield Health Services	King	No	Excluded	Skilled nursing, no therapies	DOH Decision: Eden 2018
10	Childrens Country Home	King	No	Excluded	Provides medically intensive home health only	DOH Decision: Eden 2018

King County Licensed In-Home Services Agencies Not Counted in Supply						
	Facility Name	**Site County**	**CN Approved?**	**Included or Excluded?**	**Exclusion Criteria**	**Source**
11	Comfort Keepers	King	No	Excluded	Home Care only - no longer licensed to provide home health	DOH Decision: Eden 2018
12	Coram CVS/Specialty Infusion Services	King	No	Excluded	Infusion services only	Phone call confirmation (425) 883-3525
13	Disabled Companion Services	King	No	Excluded	Home care only, no therapies.	Website
14	EKL Health	King	No	Excluded	Skilled nursing, no therapies	DOH Decision: Eden 2018
15	Estelita Su Homecare	King	No	Excluded	No information available	No website. Phone number listed, but unreachable.
16	Family Resource Home Care	King	No	Excluded	Skilled Nursing, Home Health Aide; only serves Seattle area	DOH Decision: Eden 2018
17	Fedelta Care Solutions	King	No	Excluded	Primarily Home Care agency with Nurse Delegation	DOH Decision: Eden 2018
18	Health People	King	No	Excluded	Nursing only, no therapies.	Website
19	Husky Senior Care	King	No	Excluded	Nursing only, no therapies.	Website
20	Judson Park	King	No	Excluded	According to website, does not provide care outside of independent living community	DOH Decision: Eden 2018

King County Licensed In-Home Services Agencies Not Counted in Supply						
	Facility Name	**Site County**	**CN Approved?**	**Included or Excluded?**	**Exclusion Criteria**	**Source**
21	Lincare	King	No	Excluded	Respiratory therapy only	Website
22	Mercy Homecare LLC	King	No	Excluded	Nursing only, no therapies.	Website
23	New Care Concepts	King	No	Excluded	Skilled nursing, respite	DOH Decision: Eden 2018
24	Nogah Home Care	King	No	Excluded	Home care only, no therapies.	Website
25	Option Care	King	No	Excluded	Infusion Services	Website
26	Optum Women's and Children's Health LLC	King	No	Excluded	Care management software	Website
27	Personal Best Services LLC	King	No	Excluded	Skilled nursing and nurse delegation only	DOH Decision: Eden 2018
28	ProactiveHome Care	King	No	Excluded	Serves "greater Seattle Area"	DOH Decision: Eden 2018
29	Providence Elder Place	King	No	Excluded	Services are not provided in-home, are provided at program location	DOH Decision: Eden 2018
30	Providence Infusion and Pharmacy Services	King	No	Excluded	Limited scope of services	Website, phone confirmation 1/3/19
31	Right At Home	King	No	Excluded	Skilled nursing, home health aide, and therapy services; Service area restricted to metropolitan areas	DOH Decision: Eden 2018

King County Licensed In-Home Services Agencies Not Counted in Supply						
	Facility Name	**Site County**	**CN Approved?**	**Included or Excluded?**	**Exclusion Criteria**	**Source**
32	Riverstone Homehealth	King	No	Excluded	Home Care only - no longer licensed to provide home health	DOH Decision: Eden 2018
33	Ro Health	King	No	Excluded	Provides medically intensive home health only	DOH Decision: Eden 2018
34	Rotech	King	No	Excluded	Primarily a DME provider. Not providing skilled services beyond respiratory therapy	Website
35	Serengeti Care	King	No	Excluded	Nursing only, no therapies	Website
36	Universal Home Care LLC	King	No	Excluded	Nursing only, no therapies.	Website
37	Wesley Home Hospice	King	Yes	Excluded	Hospice CN Approved Agency	Website
38	Wesley Homes at Home	King	No	Excluded	Expired license	DOH Facility Search
39	Wilderness Shores Nursing	King	No	Excluded	Nursing only, no therapies.	DOH Decision: Eden 2018

Exhibit 10: Amicable Policies

Amicable Healthcare, Inc.

Category:	Administrative	Number:	1.009.1
Subject:	Admission Criteria		
Applies:	Intake Staff	Page:	1 of 4

Purpose: To establish criteria for admission to the Agency.

Policy: **The Agency will evaluate each individual for the appropriateness of admission without regard to race, age, color, creed, sex, national origin, ancestry, religion, handicap, or disability**.

Procedure: The Staff determines appropriateness for admission. He/she may consult with other staff members if necessary.

1. Patients are accepted for Home Health Services based on a reasonable expectation that the patient's health care/rehabilitation needs can be met adequately in the patient's residence.
2. The agency must accept a patient for home health services based on a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately in the patient's residence. An agency has made a reasonable expectation that it can meet a patient's needs if, at the time of the agency's acceptance of the patient, the patient and the agency have agreed as to what needs the agency would meet; for instance, the agency and the patient could agree that some needs would be met but not necessarily all needs.
3. The agency must start providing licensed home health services to a patient within a reasonable time after acceptance of the patient and according to the agency's policy. The initiation of licensed home health services must be based on the patient's health service needs.
4. Prior to initiation of services the RN will ensure that the patient or their legal representative receives a written notice concerning all policies governing patient conduct and responsibility, advance directives, and patient rights and confidentiality. If the patient cannot read the nurse will read the statement of rights and responsibility to the patient.
5. An initial health assessment must be performed in the patient's residence by the appropriate health care professional prior to or at the time that licensed home health services are initially provided to the patient. The assessment must determine whether the agency has the ability to provide the necessary services.

a. If a practitioner has not ordered skilled nursing care for a patient, then the appropriate registered nurse must prepare a care plan. The care plan must be developed after consultation with the patient and the patient's family and must include services to be rendered, the frequency of visits or hours of service, identified problems, method of intervention, and projected date of resolution. The care plan must be reviewed and updated by all appropriate staff members involved in patient care at least annually, or more often as necessary to meet the needs of the patient.
b. If a practitioner orders therapy, then the appropriate PT, OT, or ST, must perform an evaluation. The plan of care must be signed and approved by a practitioner in a timely manner. The plan of care must be developed in conjunction with agency staff and must cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits at the time of admission, prognoses, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, and any other appropriate items. The appropriate health care personnel must perform services as specified in the plan of care. The plan of care must be revised as necessary, but it must be reviewed and updated at least every sixty days.

6. Considerations relevant to acceptance of a patient may include:
   a. Adequacy and suitability of Agency personnel and resources to provide the services required by the patient.
   b. Attitudes of patient and family members toward home care.
   c. Comparative benefits of home care to institutional care.
   d. Adequate physical facilities in the patient’s residence.
   e. Availability and willingness of family members or substitute family members to participate in care.
   f. Availability and cooperation of the patient’s personal physician in establishing and managing the plan of care.
   g. Conditions of coverage, including homebound status, if applicable.
   h. Safety of staff related to patient’s housing, neighborhood and attitude of members in the home.

7. The decision regarding acceptance for admission to the Agency is not based solely on the physician's referral or the patient's request. It is based on the determined need for skilled intervention.

8. Upon referral, the decision regarding acceptance of and initiation of service by licensed staff will be made within 48 hours, of the referral or within 48 hours of the patients return home or knowledge of return home or on the physicians ordered start of care date.

9. No patient is admitted for services without an order from a physician. However, a visit may be made by the Agency's staff without a physician's order for the purpose of:
   a. Evaluation of patient meeting criteria of home health services.
   b. Offering guidance to the individual regarding the selection of a physician.
   c. The use of community resources.

10. If the patient cannot be admitted for services or be required to terminate a patient for any reason, appropriate persons are notified, and the Agency will make every effort to refer the individual to other community resources related to the patient's needs.

11. All patients shall be under the care of a Doctor of Medicine, osteopathy, podiatry medicine. It is expected that the patient will be seen by the doctor when medically indicated, but at least every six months if possible.

12. The agency shall establish and maintain for each patient accepted for care a health record which shall include at least the following information
    a) Name
    b) Current address
    c) Date of birth
    d) Sex
    e) Date of admission
    f) Name, address and telephone number of the responsible party

g) Name, address, and telephone number of the attending physician, dentist, podiatrist, or other licensed and legally authorized person whose orders or recommendations are being implemented by the home health agency.
h) Admission diagnosis or pertinent health information
i) Reason for admission
j) Notation of the conditions and diagnoses which are relevant to the plan of treatment, plan of care, or plan for personal care services.
k) Plan of treatment, plan of care, or plan for personal care services in its entirety.
l) Allergies and known untoward reactions to drugs and food. This information shall be given such prominence in the record that it is obvious to any health practitioner or agency personnel who have reasons to provide food or medication to the patient.
m) Clinical notes dictated or written at the time of service by personnel rendering the services. Clinical notes shall be signed and incorporated into the patient's health record at least every seven working days.
n) Laboratory and X-ray reports, if applicable.
o) Treatment consent or service authorization forms.
p) Documentation that a list of patient rights has been made available to each patient, patient's representative, or next of kin.
q) Patients who will receive PT, OT, and/or ST will receive a discipline specific evaluation by a therapist qualified to perform the evaluation.
r) Discharge statement. The discharge statement shall include the date of discharge, reason for termination of services, and condition upon discharge.

Amicable Healthcare, Inc.

Category:	Administrative	Number:	1.009.2
Subject:	**Charity Care Policy**		
Applies:	Intake Staff	Page:	1 of 4

Policy Statement: It is the policy of Amicable Healthcare, Inc. to provide necessary medical care to all patients regardless of ability to pay. The agency shall allocate resources to identify charity cases and provide discounted or uncompensated care based upon the information provided at the time of application for charity care by the patient or their representative.

Purpose:

To provide medically necessary home health care at a discounted rate or at no cost to patients or their representative, when adequate income or assets are not available to pay for home health services. Amicable Healthcare will provide charity care as dictated by its available resources and consistent with the following procedure. Amicable Healthcare will not deny medically necessary care to any patients based on their ability to pay, national origin, age, physical disabilities, race, color, sex, or religion

The followings provide information about how AHI's charity care policy is structured, how eligibility is determined and how the application process works.

Charity adjustments may only be granted to patients receiving non-elective care. Charity adjustments may be applied to approved accounts for uninsured patients based on the patient's total gross family income and the patient's willful cooperation in applying for Medicaid or other available coverage.

In order to ensure the funds for uncompensated care are not abused and will be available for those in need, Amicable Healthcare, Inc. will make reasonable attempts to assist eligible candidates to become covered under any available assistance programs in the community.

Amicable Healthcare will proactively makes reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in any collection activities -

DEFINITIONS

Family Unit Size is defined as the applicant (patient, if applicable), spouse, and all legal dependents as allowed by the Federal Government. If patient/applicant is a minor, the family unit will include parent(s)/legal guardian(s) and all household dependents as allowed by the Federal Government.

Family Unit Income is defined as gross income for all members of the family unit for the last three months or the last calendar year, whichever is the lesser amount. Examples of income are retirement, veteran's administration, workers compensation, sick leave, disability compensation, welfare, social security retirement (SSI not included in income determination), alimony, child support, stock/certificate dividends, interest, or income from property.

Medically Indigent is defined as an uninsured person who is not eligible for other health insurance coverage such as Medicare, Medicaid, or other private insurance. Those that are "medically indigent" make too much to qualify for Medicaid but too little to purchase health insurance or health care.

Uninsured patients are defined as patients without third party insurance coverage for health services.

Amicable Healthcare, Inc.

Category:	Administrative	Number:	1.009.2
Subject:	**Charity Care Policy**		
Applies:	Intake Staff	Page:	2 of 4

SCOPE/PROCEDURE

The calculation of the discount for uninsured patients qualified for a charity care adjustment will be based on our Medicare reimbursement rate. This discount will be updated annually when new Medicare rates are received.

Uninsured patients (i.e. those patients without third party coverage for health care services) qualify for a charity adjustment on a sliding scale as follows:

- Family income of 200% or less of the Federal Poverty Guidelines qualifies for a 100% charity adjustment, which means that their services are free.
- A family income above 200% of the Federal Poverty Guidelines may qualify for an adjustment rate or partial charity care when circumstances determined by Amicable Healthcare indicate that full payment may cause social and financial hardship to significantly harm the patient or family unit.
-

CATASTROPHIC PROVISION: Insured patients or uninsured patients who are not eligible for charity care and the patient's responsibility exceeds 25% of the annual gross family income may qualify for a catastrophic charity adjustment. (Based on fairness and ability to pay)

ELIGIBILITY CRITERIA:

1. Charity care is secondary to all other financial resources available to the patient. Insured patients are eligible for charity if their family income is 200% or less of the Federal Poverty Guidelines and they meet all other criteria.

2. Patients who are insured and their family income is more than 200% of the Federal Poverty Guidelines are ineligible for the charity program but will be considered under the catastrophic provision should the remaining balance for which they are responsible exceed 25% of the family's annual gross income.
3. Determination of eligibility of a patient for charity care shall be applied regardless of the source of referral and without discrimination as to race, color, creed, national origin, age, handicap status, or marital status.
    1. Charity care will be provided to uninsured patients when net available assets are not sufficient and gross family income is between 0 and 200 percent of the Federal Poverty Guidelines adjusted for family size.
    2. Charity care will be provided to insured patients when net available assets are not sufficient and gross family income is between 0 and 200 percent of the Federal Poverty Guidelines adjusted for family size.
4. A patient who does not qualify for charity care, but whose patient responsibility incurred for medical care at Amicable Healthcare, even after payment by third-party payers, significantly exceeds the patient's ability to pay the balance in full (25% or more of the patient's gross income, considering all assets and resources) may be considered for a catastrophic charity adjustment

ELIGIBILITY DETERMINATION

1. Charity eligibility can be determined once a completed application has been received along with **ALL** supporting documentation or through other criteria-based methods to determine charity eligibility. Should documentation not be supplied, or should the application remain incomplete, charity will **NOT** be granted. In these instances, the account(s) will be noted as uncooperative and will be subject to the normal account flow process of self-pay collection statements and outsourcing to bad debt collection agencies as well as debt collection attorneys as appropriate.
2. Cases for consideration may be requested by the patient, the patient's family, the patient's physician, Agency personnel who have been made aware of the financial need of the patient or recognized social agencies.
3. Following the initial request for charity care, the Agency will pursue other sources of funding, including Medicaid and/or state programs. If a patient refuses to pursue any other source of funding, the patient will be ineligible for the Charity Care Program. All outstanding accounts will be notated as uncooperative and will be subject to the normal account flow process of self-pay collection statements and outsourcing to bad debt collection agencies as well as debt collection attorneys if appropriate
4. Forms and instructions will be furnished to the responsible party when charity care is requested, when need is indicated, or when financial screening indicates potential needs. Refusal to complete the forms will result in denial of charity care and will subject the account to the normal escalation process including self-pay collection statements and outsourcing to bad debt collection agencies as well as debt collection attorneys.
5. The responsible party will be given fifteen (15) business days or a reasonable time as required by the person's medical condition to complete the required forms and furnish proof of income and assets.
6. Designations of charity care, while generally determined at the time of application, may occur at any time prior to judgment upon learning of facts that would indicate financial need. If a responsible party pays a portion or all of the charges related to medical care and is subsequently found to have met the charity care criteria at the time of application, the amount that will be eligible for charity care will be the balance due on the patient's account at the time of reapplication.
7. Approval for charity is granted for periods of six (6) months. If it has been longer than 6 months since an application and financial documentation have been supplied to Amicable Healthcare, Inc., a new application and required documentation must be provided for reconsideration of charity care.
8. If the patient/responsible party's financial situation changes after charity has been approved and awarded, AHI reserves the right to reverse their decision at the discretion of the Program Administrator. Examples include but are not limited to a payout from court settlement, lottery, etc.

Amicable Healthcare, Inc.

Category:	Administrative	Number:	1.009.2
Subject:	**Charity Care Policy**		
Applies:	Intake Staff	Page:	4 of 4

APPLICATION PROCESS

1. All patients desiring consideration under the Amicable Healthcare, Inc. Charity Care Program must apply for assistance in writing disclosing financial information that is considered pertinent to the determination of the patient's eligibility for charity care. Persons requesting assistance will be given a Charity Care Application form. The patient will authorize the Agency to make inquiries of employers, banks, credit bureaus, and other institutions for verifying statements made by the patient in applying for assistance.
2. When returned, the financial statement shall be accompanied by one or more of the following types of documentation as needed for purposes of verifying income:
    1. Payroll check stubs for the last three months.
    2. IRS tax return forms from the most recently completed calendar year.
    3. Forms denying unemployment or worker's compensation benefits.
    4. Income shall be annualized, when appropriate, based upon documentation provided and upon verbal information provided by the patient. This process will take into consideration seasonal employment and temporary increases and/or decreases of income.
3. All applications, supporting documentation, and communications will be treated with proper regard for patient confidentiality. AHI will exercise reasonable care to maintain supporting documents with the application form.
4. Additional information may be requested to complete the application

NOTIFICATION

1. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined eligible for charity care.
2. The Agency will make reasonable efforts to notify the patient of the final determination within fifteen (15) working days of receipt of financial statement with related documented materials (proof of income, etc.). The notification will include a determination of the amount for which the responsible party will be financially accountable. Denials will be written and include instructions for reconsideration.

APPEALS PROCESS

The responsible party may request reconsideration of eligibility for charity care by providing additional verification of income or family size within thirty (30) calendar days of receipt of notification. The Program Administrator of Amicable Healthcare will review all requests for reconsideration and will make the final determination. If the determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor.

Policy Administration:

Amicable Healthcare, Inc.'s Program Administrator shall oversee this policy. The administrator shall be responsible for:

- assuring that current Federal Poverty guidelines are available to applicants and staff assisting with administering this policy
- assuring that initial determinations for charity care meet the requirements of the policy;
- for reviewing application for charity care
- for assuring that a timely determination of eligibility is made
- for notifying the applicant of the results of determination
- and for considering any appeals.

Exhibit 11: Audited Financial Statements 2015-2017

AMICABLE HEALTHCARE, INC.

Financial Statements

As of and For the Years Ended December 31, 2017 and 2016

with Independent Accountant's Review Report

AMICABLE HEALTHCARE, INC.
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LAURA LINDAL

INDEPENDENT ACCOUNTANT'S REVIEW REPORT

Shareholders
Amicable Healthcare, Inc.
SeaTac, Washington

I have reviewed the accompanying financial statements of Amicable Healthcare, Inc. (a Washington S-corporation), which comprise the balance sheets as of December 31, 2017 and 2016, and the related statements of income and changes in shareholders' equity and cash flows for the years then ended, and the related notes to the financial statements. A review includes primarily applying analytical procedures to management's financial data and making inquiries of company management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, I do not express such an opinion.

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

Accountant's Responsibility
My responsibility is to conduct the review in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the American Institute of Certified Public Accountants. Those standards require me to perform procedures to obtain limited assurance as a basis for reporting whether I am aware of any material modifications that should be made to the financial statements for them to be in accordance with accounting principles generally accepted in the United States of America. I believe that the results of my procedures provide a reasonable basis for my conclusion.

Accountant's Conclusion
Based on my review, I am not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with accounting principles generally accepted in the United States of America.

February 20, 2018

Laura Lindal CPA

Kirkland, Washington

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AMICABLE HEALTHCARE, INC.
Balance Sheets
December 31, 2017 and 2016

ASSETS

	2017	2016
Current assets:		
Cash	$ 1,836,731	$ 1,184,832
Accounts receivable, net	571,744	789,924
Prepaid expenses	36,997	18,978
Total current assets	2,445,472	1,993,734
Property and equipment		
Office equipment	318,564	315,742
Furniture	165,691	98,578
Vehicles	29,850	29,850
Total property and equipment	514,105	444,170
Accumulated depreciation	(420,902)	(358,061)
Total property and equipment, net	93,203	86,109
Note receivable from shareholder	-	137,531
Investment, net	-	-
Total assets	$ 2,538,675	$ 2,217,374

LIABILITIES AND SHAREHOLDERS' EQUITY

Current liabilities:		
Accounts payable	$ 64,260	$ 65,073
Accrued payroll and payroll taxes	531,772	348,938
Business taxes payable	16,140	14,829
Total current liabilities	612,172	428,840
Shareholders' equity	1,926,503	1,788,534
Total liabilities and shareholders' equity	$ 2,538,675	$ 2,217,374

See Independent Accountant's Review Report.
The accompanying notes should be read with these financial statements.

AMICABLE HEALTHCARE, INC.
Statements of Income and Changes in Shareholders' Equity
For the Years Ended December 31, 2017 and 2016

	2017	2016
Revenue	$ 13,411,023	$ 10,707,352
Operating expenses:		
Wages	8,498,325	6,772,610
Health insurance and benefits	1,773,729	1,428,404
Payroll taxes	1,105,382	925,324
Supplies	433,206	367,565
Occupancy	300,513	154,037
Business taxes	192,634	156,856
Travel and auto expense	175,248	165,247
Telephone	115,135	85,608
Depreciation	62,841	30,498
Business insurance	40,554	45,205
Advertising	29,264	26,164
Bank charges	27,895	25,685
Professional fees	22,315	26,339
License and permits	22,181	15,205
Other expenses	7,037	1,333
Bad debt expense	16,140	57,243
Equipment expense	15,157	15,680
Payments to counties	8,503	-
Total operating expenses	12,846,059	10,299,003
Net operating income	564,964	408,349
Interest and other income	1,909	4,579
Interest expense	(1,551)	-
Net income (loss)	565,322	412,928
Shareholder distributions	(427,353)	(307,659)
Shareholders' equity, beginning of year	1,788,534	1,683,265
Shareholders' equity, end of year	$ 1,926,503	$ 1,788,534

See Independent Accountant's Review Report.
The accompanying notes should be read with these financial statements.

AMICABLE HEALTHCARE, INC.
Statements of Cash Flows
For the Years Ended December 31, 2017 and 2016

	2017	2016
Cash flows from operating activities:		
Net income (loss)	$ 565,322	$ 412,928
Adjustments to reconcile net income to net cash flows from operating activities:		
Depreciation	62,841	30,498
Changes in assets and liabilities:		
Accounts receivable, net	218,180	37,212
Prepaid expenses	(18,019)	(7,289)
Accounts payable	(813)	12,965
Accrued payroll and payroll taxes	182,834	74,597
Business taxes payable	1,311	2,719
Net cash flows from operating activities	1,011,656	563,630
Cash flows from investing activities:		
Purchase of property and equipment	(69,935)	(59,794)
Net cash flows from investing activities	(69,935)	(59,794)
Cash flows from financing activities:		
Shareholder distributions	(289,822)	(307,659)
Net cash flows from investing activities	(289,822)	(307,659)
Net change in cash	651,899	196,177
Cash, beginning of year	1,184,832	988,655
Cash, ending of year	$ 1,836,731	$ 1,184,832

See Independent Accountant's Review Report.
The accompanying notes should be read with these financial statements.

NOTE 1 – NATURE OF BUSINESS AND SIGNIFICANT ACCOUNTING POLICIES

Amicable Healthcare, Inc. is an S-corporation organized in the state of Washington. The Company is a health care agency licensed by the Washington State Department of Social and Health Services (DSHS) to provide in-home health care services to individuals. The Company is also licensed to provide services to nursing homes and other health care facilities, but this is not a significant part of the Company's operations. In-home services involve providing care of the elderly or disabled who are unable to carry out certain routine activities of daily life.

The Company presently has contracts with the City of Seattle Human Services Department, including the division of Aging and Disability Services. The Company also contracts with the DSHS Division of Development Disabilities. All of these contracts are funded by DSHS. The Company provides services in both King and Pierce counties in the state of Washington.

Cash and cash equivalents
Cash includes cash in checking accounts and in money market accounts. The Company had no cash equivalents at December 31, 2017 and 2016. The Company maintains cash balances that may, at times, exceed federally insured deposit limits.

Accounts receivable
Accounts receivable consist of amounts due from government entities, nursing homes and other health care facilities, and individual clients. Terms for customers can vary. The allowance for doubtful accounts is determined by management based on an evaluation of the collectability of individual accounts. Accounts determined to be uncollectible are written off against the allowance. Accounts receivable is net of an allowance of $16,140 at December 31, 2017. No allowance was considered necessary at December 31, 2016.

Property and equipment
Property and equipment is carried at cost. Depreciation is computed using the straight-line method over the estimated useful lives ranging from three to five years. The Company capitalizes all assets with estimated useful lives longer than one year.

Shareholders' equity
The Company has 10,000 shares of no-par common stock authorized, of which 8,000 shares were issued and outstanding at December 31, 2017 and 2016.

Revenue recognition
Revenue is recognized when services are performed. In-home services are generally charged at DSHS established monthly rates. Charges to other facilities are generally at negotiated hourly rates. DSHS established monthly rates are based on the client's income and assessed needs. Assessed needs include services to be performed and frequency of those services.

NOTE 1 – NATURE OF BUSINESS AND SIGNIFICANT ACCOUNTING POLICIES, continued

Advertising
Nondirect-response advertising costs are expensed as incurred.

Income taxes
The Company has elected to be treated as an S-corporation for federal income tax purposes. In lieu of corporation income taxes, the shareholders of an S-corporation are taxed on their proportionate share of the Company's taxable income. Therefore, no provision for federal income taxes has been included in the financial statements.

The Company's tax years 2014 through 2017 are open for examination by the Internal Revenue Service. Management has evaluated its tax positions for years ended December 31, 2014 through 2017 in conformity with accounting principles generally accepted in the United States and has determined it has no uncertain tax positions required to be disclosed.

Taxes based on revenue
The Company incurred taxes levied by the state of Washington for the years ended December 31, 2017 and 2016 in the amount of $192,634 and $156,856, respectively, which is included in business taxes.

Cash flow information
The Company paid no amounts for income taxes during 2017 or 2016. Cash paid for interest during 2017 and 2016 was $1,551and $0, respectively.

Noncash transactions in 2017 were the note receivable from shareholder was distributed to the shareholder. There were no noncash transactions in 2016.

Use of estimates in the financial statements
The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Subsequent Events
Subsequent events have been evaluated through February 20, 2018, which approximates the date of the financial statements were available to be issued.

Consolidation of Related Entity
The Company has elected under Accounting Standards Codification 810-10-65 to not consolidate in these financial statements variable interest entities with common control leasing arrangements.

NOTE 2 – LINES OF CREDIT

The Company has a $250,000 revolving line of credit with monthly payments of interest only at the bank's prime rate plus 2% (6.5% at December 31, 2017). The Company has a second $50,000 revolving line of credit with monthly payments of interest only at the bank's prime rate plus 2.75% (7.25% at December 31, 2017). Both lines of credit are unsecured and had no amounts outstanding at December 31, 2017 and 2016.

NOTE 3 – RELATED PARTY TRANSACTIONS

Office Lease

The Company leases its office space from a related entity on a month-to-month basis. Rent expense incurred to the related entity in 2017 and 2016 was $150,000 and $127,948, respectively, and is included in occupancy expense.

Note Receivable from Shareholder

During 2017, the note receivable from the shareholder of $137,531 was distributed to the shareholder.

NOTE 4 – CONCENTRATIONS

The Company is dependent on DSHS for virtually all of its revenue. The Company has signed a service contract with DSHS that expires June 30, 2018.

The Company's health care workers are members of Service Employees International Union Healthcare 775 NW labor union. The Company's contract with the labor union coincides with the Company's contract with DSHS and expires June 30, 2018.

NOTE 5 – COMMITMENTS

In November 2016, the Company signed a lease for an office in Pierce County and in 2017 the Company moved to bigger space. The lease expires November 30, 2019 and requires monthly lease payments of $1,825 with annual escalations. Rent expense in 2017 and 2016 was $15,923 and $825, respectively, for this lease and is included in occupancy expense.

In January 2017, the Company signed a lease for an office in Snohomish County. The lease expires January 2020 and requires monthly lease payments of $690 with annual escalations. Rent expense in 2017 and 2016 was $7,590 and $0, respectively, for this lease and is included in occupancy expense. The Company is also charged for common area maintenance and parking space in addition to rent.

Future commitments for rent under these leases is as follows

2018	$ 30,699
2019	29,343
2020	732
	$ 60,774

NOTE 6 – INVESTMENT IN SUBSIDIARY

As of December 31, 2017 and 2016, the Company had invested a cumulative total of $650,000 in Adma Groups, Inc., an information-technology consulting and software-development company. The Company holds a 66% ownership interest. Accounting principles generally accepted in the United States requires that investments be presented at fair value.

Fair value of this investment was measured using the lowest priority of valuation techniques in the fair value hierarchy (Level 3). Level 3 uses unobservable inputs, which are typically based on the Company's assumptions as there is no related market activity. Consequently, the Company has recorded a 100% valuation allowance for this investment. If any distributions are received in the future from this investment, the Company will adjust the valuation allowance accordingly.

AMICABLE HEALTHCARE, INC.

Financial Statements

As of and For the Years Ended December 31, 2016 and 2015

with Independent Accountant's Review Report

AMICABLE HEALTHCARE, INC.
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LAURA LINDAL CPA

INDEPENDENT ACCOUNTANT'S REVIEW REPORT

Shareholders
Amicable Healthcare, Inc.
SeaTac, Washington

I have reviewed the accompanying financial statements of Amicable Healthcare, Inc. (a Washington S-corporation), which comprise the balance sheets as of December 31, 2016 and 2015, and the related statements of income and changes in shareholders' equity and cash flows for the years then ended, and the related notes to the financial statements. A review includes primarily applying analytical procedures to management's financial data and making inquiries of those with management responsibilities for the Company. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, I do not express such an opinion.

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

Accountant's Responsibility
My responsibility is to conduct the review in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the American Institute of Certified Public Accountants. Those standards require me to perform procedures to obtain limited assurance as a basis for reporting whether I am aware of any material modifications that should be made to the financial statements for them to be in accordance with accounting principles generally accepted in the United States of America. I believe that the results of my procedures provide a reasonable basis for my conclusion.

Accountant's Conclusion
Based on my review, I am not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with accounting principles generally accepted in the United States of America.

February 15, 2017

Laura Lindal CPA

Kirkland, Washington

AMICABLE HEALTHCARE, INC.
Balance Sheets
December 31, 2016 and 2015

ASSETS

	2016	2015
Current assets:		
Cash	$ 1,184,832	$ 988,655
Accounts receivable, net	789,924	827,136
Prepaid expenses	18,978	11,689
Total current assets	1,993,734	1,827,480
Property and equipment		
Office equipment	315,742	288,942
Furniture	98,578	65,584
Vehicles	29,850	29,850
Total property and equipment	444,170	384,376
Accumulated depreciation	(358,061)	(327,563)
Total property and equipment, net	86,109	56,813
Note receivable from shareholder	137,531	137,531
Investment, net	-	-
Total assets	$ 2,217,374	$ 2,021,824

LIABILITIES AND SHAREHOLDERS' EQUITY

Current liabilities:		
Accounts payable	$ 65,073	$ 52,108
Accrued payroll and payroll taxes	348,938	274,341
Business taxes payable	14,829	12,110
Total current liabilities	428,840	338,559
Shareholders' equity	1,788,534	1,683,265
Total liabilities and shareholders' equity	$ 2,217,374	$ 2,021,824

See Independent Accountant's Review Report.
The accompanying notes should be read with these financial statements.

AMICABLE HEALTHCARE, INC.
Statements of Income and Changes in Shareholders' Equity
For the Years Ended December 31, 2016 and 2015

	2016	2015
Revenue	$ 10,707,352	$ 9,082,350
Operating expenses:		
Wages	6,772,610	5,813,263
Payroll taxes	925,324	857,638
Health insurance and benefits	1,428,404	1,162,308
Supplies	367,565	262,289
Travel and auto expense	165,247	140,558
Business taxes	156,856	135,203
Occupancy	154,037	114,270
Telephone	85,608	75,685
Bad debt expense	57,243	-
Business insurance	45,205	30,727
Depreciation	30,498	19,539
Professional fees	26,339	71,539
Advertising	26,164	25,135
Bank charges	25,685	12,758
Equipment expense	15,680	15,651
License and permits	15,205	12,507
Other expenses	1,333	700
Total operating expenses	10,299,003	8,749,770
Net operating income	408,349	332,580
Interest income	4,579	-
Net income (loss)	412,928	332,580
Shareholder contributions (distributions)	(307,659)	419,891
Shareholders' equity, beginning of year	1,683,265	930,794
Shareholders' equity, end of year	$ 1,788,534	$ 1,683,265

See Independent Accountant's Review Report.
The accompanying notes should be read with these financial statements.

AMICABLE HEALTHCARE, INC.
Statements of Cash Flows
For the Years Ended December 31, 2016 and 2015

	2016	2015
Cash flows from operating activities:		
Net income (loss)	$ 412,928	$ 332,580
Adjustments to reconcile net income to net cash flows from operating activities:		
Depreciation	30,498	19,539
Changes in assets and liabilities:		
Accounts receivable, net	37,212	(125,430)
Prepaid expenses	(7,289)	(5,185)
Accounts payable	12,965	(1,273)
Accrued payroll and payroll taxes	74,597	30,458
Business taxes payable	2,719	1,528
Net cash flows from operating activities	563,630	252,217
Cash flows from investing activities:		
Purchase of property and equipment	(59,794)	(34,033)
Net cash flows from investing activities	(59,794)	(34,033)
Cash flows from financing activities:		
Shareholder contributions (distributions)	(307,659)	419,891
Net cash flows from investing activities	(307,659)	419,891
Net change in cash	196,177	638,075
Cash, beginning of year	988,655	350,580
Cash, ending of year	$ 1,184,832	$ 988,655

See Independent Accountant's Review Report.
The accompanying notes should be read with these financial statements.

NOTE 1 – NATURE OF BUSINESS AND SIGNIFICANT ACCOUNTING POLICIES

Amicable Healthcare, Inc. is an S-corporation organized in the state of Washington. The Company is a health care agency licensed by the Washington State Department of Social and Health Services (DSHS) to provide in-home health care services to individuals. The Company is also licensed to provide services to nursing homes and other health care facilities, but this is not a significant part of the Company's operations. In-home services involve providing care of the elderly or disabled who are unable to carry out certain routine activities of daily life.

The Company presently has contracts with the City of Seattle Human Services Department, including the division of Aging and Disability Services. The Company also contracts with the DSHS Division of Development Disabilities. All of these contracts are funded by DSHS. The Company provides services in both King and Pierce counties in the state of Washington.

Cash and cash equivalents
Cash includes cash in checking accounts and in money market accounts. The Company had no cash equivalents at December 31, 2016 and 2015. The Company maintains cash balances that may, at times, exceed federally insured deposit limits.

Accounts receivable
Accounts receivable consist of amounts due from government entities, nursing homes and other health care facilities, and individual clients. Terms for customers can vary. The allowance for doubtful accounts is determined by management based on an evaluation of the collectability of individual accounts. Accounts determined to be uncollectible are written off against the allowance. No allowance was considered necessary at December 31, 2016 and 2015.

Property and equipment
Property and equipment is carried at cost. Depreciation is computed using the straight-line method over the estimated useful lives ranging from three to five years. The Company capitalizes all assets with estimated useful lives longer than one year.

Shareholders' equity
The Company has 10,000 shares of no-par common stock authorized, of which 8,000 shares were issued and outstanding at December 31, 2016 and 2015.

Revenue recognition
Revenue is recognized when services are performed. In-home services are generally charged at DSHS established monthly rates. Charges to other facilities are generally at negotiated hourly rates. DSHS established monthly rates are based on the client's income and assessed needs. Assessed needs include services to be performed and frequency of those services.

NOTE 1 – NATURE OF BUSINESS AND SIGNIFICANT ACCOUNTING POLICIES, continued

Advertising
Nondirect-response advertising costs are expensed as incurred.

Income taxes
The Company has elected to be treated as an S-corporation for federal income tax purposes. In lieu of corporation income taxes, the shareholders of an S-corporation are taxed on their proportionate share of the Company's taxable income. Therefore, no provision for federal income taxes has been included in the financial statements.

The Company's tax years 2013 through 2016 are open for examination by the Internal Revenue Service. Management has evaluated its tax positions for years ended December 31, 2013 through 2016 in conformity with accounting principles generally accepted in the United States and has determined it has no uncertain tax positions required to be disclosed.

Taxes based on revenue
The Company incurred taxes levied by the state of Washington for the years ended December 31, 2016 and 2015 in the amount of $156,856 and $135,203, respectively, which is included in business taxes.

Cash flow information
The Company paid no amounts for interest or income taxes during 2016 or 2015.

Use of estimates in the financial statements
The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Subsequent Events
Subsequent events have been evaluated through February 15, 2017, which approximates the date of the financial statements were available to be issued.

Consolidation of Related Entity
The Company has elected under Accounting Standards Codification 810-10-65 to not consolidate in these financial statements variable interest entities with common control leasing arrangements.

Reclassifications
Certain revenue and expense items in the prior year have been reclassified to be consistent with the current year presentation.

NOTE 2 – LINES OF CREDIT

The Company has a $250,000 revolving line of credit with monthly payments of interest only at the bank's prime rate plus 2% (5.75% at December 31, 2016). The Company has a second $50,000 revolving line of credit with monthly payments of interest only at the bank's prime rate plus 2.75% (6.50% at December 31, 2016). Both lines of credit are unsecured and had no amounts outstanding at December 31, 2016 and 2015.

NOTE 3 – RELATED PARTY TRANSACTIONS

Office Lease

The Company leases its office space from a related entity on a month-to-month basis. Rent expense incurred to the related entity in 2016 and 2015 was $127,948 and $90,077, respectively, and is included in occupancy expense.

Note Receivable from Shareholder

During 2011, the Company loaned a shareholder $306,250, of which $137,531 remains outstanding at December 31, 2016 and 2015 and is due upon demand. Interest is charged to the shareholder in accordance with Internal Revenue Service requirements. Interest income from the note during 2016 and 2015 was negligible.

NOTE 4 – CONCENTRATIONS

The Company is dependent on DSHS for virtually all of its revenue. The Company has signed a service contract with DSHS that expires June 30, 2018.

The Company's health care workers are members of Service Employees International Union Healthcare 775 NW labor union. The Company's contract with the labor union coincides with the Company's contract with DSHS, and expires June 30, 2018.

NOTE 5 – INVESTMENT IN SUBSIDIARY

As of December 31, 2016 and 2015, the Company had invested a cumulative total of $650,000 in Adma Groups, Inc., an information-technology consulting and software-development company. The Company holds a 66% ownership interest. Accounting principles generally accepted in the United States requires that investments be presented at fair value.

Fair value of this investment was measured using the lowest priority of valuation techniques in the fair value hierarchy (Level 3). Level 3 uses unobservable inputs, which are typically based on the Company's assumptions as there is no related market activity. Consequently, the Company has recorded a 100% valuation allowance for this investment. If any distributions are received in the future from this investment, the Company will adjust the valuation allowance accordingly.

NOTE 6 – COMMITMENTS AND SUBSEQUENT EVENT

In November 2016, the Company signed a lease for an office in Pierce County. The lease expires November 30, 2019 and requires monthly lease payments of $825 with annual escalations. Rent expense of $825 for 2016 was incurred on this lease is included in occupancy expense.

In January 2017, the Company signed a lease for an office in Snohomish County. The lease expires January 2020 and requires monthly lease payments of $690 with annual escalations.

Exhibit 12: Proforma Financials & Assumptions

Summary of financial assumptions

Balance Sheet

- Accounts receivable – 21 days of net patient revenue
- Property and equipment – plans for purchases of various office equipment, information technology equipment, and furnishings with a total cost of approximately $24,000 and useful lives ranging from 3-20 years
- Accounts payable – 26 days of expenses (excluding depreciation, salaries, wages, health insurance and benefits, payroll taxes, and business taxes)
- Accrued payroll and payroll taxes – 4.2% of salaries and wages, health insurance and benefits, and payroll taxes
- Business taxes payable – 1/12 of business taxes

Income Statement & Change in Shareholder's Equity

- Patient service revenue – estimated prices for each service were multiplied by estimated volumes. Net revenue for services are listed below.
    - Skilled Nursing - $40.85
    - Physical Therapy - $35.72
    - Speech Therapy - $35.72
    - OT- $35.72
    - MSW/Other - $35.55
    - Home Health Aide - $22.18
- Other in patient service revenue includes, but is not limited to commercial, & other government payers.
- Contractual allowances – 15% of gross patient service revenue, net of bad debt and the adjustment for charity care
- Bad debt – 1.5% of gross patient service revenue
- Adjustment for charity care – 2.5% of gross patient service revenue
- Salaries and wages – Based on expected staffing levels needed for the expected volumes and estimated salaries for each position. Salaries are found in Table 15.
- Health insurance and benefits – 21% of salaries
- Payroll taxes – 13.3% of salaries
- Supplies – 2.5% of gross patient service revenue
- Occupancy Allocation – .75% of gross patient service revenue.
- Business taxes – 1.5% of net patient service revenue
- Travel and auto expenses – 3.5% of gross patient service revenue
- Depreciation – Calculated based on planned purchases of various office equipment,
    - information technology equipment, and furnishings with a total cost of approximately $24,000 and useful lives ranging from 3-20 years
- Contract labor (therapy) - $90 per visit for contract physical, occupational, and speech
    - therapy

- Contract labor (medical director) – $150 per hour for four hours per month
- Allocated overhead – 25% allocation of $80,000 budgeted for human resources plus $6,000 annually for Chief Financial Officer allocation
- Information technology - $1,500 per year for software plus 3% of net Medicare revenue
- Other – 1% of gross patient service revenue
    - Includes, but is not limited to:
        - Dues and subscriptions
        - Miscellaneous fees
        - Professional fees & training
- Does not include inflation

Proforma Income Statement: Amicable Healthcare

	Nine-Months Ending 2020	2021	2022	2023
Patient service revenue				
Medicare	**$ 461,000**	$ 931,000	$ 1,149,000	$ 1,384,000
Medicaid	**31,000**	62,000	77,000	92,000
Other	**139,000**	280,000	345,000	416,000
Total gross patient service revenue	**631,000**	1,273,000	1,571,000	1,892,000
Deductions from patient service revenue				
Contractual adjustments	**70,000**	140,000	173,000	209,000
Bad debt	**9,000**	19,000	24,000	28,000
Adjustment for charity care	**16,000**	32,000	39,000	47,000
Total deductions from patient service revenue	**95,000**	191,000	236,000	284,000
Total net patient service revenue	**536,000**	1,082,000	1,335,000	1,608,000
Operating expenses				
Salaries and wages	**282,000**	458,000	516,000	578,000
Health insurance and benefits	**59,000**	96,000	108,000	121,000
Payroll taxes	**38,000**	61,000	69,000	77,000
Supplies	**16,000**	32,000	39,000	47,000
Occupancy	**5,000**	10,000	12,000	14,000
Business taxes	**8,000**	16,000	20,000	24,000
Travel and auto expenses	**22,000**	45,000	55,000	66,000
Depreciation	**4,000**	5,000	5,000	5,000
Contract labor (therapy)	**156,000**	314,000	388,000	467,000
Contract labor (medical director)	**5,000**	7,000	7,000	7,000
Allocated overhead	**20,000**	26,000	26,000	26,000
Information technology	**13,000**	25,000	31,000	37,000
Other	**6,000**	13,000	16,000	19,000
Total operating expenses	**634,000**	1,108,000	1,292,000	1,488,000
Net income	**(98,000)**	(26,000)	43,000	120,000

Proforma Balance Sheet: Amicable Healthcare

ASSETS	**2020**	**2021**	**2022**	**2023**
Current assets				
Cash and cash equivalents	**$ -**	$ -	$ -	$ 25,000
Accounts receivable, net	**31,000**	62,000	77,000	93,000
Total current assets	**31,000**	62,000	77,000	118,000
Property and equipment				
Office equipment	**12,000**	12,000	12,000	12,000
Furniture	**12,000**	12,000	12,000	12,000
Total property and equipment	**24,000**	24,000	24,000	24,000
Accumulated depreciation	**(4,000)**	(9,000)	(14,000)	(19,000)
Total property and equipment, net	**20,000**	15,000	10,000	5,000
Total assets	**$ 51,000**	$ 77,000	$ 87,000	$ 123,000
LIABILITIES AND RETAINED EARNINGS				
Current liabilities				
Accounts payable	**$ 17,000**	$ 34,000	$ 41,000	$ 49,000
Accrued payroll and payroll taxes	**16,000**	26,000	29,000	33,000
Business taxes payable	**1,000**	1,000	2,000	2,000
Related party line of credit	**115,000**	140,000	96,000	-
Total current liabilities	**149,000**	201,000	168,000	84,000
Retained earnings	**(98,000)**	(124,000)	(81,000)	39,000
Total liabilities and retained earnings	**$ 51,000**	$ 77,000	$ 87,000	$ 123,000

Proforma Cash Flow Statement: Amicable Healthcare

	Nine-Months Ending 2020	2021	2022	2023
Increase (Decrease) in Cash and Cash Equivalents				
Cash flows from operating activities				
Receipts from and on behalf of patients	**$ 505,000**	$ 1,051,000	$ 1,320,000	$ 1,592,000
Payments to and on behalf of employees	**(363,000)**	(605,000)	(690,000)	(772,000)
Payments to suppliers and contractors	**(233,000)**	(471,000)	(586,000)	(699,000)
Net cash provided by (used in) operating activities	**(91,000)**	(25,000)	44,000	121,000
Cash flows from investing activities				
Purchase of property and equipment	**(24,000)**	-	-	-
Net cash used in investing activities	**(24,000)**	-	-	-
Cash flows from financing activities				
Proceeds from line of credit	**115,000**	25,000	-	-
Payments on line of credit	**-**	-	(44,000)	(96,000)
Net cash provided by (used in) financing activities	**115,000**	25,000	(44,000)	(96,000)
Net increase in cash and cash equivalents	**-**	-	-	25,000
Cash and cash equivalents, beginning of year	**-**	-	-	-
Cash and cash equivalents, end of year	**$ -**	$ -	$ -	$ 25,000

	Nine-Months Ending 2020	2021	2022	2023
Reconciliation of Net Income (Loss) to Net Cash Provided by (Used in) Operating Activities				
Net income (loss)	**$ (98,000)**	$ (26,000)	$ 43,000	$ 120,000
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities				
Depreciation	**4,000**	5,000	5,000	5,000
Bad debts	**9,000**	19,000	24,000	28,000
Decrease (increase) in assets:				
Accounts receivable	**(40,000)**	(50,000)	(39,000)	(44,000)
Increase (decrease) in liabilities:				
Accounts payable	**17,000**	17,000	7,000	8,000
Accrued payroll and payroll taxes	**16,000**	10,000	3,000	4,000
Business taxes payable	**1,000**	-	1,000	-
Net cash provided by (used in) operating activities	**$ (91,000)**	$ (25,000)	$ 44,000	$ 121,000

Exhibit 13: Forms for Fiscal Intermediary

SECTION 12: SPECIAL REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAS)

INSTRUCTIONS

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section. HHAs and HHA sub-units initially enrolling in Medicare, Medicaid, or both programs on or after January 1, 1998 are required to provide documentation supporting that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months in the Medicare and/or Medicaid program(s). The capitalization requirement applies to all HHAs and HHA sub-units enrolling in the Medicare program, including HHAs or HHA sub-units currently participating in the Medicare program that, as a result of a change of ownership, will be issued a new provider number. The capitalization requirement does not apply to a branch of an HHA. Regulations found at 42 C.F.R. 489.28 require that the fee-for-service contractor determine the required amount of reserve operating funds needed for the enrolling HHA or HHA sub-unit by comparing the enrolling HHA or HHA sub-unit to at least three other new HHAs that it serves which are comparable to the enrolling HHA or HHA sub-unit. Factors to be considered are geographic location, number of visits, type of HHA or HHA sub-unit and business structure of the HHA or HHA sub-unit. The fee-for-service contractor then verifies that the enrolling HHA or HHA sub-unit has the required funds. To assist the fee-for-service contractor in determining the amount of funds necessary, the enrolling HHA or HHA sub-unit should complete this section.

Check here ☐ if this section does not apply and skip to Section 13.

A. Type of Home Health Agency

1. CHECK ONE:

☐ Non-Profit Agency ☒ Proprietary Agency

2. PROJECTED NUMBER OF VISITS BY THIS HOME HEALTH AGENCY

How many visits does this HHA project it will make in the first:

three months of operation? 300

twelve months of operation? 4535

3. FINANCIAL DOCUMENTATION

A) In order to expedite the enrollment process, the HHA may attach a copy of its most current savings, checking, or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:

1) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

2) Certification from the HHA attesting that at least 50% of the reserve operating funds are non-borrowed funds.

B) Will the HHA be submitting the above documentation with this application? ☒ YES ☐ NO

NOTE: The fee-for-service contractor may require a subsequent attestation that the funds are still available. If the fee-for-service contractor determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

SECTION 12: SPECIAL REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAS) *(Continued)*

4. ADDITIONAL INFORMATION

Provide any additional documentation necessary to assist the fee-for-service contractor or State agency in properly comparing this HHA with other comparable HHAs. Use this space to explain or justify any unique financial situations of this HHA that may be helpful in determining the HHA's compliance with the capitalization requirements.

B. Nursing Registries

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Does this HHA contract with a nursing registry whereby the latter furnishes personnel to perform HHA services on behalf of the provider?

☐ YES–Furnish the information below

☒ NO–Skip to Section 13

Legal Business/Individual Name as Reported to the Internal Revenue Service

Tax Identification Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Street Address Line 1 *(Street Name and Number)*

Billing Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Exhibit 14: Letter of Financial Commitment

November 9, 2018

Certificate of Need Program
Office of Certification and Enforcement
Department of Health
P.O.BOX 47852
Olympia, WA 98504-7852

To Whom It May Concern,

LETTER OF COMMITMENT

Amicable Healthcare, Inc. Board of Directors hereby agreed to provide all working capital to finance the entire project. In addition, the company has a revolving Line of Credit of $500,000 with both Bank of America and Key Bank that is available to be utilized in case of cash-flow need.

Thank for your cooperation,

Dapo Amosun, President

For: Amicable Healthcare, Inc.

Exhibit 15: Training Plan and Materials

Section 1

Aide Training

Advance Directives and End of Life Training

Questions and Answers about Advance Directives

More than ever before, people are being asked to take part in decision about end-of-life care. Yet, most people still do not discuss end-of-life care at all, even if they are seriously thinking about these issues and some guidelines for discussions with their physicians, families, and loved ones. This fact sheet is also designed to help patients understand the medical, legal, and personal choice they may face in the future.

1. What rights do patient have regarding their medical treatment?

Patients are entitled to have complete information about their illness and how it may affect their lives, and they have the right to share or withhold that information from others. People with cancer should also be informed about any procedures and treatments that are planned, the benefits and risks, and any alternative that may be available. Patients may be asked to sign an "informed consent" form, which includes this information. Before signing such a form, patients should read it carefully and ask the physician any questions they might have.

Patents have the right to make decisions about their own treatment. These decisions may change over time. In the face of worsening disease, some patients may want to try every available drug or treatment in the hope that something will be effective. Other patients may choose to forgo aggressive medical treatment. Many patients turn to family member, friends, or caregivers for advice. But, it is the patient's decision how much for how little treatment to have. Sometimes a patient is unable to make this decision, due to severe illness or change in mental condition. That is why it is important for people with cancer to make their wishes known in advance.

2. What is end-of-life care? What are advance directives?

End-of-life care is a general term that refers to the medical and psychosocial care given in the advanced or terminal stages of illness. **Advance Directives** are the legal documents such as the living will, durable power of attorney, and healthcare proxy that allow people to convey their decision about end-of-life care ahead of time. Advance directives provide a way for patients to communicate their wishes to family, friends, and health care professionals and to avoid confusion later on, should they become unable to do so.

Ideally, the process of discussing and writing advance directive should be ongoing, rather than a single event. Advance directive can be modified as a patient's situation changes. Even after advance directive have been signed, patients can change their minds at any time.

3. Why are advance directive important?

Complex choices about end-of-life care are difficult even when people are well. If a person is seriously ill, these decisions can seem overwhelming. But, patients should keep in mind that avoiding these decisions when they are well will only place a heavier burden on them and their loved ones later on. Communicating wishes about end-of-life care will ensure that people with terminal illnesses face the end of their lives with dignity and with the same values by which they have lived.

4. Why is it important to write a will?

A will is important so that patients can give instruction about distribution of their money and property when they die. Patient can name a trusted family member, friend, or professional to handle their personal affairs (also known as an executor). It is advisable to seek the expert advice of a lawyer in drawing up a will so that the decision made about taxes, beneficiaries, and asset distribution will be legally binding. This process can relieve a patient's family and friends of an enormous burden in case of dispute or question about allocation of the patient's assets.

5. What is a living will?

A living will be a set of instruction documenting a person's wishes about medical are intended to sustain life. It is used if a patient becomes terminally ill, incapacitated, or unable to communicate or make decisions. Everyone has the right to accept or refuse medical care. A living will protect the patient's right and removes the burden for making decision from family, friends, and physicians.

Advance Directives and End of Life Training

There are many types of life-sustaining care that should be taken into consideration when drafting a living will. These include:

- The use of life-sustaining equipment (dialysis machines, ventilators, and respirators)
- "do not resuscitate" orders; that is, instruction not to use CPR if breathing or heartbeat stops
- artificial hydration and nutrition (feeding tube)
- withholding of food and fluids
- palliative/comfort care
- organ and tissue donation

It is also important to understand that a decision not to receive "aggressive medical treatment" is not the same as withholding all medical care. A patient can still receive antibiotics, nutrition, pain medication, radiation therapy, and other intervention when the goal of treatment becomes comfort rather than cure. This is called palliative care; its primary focus is helping the patient remain as comfortable as possible. Patients can change their mind and ask to resume more aggressive treatment. If the type of treatment a patient would like to receive changes, however, it is important to be aware that such a decision may raise insurance issue that will need to be explored with the patient's health care plan. Any change in the type of treatment a patient wants to receive should be reflected in the patient's living will.

After a living will has been drawn up, patients may want to talk about their decision with the people who matter most to them, explaining the values underlying their decisions. Most states require the document be witnessed. Then, it is advisable to make copies of the document, place the original in a safe, accessible place, and give copies to the patient's physician, hospital, and next of kin. Patients may also want to consider keeping a card in their wallet declaring that they have a living will and where it can be found.

6. What is a health care proxy and durable power of attorney for health care?

A health care proxy is an agent (a person) appointed to make a patient's medical decision if the patient is unable to do so. Generally, people assign someone they know well and trust to represent their preferences when they can no longer do so. Patients should be sure to ask this person for agreement to act as their agent. An agent may have to exercise judgment in the event of a medial decision for which the patient's wishes are not known.

The durable power of attorney for health care is the legal document. After it is written, it should be signed, dated, witnessed, notarized, copied, distributed, and incorporated into the patient's medical record.

Patients may also want to appoint someone to manage their financial affairs if they cannot. This is called a durable power of attorney for finances and is a separate legal document from the durable power of attorney for health care. Patient may choose the same person or someone different from their health care proxy to act as their agent in financial matters.

7. Where can people get assistance with their advance directives?

If patients need help making the decisions discussed in this fact sheet, they should not hesitate to call on family, friends, and other loved ones.

Although a lawyer is not needed to complete advance directive, it is important to be aware that each state has its own laws for creating advance directive. Because these laws can vary in important details, special care should be taken to adhere to the laws of the state a patient lives in or is treated in. It is possible that a living will, or durable power of attorney signed in one state may not be recognized in another. Appropriate forms can be obtained from health care provider, legal offices, offices on aging, and state health departments.

Advance Directives and End of Life Training

The patient with end-stage illness will most probably have various symptomatic problems that will affect ability to eat. A few of these are mentioned below with some suggestion to offer the patient.

Bloating or early satiety

- Eat small, frequent meals
- Eat slowly
- Sit upright when eating
- Eat easily digestible foods avoiding fatty foods & gas forming vegetables
- Drink fluids between rather than with meals

Chewing problems

- Modify food consistency, going from soft to ground to pureed based on severity of problem
- Moisten foods
- Emphasize soups, stews, cooked & cold cereals, eggs, custards, puddings, & liquids
- Chop, mash, or strain cooked fruits & vegetables
- Try baby foods, they can be used along (spice to taste) or added to soups & broths

Colostomies

- Chew foods thoroughly & avoid swallowing air
- Avoid foods that can cause irritation: nuts, popcorn, skins & seeds from fruits & vegetables or coconut
- Avoid gas forming foods: cabbage, brussel sprouts, green peppers, cucumbers, onions, beans, peas, corn, broccoli, & cauliflower
- Avoid foods that may produce odors; onions, fish, & eggs

Constipation

- Drink plenty of fluids
- Drink a glass of prune juice or hot liquid in the morning or evening to stimulate bowel function
- Increase fiber or bulk in diet if able

Diarrhea

- Decrease fiber in diet
- Avoid foods that may cause cramps; fatty foods, caffeine, spicy foods, carbonated beverages, & gum
- Keep liquids warm or at room temperature because extremes in temperature may stimulate the bowel & aggravate diarrhea
- Avoid lactose-containing foods if a lactase deficiency is suspected
- Take liquids between rather than with meals
- Potassium can be depleted with large fluid losses. If a patient has large volume, frequent diarrhea, encourage increased fluid & potassium intakes (unless contraindicated). Some high potassium foods: bananas, oranges, orange juice, watermelon, tomato sauce & juice, potatoes, meat, kidney beans, peanut butter, wheat germ, milk, yogurt, molasses, raisins, & apricots.

Dry mouth

- Encourage frequent mouth rinsing with salt/soda water (1tsp salt & baking soda per quart of warm water). Avoid commercial mouth washers due to alcohol which causes dryness.
- Increase fluid intake
- Use a humidifier
- Use moistened mouth swabs

Pain • Pain must be adequately controlled before any thought can be given to nutritional therapy Swallow dysfunction (dysphagia) • Modify food consistencies (refer to chewing problems) • Thick liquids are sometimes better tolerated than thin (they cause less gagging). Add ice cream or mashed banana to milk or milk shakes to make them thicker. • Recommend high-calorie, commercial supplements • Recommend liquid multivitamins • Have the patient try tilting their head back or forward to facilitate swallowing.	Taste alterations (ageusia) • Experiment with new flavors & foods • Use condiments on chicken, meat, & fish • Drink or rinse mouth with carbonated water, ginger ale, or tea after meals to help get rid of bad tastes. Viscous saliva • Milk & milk products may cause increased phlegm production. Patients can try low fat or soybean milk products or use ginger ale or club soda to "cut" milk & shakes. • Clear liquids, broths, hot tea with lemon, popsicles, lemonade, carbonated beverages, sherbets, & ices may be better tolerated than thick liquids (commercial clear liquid high-calorie protein supplements are available)

Alzheimer and Dementia Training

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is not normal aging and is not dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitable need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places
- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions
Suspiciousness: accusing others of stealing their belongings
People are "out to get them"
Fear that caregiver is going to abandon
Current living space is not "home"

Hallucinations
Seeing or hearing people who are not present

Repetitive actions or questions
They forget they asked the question
Repetitive action such as wringing a towel

Wandering
Pacing
Sundowning: trying to get "home"
Generally feeling uncomfortable or restless
Increased agitation at night

Losing thing/Hiding things
Simply do not remember where items are
Might hide things so that people don't "steal" them

Inappropriate sexual behavior
Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects
A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help
Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object.

Apraxia: loss of ability to perform purposeful motor movements
Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked to many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable; however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification.

FAMILY ISSUES

The roles that family caregivers must accept can be overwhelming. In addition to meeting the physical needs of the relative with Alzheimer's, such as helping with personal hygiene and dressing, preparing meals, and housekeeping, it is important to ensure that the person is stimulated by both social and physical activity. The caregiver must also think to the future, plan for increasing custodial and medical care, and usually take over fiduciary responsibilities. Faced with all these tasks, caregivers can easily fall victim to illness and depression. Another danger for the overburdened caregiver is becoming resentful to the point of neglecting the care recipient's needs or engaging in abusive behavior--psychological or physical. The National Elder Abuse Incidence Study reported that in one year, 1996, more than 550,000 persons age 60 or older had experienced some type of neglect or abuse, 90% at the hands of a family member. Elderly persons with advancing Alzheimer's or other dementia are more vulnerable than most because they cannot understand what is happening to them, defend themselves, or communicate their distress to those who might help them.

Activities of Daily Living

Activities of daily living (ADLs) are those things we all need to do on a regular basis to ensure our health and well-being. ADLs are those need-to-do things that take up so much of our day and that we all take for granted – until we can't do them anymore. Activities involving health and hygiene are called basic activities of daily living. By contrast instrumental activities of daily living are those abilities that allow a person to live independently.

Basic Activities of Daily Living

- Eating
- Bathing
- Dressing
- Toileting
- Continence
- Ability to get out of bed or a chair
- Walking (can be with the aid of a cane or walker)

Instrumental Activities of Daily Living

- Food Preparation
- Housekeeping and Laundry
- Managing Financial Matters
- Shopping
- Use Telephone
- Take Medication
- Responsible for Transportation (public transit, auto, etc.)

Nutrition Components

3 major groups :

- Proteins
- Carbohydrates
- Fats

Other important components:

- Vitamins
- Minerals
- Water

Principles of Good Nutrition

1. Balance
2. Variety, Variety, Variety
3. Moderation

Balance

We need a good balance of the 3 main groups of nutrition, ie carbohydrates, proteins and fats to stay healthy. Vitamins, minerals and water should also be taken in the right amounts.
The general guideline for our caloric intakes is:

- 15% to 20% from proteins
- 15% to 30% from fats
- 50% to 85% from carbohydrates

Variety

- Every food or food group has its own unique nutritional values
- Only a good mix of the various food groups will give you the complete essential nutritional needs
- A wide variety of food groups helps to complement each other in nutrition's

Moderation

- Too much of any particular food can result in unbalanced nutritional intakes, causing excess weight and too much of certain nutrients
- On the other hand, too little of any particular food can lead to certain nutritional deficiencies
- Taking food in moderate amounts helps to prevent any imbalance

Complications of Poor Nutrition

- Heart disease
- Cancer
- Stroke
- Diabetes
- Osteoporosis
- Many others...

Dehydration

How do you know if you're properly hydrated? Generally speaking, the clearer the urine, the better hydrated you are. If it is a clear-pale lemonade color, you are hydrated. If it is a darker lemonade to apple juice color, you are dehydrated. And if it is dark and cloudy, you are severely dehydrated.

Why is it so important to stay hydrated?

The body depends on water for survival. Did you know that water makes up more than half of your body weight? Every cell, tissue and organ in your body needs water to function correctly. For example, the body uses water to maintain its temperature, remove waste and lubricate joints. Water is essential for good health.

How does a body lose water?

When you go to the bathroom, sweat, and even when you breathe. Water is lost even faster when the weather is really hot, during exercise, or with a fever. Vomiting and diarrhea can also lead to rapid fluid loss. If you don't replace the water you lose, you can become dehydrated.

Symptoms of dehydration include:

- Little or no urine, or urine that is darker than usual
- Dry mouth
- Sleepiness or fatigue
- Extreme thirst
- Headache
- Confusion
- Feeling dizzy or lightheaded
- No tears when crying

Special Diets

There are many types of diets for all different reasons, such as weight loss, religious beliefs, vegetarian, but the diets most associated to our patient are medical based. Here are a few of those types of diets.

People's dietary choices are sometimes affected by intolerance or allergy to certain types of food. There are also dietary patterns that might be recommended, prescribed or administered by medical professionals for people with specific medical needs.

- Best Bet Diet: A diet designed to help prevent or mitigate multiple sclerosis, by avoiding foods with certain types of protein.
- Colon Cancer Diet: Calcium, milk and garlic are thought to help prevent colon cancer. Red meat and processed meat may increase risk.

- Diabetic diet: An umbrella term for diets recommended to people with diabetes. There is considerable disagreement in the scientific community as to what sort of diet is best for sufferers.
- DASH Diet (Dietary Approaches to Stop Hypertension): A recommendation that those with high blood pressure consume large quantities of fruits, vegetables, whole-grains and low-fat dairy foods as part of their diet, and avoid sugar sweetened foods, red meat and fats. Promoted by the US Department of Health and Human Services, a United States government organization.
- Elemental diet: A medical, liquid-only diet, in which liquid nutrients are consumed for ease of ingestion.
- Elimination diet: A method of identifying foods which cause a person adverse effects, by process of elimination.
- Gluten-free diet: A diet which avoids the protein gluten, which is found in barley, rye and wheat. It is a medical treatment for coeliac disease.
- Gluten-free, casein-free diet: A gluten-free diet which also avoids casein, a protein commonly found in milk and cheese.
- Ketogenic diet: A high-fat, low-carb diet, in which dietary and body fat is converted into energy. Used as a medical treatment for refractory epilepsy.
- Liquid diet: A diet in which only liquids are consumed. May be administered by clinicians for medical reasons, such as after a gastric bypass or to prevent death through starvation from a hunger strike.
- Specific Carbohydrate Diet: A diet that aims to restrict the intake of complex carbohydrates such as found in grains and complex sugars. It is promoted as a way of reducing the symptoms of irritable bowel syndrome (IBS), Crohn's disease, ulcerative colitis, coeliac disease and autism.

Meal Preparation

1. Get the patients input on what meal items they want prepared. Consider if the requested item fits in the patient's diet. (Regardless it is the patient's choice but encourage the patient to consider their diet, if the patient is not willing to change their request, prepare the request meal.
2. Clean.

   This allows for clear counters for food prep and it's easier to find your equipment. An empty dishwasher and sink give you somewhere to put your dirty stuff and a head start on cleaning. Remember to *clean as you go.* This is a key tip for meal preparation.
3. Check the refrigerator for items that may go with the meal.

   A little left over roasted sweet potatoes will add a nice richness and color to the mashed potatoes.
4. Put all the food on the counter that you need and determine the order to start each item.
5. Prepare the items per recipe or carton instructions.
6. Serve and remind patient if items are hot!
7. Clean up any mess!

Erikson's Stages of Development

These eight stages, spanning from birth to death, are split in general age ranges.

1. Infancy: Birth-18 Months Old

Basic Trust vs. Mistrust – Hope

During the first or second year of life, the major emphasis is on the mother and father's nurturing ability and care for a child, especially in terms of visual contact and touch. The child will develop optimism, trust, confidence, and security if properly cared for and handled. If a child does not experience trust, he or she may develop insecurity, worthlessness, and general mistrust to the world.

2. Toddler / Early Childhood Years: 18 Months to 3 Years

Autonomy vs. Shame – Will

The second stage occurs between 18 months and 3 years. At this point, the child has an opportunity to build self-esteem and autonomy as he or she learns new skills and right from wrong. The well-cared for child is sure of himself, carrying himself or herself with pride rather than shame. During this time of the "terrible twos", defiance, temper tantrums, and stubbornness can also appear. Children tend to be vulnerable during this stage, sometimes feeling shame and low self-esteem during an inability to learn certain skills.

3. Preschooler: 3 to 5 Years

Initiative vs. Guilt – Purpose

During this period we experience a desire to copy the adults around us and take initiative in creating play situations. We make up stories with Barbie's and Ken's, toy phones and miniature cars, playing out roles in a trial universe, experimenting with the blueprint for what we believe it means to be an adult. We also begin to use that wonderful word for exploring the world—" WHY?"

While Erikson was influenced by Freud, he downplays biological sexuality in favor of the psychosocial features of conflict between child and parents. Nevertheless, he said that at this stage we usually become involved in the classic "Oedipal struggle" and resolve this struggle through "social role identification." If we're frustrated over natural desires and goals, we may easily experience guilt.

The most significant relationship is with the basic family.

4. School Age Child: 6 to 12 Years

Industry vs. Inferiority – Competence

During this stage, often called the Latency, we are capable of learning, creating and accomplishing numerous new skills and knowledge, thus developing a sense of industry. This is also a very social stage of development and if we experience unresolved feelings of inadequacy and inferiority among our peers, we can have serious problems in terms of competence and self-esteem.

As the world expands a bit, our most significant relationship is with the school and neighborhood. Parents are no longer the complete authorities they once were, although they are still important.

5. Adolescent: 12 to 18 Years

Identity vs. Role Confusion – Fidelity

Up until this fifth stage, development depends on what is done to a person. At this point, development now depends primarily upon what a person does. An adolescent must struggle to discover and find his or her own identity, while negotiating and struggling with social interactions and "fitting in" and developing a sense of morality and right from wrong.

Some attempt to delay entrance to adulthood and withdraw from responsibilities (moratorium). Those unsuccessful with this stage tend to experience role confusion and upheaval. Adolescents begin to develop a strong affiliation and devotion to ideals, causes, and friends.

6. Young adult: 18 to 35

Intimacy and Solidarity vs. Isolation – Love

At the young adult stage, people tend to seek companions' hip and love. Some also begin to "settle down" and start families, although seems to have been pushed back farther in recent years.

Young adults seek deep intimacy and satisfying relationships, but if unsuccessful, isolation may occur. Significant relationships at this stage are with marital partners and friends.

7. Middle-aged Adult: 35 to 55 or 65

Generativity vs. Self-absorption or Stagnation – Care

Career and work are the most important things at this stage, along with family. Middle adulthood is also the time when people can take on greater responsibilities and control.

For this stage, working to establish stability and Erikson's idea of *generativity* – attempting to produce something that makes a difference to society. Inactivity and meaninglessness are common fears during this stage.

Major life shifts can occur during this stage. For example, children leave the household, careers can change, and so on. Some may struggle with finding purpose. Significant relationships are those within the family, workplace, local church and other communities.

8. Late Adult: 55 or 65 to Death

Integrity vs. Despair – Wisdom

Erikson believed that much of life is preparing for the middle adulthood stage and the last stage involves much reflection. As older adults, some can look back with a feeling of *integrity* — that is, contentment and fulfillment, having led a meaningful life and valuable contribution to society. Others may have a sense of despair during this stage, reflecting upon their experiences and failures. They may fear death as they struggle to find a purpose to their lives, wondering "What was the point of life? Was it worth it?"

Communication and Interpersonal Skills

A. Guidelines for Starting a Conversation

1. Knock on the door before entering, identify yourself by name and title and greet patient by the preferred name.
2. Approach the patient in a calm and courteous manner.
3. Explain why you are there and what you are going to do.
4. If you are going to perform a procedure, explain the procedure to patient and encourage patient to participate as appropriate.

B. Guidelines for Talking and Listening

1. Get patient's attention before speaking.
2. Use courtesy when communicating. Talk courteously with patient during care, listening and responding appropriately.
3. Speak in a language that is familiar and appropriate for the patient--avoid slang or words with more than one meaning.
4. Use a normal tone of voice and adjust your volume to the patient's needs.
5. Speak slowly and adjust your rate to the individual patient's needs.
6. Speak clearly--avoid mumbling.
7. Keep your message brief and concise--avoid rambling.
8. Face the patient. Sit at patient's eye level and maintain frequent eye contact with patient as appropriate.
9. Send positive messages by use of encouragement, praise, smiles, gentle touch and other methods acceptable to patient.
10. Be sure your verbal and nonverbal message match.
11. Use open posture, leaning slightly toward patient while listening.
12. Pay attention and really listen to what the patient is saying.
13. Give, receive and/or request feedback as appropriate to assure that the communication is understood.

C. Guidelines For Encouraging Patients To Express Feelings

1. Use silence to allow patient to think and continue talking (this shows respect and acceptance).
2. Use broad opening statements like "You seem quiet today".
3. Use open-ended questions like "and then what happened?"
4. Use noncommittal responses like "Oh, I see", "Go on", "Hmm..."
5. Use responses that indicate you understand the patient's feelings such as "You really miss your son."

D. Guidelines for Avoiding Barriers to Conversation

1. Avoid interrupting or changing the subject.
2. Avoid expressing your opinion if it implies passing judgment.
3. Avoid talking about your own personal problems and the problems of other patients and co-workers.
4. Avoid pat answers such as "Don't worry" as this can make patients feel their concerns are not important.
5. Avoid questions that can be answered with "Yes" or "No" unless you want only direct answers.
6. Avoid questions that start with "Why" to avoid defensive responses.

E. Guidelines for Ending a Conversation

1. Tell patient that you are finished, that you have to leave and, if appropriate, when you will be back. Be sure to come back at designated time.
2. Tell the patient that you enjoyed the conversation.
3. Leave the patient in a position of comfort and safety, with call signal and other needed items within easy reach.

F. Communicating with Patients who have Vision Loss

1. Follow steps A thru E of this Procedural Guideline.
2. Identify self by name and title as you enter room to avoid startling patient.
3. Encourage and assist patient to keep glasses clean and to wear them.
4. Stand comfortably close to patient in a good light and face patient when you speak.
5. Speak in a normal tone of voice. Do not speak too loud.
6. Use talk and touch to communicate. Encourage patient to do the same.
7. Give ongoing, step by step explanations of what you are going to do and what is expected of the patient.
Clarify patient's understanding as appropriate.
8. Do not rearrange the environment without the patient's knowledge and approval. Replace items to their original location in patient's room.
9. Tell patient when you are finished and when you are leaving.

G. Communicating with Patients who have Hearing Loss

1. Follow steps A thru E of this Procedural Guideline.
2. Alert the patient by approaching from the front or side and lightly touching patient's arm. Avoid startling the patient.
3. Eliminate distracting background noise and activity if possible.
4. Speak at a slightly lower pitch and at a normal or only slightly increased volume--avoid shouting.
5. Encourage and assist the patient to use a hearing aid as appropriate.
6. If the patient hears better in one ear, stand on the preferred side.
7. Stand comfortably close to patient in a good light and face patient while you speak.

8. Speak slowly, clearly and distinctly using your lips to emphasize sounds--do not chew gum or cover your face with your hands while talking.
9. Use short words and sentences, clarify patient's understanding then rephrase message if needed.
10. Keep conversations short and limited to a single topic.
11. Do not convey negative messages by your tone of voice or body language.
12. Write out key words, if needed, or use other communication assistive devices such as communication boards if available.
13. If the patient uses sign language, try to find someone who "signs" to interpret.

H. Communicating with Patients who have Problems with Speaking
1. Follow steps A thru E of this Procedural Guideline.
2. Keep conversation short, but frequent. Ask direct questions if patient can answer "Yes" or "No."
3. Allow the patient adequate time to respond.
4. Listen carefully. Don't pretend to understand the patient if you don't.
5. Emphasize the positive aspects such as the words you understand.
6. If you can't understand the words, validate what you think the patient is saying or feeling.
7. Take time to complete each conversation to avoid conveying impatience.
8. Monitor your body language to assure you are not sending negative messages.
9. Encourage and assist the patient to point, nod, write, or to use assistive devices for communication such as picture boards and word boards as appropriate.

Guidelines for Effective Interpersonal Relations
1. Maintain open communication, be a good listener and encourage patients to express their feelings.
2. Be honest. Your best efforts will fail if you are not sincere.
3. Respect each patient as a unique individual with own behavior patterns.
4. Be courteous, patient and hopeful.
5. Develop supportive and trusting relationships with patients by being supportive and trustworthy.
6. Show patients that you care "about" them as well as caring "for" them.
7. Understand and accept patients – without judging.
8. Don't take patient's behavior personally.
9. Identify honest examples of patients' strengths and successes and provide positive feedback to patient.

Communication and Interpersonal Skills

Why is non-verbal communication important?

Basically, it is one of the key aspects of communication (and especially important in a high-context culture). It has multiple functions:

- Used to **repeat** the verbal message (e.g. point in a direction while stating directions.
- Often used to **accent** a verbal message. (e.g. verbal tone indicates the actual meaning of the specific words).
- Often **complement** the verbal message but also may contradict. E.g.: a nod reinforces a positive message (among Americans); a "wink" may contradict a stated positive message.
- **Regulate** interactions (non-verbal cues covey when the other person should speak or not speak).
- May **substitute** for the verbal message (especially if it is blocked by noise, interruption, etc.) — i.e. gestures (finger to lips to indicate need for quiet), facial expressions (i.e. a nod instead of a yes).

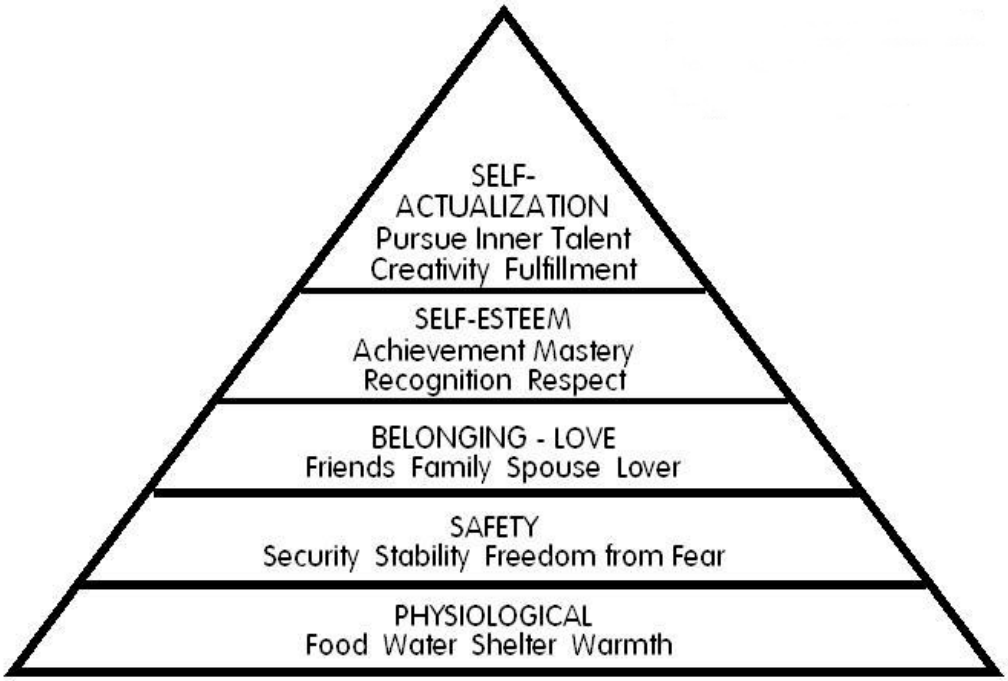
Body Mechanics

A. Purpose
1. To maximize strength
2. To avoid injury to the aide and the patient

B. General Guidelines and Precautions for Lifting and Moving
1. Wear loose clothing and low heeled, comfortable, non-skid shoes to allow good body mechanics.
2. Always get help from co-workers when needed before lifting heavy objects or patients who are unable to stand.
    a. Plan the lift ahead of time.
    b. Lift on signal such as "on the count of three."
3. Elevate the bed to comfortable working height when working at the bedside. Remember to return the bed to the lowest horizontal position when finished for patient safety.
4. Maintain good posture and good body alignment while lifting.
    a. Keep your back straight.
    b. Keep your knees bent.
    c. Keep your weight evenly distributed on both feet.
    d. Keep your feet at shoulder width (about 12 inches apart) to provide a broad base of support.
5. Use the strongest and largest muscles to do the job. Leg and arm muscles are the strongest. Back and abdominal muscles are the weakest.
6. Bend from the hip and knees--not waist--when lifting objects.
7. Always squat down to lift heavy objects from the floor.
8. Keep objects close to your body when lifting and carrying.
9. Use both hands when lifting or moving heavy objects.
10. Slide, push or pull heavy objects rather than lifting them, when possible.
11. Use the weight of your body to help push or pull objects.
12. Work with smooth, even movements--not quick, jerky motions.
13. Face your work and avoid twisting your body.
14. To change the direction of your work, take short steps and turn your whole body without twisting your back and neck.
15. Avoid unnecessary bending and reaching.
16. Do not lift objects higher than your shoulders.

Maslow's Hierarchy of Needs

This hierarchy suggests that people are motivated to fulfill basic needs before moving on to other needs. As people progress up the pyramid, needs become increasingly psychological and social.



Assistive Technology

Assistive technology devices are mechanical aids which substitute for or enhance the function of some physical or mental ability that is impaired. Assistive technology can be anything homemade, purchased off the shelf, modified, or commercially available which is used to help an individual perform some task of daily living. The term assistive technology encompasses a broad range of devices from “low tech” (e.g., pencil grips, splints, paper stabilizers) to “high tech” (e.g., computers, voice synthesizers, braille readers). These devices include the entire range of supportive tools and equipment from adapted spoons to wheelchairs and computer systems for environmental control. The Individuals with Disabilities Education Act (IDEA), the federal special education law, provides the following legal definition of an assistive technology device: “any item, piece of equipment, or product system... that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.” Under IDEA, assistive technology devices can be used in the educational setting to provide a variety of accommodations or adaptations for people with disabilities.

The emotional effects of having a serious physical illness

A serious physical illness can affect every area of your life:

- relationships
- work
- spiritual beliefs
- how we socialize with other people.

A serious illness can make us feel sad, frightened, worried or angry.

It may be because:

- You feel out of control of your body and your situation generally. You may feel that there is nothing that you can do.
- You feel lonely and isolated from family and friends. Sometimes it can be difficult to talk about the illness with those close to you. You don't want to worry or upset them.

For some of us, the emotional impact of a serious physical illness can be overwhelming. Cancer or heart disease, for example, can make us very anxious and depressed. It can stop us from doing the things we need to do in our daily lives.

Why are depression and anxiety more likely to happen if you have a serious physical illness?

- People become depressed and anxious when they are stressed for any reason. Being ill and having treatment are stressful. This is probably the most common reason.
- Some drug treatments, such as steroids, affect the way the brain works and so cause anxiety and depression directly.
- Some physical illnesses, such as an under-active thyroid, affect the way the brain works. They cause anxiety and depression directly.
- Anxiety and depression are common. You may just happen by chance to become anxious or depressed at the same time as you become physically ill.

How can depression and anxiety be helped?

There are several different types of professional who may be able to help you. These include your GP, trained counselors, psychotherapists, clinical psychologists and psychiatrists. Any treatment suggested will depend on your symptoms, the severity of your anxiety and depression, and your circumstances. It may involve talking, antidepressant tablets or both.

Perineal Care

Perineal care is performed after a patient uses the bedpan, becomes incontinent, and as a part of daily bathing. As the nurse's aide performs perineal care, she is able to observe the skin on the perineal area for signs of infection such as lesions or swelling, which can be early signs of more serious conditions. Care performed regularly and properly will reduce the risk of urinary tract infection which can lead to bladder and kidney infection. Before you begin, wash your hands thoroughly and put on a pair of gloves. Then, follow these steps:

1. Ask the patient to open his or her legs if they are able. If not, you will need to gently separate the legs.
2. Using a washcloth and warm water, gently clean the skin of the perineal area moving from front to back. Do not move from back to front due to the risk of introducing germs from the anal area into the urethra, a primary source of urinary tract infection.
3. When you are finished washing, dry the area thoroughly to prevent skin from becoming chapped.
4. Never reuse linens used to clean the perineal area to clean any other part of the body. Use a clean washcloth for this area only to minimize the spread of germs.
5. If bed linens are soiled or become wet during the cleaning process, you will need to replace them as quickly as possible.
6. Place used linens in the appropriate receptacle. Help the patient move to a comfortable position. Dispose of gloves and wash hands.

As you work, remember it is important to look for signs that may indicate infection. This can include pain or tenderness in an area, rashes, sores, or boils. If you notice any of these signs, report them to your supervisor immediately. Proper care can help your patient remain comfortable as they recover.

Bedpan

Find out how to assist with use of a bed pan in this important PCA skill. For patients who are unable to walk or stand, the use of a bedpan may be necessary. Assisting your patient in the use of the bedpan can minimize embarrassment and prevent unpleasant messes. Before you begin, wash your hands to prevent the spread of germs. Greet your patient and explain that you will be helping him/her to use the bedpan. Ensure the patient has adequate privacy and put on a pair of gloves. Assist the patient into a supine position (laying on the back, face up), and then help him/her turn onto their side. Follow these steps to make the process safe and efficient:

- Place the bedpan against the patient buttocks, and then roll the patient back onto his/her back. Ask the patient to spread their legs to ensure the bedpan has been properly placed. Raise the head of the bed to make the patient comfortable, and then step away to allow the patient privacy. Remove gloves and dispose of them properly. Wash your hands thoroughly.

- When the patient is finished, again ensure that the patient has adequate privacy. Wash your hands and put on gloves.
- Return the head of the bed to a flat position and assist the patient in turning onto his/her side. As you turn the patient, support the bedpan in order to prevent contents from spilling onto the bed. If a spill does occur, you will need to immediately change bed linens.
- Remove the bedpan and set it aside. Ensure that the patients buttock and genitals are clean to prevent infection. Return the patient to a comfortable position of his/her choice. Provide a damp cloth to allow the patient to wash his/her hands, if the patient wishes.
- Measure the output and record appropriately, then dispose of the secretions as directed. Ensure that the bedpan is either replaced or cleaned.
- Remove your gloves and immediately wash hands for at least one minute.

Careful use of the bedpan will prevent infection and allow the patient to complete necessary bodily or bowel functions with a minimum of discomfort. Try to remain professional as you assist the patient with this process, and ensure proper hand washing procedures are followed.

Catheter Cleaning

A Foley catheter is a sterile (germ-free) tube that is inserted through your urethra and into your bladder to drain urine. The catheter has a small balloon filled with solution that holds the catheter inside your bladder. A Foley catheter is also called an indwelling urinary catheter.

Gather all of the supplies needed for your catheter care. This would include:

- A basin of clean warm water or use of a clean sink with running warm water.
- Two clean washcloths and a clean towel
- Soap

1. Wash your hands thoroughly with soap and water before and after cleaning and touching the catheter, drainage bag, or urine.
2. Apply soap and water to one washcloth and thoroughly clean the area around the meatus then rinse well to remove all soap.
3. Rinse the washcloth, apply more soap, and clean the rest of the area between your legs and buttocks. For female patients, it is important to wipe from front to back to prevent an infection. For male patients, it is important to begin at the tip of the penis and wash downward toward the body.
4. Rinse and pat dry the area well with the towel.
5. Change the water in the basin and clean the catheter next.
6. Apply soap to the second washcloth.
7. Firmly grasp the catheter to prevent tugging on it and gently wash the tubing. Begin at the meatus and wash the first 2 to 3 inches of the tube, moving away from the body toward the drainage bag. **DO NOT** wash from the tubing toward the body because this may push bacteria into the meatus.
8. Gently remove any drainage or crusting that may be present on the tube.

9. Gently dry the tubing.
10. Do not use any powders in this area.
11. After cleansing, the catheter should be secured to the inner thigh to prevent irritation around the meatus and to prevent pulling the catheter out.

Drainage Bag

The drainage bag should be emptied, at a minimum, two to three times a day. The bag should not be allowed to become full. This will put pressure on the catheter and cause tugging and irritation at the meatus. It also will be too heavy and bulky to carry around.

1. Wash your hands before and after emptying the bag.
2. The bag should be kept below the level of the hip (bladder) at all times to prevent urine from flowing back into the tubing and into the bladder.
3. Use a clean container to empty urine into if your doctor wants you to measure the amounts in the drainage bag. Otherwise, you can also empty the bag directly into the toilet.
4. Carefully open the spigot (pour spout) at the bottom of the bag to empty. Do not allow the spigot to touch the container or toilet. This causes contamination of the bag with bacteria.
5. Clean the end of the spigot with rubbing alcohol on a gauze pad or cotton ball.
6. Close the spigot securely to prevent leaking.
7. Do not allow the drainage bag to rest on the floor.
8. When completed position drainage bag so that is the tubing is not kinked and the bag does not tug on the patient.

Urinary Tract Infection (UTI)

Symptoms of lower urinary tract infections usually begin suddenly and may include one or more of the following signs:

- The urge to urinate frequently, which may recur immediately after the bladder is emptied.
- A painful burning sensation when urinating. (If this is the only symptom, then the infection is most likely urethritis, an infection limited to the urethra.)
- Discomfort or pressure in the lower abdomen. The abdomen can feel bloated.
- Pain in the pelvic area or back.
- The urine often has a strong smell, looks cloudy, or contains blood. This is a sign of *pyuria*, or a high white blood cell count in the urine and is a very reliable indicator of urinary tract infections.
- Occasionally, fever develops.

Colostomy

A surgically-created opening in the abdomen and the colon (or large intestine). The surgeon brings the colon through the abdominal opening and sews it down to the skin.

• You will hear this new opening referred to as “stoma”, “ostomy”, or “colostomy”.

Types of Ostomies:

Colostomy: Typically installed as a result of the loss of all or a portion of the patient's colon (large intestine).

Ileostomy: Similar to a colostomy, an ileostomy is connected to the small intestine and can also be temporary or permanent.

Urostomy: A common form of ostomy which is designed to divert urine from the genitals into a pouch for collection.

Handling an ostomy means dealing with human waste and as a result, you must handle it carefully. Always wear latex gloves when handling the ostomy valve and be sure to clean the tube thoroughly after each evacuation. Pay close attention to the instructions included with the ostomy to ensure that you handle it correctly and that you replace the valve as needed. It's best to empty the bag before it gets too full to prevent leaks and spills.

Procedure:

Changing a 1-Piece Pouch
1. Gather all supplies (Washcloth, Pen, Pouch, Scissors, Stoma Paste, Stoma Measuring Guide)
2. Gently remove the pouch from skin working from top to bottom.
3. Wash skin around your stoma with a soft cloth and water.
4. As needed, shave the hair around stoma starting close to the stoma and moving outward in order to prevent nicking the stoma.
5. Using the Stoma Measuring Guide, measure and select the smallest size that fits around the stoma without touching it.
6. Trace the correctly-sized pattern on back of pouch.
7. Cut along traced line.
8. Check the fit of the pouch.
9. Remove backing paper from the wafer adhesive.
10. Squeeze out stoma paste, or “caulking” around cut opening on the back of wafer.
11. Re-clean skin and dry well.
12. Apply pouch to the skin.
13. Remove remaining strips of backing paper.
14. Close tail.
15. Cover pouch with hand for 5 minutes to trap body heat, which “melts” wafer onto skin.

Changing a 2-Piece Pouch
1. Gather all supplies (Washcloth, Pen, Wafer/Pouch, Scissors, Stoma Paste, Stoma Measuring Guide)
2. Gently remove the pouch from skin working from top to bottom.
3. Wash skin around your stoma with a soft cloth and water.

4. As needed, shave the hair around stoma starting close to the stoma and moving outward in order to prevent nicking the stoma.
5. Using the Stoma Measuring Guide, measure and select the smallest size that fits around the stoma without touching it.
6. Trace the correctly-sized pattern on back of wafer.
7. Cut along traced line.
8. Check the fit of the wafer.
9. Snap the wafer and pouch together and check the seal.
10. Remove backing paper from the wafer adhesive.
11. Squeeze out stoma paste, or "caulking" around cut opening on the back of wafer.
12. Re-clean skin and dry well.
13. Apply pouch to the skin.
14. Remove remaining strips of backing paper.
15. Close tail.
16. Cover pouch with hand for 5 minutes to trap body heat, which "melts" wafer onto skin.

Constipation and Diarrhea Symptoms

Constipation is a symptom, not a disease. Constipation is when a person passes small amounts of hard, dry stool, usually fewer than three times a week. People who are constipated may find it difficult and painful to have a bowel movement.

Other constipation symptoms include feeling:

- Bloated
- Uncomfortable
- Sluggish.

Diarrhea is a not an illness; it is a symptom, similar to the way fever is a symptom. Depending on the cause of diarrhea, other symptoms may or may not accompany it. So when someone asks, "What are diarrhea symptoms?" he or she is most likely interested in the other symptoms that may come along with diarrhea.

While diarrhea is extremely common, many people are not familiar with its formal definition. Diarrhea is defined as loose, watery, unformed stools occurring more than three times in one day. People with diarrhea may pass more than a quart of stool a day. Diarrhea is not the occasional loose stool or the frequent passing of formed stools.

Diarrhea may be accompanied by a number of other symptoms. These symptoms can help your healthcare provider diagnose the cause of diarrhea. Symptoms that may be present with diarrhea include:

- Cramping abdominal pain (or stomach pain)
- Bloating
- Nausea
- An urgent need to use the bathroom
- An inability to control the bowels (fecal incontinence)

- Feeling sick to the stomach
- Fever
- Chills
- Muscle aches or pain
- Headache
- Low heart rate
- Joint pain
- Alternating constipation
- Blood in stool
- Mucus in stool

Skin Care

The skin consists of three layers: Epidermis, dermis, and subcutaneous tissue. The outermost layer, the epidermis, is composed mostly of dead skin cells that are constantly being shed and replaced. The dermis or second layer has sweat glands, oil glands, nerve endings, and small blood vessels called capillaries, which are all woven together by a protein called collagen. Collagen provides nourishment and support for skin cells. The nerves ending in this layer transmit sensations of pain, itch, touch and pleasure. The hair follicles also originate in this layer. Destruction of either the epidermis or dermis can leave the body open and susceptible to infection. The subcutaneous adipose tissue is the deepest layer of skin and is a layer of fat and collagen that houses larger blood vessels and nerves. This layer is important in controlling the temperature of the skin itself and the body and protects the body from injury by acting as a shock absorber. The thickness of this layer varies throughout the body and from person to person. Underneath the subcutaneous tissue lays muscle and bone.

For the most part, the skin is tough, pliable and resistant to injury. If the skin becomes injured or broken, it is generally very resilient and has an amazing ability to self-repair and heal. Despite this resiliency, the skin is susceptible to breakdown, if subjected to prolonged abuses, such as excessive pressure, shear force, friction or moisture. This is a major concern for persons with transverse myelitis or other neuroimmunology conditions that cause paralysis and/or decreased sensation.

For people with paralysis, the skin is at increased risk for breakdown for several reasons. Paralysis itself affects the skin and underlying tissue. There is loss of collagen which weakens the skin and makes it less elastic. The lack of muscle function around boney areas of the body leads to muscle atrophy, resulting in less padding, which in turn, adds to the risk of skin breakdown. People with paralysis often have difficulty shifting their weight, repositioning themselves, or transferring without assistance.

Impaired sensation is often present, limiting the ability to sense when to make a weight shift or position adjustment. People with impaired sensation are also vulnerable to injury from many other hazards, such as, heat, cold, sun and trauma. Loss of sensation put an individual at risk for burns from very ordinary activities, such as using a lap top computer sitting directly on your lap

or sitting too close to a fireplace. Injury can be caused from things that are too cold such as, ice packs or cold exposure causing frostbite. Ingrown toenails can become infected and sunburn can become severe without feeling it.

When limited mobility is coupled with decreased sensation, a person is more likely to develop a specific type of skin breakdown called a pressure ulcer. According to the National Pressure Ulcer Advisory Panel, a pressure ulcer is defined as a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are one of the leading causes of complication across the life span of persons with paralysis. Up to 95 % of adults with spinal cord injury will develop at least one serious pressure ulcer at some time during their life.

Skin breakdown can range from minor scrapes, cuts, tears, blisters or burns to the most serious pressure ulcers with the destruction of tissue down to and even including the bone. A pressure ulcer, especially one that requires surgery, such as a muscle flap or skin graft, can cost thousands of dollars to treat, require lengthy hospitalization, and weeks to months away from family, work, school or community activities. It has been estimated that for persons with spinal cord injury the cost of care for pressure ulcers is about $1.2 to 1.3 billion dollars annually.

With a concerted effort, skin breakdown is, for the most part, preventable. It can occur, however, even in people who maintain the most diligent care and use the proper equipment. If skin breakdown is identified early, when still in the minor stages, and if the cause of the breakdown can be identified and eliminated, healing should occur fairly quickly. If it is not identified in its early stages, skin breakdown can rapidly progress from minor to serious.

Skin breakdown is caused in several different ways, including friction, shear, moisture and pressure. These causes can occur individually or in combination. Friction, moisture and sheer are identified as contributing factors to pressure ulcers. A friction injury occurs when the skin rubs on surfaces, such as a bed sheet, arm rest or brace and has the appearance of a scrape, abrasion or blister. This type of injury is typically seen on the heels and elbows and may result from repositioning, propping or rubbing due to increased spasticity.

A shearing injury occurs with dragging or sliding of a body part across a surface and has the appearance of a cut or tear. This type of injury can occur from dragging your bottom during a transfer or sliding down in bed when the head of the bed is elevated. With the sliding force, bone is moved against the subcutaneous tissue while the epidermis and dermis remain essentially in the same position; against the supporting surface such as a wheelchair or bed. This action causes occlusion of the blood vessels, decreasing blood flow, oxygen and nourishment to the skin, which eventually leads to breakdown. Sometimes a shear injury will actually tear the tissue over the tailbone and with unrelieved pressure will become a pressure ulcer.

Too much moisture over-hydrates the skin, making it weak and more sensitive to friction, shear and breakdown (think about being in the tub or pool for a long time). Primary sources of excess skin moisture include sweating, bowel and bladder accidents, and drainage from wounds.

Pressure ulcers occur when skin, soft tissue and blood vessels are compressed or squeezed between a bony prominence (such as your tailbone) and an external surface (such as your wheelchair cushion). With compression of these vessels, the blood that nourishes the cells and takes away waste is cut off, starving the tissue of oxygen and vital nutrients. Without food and oxygen, tissue dies, and skin breakdown begins. The body tries to compensate by sending more blood to the area. This process results in redness and swelling, places even more pressure on the blood vessels, and further endangers the health of the skin and underlying tissue. Ultimately, a pressure ulcer form. Increased pressure over short periods of time and slight pressure over long periods of time have been shown to cause equal amounts of damage.

Many factors have been identified as responsible for the development of skin breakdown and pressure ulcer formation. In addition to immobility, impaired sensation and the external factors described above, many internal contributing factors have been identified. These internal factors include poor nutrition and hydration, weight, impaired circulation and oxygenation, impaired cognition or thinking, substance abuse, depression and age. Nutritional factors important to prevent or heal wounds include a balanced diet with an adequate intake of protein, vitamin C, vitamin A, and zinc, as well as an adequate intake of fluids (8). When a person is overweight, extra pounds place extra pressure on vulnerable skin areas increasing the risk of compression of blood vessels. Individuals that are underweight often have decreased muscle mass with less fat padding over boney areas leaving them vulnerable to skin breakdown. Smoking, diabetes, anemia and other vascular conditions all lead to decreased circulation, increasing risk for skin breakdown. Individuals who are depressed or have impaired thinking and judgment due to substance abuse are less likely to be vigilant with regard to important self-care issues, such as skin health. Young children generally have more resilient and elastic skin and more baby fat and padding so they often have very little difficulty with skin break down. As children move into adolescence, their skin loses some of its elasticity. They generally have more body weight, putting more stress on pressure areas, such as the ischealtuberosicties and tailbone with sitting. Teens often begin to have more difficulty with skin breakdown. As we continue to age, our skin becomes increasingly less pliable and resilient. We experience the loss of collagen and muscle mass, as well as decreased circulation, making the skin more vulnerable. The elderlies are most prone to skin tears and stripping due to fragile, thin, and vulnerable skin. In addition, incontinence may become a more frequent issue for bedridden or ill persons, increasing problems with moisture as described above.

Avoid prolonged pressure on any one spot

Encourage patients to reposition frequently. If the patient is unable the aide must assist with relieving pressure. When seated in a wheelchair, do weight shifts every 15 minutes. When lying in bed, reposition every 2 - 4 hours. Use pillows or wedges behind your back and between bony areas, such as knees and ankles. “Float” your heels and ankles off of the bed by supporting your lower leg with a pillow. Keep the head of the bed up less than 30 degrees to prevent shearing of skin from sliding down or the need to be pulled back up. If you use a wheelchair most of the day, avoid lying on your back at night. Instead, turn side to side to give your backside a break. Better yet, sleep on your stomach, if this position is comfortable and you are able to breathe safely. When positioned on your stomach, you have fewer pressure points, and can

generally turn less frequently. Being on your stomach gives your backside a break and allows you to stretch your hip flexor muscles and hamstring muscles, all for the price of one!

Maintenance of a clean and safe environment

Ensuring that the homes of our home health patients are clean and safe is an essential component in the provision of effective healthcare. It is also of paramount importance for our patients and their families to ensure a germ free environment to maintain optimal health and ward off respiratory problems, insect and rodent infestation and other health and environmental problems. A clean and tidy premise is also fundamental to assist our patients to remain healthy. And finally, a clean, safe and healthy home environment is critical to prevent and/or control the spread of healthcare associated infections.

The goal of healthy housekeeping is to reduce the number of microorganisms in the home to minimize the risk of infection and accidents to both the patient and other family members.

Keep patient area free of clutter and filth.

Mobility and Transfers

Assisting your patient to ambulate regularly provides exercise and helps prevent mobility and circulation problems for the patient. Many patients who need your assistance may have difficulty getting to a standing position and then walking without help. Falls can be very dangerous for patients, particularly the elderly, and may result in severe injuries. For this reason, the use of a transfer belt can make the process safer and more comfortable for the patient. Before you begin, assist the patient into suitably warm and comfortable clothing that will not hamper movement, such as a robe. Then, ensure the patient is wearing rubber-soled shoes or slippers that will provide traction. If your patient requires oxygen or an IV, ensure that the proper equipment is available such as a portable oxygen tank or IV pole with wheels. If necessary, provide the patient with a walker or cane to assist with movement. Once you are ready, follow these steps to ensure safety:

1. Lower the patient's bed to the lowest level and lock the wheels. Assist the patient in sitting, and then moving legs so that they hang over the edge of the bed. Allow the person to remain in this position for a period of time to ensure the patient is not becoming dizzy.
2. Apply the transfer belt around the patient's waist. Help the person to stand by first standing in front of the patient. Have the patient place his/her hands on the bed alongside the legs, and feet on the floor. Tell the patient to lean forward, while you grasp the transfer belt with an underhand grip. Place your feet alongside the patient's feet and flex your knees slightly. Assist the patient to a standing position by gently lifting and steadying the person. Remain in this position for a brief period to ensure the patient does not feel dizzy and his/her respiration remains constant.
3. Once you are certain the patient is steady, provide a cane or walker. The patient should hold a cane using their strong side. Assist the person to walk by standing slightly behind the patient on their weaker side and holding the transfer belt using an underhanded grip.

4. As you walk, monitor the patient carefully. If you notice changes in the persons respiration, or if the patient reports feeling dizzy or tired, you will need to discontinue the walk. Be sure you do not rush the patient and allow them to move at whatever pace is comfortable. If the patient needs a rest, allow him or her to sit until they feel ready to walk again. Use the same procedure for standing from a chair as you did when helping them get up from bed.
5. After the patient is returned to his/her bed, be sure to again wash your hands. Do not leave the transfer belt on the patient after they return to bed.

Passive ROM

Performing passive range of motion checks on a patient can indicate the progress of the patient's recovery and prevent complications from stiff joints. If practical, range of motion exercises should be performed as you give a patient his or her bath. Before you begin, wash your hands. Greet your patient and explain that you will be checking his or her range of motion by performing several exercises. Then, follow these steps:

1. Raise the height of the bed until you can comfortably reach the patient to assist if necessary.
2. Start with range of motion tests on the head. As the patient to turn the head from one side to the other. This check should not be performed on a patient who has a neck or spinal cord injury as it could aggravate the problem.
3. Next, move to the arms. Have the patient flex and extend both arms at the elbow. Then, have the patient move the arms in a crossing motion toward the body and then away. Ask the patient to move all fingers and flex their wrists. Perform each test ten times per arm.
4. Move to the legs and ask the patient to flex and extend each knee, then move the leg toward the centerline of the body and back. Perform ten times on each leg. Ask the patient to flex and extend feet at the ankles, and then move or wiggle the toes.

For a bed-bound patient, checks should be performed once or twice per day to ensure that joints do not become contracted. If the patient experiences stiffness or an inability to move a joint, it may be an indication of contractures and should be reported immediately. As you perform each test, observe the patient for signs of swelling or inflammation in any of the joints. If your patient reports severe pain or shows signs of respiratory distress while performing tests, notify nursing staff right away. There are six different positions that you can use to perform checks:

Supine Position – the patient lies on the back with arms extended to each side.
Sims Position – the patient is positioned on either side with both legs straightened.
Lateral Position – the patient is lying on one side with the top leg flexed, and the flexed leg and top arm are elevated on a pillow for support.
Semi-Fowler Position – the patient lies on the back with the head of the bed elevated to a 45 degree angle.
High-Fowler Position – the patient lies with the head of the bed raised to a 90 degree angle.

As you perform these checks, monitor the patient for any difficulty completing exercises. Notify nursing staff of any issues right away. Range of motion checks will help your patient to remain more comfortable and prevent complications arising from contractures of joints.

Contractures

Prevention of contractures is very important in maintaining ability to walk and to do daily living activities. Contractures are prevented by actively exercising the muscles and joints through their range daily. If the individual cannot do so due to muscle weakness, the family, caregivers, aides, or friends can do gentle passive range of motion under the guidance of programs developed by the physician, the physical therapist, or the occupational therapist. Splints are also important in preventing contractures, especially at night when sleeping postures frequently encourage the development of contractures.

Special Needs of the Elderly

There are a number of aspects that are involved in taking care of elderly or aged people. Having a good amount of awareness about the various possible needs and requirements of the elders, is extremely important for those people who have the responsibility of taking care of their aged family members, parents or relatives.

Financial Needs
If elderly individuals happen to be living on their own, i.e. without anyone else's support, it is but natural that they will have a certain amount of financial needs. They will need to fend for themselves for everything such as food, groceries, medicines, etc. Pensioners would have the benefit of a steady source of monthly income (whatever be the amount trickling in). However, those senior citizens who do not have any pension facilities or any other sources of income would have to live entirely on the basis of their savings or through special senior citizen government finance schemes.

Health Care Requirements
Senior health is the most important requirement when it comes to elderly needs. With advancing age, the body tends to slow down and becomes less efficient. Elderly people are prone to a few age-related health issues. This is a normal aspect of life and one cannot help it. However, through proper care and nursing facilities, one can definitely help in keeping most of these health issues in check and preventing them from causing any serious harm. Regular medical checkups are necessary. They can help in anticipating potential future health-related issues. At the same time, they may help in identifying serious health problems at an early enough stage during which treatment is possible.

Dietary Requirements
As people age, their digestive system gradually starts weakening. Aged and elderly people especially, face this problem wherein they start finding certain foods indigestible or difficult to digest. What one must realize is that their diet can no longer be the same as it was say, twenty

years ago. Their diet should now be modified accordingly such that it remains a nutritious, balanced diet and yet, contains foodstuffs that their system is able to accept, without causing them any discomfort or problems. Often, the diets of elderly people need to be altered depending on their medicinal prescriptions.

Activities of Daily Living (ADLS)
Elderly people whose mobility has become limited due to aging, he or she would require a certain amount of assistance in his or her daily routine They may require assistance in basic activities like walking, eating, bathing, dressing, etc.

Social and Other Needs
Just because they have become older and slower, does not mean that you should ignore them or let them be confined to themselves. Remember, a few years down the line, you yourself will be in their position. Spend time with them, chat with them and make them feel wanted, cared for and loved. Pay special attention to their room. You could consider installing a few senior citizen friendly appliances which they would be comfortable using. Also, you should consider installing certain medical alarms that are specially made keeping in mind elderly citizens.

AIDE Training

Certificate of Completion

Name_____ **Date**_____

The person named above has completed AIDE Training

Presented by

AMICABLE Healthcare, Inc.
15220 32nd Ave., South, Suite B
SeaTac, WA 98188

Presenter Name and Title_____

Date of Completion_____

Number of hours training _____

AMICABLE Healthcare, Inc.

Category:	Human Resources	Number:	2.007.1
Subject:	Orientation and Staff Development		
Applies:	All Staff	Page:	1 of 2

Purpose: To provide employees with knowledge of the organization and an opportunity for ongoing development.

Policy: At or near the time of hire, all employees, including contracted personnel are required to be presented with the Agency's general orientation program and Employee Handbook, and are required to attend all of the Agency's orientation and training programs which are scheduled for them. Through an orientation period, each new employee/contracted personnel shall become acquainted with the purpose and program of the organization. Orientation must be completed prior to assuming patient assignments. Through an orientation period, each new employee/contracted personnel shall become acquainted with the purpose and program of the organization. Orientation must be completed prior to assuming patient assignments.

Procedure:
The orientation process is instructed by either the Administrator or the Director of Nurses or by appointed personnel that is duly qualified to perform the orientation process. During the orientation period, the employee will learn, at a minimum:

a. The broad goals and scope of the Agency's services.
b. The Agency Policy and Procedure Manual.
c. The duties and responsibilities of the job.
d. Methods in preventing the spread of infectious diseases.
e. Exposure Control Plan.
f. Disaster Plan
g. Patient Rights (taught at orientation and annually thereafter)
h. Emergency Preparedness'
i. Infection Control
j. Cultural Awareness (taught at orientation and annually thereafter)
k. Confidentiality and PHI
l. Education about Personal Protective Equipment
m. Education about eliminating and minimizing physical risk to staff and patients
n. Employee regulations, applicable laws.
o. Skills competency (verbal and/or direct, including testing) will be performed during orientation by a RN and at repeated at least annually.
p. How to report emergencies, abuse, neglect, accidents, incidents, or adverse effects.
q. Advance Directives and End of Life Training

r. All staff providing direct patient care will sign a statement stating that they have read and understand and will comply with all applicable Agency policies.
s. Clinical staff must complete OASIS Training Here is a possible resource: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/EducationalResources.html
t. Location of equipment and orientation to equipment
u. Professional boundaries
v. Patient complaint handling
w. Ethics
x. Pain Management
y. Available Community Resources
z. Orientation to the Performance Improvement Plan
aa. Mission, Goals, and Philosophy
bb. Record keeping and reporting
cc. Conflict of Interest
dd. Sentinel Events
ee. Special Population Training (if applicable)
ff. Communication Barriers
gg. Corporate Compliance Plan
hh. Conveying of charges for care/service
ii. OSHA (Right to Know laws)
jj. OSHA requirements, safety and infection control
kk. Incident/ variance reporting
ll. Organization Chart
mm. Job Descriptions

Ongoing staff development will be accomplished by:
a. Yearly attendance by professional clinical staff to at least one development program or programs required to maintain licensure. In service education as needed.
b. On-going patient discussion with professional staff.

Refer to the Human Resources Orientation Manual

AMICABLE Healthcare, Inc.

Category:	All	Number:	2.008.1
Subject:	Policy and Procedure Agreement		
Applies:	All Staff	Page:	1 of 1

ALL STAFF:

I, _____ have read, understand and agree to abide by the
(please print)

policies and procedures set forth by AMICABLE Healthcare, Inc...

I also understand that I may view or copy any or all AMICABLE Healthcare, Inc. policy and procedure manual for review or retention.

I also agree to adhere to all local, state and federal procedures regulated as precedent for the home health care industry for compliance in providing care to Agency patients as designated.

Staff Signature: _____ Date: _____

Administrative Signature: _____ Date: _____

AMICABLE Healthcare, Inc.

Category:	Human Resources	Number:	2.009.1
Subject:	Competency Evaluation		
Applies:	All Field Staff	Page:	1 of 3

Purpose: To assess competency of all field staff.

Policy: Field staff must demonstrate competency within the job description that applies to that staff member, prior to be permitted direct contact with patients. This may be established through several methods, such as demonstration of skills by the employee to the supervisor as long as the supervisor has at least equal credentials. For example, a RN cannot assess skills of a PT, but the RN can assess another RN, LPN or CNA. Testing may be used to assess competencies. Skills checklist may also be used in conjunction with testing.

Procedure:

1. All field staff must be evaluated for competency with relation to their job description prior to receiving patient assignments and prior to performing new tasks.
2. Written tests are one method of evaluation and may be used in coordination with skills checklists.
3. Any skills that are deemed unsatisfactory must be retrained, and return demonstrated, and documented before the employee may perform that skill in the field.
4. Skills check must be completed annually.
5. Nurse aide competency must be evaluated by a RN with at least 2 years of nursing experience and at least one year of which must be in the provision of home health care. Competency will be determined prior to allowing the aide to work independently. Proof of competency will be kept in the employees personnel file.
6. The competency evaluation program for the nurse aide includes, but is not limited to:
   (i) Communications skills
   (ii) Observation, reporting and documentation of patient status and the care or service furnished
   (iii) Reading and recording temperature, pulse, and respiration
   (iv) Basic infection control procedures
   (v) Basic elements of body functioning and changes in body function that must be reported to an aid's supervisor
   (vi) Maintenance of a clean, safe, and healthy environment
   (vii) Recognizing emergencies and knowledge of emergency procedures

(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy and his or her property

(ix) Appropriate and safe techniques in personal hygiene and grooming that include-

(A) Bed bath
(B) Sponge, tub, or shower bath
(C) Shampoo, sink, tub, or bed
(D) Nail and skin care
(E) Oral hygiene
(F) Toileting and elimination

(x) Safe transfer techniques and ambulation

(xi) Normal range of motion and positioning

(xii) Adequate nutrition and fluid intake

(xiii) Any other task that the HHA may choose to have the home health aide perform

7. The following competencies must be evaluated while the aide is performing the tasks with a patient or pseudo-patient.

- Reading and recording temperature, pulse, and respiration.
- Safe transfer techniques and ambulation.
- Normal range of motion and positioning
- Appropriate and safe techniques in personal hygiene and grooming that include--

(A) Bed bath
(B) Sponge, tub, or shower bath
(C) Shampoo, sink, tub, or bed
(D) Nail and skin care
(E) Oral hygiene
(F) Toileting and elimination

8. A Home Health Aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. The aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated as unsatisfactory and passes a subsequent evaluation with satisfactory.

9. Job Descriptions are an extension of this policy in regard to licensure, education, training, and competency requirements for each position.
10. To provide Skilled Nursing Services employees must either have a valid State issues RN license or LPN license.
11. To provide Physical Therapy Services employees must either have a valid State issued PT or PTA license.
12. To provide Occupational Therapy Services employees must either have a valid State issued OT or OTA license.
13. To provide Social Workers services employees must have a valid State issued Masters Level Social Workers Licenses.
14. To provide Speech Therapy Services employees must have a valid State issued Speech and Language Pathology License.
15. To provide Home Health Aide services employees must have a valid State issued Nurse Aide Certification or have a valid State issued RN or LPN license.
16. To provide Dietary Services employees must have a valid State issued Registered Dietician license.
17. All licenses/certifications will be verified as current and active in this State prior to allowing the employee access to any patient or patient record. Copies of licenses/certification verification will be kept in the personnel file.

Refer to:
Skills Checklist
Competency Tests
Job Descriptions

AMICABLE Healthcare, Inc.

Category:	Human Resources	Number:	2.007.1
Subject:	Orientation and Staff Development		
Applies:	All Staff	Page:	1 of 2

Purpose: To provide employees with knowledge of the organization and an opportunity for ongoing development.

Policy: At or near the time of hire, all employees, including contracted personnel are required to be presented with the Agency's general orientation program and Employee Handbook, and are required to attend all of the Agency's orientation and training programs which are scheduled for them. Through an orientation period, each new employee/contracted personnel shall become acquainted with the purpose and program of the organization. Orientation must be completed prior to assuming patient assignments. Through an orientation period, each new employee/contracted personnel shall become acquainted with the purpose and program of the organization. Orientation must be completed prior to assuming patient assignments.

Procedure:

- The orientation process is instructed by either the Administrator or the Director of Nurses or by appointed personnel that is duly qualified to perform the orientation process. During the orientation period, the employee will learn, at a minimum:
- The broad goals and scope of the Agency's services.
- The Agency Policy and Procedure Manual.
- The duties and responsibilities of the job.
- Methods in preventing the spread of infectious diseases.
- Exposure Control Plan.
- Disaster Plan
- Patient Rights (taught at orientation and annually thereafter)
- Emergency Preparedness'
- Infection Control
- Cultural Awareness (taught at orientation and annually thereafter)
- Confidentiality and PHI
- Education about Personal Protective Equipment
- Education about eliminating and minimizing physical risk to staff and patients
- Employee regulations, applicable laws.
- Skills competency (verbal and/or direct, including testing) will be performed during orientation by a RN and at repeated at least annually.
- How to report emergencies, abuse, neglect, accidents, incidents, or adverse effects.
- Advance Directives and End of Life Training

- **AMICABLE Healthcare, Inc.**

Category:	Human Resources	Number:	2.007.1
Subject:	Orientation and Staff Development		
Applies:	All Staff	Page:	2 of 2

- All staff providing direct patient care will sign a statement stating that they have read and understand and will comply with all applicable Agency policies.
- Clinical staff must complete OASIS Training Here is a possible resource: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/EducationalResources.html
- Location of equipment and orientation to equipment
- Professional boundaries
- Patient complaint handling
- Ethics
- Pain Management
- Available Community Resources
- Orientation to the Performance Improvement Plan
- Mission, Goals, and Philosophy
- Record keeping and reporting
- Conflict of Interest
- Sentinel Events
- Special Population Training (if applicable)
- Communication Barriers
- Corporate Compliance Plan
- Conveying of charges for care/service
- OSHA (Right to Know laws)
- OSHA requirements, safety and infection control
- Incident/ variance reporting
- Organization Chart
- Job Descriptions

Ongoing staff development will be accomplished by:

a) Yearly attendance by professional clinical staff to at least one development program or programs required to maintain licensure. In service education as needed.
b) On-going patient discussion with professional staff.

Refer to the Human Resources Orientation Manual

AMICABLE Healthcare, Inc.

Category:	Clinical	Number:	6.001.1
Subject:	In-Service Education		
Applies to:	All Staff	Page:	1 of 2

Purpose: To provide staff members with information, to improve the Agency's performance, and to ensure the competency of the Agency's staff.

Policy: The Agency provides in-service education programs for its staff.

Procedure:

1. Director of Nurses (DON) plans annual in-service calendar based on:
   a) Needs assessment including QA follow-up
   b) Agency program objectives
   c) Regulatory requirements
   d) Patient care policies and procedures
   e) Infection control policies and procedures
   f) Incident/Accident Reporting
   g) Patient rights and responsibilities
   h) Safety testing on equipment used in the work environment
   i) Work place and patient safety
   j) Cultural Awareness
   k) Emergency/Disaster Preparedness
   l) Patient Complaints
   m) Ethics and Ethical Issues
   n) Services provided
   o) Communication Barriers
   p) OSHA (Right to Know Laws)
   q) Reporting requirements for suspected abuse, neglect and exploitation annually.

2. The DON notifies staff of scheduled in-services by phone, mail or office postings.

3. A staff RN will participate in all in service educations.

4. All unlicensed home care staff must attend at least one in-service program annually, but are encouraged to attend as many as possible. At times, mandatory in-services will be held, that would be considered in addition to the one annual in-service.

5. Direct care staff including aides must attend twelve (12) hours of in-service during each twelve (12) month period. The 12 month period shall begin on the Date of Hire. Non direct care staff will receive at least eight (8) hours of in service/continuing

education each twelve (12) month period. The 12 month period shall begin on the Date of Hire. A staff RN supervisors this in service requirement.

6. Evidence of a staff member's attendance at in-service are:
   a) Signature on in-service attendance log.
   b) Signature of attendance after reading/viewing material and discussing with supervisor.
   c) Copies of certificate of attendance at outside professional continuing education programs.

7. Maintain an in-service notebook which contains:
   a) In-service content materials
   b) Minutes/Attendance sheets
   c) Employee In-service/Continuing Education Record
   d) Make this notebook available to the QA committee.

8. Any change in job position requires documented education related to the new position.

Refer to:
In-service minutes
Individual In-service/Continuing Education Record

AMICABLE Healthcare, Inc.

Category:	Human Resources	Number:	2.009.1
Subject:	Competency Evaluation		
Applies:	All Field Staff	Page:	1 of 3

Purpose: To assess competency of all field staff.

Policy: Field staff must demonstrate competency within the job description that applies to that staff member, prior to be permitted direct contact with patients. This may be established through several methods, such as demonstration of skills by the employee to the supervisor as long as the supervisor has at least equal credentials. For example, a RN cannot assess skills of a PT, but the RN can assess another RN, LPN or CNA. Testing may be used to assess competencies. Skills checklist may also be used in conjunction with testing.

Procedure:

7. All field staff must be evaluated for competency with relation to their job description prior to receiving patient assignments and prior to performing new tasks.
8. Written tests are one method of evaluation and may be used in coordination with skills checklists.
9. Any skills that are deemed unsatisfactory must be retrained, and return demonstrated, and documented before the employee may perform that skill in the field.
10. Skills check must be completed annually.
11. Nurse aide competency must be evaluated by a RN with at least 2 years of nursing experience and at least one year of which must be in the provision of home health care. Competency will be determined prior to allowing the aide to work independently. Proof of competency will be kept in the employees personnel file.
12. The competency evaluation program for the nurse aide includes, but is not limited to:
    (i) Communications skills
    (ii) Observation, reporting and documentation of patient status and the care or service furnished
    (iii) Reading and recording temperature, pulse, and respiration
    (iv) Basic infection control procedures
    (v) Basic elements of body functioning and changes in body function that must be reported to an aid's supervisor
    (vi) Maintenance of a clean, safe, and healthy environment
    (vii) Recognizing emergencies and knowledge of emergency procedures

(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy and his or her property

(ix) Appropriate and safe techniques in personal hygiene and grooming that include-

(A) Bed bath
(B) Sponge, tub, or shower bath
(C) Shampoo, sink, tub, or bed
(D) Nail and skin care
(E) Oral hygiene
(F) Toileting and elimination

(x) Safe transfer techniques and ambulation

(xi) Normal range of motion and positioning

(xii) Adequate nutrition and fluid intake

(xiii) Any other task that the HHA may choose to have the home health aide perform

18. The following competencies must be evaluated while the aide is performing the tasks with a patient or pseudo-patient.

- Reading and recording temperature, pulse, and respiration.
- Safe transfer techniques and ambulation.
- Normal range of motion and positioning
- Appropriate and safe techniques in personal hygiene and grooming that include--

(A) Bed bath
(B) Sponge, tub, or shower bath
(C) Shampoo, sink, tub, or bed
(D) Nail and skin care
(E) Oral hygiene
(F) Toileting and elimination

19. A Home Health Aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. The aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated as unsatisfactory and passes a subsequent evaluation with satisfactory.

20. Job Descriptions are an extension of this policy in regard to licensure, education, training, and competency requirements for each position.
21. To provide Skilled Nursing Services employees must either have a valid State issues RN license or LPN license.
22. To provide Physical Therapy Services employees must either have a valid State issued PT or PTA license.
23. To provide Occupational Therapy Services employees must either have a valid State issued OT or OTA license.
24. To provide Social Workers services employees must have a valid State issued Masters Level Social Workers Licenses.
25. To provide Speech Therapy Services employees must have a valid State issued Speech and Language Pathology License.
26. To provide Home Health Aide services employees must have a valid State issued Nurse Aide Certification or have a valid State issued RN or LPN license.
27. To provide Dietary Services employees must have a valid State issued Registered Dietician license.
28. All licenses/certifications will be verified as current and active in this State prior to allowing the employee access to any patient or patient record. Copies of licenses/certification verification will be kept in the personnel file.

Refer to:
Skills Checklist
Competency Tests
Job Descriptions

Exhibit 16: Key Personnel

Key Personnel & Accomplishments

The company principals have over 60 years of wide-ranging experience in healthcare industry and business management. With the diverse expertise in healthcare and technology, Amicable Healthcare will adopt state-of-the-art software solutions and training to address challenging healthcare management problems. Our approach is to utilize both Microsoft's suite of powerful enterprise tools and off the shelf sourced technologies, for day to day management of the agency. The combined affiliation of the management is listed below:

- **Ferguson Adesoye – Co-founder**, **CEO**
  - MBA and CPA, with 21 Yrs. Business Management experience
  - Co-Founder of a 21-Yr. $20M+/year Healthcare company
  - Former University Professor of Accounting & Economics
- **Dapo Amosun – Co-founder**, **President**
  - MBA with 21 years in healthcare business management
  - Co-Founder of a 21-Yr. $20M+/year Healthcare company
  - Experience in Strategic Planning, Real Estate & Business Development
- **Segun Amosun- Marketing Manager/Business Development**
  - Master of Science in Marketing Research- Experience in coordinating activities relating to Business promotion.
- **Cristina Serrano- Admin Officer**
  - B.S. Psychology and Management with over 12 years Business Management experience in Healthcare Industry