# HOSPICE OF HUNTINGTON IN 2009: NEW PROBLEMS IN A NEW CENTURY

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*Charlene Farrell, the CEO & President of Hospice of Huntington, Inc. was examining the organization's financial statements and operations analysis and noted that, in spite of Hospice's successes, the organization was facing struggles. One area of concern was potential Medicare reimbursement rate cuts by the Centers for Medicare and Medicaid (CMS). Over 90 percent of Hospice of Huntington, Inc.'s revenues came from Medicare reimbursements, thus the future of federal health care funding was critical to the organization's survival. Another concern for Ms Farrell was that the Emogene Dolin Jones Hospice House, a 14-bed inpatient facility, was facing high fixed operating and staffing expenses, and low occupancy.*

*Hospice of Huntington, Inc. provides compassionate physical, emotional and spiritual care for those at the end of life and continuing support for their families. Hospice of Huntington wants to be seen as the first choice for end of life care. Five core values, established by the Leadership Council, held at the heart of the organization and by staff members include honesty, empathy, accountability, respect and trust, hence the acronym H-E-A-R-T listed on the back of every employee's name tag.(see Exhibit 1)*

## INTRODUCTION

Charlene Farrell, President and CEO of Hospice of Huntington, Inc. (Hospice) and one of the founders of the organization, joined Hospice in 1983 as the Executive Director and the first paid employee. She had a vision for the organization and helped make Hospice the first Hospice in West Virginia to become Medicare certified, which allowed the organization to secure financial support. Mrs. Farrell had seen the organization grow from a single volunteer managed group working out of a hotel room to a licensed non-profit organization equipped with a 12 million dollar budget, a staff of 150 employees and 200 volunteers, branch offices in three counties, and a 6.6 million dollar inpatient facility. In addition to training her new assistant, who had educational experience within the health

care field, Mrs. Farrell hoped her assistant could provide fresh insight on the direction Hospice of Huntington was headed. Farrell questioned the implications of the proposed 2009 changes to national health care. Some of the cost containment provisions of this proposed legislation were expected to cut overall Medicare reimbursement for services. These changes would likely effect the country as a whole and Hospice specifically.

In addition to national issues, the inpatient facility posed significant financial concerns. The Emogene Dolin Jones Hospice House (EDJHH), named after the first Hospice patient in Huntington, was experiencing continual low occupancy (generally referred to as "census" in the Medicare lexicon), in comparison to benchmark breakeven average daily census figures, which yield lower revenue from Medicare reimbursement(see Exhibit 3). In addition to the low census at the inpatient facility, Hospice was also experiencing a decline in census in the homecare program as well (see Exhibit 4). Maintaining staffing levels to meet full occupancy levels without sufficient patients was financially uneconomical but the option of reducing staff on low census days was risky due to random variability in new admissions. Patient care could be compromised without adequate staff in the event of an unexpected increase in patient admissions. Therefore, the combination of low Medicare reimbursement levels, with high staffing and other fixed costs yielded large operational losses for the EDJHH (Farrell 2009).

The primary beneficiaries of Hospice included the patients, Hospice caregivers and staff, physicians, and hospitals in the surrounding health care communities. Secondary beneficiaries included the bereaved, family members of the dying, and the community as a whole. For patients and their families the greatest need was for quality end-of-life care. For the community, such as caregivers, physicians, and medical facilities, it was essential to remain financially viable in order to be able to provide for those in need in the future.

## INTERNATIONAL/ NATIONAL HISTORY

In order to understand what hospice is, one must understand the meaning. The term "Hospice" comes from the Latin word "hospitium" (guesthouse), which described a place for shelter for travelers especially those returning from religious pilgrimages (Hospice: A Historical Perspective 2009).

Dame Cicely Saunders, a British physician, founded the modern hospice movement from her work with dying patients in the late 1940s. Cicely Saunders was born on June 22, 1918 in Barnet, Hertfordshire, England and worked as a nurse until she came to realize the wants and needs of the dying were not being heard in the medical community. Cicely Saunders decided to take action but understood a nurse would not be taken seriously within the medical community without adequate education. Therefore, at the age of 33 and during a time when there were few women doctors, she enrolled in medical school

and studied to become a physician. After earning her medical degree in 1957, Cicely Saunders became the first modern doctor to devote her career to dying patients with the establishment of hospice and the new field of palliative medicine.

In contrast to hospice, the medical community focused on medical treatments that cured disease. Death was not treated as disease and was therefore not subject to medical treatment. The hospice movement legitimized the use of medical resources for the mitigation of suffering and comfort of the dying as opposed to curative treatment of disease.

She opened the St. Christopher's Hospice in 1967 in London, which was originally used as an educational and research facility for the physical, emotional and spiritual care of the dying. St. Christopher's was established to provide a facility in between a hospital and a home that charted new directions in the philosophy and techniques for treatment of the terminally ill. The care given at St. Christopher's used a team approach to care giving and was actually the first program to use modern pain management techniques to compassionately care for dying patients. Hospice in the United States originated with a group of Yale students who invited Cicely Saunders to speak on the concept of holistic hospice care in 1963. With inspiration, those students developed the hospice movement in the United States (Field 2007).

The book, On Death and Dying, written by Dr. Elisabeth Kubler-Ross and published in 1972 identified the five steps that terminally ill patients progress through based on 500 or more interviews with dying patients. Kubler-Ross endorsed home care in lieu of institutional care and argued that patients have the right to be involved with their end of life care. The book became an international best seller that helped gain awareness and support for palliative care.

It is important to note a major shift in social policy that occurred during this period with the approval of public funds to treat the medical needs of private citizens. Previously, public tax dollars were not allocated for the private benefit of individuals. People were expected to pay for their own medical care. A variety of reasons were offered for this shift in public policy including these arguments: (1) healthy workers needed to be put back into the workforce, (2) the public had a responsibility to care for those who suffer and (3) economically disadvantaged people had a right to healthcare paid for by others. While this public policy perspective seems to have been partly if not completely inculcated into American society by the end of the twentieth century, it was still quite controversial in the 1970s and 1980s.

During the 1970s and 1980s, several events occurred that legitimized hospice to treat the dying. National hearings were conducted in 1972 and Congressional Bills were introduced supporting Hospice. Although these Bills did not pass at the time, the first Hospice was opened in New Haven, Connecticut in 1974 with private funds. This

Hospice Home Care provided an in-home visit by a hospice nurse and volunteer to a terminally ill patient. Connecticut Hospice spent the next six years selling the idea of hospice and providing services within the homes of patients. Additional Hospices were established across the United States. The National Cancer Institute (NCI) funded the Connecticut Hospice for three years. Between 1978 and 1980 additional Hospices throughout the United States received similar contracts from NCI.

In 1979, the Health Care Financing Administration (HCFA) assessed 26 Hospices across the country to assess the cost effectiveness of hospice care and to determine what services Hospices should provide in terms of care. In 1980 the W.K. Kellogg Foundation gave a grant to the Joint Commission on Accreditation of Hospitals in order to investigate the status of Hospice and develop standards for accreditation. The Connecticut Hospice opened the nation's first specially-designed, free-standing Hospice inpatient care center in 1980.

Public funding for Hospice was achieved in 1982 when Congress included a provision to create a Medicare Hospice Benefit in the Tax Equity and Fiscal Responsibility Act. In 1986, Congress made the Medicare Hospice Benefit permanent and states had the option to include hospice in their Medicaid program.

In 1989, a study concluded that only 35 percent of eligible Hospices were Medicare certified. Several reasons were offered for the low rate of certification but the most reasonable reason was that low payment rates established by the HCFA made it uneconomical to use Medicare to provide hospice care. As a result of this study, Hospice received their first increase in reimbursement and provided for future increases.

By 1993, more than 1288 Hospices were participating in the Medicare program with the largest growth from the home care agency-based and freestanding Hospices. The average cost per patient was significantly less than the Medicare Hospice cap amount. In regards to Medicaid, six states offered the Hospice option. The President's basic benefit package allowed for Hospice to be accepted as part of the health care continuum of care (National Hospice and Palliative Care Organization 2009).

## THE END OF LIFE CARE INDUSTRY IN THE UNITED STATES

The increasing need for hospice care is illustrated by examining US population over the last half century and using population forecasts for the next half century (Exhibits 12 & 13). One trend that should be noted is that people are living longer. Another trend is evident from changes in the population over time. The generation of people born between 1946 and 1963 is far larger than the generations before and after. This generation, dubbed the baby boomers, represents a large temporary increase in the forecasted number of deaths during the period 2028-2048 (Pine 2005).

**LOCAL HISTORY**

Hospices are located throughout the country including the state of West Virginia. Laura Darby, a nursing student at Marshall University, founded Hospice of Huntington in 1982 after developing a proposal for a senior project. Hospice operated out of a room at the Prichard Hotel with a staff of two full-time and one part-time worker. The first hospice patient was cared for in June 1982. Dr. David Daniels, a local oncologist, became the first Medical Director for in 1982 and retained this position until his retirement in 2008. During the first year of operation, Hospice had 5 volunteer nurses who made themselves available 24 hours a day, 7 days a week, in addition to working their full time positions. The lack of nursing staff prevented Hospice from accepting a large number of patients. After recognizing competitive deficiencies in compensation in the 1990's, the executive staff of Hospice revamped the pay and benefits to better attract and retain staff, especially nurses.

A continuous challenge for Hospice was to adhere to the mission while remaining financial viable. The organization became financially stable once third party reimbursement was obtained through Medicare. Hospice was the first in West Virginia to receive Medicare certification in 1986. Medicare certification enabled the organization to expand into a fully functioning health care provider by providing the means to hire supportive staff and give patients full hospice health care for their terminal illness (Farrell 2009).

In order to maintain financial stability, Hospice had to maintain a strong census of patients. Cabell Huntington Hospital and St. Mary's Medical Center, both local hospitals, were major sources of referrals and by 1993 Hospice had an average daily census of 100 patients. Hospice has served over 10,000 patients and their families in the 26 years of operation. By 2009, roughly 200 patients were served daily by Hospice within their homes, at a nursing home, assisted-living facility or at the EDJHH.

While some Hospices functioned as For-Profit medical providers, Hospice of Huntington was a non-profit 501(c) 3 organization. It was a member of the National Hospice and Palliative Care Organization and the Hospice Council of West Virginia. The Hospice Council of West Virginia (HCWV) was an organization that lobbied for legislative action regarding Hospices. Hospice of Huntington joined HCWV in the 1980s (Farrell 2009).

In 2009, Hospice of Huntington served patients in Cabell, Lincoln, Mason and Wayne Counties in West Virginia and patients in Lawrence and the surrounding Counties of Ohio. It operates with a 12 million dollar budget and approximately 150 staff members. The primary patients are those who have been diagnosed with terminal illnesses such as cancer; or with end-stage heart, lung, kidney and/or liver disease. Patients with Parkinson's Disease, stroke, Lou Gehrig's Disease (ALS), and Multiple Sclerosis may be treated if there are no more treatments available to cure the disease and with a diagnosis of six months or less to live. Hospice care allows patients to retain control

of the health care choices concerning the care provided and to live life without pain or suffering (Hospice of Huntington, Inc.; Website 2009a).

## STRUCTURE

Hospice was organized as a not-for-profit organization and therefore had no owners. Overseen by a Board of Trustees, the President & CEO, and a number of staff Medical Directors, these individuals provide stewardship over Hospice assets and resources in a way that is similar to the owners of private organizations. The President and CEO was responsible for daily operational decision making that was to be implemented by the Leadership Council and operational staff. The Leadership Council included the CFO, Director of Human Resources, VP of Clinical Services, Director of the Hospice House, Director of QAPI, VP of Family Services, Director of Volunteer Services, Director of Development and Director of Planned Giving & Major Gifts. The Leadership Council was accountable to the President and CEO for day to day operations and was responsible for providing the President and CEO with advice on matters related to hospice policy. The operational staff included a variety of managers, coordinators, and supervisors who are directly responsible for implementing day to day operations. The operational staff included RNs, LPNs, Hospice Aides, service workers, volunteers, administrative staff, etc. (see Exhibit 11).

Once a patient was admitted to Hospice, one of 16 teams was assigned to that patient. The teams included a Medical Director, a patient care coordinator, a registered nurse, a Hospice aide and a social worker. Each team developed and implemented a plan of care specific to the patient's needs (Thornton 2009).

## LOCATION

Hospice began working out of a single hotel room in the Prichard building but in 1984 the Trinity Episcopal Church of Huntington offered rooms for office space to accommodate the members of Hospice. Hospice of Huntington operated out of the church until 1993 when the organization was able to purchase the current Sixth Avenue main office, which is located at 1101 Sixth Avenue in Huntington.

Currently, Hospice has three fully operated and staffed branch offices. The first branch office was located in Lawrence County and opened in December 2005. Three years later in 2008 Hospice opened a second branch office in Wayne County. Most recently, a branch office was established in Lincoln County and is set to open in late 2009. These offices gave Hospice a physical presence in these areas, thus increasing visibility and opportunities for Hospice to expand their recruitment efforts (Farrell 2009).

In order to better serve the needs of patients, Hospice proposed a plan in 2002 to develop

an offsite inpatient facility where patients could receive acute care related to their terminal illness in addition to pain and symptom control. After careful structural, financial and feasibility planning, the $6.6 million dollar, 14-bed inpatient facility was established. The EDJHH, located at 3100 Staunton Road in Huntington, WV overlooking the Ohio River, opened in the spring of 2006 (see Exhibit 2).

## SERVICES AND FACILITIES

Hospice is comprised of nursing, bereavement and social work departments that offer a variety of services to patients and their families. Hospice offers a several levels of direct patient care including home care, nursing home or assisted living, continuous care and care at the EDJHH.

Over 90 percent of Hospice patients receive care within their home. The home care patient teams are dispersed to each home to provide routine health care, assistance with daily living and provide support to the patient and family. In addition to home care teams, Hospice has a nursing home care team designed to deliver care to patients in other health care settings. Hospice patients have the opportunity receive care at the local hospitals, nursing homes and assisted living facilities.

The EDJHH was built to serve as a tranquil, peaceful health care facility for patients. Patients can be admitted to the EDJHH for pain management, symptom control and respite care, which offers caregivers at home a much-needed break for up to five days at a time. The EDJHH only accepts patients who are a no code in order to maintain a peaceful environment to those at the very end of their life.

Hospice care includes direct patient care, assistance to family members, grief support, and works as an information and referral service to identify key community resources that may be of assistance. Other programs and services offered through Hospice include emotional guidance, support before and after the death of a loved one. Hospice also provides services to children with Camp Good Grief, a bereavement camp free of charge for children between the ages of 8-16 held each year to provide a safe and accepting environment to share their experiences with other children (Hospice of Huntington, Inc.; Website 2009a).

## FUNDING

Hospice financial information is listed in Exhibits 7-9. Hospice care can be paid for in a variety of ways with Medicare as the most common source of payment, which patients have essentially already "paid for" throughout their working careers. Over 90 percent of Hospice care is paid for through Medicare. The Hospice Medicare Benefit provided a Hospice care option within the covered services and allowed Hospice to have total

control and oversight of the patient's care. In order to qualify for the Hospice benefit, a patient had to be diagnosed as terminally ill with an estimated 6 months or less to live. Patients who chose to the Hospice benefit relinquished their rights to all other Medicare covered services for the terminal illness (National Hospice and Palliative Care Organization 2009).

Hospice care is also covered by most Medicaid and commercial insurance plans with few, if any, out-of-pocket costs. Services covered 100 percent include physician consultations, visits by nurses, emotional and spiritual support from social workers and chaplains, medical support and homemaking services by home healthcare aides, medications, medical equipment, routine home care in the comfort of your own home, general inpatient care in medical setting, as needed, continuous care with round-the-clock support to manage a patient's medical crisis, respite care to provide rest and comfort to the family of caregivers and bereavement support for 13 months following the patient's death (Hospice of Huntington, Inc.; Website 2009a).

Hospice care and operational expenses including staff salaries/ benefits are paid for through a combination of Medicare reimbursement and donations. All Medicare reimbursements are essentially put into one risk pool, where all expenses (patients and operational) are paid out (Cassidy 2009).

The statement of income for the nine months ending September 30, 2009 showed a year to date operating income of $123,325 for the home care program but an operating income loss of $334,898 for the EDJHH, thus leaving the organization as a whole with a year to date operating income loss of $211,573. The year to date net income figures, which include all donations, fundraising revenue and proceeds from the gift shop, showed the home care program with $324,023 and the EDJHH with a $295,740 loss, thus giving the organization a net income of $28,546. (see Exhibits 8 and 9)

Hospice operates as any other health care facility/organization, in that the financial stability relies heavily on patient census. Patient census is a number used for requesting Medicare reimbursement and is usually close to the number of patients receiving treatment. The ability to admit more patients to the Hospice program will yield a higher patient census. This allows the organization to bill for more patients, thus increasing revenue. Hospice of Huntington's average daily census in the inpatient facility in September 2009 was 8 patients. This was below the 20 patients per day, recommended by the MVI Hospice Financial Model analysis tool.

## MEDICARE

The Medicare reimbursement system provides a flat per diem payment per patient per day depending on four levels of care and location. (Reimbursement rates for patients

residing in rural locations are slightly less.) These rates are revised by the Centers for Medicare and Medicaid Services annually and the following rates are those effective October 1, 2008- September 30, 2009. (Note: The rates effective October 1, 2009 are included in exhibit 5.)

The first level is routine home care, which will be reimbursed at $135.07 per patient day in urban areas and $127.47 in rural areas. The second level covers continuous home care, which includes patients who reside at home but receives continuous nursing care during periods of medical crisis. The reimbursement rate per patient day in urban areas is $788.31 and $744.02 in rural areas. The third level is for inpatient care for acute pain or symptom control. The Hospice must contract with the inpatient facility to deliver care to the Hospice patients and reimbursed at $602.33 per patient day for urban areas and $570.89 in rural areas. The fourth level covers inpatient respite care, which relieves family caregivers for up to five days at a rate of $140.79 per patient day for patients residing in urban areas and $134.61 for patients residing in rural areas (see Exhibit 5).

The requirements for a Hospice to receive Medicare reimbursement include a variety of actions including obtaining a state license and then applying for a state provider number. Since Hospice serves patients in both West Virginia and Ohio, state licenses and provider numbers must be obtained for each state and each state has different requirements to obtain provider numbers (see Exhibit 6). Even volunteer hours are part of the rule with the requirement of at least five percent of all volunteer hours directly related to patient care.

Hospice will not turn away any patient in need, regardless of their ability to pay. Therefore, in addition to Medicare, Medicaid and private insurance, Hospice supplements the cost of care and operating expenses through donations and excess revenue (Hospice of Huntington, Inc.; Website 2009a).

## FUNDRAISING

Hospice provides several ways for the community to give no matter how large of a donation or small. For example, families often make donations in honor or memory of family members. Donations are accepted in the form of cash, securities and real estate, wills or living trusts, life insurance, gift annuities, charitable remainder trusts, charitable lead trusts, grantor lead trusts and non-grantor lead trusts. Hospice also encourages in-kind gifts, which are donations of office supplies, household items, toys, toiletries, etc. Exhibit 8 lists aggregate donations.

According to the MVI Hospice Financial Model analysis tool, the organization would not be able to operate without the revenue brought in through fundraising. Fundraisers are conducted throughout the year but the majority of donations come from planned giv-

ing and / or major gifts. Hospice has two donor associations including a Legacy Circle that includes anyone who names Hospice in their will and the Dame Cicely Saunders Society is for donors of major monetary gifts (Dickson 2009).

## FUTURE OF HOSPICE OF HUNTINGTON

The future for Hospice depended on the organization's response to external restraints on funding. The decisions made by the federal government legislative members regarding health care services and funding, which affect consumers, physicians, insurance companies, organizations and the health care industry as a whole, will determine the future of the United States health care system. The Medicare reimbursement rate will affect the financial security and feasibility future for Hospice of Huntington. The outcome of the vote on the Obama health proposal will also have significant effects on Hospice of Huntington, Inc.'s funding and services. Only time and the political legislative process will yield answers to these complex and critical questions.

Internal obstacles include the continual operational losses from the EDJHH, which have resulted in an operational loss for the entire organization. The Leadership Council must reevaluate the organization's financial position, restructure the staffing models, and revamp the means of patient referrals and admissions in order to confront the current operational losses incurred by the EDJHH.

## EXHIBIT 1

**Hospice Website Information**

Source: http://www.Hospiceofhuntington.org

**Mission Statement**

Hospice of Huntington provides compassionate physical, emotional, and spiritual care for those at the end of life and continuing support for their families.

**Vision Statement**

Hospice of Huntington will be seen as the first choice for the end of life care.

**Our Story**

Hospice of Huntington was founded in 1982 by a senior nursing student from Marshall University who had a passion for Hospice care. As the first Hospice in the State of West Virginia to become Medicare certified, we remain true to our Core Values, which are at the H.E.A.R.T. of our organization: Honesty, Empathy, Accountability, Respect and Trust.

We provide care for terminally ill patients who live in Cabell, Lincoln, Mason, and

Wayne Counties in West Virginia and Lawrence County in Ohio. In our 25-year history, Hospice of Huntington has cared for more than 10,000 patients and their families. Today, we serve nearly 200 patients each day in their own homes, at a nursing home, assisted-living facility, or at the new Emogene Dolin Jones Hospice House of Huntington, which opened in May of 2006.

**Understanding Hospice**

"You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but to live until you die."
- Dame Cecily Saunders,
Founder of the modern Hospice movement

**What is Hospice?**

Hospice is a special way of caring for patients diagnosed with a terminal illness, when nothing more can be done to cure the disease. It allows patients to live life to the fullest and be in control of their life and to make choices concerning the care provided. The focus of Hospice is to help patients to be as pain and symptom free as possible, so that they can enjoy life surrounded by loved ones. Hospice of Huntington delivers quality care in the patient's home, nursing home, assisted-living facility or at our very own Hospice House.

**Dignity, Choice, Compassion**

Hospice is not about how you die, but rather how you live. Hospice care helps patients and their families to make informed choices; provides companionship to patients and relief to caregivers; offers grief support, and serves as an information and referral service to identify key community resources that may be of assistance.

Hospice can help improve the quality of life at any age for someone with a terminal illness. While many Hospice patients have cancer, Hospice care includes such terminal diagnoses as end-stage heart, lung, kidney and/or liver disease; Parkinson's Disease; stroke, Lou Gehrig's Disease (ALS); and Multiple Sclerosis.

**Team Approach to Care**

Our team of professional health care providers includes the Hospice medical directors, nurses, certified nursing assistants, social workers, grief support counselors, clergy and patient care volunteers, all of whom have specialized training in end-of-life issues. Through skilled, compassionate care, they strive to meet the physical, emotional, social and spiritual needs of patients and families.

At Hospice of Huntington, our 25 years' experience in caring for patients at the end of life has taught us that Hospice care is most effective when it is begun early in a terminal diagnosis. That way, the patient and his or her family can fully benefit from the educa-

tion, support and counseling services offered by the Hospice team.

**Programs and Services**

Along with our unique approach to patient care for people of all ages diagnosed with a terminal illness, our programs and services include specialized support, such as emotional guidance and support before and after the death of a loved one. Camp Good Grief, a bereavement camp for children held each year in late June, offers children ages 8-16 an opportunity to meet in a safe and accepting environment and to share their experiences with other children. The camp is free of charge to participants.

**Insurance Coverage**

Most patients have already "paid" for Hospice services throughout their working life via Medicare payroll deductions. So there are no further payments, and no reason not to take full advantage of Hospice services. In addition, Hospice care is covered by most Medicaid and commercial insurance plans with few, if any, out-of-pocket costs. This includes 100% coverage of the following:

Physician consultations
Visits by nurses
Emotional and spiritual support from social workers and chaplains
Medical support and homemaking services by home healthcare aides
Medications
Medical equipment
Routine home care in the comfort of your own home
General inpatient care in medical setting, as needed
Continuous care with round-the-clock support to manage a patient's medical crisis
Respite care to provide rest and comfort to the family of caregivers
Bereavement support for 13 months following the patient's death

**Frequently Asked Questions (Edited)**

**What is Hospice?**

Today, Hospice is seen my many as a philosophy, rather than a place. The Hospice approach to care is a comprehensive program for terminally ill patients to help them live to the fullest by meeting their physical, emotional and spiritual needs at the end of life. The goal of Hospice is to help patients be as pain and symptom free as possible, so that they can enjoy life surrounded by loved ones. At Hospice of Huntington, we understand the effect a terminal illness can have upon a patient and family. When Hospice care is introduced in the early stages of a terminal illness, patients may find that their pain and symptoms are managed so effectively they are able to join in many activities they enjoyed prior to their illness. Hospice services are provided wherever the patient may

reside; at home, in a skilled nursing facility, or residential care facility.

**When should Hospice care be considered?**
At any time during a life-limiting illness, it is appropriate to discuss all options for care available to a patient, including Hospice. The time may come when pain and other distressing symptoms interfere with a patient's daily life and normal routine. Hospice concentrates on comfort measures that may actually improve the patient's quality of life. The earlier Hospice is involved, the more likely it is that a patient's final days, weeks or months can be comfortable and satisfying.

**Who is eligible to receive Hospice care?**
Typically, Hospice services are available when the doctor determines that the patient likely has six months or less to live, if the disease follows its normal course.

**Who pays for Hospice care?**
Hospice services are covered by Medicare, Medicaid and most private insurance plans. Hospice of Huntington also cares for patients with limited or no insurance. To offset costs, we host a number of fundraising activities and events throughout the year. If you would like to learn more about ways of giving, please contact our Development Department at (304) 529-4217 or 1 (800) 788-5480.

**Do I have to leave my doctor's care to enter Hospice?**
No. In fact, a patient's doctor will serve on the Hospice team as the "attending physician."

**Are all Hospices part of the same organization?**
Most Hospices across the country are not related to one another and not all are non-profit organizations. Hospice of Huntington is a non-profit 501(c) 3 organization. We have memberships with the Hospice Council of West Virginia and the National Hospice and Palliative Care Organization.

**What types of illness are cared for by Hospice?**
Hospice care is provided for people who have any type of end-stage heart, lung, kidney and/or liver disease, Parkinson's, stroke, Lou Gehrig's disease (ALS), emphysema, Alzheimer's, and AIDS. Often, a patient may not have just one diagnosis that is end-stage, but may have multiple diagnoses that create a life-limiting condition.

**Is Hospice care an option if the patient does not have a caregiver in the home?**
Yes. Hospice of Huntington accepts patients regardless of their caregiver situation. However, we encourage patients to create a plan to support their current and future needs using existing and outside resources.

**Who goes to the Hospice House?**

Patients are brought to the Emogene Dolin Jones Hospice House for reasons such as pain management and symptom control. They may also be admitted for respite care, which offers caregivers at home a much-needed break for up to five days at a time. Many of our patients are at the very end of their life and have made the choice to be in a peaceful and comfortable environment in those final days.

**Core Values**

Core Values are at the "heart" of all that we do. We must always measure what we do against the values we hold dear to our organization. These values are:

**H** Honesty: We believe in an honest way so that those most vulnerable in our care can trust what we say and do. Physicians families and patients as well as the community expect us to have the utmost integrity founded on honesty.

**E** Empathy: Honesty in tempered with empathy. Our patients deserve to have their stories heard with a compassionate ear so that they feel cared for as individuals.

**A** Accountability: In order to be held as experts in end-of-life care we maintain a high degree of competence in our skills as caregivers. We must also be good stewards of the resources we have and the donations that are so generously given to us by our community.

**R** Respect: All care is based upon the respect we hold for human life not only of our patients and families but also of each other. We value the individual and interact with others in a courteous and loving manner because each human life matters.

**T** Trust: Without trust all else fails. We behave in an honest, consistent, competent manner so that all who come in contact with us can rely on the care we provide.

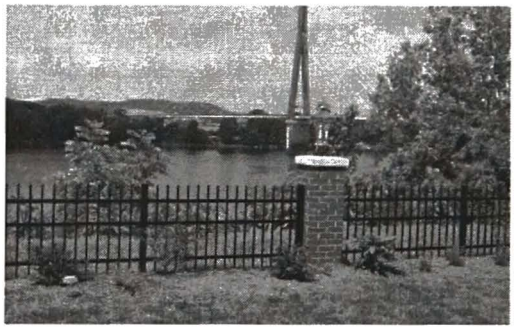
## EXHIBIT 2

**Photos of EDJHH**


*A view from the front of the house*

*The living room*

*A guest room*

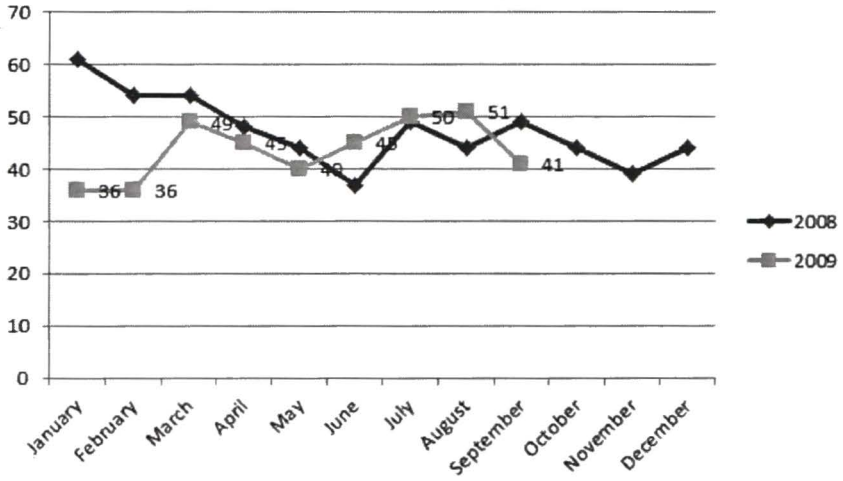


*A view from the yard*

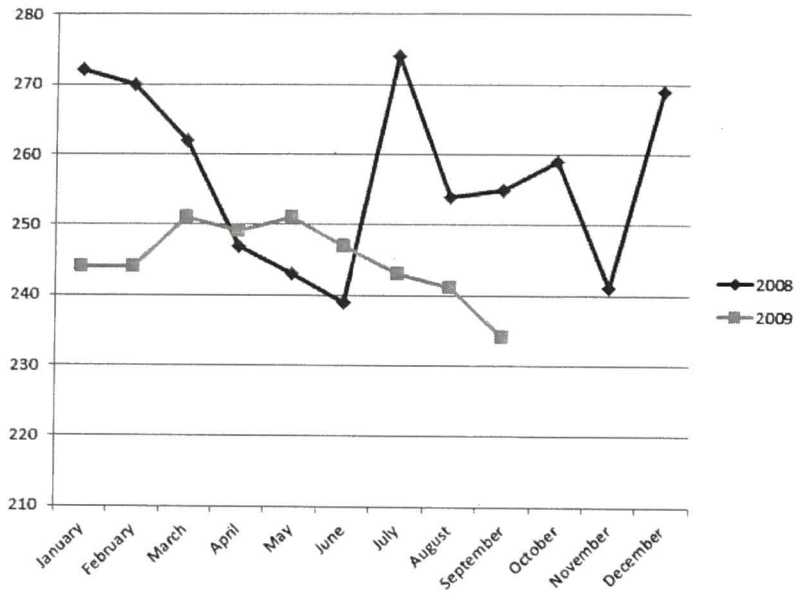
## EXHIBIT 3

**Emogene Dolin Jones Hospice House (EDJHH)**

Number of Patients Admitted by Month

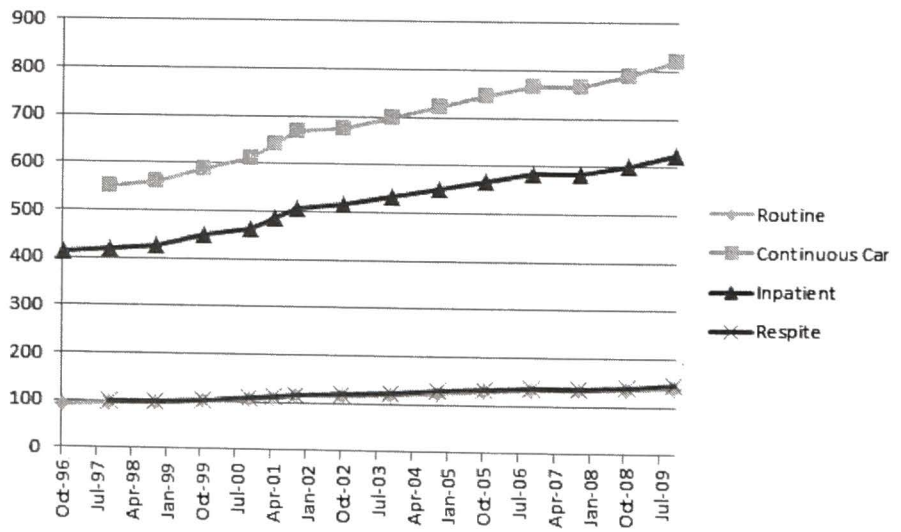


## EXHIBIT 4
**Hospice Patients Served Each Month**




Source: (Hospice of Huntington, Inc. 2009b)

## EXHIBIT 5:
**Medicare Reimbursement System**




Source: Medicare and Medicaid Services

## EXHIBIT 5a:

**ADDITIONAL EXPLANATION OF TERMS USED IN EXHIBIT 5**

Medicare Reimbursement Daily Rates are provided to Hospice annually from Medicare and Medicaid Services and are effective as of the 1st day of the month. Continuous Care hourly rates available for a minimum of 8 hours billed.

## EXHIBIT 5b:

**DESCRIPTIONS OF TYPE CARES LISTED IN EXHIBIT 5**

Continuous Care – Inpatient Care provided to patients in a hospital setting for terminal conditions such as congestive heart failure.
Inpatient Care - Inpatient Care provided to patient in a hospital or Hospice setting.
Respite Care – Care provided to patient to provide relief to family caregivers.
Routine Care – Care provided to patient in the patient's home.

## EXHIBIT 5c:

**MEDICARE REIMBURSEMENT DAILY RATES**
**(for MSA including Ashland Kentucky and Huntington West Virginia)**

## EXHIBIT 6:

**Hospice of Huntington**
**Statement of Financial Position – Balance Sheet**

| | 30 Sep 2009 | 31 Dec 2008 | 31 Dec 2007 |
|---|---|---|---|
| **ASSETS** | | | |
| CURRENT ASSETS | | | |
| Cash and cash equivalents | $1,141,200 | $1,494,124 | $2,007,436 |
| Accounts Receivable | $1,172,602 | $1,280,916 | $1,249,142 |
| Unconditional promises to give | $471,597 | $552,210 | $646,452 |
| Other receivables | $5,622 | $25,200 | $19,966 |
| Inventory | $52,077 | $41,031 | $33,078 |
| Prepaid expenses | $189,871 | $48,730 | $25,500 |
| **TOTAL CURRENT ASSETS** | **$3,032,969** | **$3,442,211** | **$3,981,575** |
| INVESTMENTS | $21,837 | $200,000 | $457,000 |
| BENEFICIAL INTEREST IN ASSETS HELD BY OTHERS | $61,827 | $122,924 | |
| PROPERTY AND EQUIPMENT, NET | $6,666,957 | $6,933,963 | $7,197,738 |
| OTHER ASSETS | | | |
| Deposits | | $500 | $500 |
| **TOTAL ASSETS** | **$9,721,764** | **$10,638,501** | **$11,759,737** |
| **LIABILITIES AND NET ASSETS** | | | |
| CURRENT LIABILITIES | | | |
| Current portion of bonds payable | | $34,367 | $51,225 |
| Current portion of obligations under capital lease | $16,987 | $7,136 | $5,955 |
| Construction Loan | $304,953 | | |
| Unvouchered Accounts Payable - Reverse Mon | $29,129 | | |
| Accounts payable | $215,935 | $498,479 | $522,790 |
| Accrued benefits | $47,315 | $23,209 | $126,669 |
| Accrued payroll | $186,307 | $393,023 | $282,186 |
| **TOTAL CURRENT LIABILITIES** | **$800,626** | **$956,214** | **$988,825** |
| LONG TERM BONDS PAYABLE, | | $774,881 | $1,603,734 |
| LONG TERM OBLIGATIONS | | $13,814 | $21,657 |
| **TOTAL LIABILITIES** | **$800,626** | **$1,744,909** | **$2,614,216** |
| NET ASSETS | | | |
| Unrestricted | | | |
| Operating | $1,775,634 | $2,284,625 | $3,164,320 |
| Board designated | $450,000 | $450,000 | $450,000 |
| Property and equipment | $6,666,957 | $6,102,765 | $5,515,167 |
| Temporary restricted | $28,546 | $55,202 | $16,034 |
| **TOTAL NET ASSETS** | **$8,921,138** | **$8,892,592** | **$9,145,521** |
| **TOTAL LIABILITIES AND NET ASSETS** | **$9,721,764** | **$10,637,501** | **$11,759,737** |

Source: (Hospice of Huntington, Inc. 2009b)

## EXHIBIT 7a:

**Hospice of Huntington - Revenues and Expenses**

**For the 9 month period ending 9/30/09**

| | Home Care | EDJHH | Total |
|---|---|---|---|
| **OPERATING REVENUE** | | | |
| Medicare | $5,455,874 | $1,124,510 | $6,580,384 |
| Medicaid | $112,337 | $58,462 | $170,799 |
| Commercial insurance | $354,398 | $161,169 | $515,567 |
| Other | $62,004 | $34,824 | $96,828 |
| Revenue adjustments | -$36,792 | -$5,727 | -$42,519 |
| **Total** | **$5,947,821** | **$1,373,238** | **$7,321,059** |
| **OPERATING EXPENSES** | | | |
| Payroll | | | |
| Salaries | $3,329,099 | $888,825 | $4,217,924 |
| Contract labor | $229 | $46,832 | $47,061 |
| Benefits | $872,415 | $232,923 | $1,105,338 |
| **Total** | **$4,201,743** | **$1,168,580** | **$5,370,323** |
| **PATIENT EXPENSES** | $997,359 | $163,947 | $1,161,306 |
| **FACILITY EXPENSES** | | | |
| Electricity and Gas | $20,270 | $78,724 | $98,993 |
| Maintenance | $8,883 | $26,925 | $35,807 |
| Rent | $17,900 | $704 | $18,604 |
| Service contracts | $1,567 | $4,830 | $6,397 |
| Interest expenses | $1,718 | $10,628 | $12,346 |
| Other | $16,374 | $21,760 | $38,134 |
| **Total** | **$66,711** | **$143,570** | **$210,281** |
| **ADMIN EXPENSES** | | | |
| Computer | $69,921 | $1,386 | $71,307 |
| Continuing education | $16,116 | $1,236 | $17,352 |
| Equipment | $8,731 | $5,085 | $13,816 |
| Dues and subscriptions | $16,397 | $430 | $16,827 |
| General supplies | $17,810 | $2,353 | $20,163 |
| Insurance | $92,390 | | $92,390 |
| Legal, accounting and payroll | $17,739 | | $17,739 |
| Postage and printing | $88,625 | $1,200 | $89,825 |
| Telephone | $15,636 | $10,342 | $25,978 |
| Other | $28,849 | $1,578 | $30,427 |
| Marketing | $71,715 | | $71,715 |
| **Total** | **$443,929** | **$23,610** | **$467,539** |
| **DEP. EXPENSES** | $114,755 | $208,429 | $323,184 |
| **OPERATING INCOME** | $123,324 | -$334,898 | -$211,574 |

## EXHIBIT 7b

**Hospice of Huntington – Statement of Income**

**For the 9 month period ending 9/30/09**

| | Home Care | EDJHH | Total |
|---|---|---|---|
| **OTHER INCOME** | | | |
| Gift Shop | $32,357 | | $32,357 |
| Support | $182,348 | $24,028 | $206,376 |
| Fundraising | $119,401 | $17,500 | $136,901 |
| Interest and investment | -$1,731 | | -$1,731 |
| **Total** | **$332,375** | **$41,528** | **$373,903** |
| **NON-OPERATING EXPENSES** | | | |
| Gift shop | $24,495 | | $24,495 |
| Support | | | $0 |
| Fundraising | $167,259 | $2,108 | $169,367 |
| Interest and Investment | | | $0 |
| **Total** | **$191,754** | **$2,108** | **$193,862** |
| **DESIGNATED EXPENSES** | | | |
| Other program | | | $0 |
| Bereavement Camp | $7,422 | | $7,422 |
| Other program | | | $0 |
| **Total** | **$7,422** | **$0** | **$7,422** |
| **CAPITAL CAMPAIGN** | | | |
| Capital Campaign - Income | $67,500 | | $67,500 |
| Capital Campaign - Expenses | | | $0 |
| **Total** | **$67,500$0** | | **$67,500** |
| **NET INCOME** | $324,023 | -$295,477 | $28,545 |

Source: (Hospice of Huntington, Inc. 2009b)

## EXHIBIT 8a

**Hospice of Huntington – Expenditures by Category**
**For the Year ending 31 Dec 2008**

| | Professional Care of Patients | Management and General | Fund raising | Total |
|---|---|---|---|---|
| Salaries | $5,103,395 | $967,453 | $66,124 | $6,136,972 |
| Fringe Benefits | $1,338,917 | $256,219 | $16,112 | $1,611,248 |
| Contributed Services | $14,870 | | | $14,870 |
| Telephones | $47,484 | $37,648 | $480 | $85,612 |
| Office Supplies | | $30,831 | $1,597 | $32,428 |
| Postage and Mailing | $2,606 | $39,618 | $6,826 | $49,050 |
| Printing and Copying | $1,078 | $104,185 | $2,919 | $108,182 |
| Insurance | $28,946 | $91,702 | | $120,648 |
| Dues and Subscriptions | $720 | $15,747 | $516 | $16,983 |
| Depreciation | $196,393 | $228,169 | $9,012 | $433,574 |
| Travel | $303,947 | $15,104 | $1,253 | $320,304 |
| Medical Supplies | $151,960 | | | $151,960 |
| Meetings | | $5,662 | $220 | $5,882 |
| Medications | $701,390 | | | $701,390 |
| Contract Labor | $56,390 | $10,808 | | $67,198 |
| Equipment Rental | $377,451 | $8,645 | | $386,096 |
| Patient Transportation | $56,628 | | | $56,628 |
| Hospital Inpatient | $516,420 | | | $516,420 |
| Nursing Home Services | $970,081 | | | $970,081 |
| Meals | $55,495 | | | $55,495 |
| Advertizing | | $86,615 | | $86,615 |
| Professional Services | $95,253 | $131,063 | | $226,316 |
| Utilities and Maintenance | $156,389 | $66,274 | | $222,663 |
| Miscellaneous | $2,337 | $19,178 | $3,155 | $24,670 |
| Physician Services | $20,019 | | | $20,019 |
| Professional Development | $8,980 | $14,683 | $2,534 | $26,197 |
| Office and Parking Rent | $24,292 | | | $24,292 |
| Interest | $46,182 | $2,286 | | $48,468 |
| Bed Debts | $47,200 | | | $47,200 |
| Gift Shop | | | $39,049 | $39,049 |
| Special Events | | | $122,740 | $122,740 |
| **TOTAL** | **$10,300,531** | **$2,156,182** | **$272,537** | **$12,729,250** |

## EXHIBIT 8b

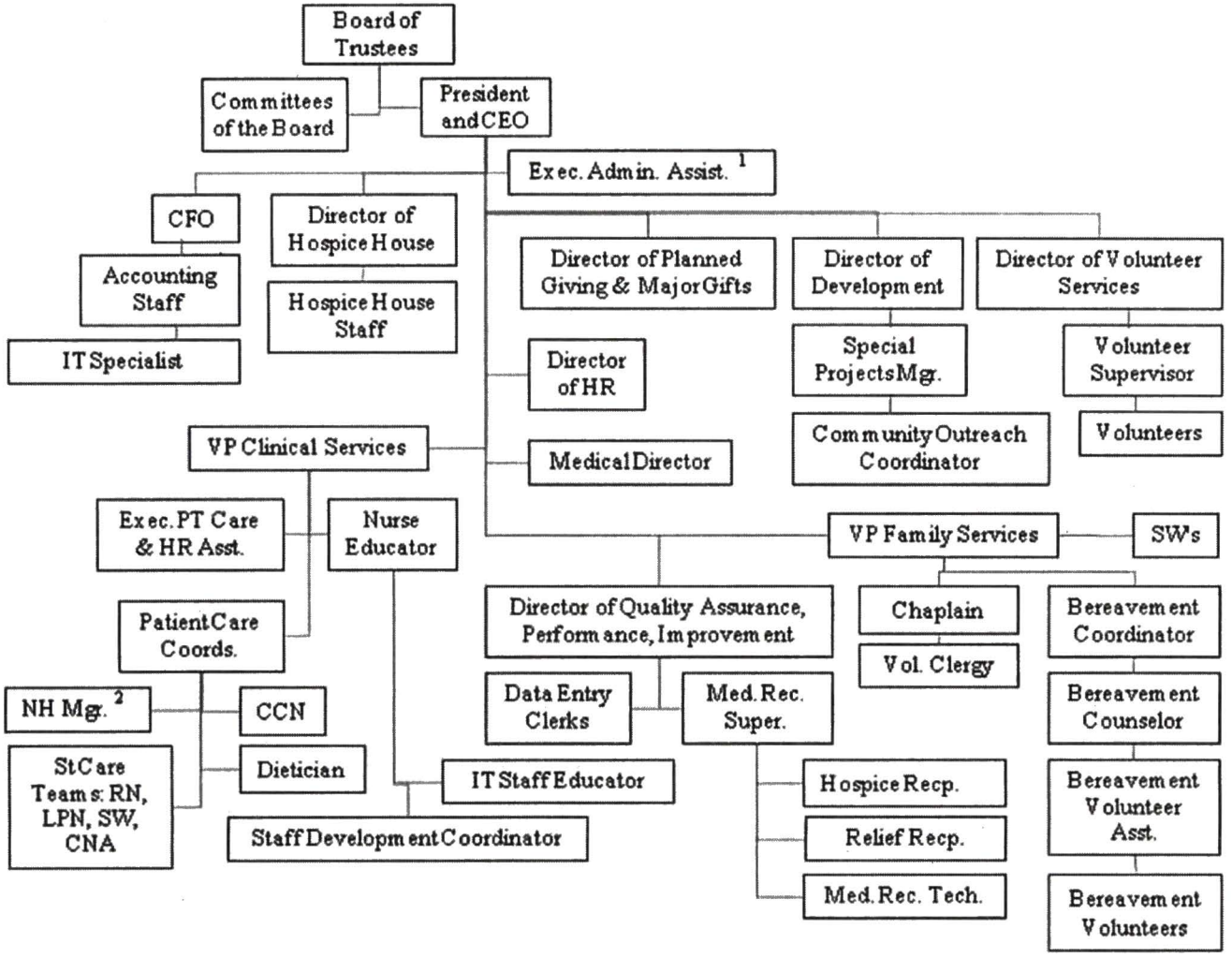
**Hospice of Huntington – Expenditures by Category**
**For the Year ending 31 Dec 2007**

| | Professional Care of Patients | Management and General | Fund raising | Total |
|---|---|---|---|---|
| Salaries | $4,646,831 | $783,518 | $46,490 | $5,476,839 |
| Fringe Benefits | $1,530,529 | $183,389 | $11,214 | $1,725,132 |
| Contributed Services | $23,283 | | | $23,283 |
| Telephones | $64,638 | $20,221 | | $84,859 |
| Office Supplies | | $77,810 | $325 | $78,135 |
| Postage and Mailing | $1,709 | $29,102 | $5,370 | $36,181 |
| Printing and Copying | $136 | $73,698 | $8,665 | $82,499 |
| Insurance | $31,004 | $85,673 | | $116,677 |
| Dues and Subscriptions | $1,608 | $14,279 | $270 | $16,157 |
| Depreciation | $237,491 | $150,411 | $7,916 | $395,818 |
| Travel | $259,105 | $10,419 | $347 | $269,871 |
| Medical Supplies | $151,911 | | | $151,911 |
| Meetings | | $12,652 | $312 | $12,964 |
| Medications | $801,721 | | | $801,721 |
| Contract Labor | $32,111 | $56,582 | | $88,693 |
| Equipment Rental | $429,272 | $9,201 | | $438,473 |
| Patient Transportation | $77,890 | | | $77,890 |
| Hospital Inpatient | $674,400 | | | $674,400 |
| Nursing Home Services | $666,253 | | | $666,253 |
| Meals | $60,000 | | | $60,000 |
| Advertizing | | $62,174 | | $62,174 |
| Professional Services | $81,564 | $36,632 | | $118,196 |
| Utilities and Maintenance | $133,396 | $63,266 | | $196,662 |
| Miscellaneous | $4,780 | $27,283 | $1,062 | $33,125 |
| Physician Services | $25,599 | | | $25,599 |
| Professional Development | $11,471 | $22,669 | $785 | $34,925 |
| Office and Parking Rent | $18,993 | | | $18,993 |
| Interest | $113,950 | $1,247 | | $115,197 |
| Bed Debts | $48,000 | | | $48,000 |
| Gift Shop | | | $34,931 | $34,931 |
| Special Events | | | $79,280 | $79,280 |
| **TOTAL** | **$10,108,652** | **$1,739,219** | **$196,967** | **$12,044,838** |

Source: (Hospice of Huntington, Inc. 2009b)

## EXHIBIT 9:

**Hospice of Huntington Organizational Chart (as of September 2009)**




Source: (Hospice of Huntington, Inc. 2009b). Notes indicate revisions that have occurred since Sep 2009

## EXHIBIT 10A – Actual and Projected Population, Births, and Deaths

Actual Population, Number of Deaths, and Number of Births

| Year of Death | Total Population | # of Deaths | Life Expectancy | Birth year | # of Births |
|---|---|---|---|---|---|
| 1950 | 151,684,000 | 1,452,454 | 68.2 | 1881.8 | 2,003,663 |
| 1951 | 154,287,000 | 1,482,099 | 68.4 | 1882.6 | 2,068,819 |
| 1952 | 156,954,000 | 1,496,838 | 68.6 | 1883.4 | 2,107,701 |
| 1953 | 159,565,000 | 1,517,541 | 68.8 | 1884.2 | 2,091,459 |
| 1954 | 162,391,000 | 1,481,091 | 69.6 | 1884.4 | 2,078,516 |
| 1955 | 165,275,000 | 1,528,717 | 69.6 | 1885.4 | 2,039,580 |
| 1956 | 168,221,000 | 1,564,476 | 69.7 | 1886.3 | 2,058,254 |
| 1957 | 171,274,000 | 1,633,128 | 69.5 | 1887.5 | 2,103,733 |
| 1958 | 174,141,000 | 1,647,886 | 69.6 | 1888.4 | 2,128,007 |
| 1959 | 177,073,000 | 1,656,814 | 69.9 | 1889.1 | 2,163,456 |
| 1960 | 180,671,000 | 1,702,000 | 69.7 | 1890.3 | 2,165,769 |
| 1961 | 183,691,000 | 1,701,522 | 70.2 | 1890.8 | 2,149,663 |
| 1962 | 186,538,000 | 1,756,720 | 70.1 | 1891.9 | 2,205,972 |
| 1963 | 186,242,000 | 1,813,549 | 69.9 | 1893.1 | 2,225,006 |
| 1964 | 191,889,000 | 1,798,051 | 70.2 | 1893.8 | 2,236,217 |
| 1965 | 194,303,000 | 1,828,136 | 70.2 | 1894.8 | 2,279,230 |
| 1966 | 196,560,000 | 1,863,149 | 70.2 | 1895.8 | 2,283,834 |
| 1967 | 198,712,000 | 1,851,323 | 70.5 | 1896.5 | 2,303,492 |
| 1968 | 200,706,000 | 1,930,082 | 70.2 | 1897.8 | 2,381,620 |
| 1969 | 202,677,000 | 1,921,031 | 70.5 | 1898.5 | 2,413,436 |
| 1970 | 203,235,000 | 1,921,031 | 70.8 | 1899.2 | 2,436,342 |
| 1971 | 208,232,000 | 1,927,542 | 71.1 | 1899.9 | 2,455,149 |
| 1972 | 208,837,000 | 1,963,944 | 71.2 | 1900.8 | 2,483,924 |
| 1973 | 209,851,000 | 1,973,003 | 71.4 | 1901.6 | 2,511,358 |
| 1974 | 211,390,000 | 1,934,388 | 72.0 | 1902.0 | 2,525,300 |
| 1975 | 215,973,000 | 1,892,879 | 72.6 | 1902.4 | 2,537,594 |

Projected Numbers of Births and Deaths

| Year of Death | Life Expectancy | Birth Year | # of Births | Projected Deaths |
|---|---|---|---|---|
| 2002 | 77.2 | 1924.8 | 2,923,000 | 2,242,291 |
| 2003 | 77.2 | 1925.8 | 2,853,000 | 2,188,593 |
| 2004 | 77.4 | 1926.6 | 2,816,800 | 2,160,823 |
| 2005 | 77.6 | 1927.4 | 2,750,800 | 2,110,193 |
| 2006 | 77.7 | 1928.3 | 2,646,400 | 2,030,106 |
| 2007 | 77.9 | 1929.1 | 2,585,600 | 1,983,465 |
| 2008 | 78.1 | 1929.9 | 2,614,400 | 2,005,558 |
| 2009 | 78.3 | 1930.7 | 2,539,600 | 1,948,178 |
| 2010 | 78.4 | 1931.6 | 2,466,400 | 1,892,024 |
| 2011 | 78.6 | 1932.4 | 2,386,800 | 1,830,962 |
| 2012 | 78.8 | 1933.2 | 2,324,800 | 1,783,400 |
| 2013 | 79.0 | 1934.0 | 2,396,000 | 1,838,019 |
| 2014 | 79.1 | 1934.9 | 2,378,900 | 1,824,902 |
| 2015 | 79.3 | 1935.7 | 2,361,600 | 1,811,630 |
| 2016 | 79.5 | 1936.5 | 2,384,000 | 1,828,814 |
| 2017 | 79.7 | 1937.3 | 2,437,900 | 1,870,162 |
| 2018 | 79.8 | 1938.2 | 2,490,000 | 1,910,129 |
| 2019 | 80.0 | 1939.0 | 2,466,000 | 1,891,718 |
| 2020 | 80.2 | 1939.8 | 2,540,400 | 1,948,791 |
| 2021 | 80.4 | 1940.6 | 2,645,400 | 2,029,339 |
| 2022 | 80.5 | 1941.5 | 2,846,000 | 2,183,223 |
| 2023 | 80.7 | 1942.3 | 3,023,500 | 2,319,387 |
| 2024 | 80.9 | 1943.1 | 3,087,500 | 2,368,483 |
| 2025 | 81.1 | 1943.9 | 2,955,500 | 2,267,223 |
| 2026 | 81.2 | 1944.8 | 2,874,200 | 2,204,856 |
| 2027 | 81.4 | 1945.6 | 3,189,800 | 2,446,959 |

## EXHIBIT 10A – Actual and Projected Population, Births, and Deaths

Actual Population, Number of Deaths, and Number of Births

| Year of Death | Total Population | # of Deaths | Life Expectancy | Birth year | # of Births |
|---|---|---|---|---|---|
| 1976 | 214,659,000 | 1,909,440 | 72.9 | 1903.1 | 2,559,254 |
| 1977 | 220,239,000 | 1,899,597 | 73.3 | 1903.7 | 2,597,482 |
| 1978 | 222,585,000 | 1,927,788 | 73.5 | 1904.5 | 2,601,738 |
| 1979 | 225,055,000 | 1,913,841 | 73.9 | 1905.1 | 2,617,762 |
| 1980 | 226,546,000 | 1,989,841 | 73.7 | 1906.3 | 2,647,017 |
| 1981 | 229,466,000 | 1,986,870 | 74.1 | 1906.9 | 2,660,241 |
| 1982 | 231,664,000 | 1,974,797 | 74.5 | 1907.5 | 2,675,179 |
| 1983 | 233,792,000 | 2,019,201 | 74.6 | 1908.4 | 2,699,948 |
| 1984 | 235,825,000 | 2,039,369 | 74.7 | 1909.3 | 2,735,700 |
| 1985 | 237,924,000 | 2,086,440 | 74.7 | 1910.3 | 2,786,600 |
| 1986 | 240,133,000 | 2,105,361 | 74.9 | 1911.1 | 2,812,100 |
| 1987 | 242,289,000 | 2,123,323 | 74.9 | 1912.1 | 2,842,900 |
| 1988 | 244,499,000 | 2,167,999 | 74.9 | 1913.1 | 2,878,700 |
| 1989 | 246,819,000 | 2,150,466 | 75.1 | 1913.9 | 2,956,300 |
| 1990 | 248,718,000 | 2,148,463 | 75.4 | 1914.6 | 2,965,400 |
| 1991 | 252,106,000 | 2,169,518 | 75.5 | 1915.5 | 2,964,500 |
| 1992 | 255,011,000 | 2,177,000 | 75.8 | 1916.2 | 2,960,000 |
| 1993 | 257,795,000 | 2,268,553 | 75.5 | 1917.5 | 2,946,000 |
| 1994 | 260,372,000 | 2,278,994 | 75.7 | 1918.3 | 2,885,600 |
| 1995 | 262,890,000 | 2,312,132 | 75.8 | 1919.2 | 2,782,000 |
| 1996 | 265,284,000 | 2,314,690 | 76.1 | 1919.9 | 2,929,000 |
| 1997 | 267,645,000 | 2,314,245 | 76.5 | 1920.5 | 3,002,500 |
| 1998 | 270,002,000 | 2,338,070 | 76.7 | 1921.3 | 3,003,100 |
| 1999 | 272,330,000 | 2,391,399 | 76.7 | 1922.3 | 2,890,400 |
| 2000 | 274,634,000 | 2,403,351 | 77.0 | 1923.0 | 2,910,000 |

Projected Numbers of Births and Deaths

| Year of Death | Life Expectancy | Birth Year | # of Births | Projected Deaths |
|---|---|---|---|---|
| 2028 | 81.6 | 1946.4 | 3,745,000 | 2,872,864 |
| 2029 | 81.8 | 1947.2 | 3,781,000 | 2,900,480 |
| 2030 | 82.0 | 1948.0 | 3,637,000 | 2,790,015 |
| 2031 | 82.1 | 1948.9 | 3,647,800 | 2,798,300 |
| 2032 | 82.3 | 1949.7 | 3,637,100 | 2,790,092 |
| 2033 | 82.5 | 1950.5 | 3,727,500 | 2,859,439 |
| 2034 | 82.7 | 1951.3 | 3,850,000 | 2,953,412 |
| 2035 | 82.8 | 1952.2 | 3,923,400 | 3,009,718 |
| 2036 | 83.0 | 1953.0 | 3,965,000 | 3,041,630 |
| 2037 | 83.2 | 1953.8 | 4,055,400 | 3,110,978 |
| 2038 | 83.4 | 1954.6 | 4,089,400 | 3,137,060 |
| 2039 | 83.5 | 1955.5 | 4,157,500 | 3,189,301 |
| 2040 | 83.7 | 1956.3 | 4,242,600 | 3,254,583 |
| 2041 | 83.9 | 1957.1 | 4,291,000 | 3,291,711 |
| 2042 | 84.1 | 1957.9 | 4,259,500 | 3,267,547 |
| 2043 | 84.2 | 1958.8 | 4,247,000 | 3,257,958 |
| 2044 | 84.4 | 1959.6 | 4,252,800 | 3,262,407 |
| 2045 | 84.6 | 1960.4 | 4,262,000 | 3,269,465 |
| 2046 | 84.8 | 1961.2 | 4,247,872 | 3,258,627 |
| 2047 | 84.9 | 1962.1 | 4,160,428 | 3,191,547 |
| 2048 | 85.1 | 1962.9 | 4,104,954 | 3,148,992 |
| 2049 | 85.3 | 1963.7 | 4,048,649 | 3,105,799 |
| 2050 | 85.5 | 1964.5 | 3,893,745 | 2,986,969 |

Table adapted from (Pine 2005)

## EXHIBIT 11

**US Population by Age Groups**

| Year | Age Groups | | | | |
|---|---|---|---|---|---|
| | 0-14 | 15-44 | 45-64 | 65+ | Total |
| 1900 | 26,147,000 | 36,385,000 | 10,463,000 | 3,099,000 | 76,094,000 |
| 1950 | 40,808,000 | 67,749,000 | 30,764,000 | 12,362,000 | 151,683,000 |
| 2000 | 55,030,000 | 123,901,000 | 60,992,000 | 34,710,000 | 274,633,000 |

Table adapted from (Pine 2005)

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